Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
April 20, 2023

Administrator
Thief River Care Center
2001 Eastwood Drive
Thief River Falls, MN 56701

RE: CCN: 245252
Cycle Start Date: December 28, 2022

Dear Administrator:

On January 27, 2023, we notified you a remedy was imposed. On March 21, 2023 the Minnesota Department(s) of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of February 16, 2023.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective February 11, 2023 did not go into effect. (42 CFR 488.417 (b))

In our letter of January 11, 2023, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from February 11, 2023. This does not apply to or affect any previously imposed NATCEP loss.

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

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

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

April 20, 2023

Administrator
Thief River Care Center
2001 Eastwood Drive
Thief River Falls, MN 56701

Re: Reinspection Results
Event ID: 8R3E12

Dear Administrator:

On February 22, 2023 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on January 12, 2023. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

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

DEPARTMENT OF HEALTH

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January 27, 2023

Administrator
Thief River Care Center
2001 Eastwood Drive
Thief River Falls, MN 56701

RE: CCN: 245252
Cycle Start Date: December 28, 2022

Dear Administrator:

On January 11, 2023, we informed you that we may impose enforcement remedies.

On January 12, 2023, the Minnesota Department(s) of Health and Public Safety completed a survey and it has been determined that your facility is not in substantial compliance. Your facility was not in substantial compliance with the participation requirements and the conditions in your facility constituted **immediate jeopardy** to resident health or safety. The most serious deficiencies in your facility were found to be widespread deficiencies that constituted immediate jeopardy (Level L), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

REMOVAL OF IMMEDIATE JEOPARDY

On January 11, 2023, the situation of immediate jeopardy to potential health and safety cited at F880 was removed. However, continued non-compliance remains at the lower scope and severity of F.

Also on January 11, 2023, the situation of immediate jeopardy to potential health and safety cited at F886 was removed. However, continued non-compliance remains at the lower scope and severity of F.

REMEDIES

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

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

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective February 11, 2023.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective February 11, 2023. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective February 11, 2023.

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

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

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

NURSE AIDE TRAINING PROHIBITION

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

If you have not achieved substantial compliance by February 11, 2023 the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Thief River Care Center will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from February 11, 2023. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

ELECTRONIC PLAN OF CORRECTION (ePOC)

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

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

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

DEPARTMENT CONTACT

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

Jen Bahr, RN, Unit Supervisor
Bemidji District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
705 5th Street NW, Suite A
Bemidji, Minnesota 56601-2933
Email: Jennifer.bahr@state.mn.us
Office: (218) 308-2104 Mobile: (218) 368-3683

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by June 28, 2023 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 488.412 and § 488.456.

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

APPEAL RIGHTS

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

Steven.Delich@cms.hhs.gov

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

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

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with

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

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

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

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

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

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245252	A. BUILDING _____ B. WING _____	01/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THIEF RIVER CARE CENTER	2001 EASTWOOD DRIVE THIEF RIVER FALLS, MN 56701

(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 1/9/23 through 1/12/23, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) was conducted during a standard recertification survey. The facility was NOT in compliance. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulation has been attained	E 000		
E 041 SS=F	Hospital CAH and LTC Emergency Power CFR(s): 483.73(e) §482.15(e) Condition for Participation: (e) Emergency and standby power systems. The hospital must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section and in the policies and procedures plan set forth in paragraphs (b)(1)(i) and (ii) of this section. §483.73(e), §485.625(e), §485.542(e) (e) Emergency and standby power systems. The [LTC facility CAH and REH] must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section. §482.15(e)(1), §483.73(e)(1), §485.542(e)(1), §485.625(e)(1)	E 041		2/16/23

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

Electronically Signed | 02/06/2023

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

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E 041	Continued From page 1 Emergency generator location. The generator must be located in accordance with the location requirements found in the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5, and TIA 12-6), Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4), and NFPA 110, when a new structure is built or when an existing structure or building is renovated. 482.15(e)(2), §483.73(e)(2), §485.625(e)(2), §485.542(e)(2) Emergency generator inspection and testing. The [hospital, CAH and LTC facility] must implement the emergency power system inspection, testing, and [maintenance] requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code. 482.15(e)(3), §483.73(e)(3), §485.625(e)(3),§485.542(e)(2) Emergency generator fuel. [Hospitals, CAHs and LTC facilities] that maintain an onsite fuel source to power emergency generators must have a plan for how it will keep emergency power systems operational during the emergency, unless it evacuates. *[For hospitals at §482.15(h), LTC at §483.73(g), REHs at §485.542(g), and and CAHs §485.625(g):] The standards incorporated by reference in this section are approved for incorporation by reference by the Director of the Office of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may obtain the material from the sources listed below. You may	E 041		

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E 041	Continued From page 2 inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the Federal Register to announce the changes. (1) National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169, www.nfpa.org, 1.617.770.3000. (i) NFPA 99, Health Care Facilities Code, 2012 edition, issued August 11, 2011. (ii) Technical interim amendment (TIA) 12-2 to NFPA 99, issued August 11, 2011. (iii) TIA 12-3 to NFPA 99, issued August 9, 2012. (iv) TIA 12-4 to NFPA 99, issued March 7, 2013. (v) TIA 12-5 to NFPA 99, issued August 1, 2013. (vi) TIA 12-6 to NFPA 99, issued March 3, 2014. (vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011. (viii) TIA 12-1 to NFPA 101, issued August 11, 2011. (ix) TIA 12-2 to NFPA 101, issued October 30, 2012. (x) TIA 12-3 to NFPA 101, issued October 22, 2013. (xi) TIA 12-4 to NFPA 101, issued October 22, 2013. (xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009.. This REQUIREMENT is not met as evidenced by:	E 041		

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E 041	Continued From page 3 Based on interview and document review, the facility failed to test and inspect the generator per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.4.4.1.1.4, and NFPA 110 (2010 edition), Standard for Emergency and Standby Power Systems, section 8.4.1 and 8.4.2. This deficient practice had the potential to affect all residents currently residing in the facility. Findings include: On 1/10/23, between 9:30 a.m. and 12:30 p.m. the emergency generator maintenance and testing inspections were reviewed. The emergency generator maintenance and annual testing and generator inspections were not performed. The last available state annual inspection was 4/13/18. An interview with the maintenance director and administrator verified these deficient findings at the time of discovery.	E 041	1. An emergency generator contractor has been scheduled to complete the 3 year annual testing on 2/8/2023 to complete the load testing of the emergency generator. The environmental services director will maintain the documentation from the testing in the inspection folder and in the survey compliance binder. 2. The environmental service director was educated on the facility□s policy and the requirement for the emergency generator testing to be completed by a contracted vendor every three years. 3. A new form was created for the 3 year testing to be maintained in the emergency generator testing binder (With the weekly and monthly inspection checklists). The 3 year generator testing will be added to the safety committee agenda to ensure it is not missed. The administrator will verify the inspection will take place 2/8/23. The same contractor was scheduled for January, 2026.	

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F 000	INITIAL COMMENTS On 1/9/23, through 1/12/23, a standard recertification survey was conducted at your facility. Complaint investigations were also conducted. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaint was found to be SUBSTANTIATED H52527244C (MN89806); however, no deficiencies were cited due to actions implemented by the facility prior to survey: The following complaint was found to be UNSUBSTANTIATED: H52527245C (MN87187). The survey resulted in an Immediate Jeopardy (IJ) to resident life and safety at F880: Based on observation, interview and document review the facility failed to ensure 5 of 5 employees, (licensed practical nurse (LPN)-A, dietary aide (DA)-D, activity aide (AA)-C, nursing assistant (NA)-D and LPN-B) were appropriately cleared to return to work following reports of potential symptoms of COVID-19; failed to initate contact tracing or facility wide testing for COVID-19 following potential exposure from a staff who tested positive for COVID-19; failed to ensure 3 of 53 residents (R108, R29, R41) were isolated while presenting with symptoms of COVID-19; and failed to utilize appropriate protective equipment for 2 of 3 residents (R41, R50) when they were placed in isolation. In addition, the facility failed to ensure twelve employees (cook (CK)-A, activity director (AD)-A, DA-B, the director of nursing (DON), DA-C, assistant dietary manager (ADM)-A, DA-B, registered nurse	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		02/06/2023

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

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F 000	Continued From page 1 (RN)-D, DA-D, NA-C, NA-A,NA-B) who were out ill with potentially communicable illness' were cleared to return to work: failed to to track resident symptoms of infection and implement an ongoing analysis of collected data to ensure patterns and trends were identified and acted upon to reduce the risk of disease spread within the facility as recommended by the Centers for Disease Control (CDC) guidance to prevent/or minimize the transmission of COVID-19. This resulted in a system wide failure in infection control procedures to prevent the spread of illness within the facility to vulnerable residents and the staff of the facility and resulted in an immediate jeopardy (IJ) which placed all 54 residents at a high likelihood to for serious illness and/or death by contracting a communicable disease, including but not limited to COVID-19. The administrator and DON were notified of the IJ on 1/11/23, at 2:00 p.m. The IJ was removed on 1/12/23, at 3:00 p.m. when the facility implemented actions to reduce/prevent the spread of illness, including COVID-19. The survey resulted in an IJ to resident life and safety at F886: Based on observation, interview and document review the facility failed to ensure 5 of 5 employees, (licensed practical nurse (LPN)-A, dietary aide (DA)-D, activity aide (AA)-C, nursing assistant (NA)-D and LPN-B) were appropriately cleared to return to work following reports of potential symptoms of COVID-19; failed to initate contact tracing or facility wide testing for COVID-19 following potential exposure from a staff who tested positive for COVID-19; failed to ensure 3 of 53 residents (R108, R29, R41) were isolated while presenting with symptoms of COVID-19; and failed to utilize appropriate protective equipment for 2 of 3	F 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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THIEF RIVER CARE CENTER	2001 EASTWOOD DRIVE THIEF RIVER FALLS, MN 56701

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F 000	Continued From page 2 residents (R41, R50) when they were placed in isolation. In addition, the facility failed to ensure twelve employees (cook (CK)-A, activity director (AD)-A, DA-B, the director of nursing (DON), DA-C, assistant dietary manager (ADM)-A, DA-B, registered nurse (RN)-D, DA-D, NA-C, NA-A,NA-B) who were out ill with potentially communicable illness' were cleared to return to work: failed to to track resident symptoms of infection and implement an ongoing analysis of collected data to ensure patterns and trends were identified and acted upon to reduce the risk of disease spread within the facility as recommended by the Centers for Disease Control (CDC) guidance to prevent/or minimize the transmission of COVID-19. This resulted in a system wide failure in infection control procedures to prevent the spread of illness within the facility to vulnerable residents and the staff of the facility and resulted in an IJ which placed all 54 residents at a high likelihood to for serious illness and/or death by contracting a communicable disease, including but not limited to COVID-19. The administrator and (DON) were notified of the IJ on 1/10/23, at 2:00 p.m. The IJ was removed on 1/11/23, at 3:00 p.m. when the facility implemented interventions to ensure all staff would be tested according to CDC guidelines. 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	F 000		

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F 000	Continued From page 3 validate that substantial compliance with the regulations has been attained.	F 000		
F 676 SS=D	Activities Daily Living (ADLs)/Mntn Abilities CFR(s): 483.24(a)(1)(b)(1)-(5)(i)-(iii) §483.24(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that: §483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section ... §483.24(b) Activities of daily living. The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living: §483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care, §483.24(b)(2) Mobility-transfer and ambulation, including walking, §483.24(b)(3) Elimination-toileting, §483.24(b)(4) Dining-eating, including meals and snacks, §483.24(b)(5) Communication, including	F 676		2/16/23

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F 676	Continued From page 4 (i) Speech, (ii) Language, (iii) Other functional communication systems. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to assist with ambulation for 1 of 3 residents (R47) reviewed for activities of daily living (ADL). Findings include: R47's quarterly Minimum Data Set (MDS) dated 12/15/22, identified R47 was cognitively intact and required assist of two staff for activities of daily living including transfers and did not walk in the room or corridor. R47 used a wheelchair for locomotion and had no functional limitation in range of motion of the upper or lower extremities. Diagnoses included acute transverse myelitis (a demyelinating disease of central nervous system), and transient ischemic attack (commonly called a mini-stroke; a temporary blockage of blood flow to the brain). R47's care plan dated 6/15/22, directed staff to ambulate R47 to the dining room with assist of 1 or 2 staff and walker three times daily. The facility undated nurse aide care sheet directed staff to walk R47 daily. R47's therapy orders were requested and not received. The facility Therapy Lite Assessment (Therapy and Restorative Minutes) Results dated 11/10/22 through 1/2/23, identified R47's total walking minutes and total walking distance was "0". The restorative therapy orders were requested but not provided.	F 676	The resident has the right to have choices and needs of activities of daily living (ADLs) addressed and provided. Residents are to be given appropriate treatment and services to maintain or improve their abilities to carry out ADLs. TRCC failed to provide ambulation for R47 on a daily basis. TRCC staff were to provide daily ambulation 1-3 times daily to R47 that didn't happen. To ensure that R47 was ambulated daily, TRCC's contracted therapy services with Big Stone Therapy reviewed R47 restorative program and identified opportunities to provide ambulation once daily with both restorative aides, CNAs, and nursing staff by providing education on mobility for R47 for 1-2 assist. Residents on the restorative program have the potential to have gaps in their ADLs. The IDT, therapy contractor, and nursing will assess all residents to see if they have the potential to participate in the restorative program. Appropriate therapy plans will be developed to match the frequency that staff permits for residents to participate in the restorative program. Interventions will be put in place depending on the findings of the assessment and care plans will be updated.	

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F 676	Continued From page 5 During interview on 1/9/23, at 1:44 p.m. R47 stated she was recently discharged from therapy and wanted staff to walk with her to lunch. R47 stated the last time she walked was on 1/6/22. During interview on 1/12/23, at 12:23 p.m. the physical therapist (PT) stated when R47 was discharged from therapy, orders were written for nursing staff to ambulate R47 to meals. The orders were written for nursing staff to complete the task because she knew the restorative nurses were not always working. The PT stated the nursing staff knew and should be walking R47. During interview on 1/12/23, at 1:40 p.m. nursing assistant (NA)-B stated staff were supposed to walk with R47 every day to lunch. NA-B did not walk R47 because the resident was not on her care group. During interview on 1/12/23, at 1:51 p.m. NA-G stated R47 was on her care group and did walk a few steps to and from the bed and wheelchair but did not walk to the bathroom or elsewhere in the room or outside of her room. It was on the care sheet to walk R47 every day but did not identify the frequency or distance and R47 did not ask, nor had she offered to walk R47 farther. During interview on 1/12/23, 2:14 p.m. NA-I stated R47 wanted to walk to get stronger and the last time NA-I walked with R47 was on 1/6/23, to the dining room for evening meal. During interview on 1/12/23, at 2:19 p.m. registered nurse (RN)-A stated she or another staff updated resident care plans and NA care sheets. Nursing staff were aware they were	F 676	All clinical staff will be re-educated on carrying out ADL activities in alignment of the restorative care program by Big Stone Therapy, and review plan of care. The findings on the assessments, interventions, and care plans will also be part of the education to be held on 2/10/23 The DON or designee will monitor if interventions, care plans, and documentation are being followed and if residents are participating in the restorative program. Random interviews with residents will also take place. This will be done 3x/week for four weeks, 2x/week for four weeks and then 1x/week for 4 weeks and then monthly. Results will be brought to IDT and Quarter 2, 2023 QAPI for recommendations for ongoing monitoring	

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F 676	Continued From page 6 supposed to walk R47 to meals. RN-A stated she expected staff to ambulate R47 as ordered by therapy and per the NA care sheet. During interview on 1/12/23, at 3:52 p.m. the director of nursing (DON) stated R47 recently was discharged from therapy with orders for staff to ambulate resident to meals. Staff was supposed to ambulate resident 1 to 3 times per day and she expected staff to complete the task. The facility's undated Walk to Dine Ambulation Program identified the program to promote a more homelike and enhanced dining experience for residents, meanwhile maintaining their strength and ambulation abilities. The program included resident encouragement to walk, staff monitoring of distance and/or time walked, monitoring participation and if declined, offering another time during the day.	F 676		
F 684 SS=G	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility to comprehensively assess, develop interventions and ensure consistent clinical monitoring was completed for 3 of 3	F 684	The resident has the right to have assessments when their condition changes and have needs addressed and provided. Residents are to be given	2/16/23

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F 684	Continued From page 7 residents (R53, R36, R4) who had experienced a change in condition. his resulted in actual harm for R53, who was hospitalized with sepsis and expired. Findings include: R53's quarterly Minimum Data Set (MDS) dated 8/9/22, identified R53 was cognitively intact, diagnosis included diabetes mellitus type 2, and required assist with activities of daily living (ADL's). R53's undated face sheet, identified diagnoses including history of clostridium difficile (C.diff - an infection in the colon which symptoms including diarrhea, belly pain and fever), diarrhea and nausea with vomiting. R53's care plan dated 4/26/22, directed staff to monitor R53 for changes in abilities, report loose foul-smelling stools and to monitor stool consistency. R53's Medication Administration Record (MAR) dated 10/1/22 through 10/30/22, identified the following: - Staff monitored R53's daily fluid restriction of 1200-1400 cc although the total daily fluid intake was not documented. - R53's daily weight was documented all but four days and ranged from 203 lbs on 10/1/22, to 207.5 lbs on 10/19/22. On 10/1/22 through 10/9/22, and on 10/11/22, R53's vital signs (blood pressure, pulse, oxygen saturation (O2 sats), respirations and temperature) was documented at least once daily. Staff had not documented vital signs from	F 684	appropriate treatment and services in accordance with professional standards of practice and person-centered care. R53 expired on 10/25/2022 R36 Family care conference with goals of care discussion for resident. Training for staff to add O2 standing orders in the hard chart and in Yardi (EMR system). Change of condition assessment completed to be completed. RN manager will notify primary care provider of concerns and further follow up. R4- Hospice has since discharged the resident. Chart audit completed. Noted verification of hospice orders for Lasix but discrepancy between start dates and follow up noted. Reached out to hospice agency to clarify. Refining communication with hospice to utilize TRCC EMR system. Complete change of condition assessment and report out to primary care provider any concerns. All residents have the potential for this to happen to them. Nurse Managers, DON and or designee will review any resident with potential for change of condition by chart review and assessments to see if any change of conditions were missed. If any are found the nurse manager will conduct assessments and update family, physician, and staff with any changes with their care. TRCC will conduct training for all clinical staff on hospice residents and	

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F 684	Continued From page 8 10/9/22, 10/10/22, or 10/12/22 through 10/20/22. 10/1/22 evening shift: 124/86, R20, O2 sats 97% RA, P88, T 97.7F 10/2/22 evening shift: 105/63, R20, 99% RA, P88, T 98.6F 10/3/22 evening shift: 94/72, morning shift: 130/66, R20, 99% RA, P 97, T 97.5F, 10/4/22 evening shift: 141/88, R20,99% RA, P 92, T 97.2F, 10/5/22 evening shift: 125/76. R20, 99% RA, P113, T 97.8F, 10/6/22 evening shift 112/80. R20, 93% RA, P93, T 98.2F, 10/7/22 evening shift 121/64, R18, 91% RA, P 100, T 97.7F, 10/8/22 evening shift 115/71, R20, 97% RA, P84, T 97.9F, 10/11/22 morning shift: 130/84, other VS not documented - R53's blood pressure was not documented on 10/9/22, 10/10/22 or 10/12/22 through 10/20/22. - R53's Respirations were not documented from 10/9/22 through 10/20/22. - R53's O2 sats were not documented from 10/9/22 through 10/20/22 - R53's pulse or temperature were not documented from 10/9/22 through 10/20/22. - Medication(s) including Loperamide (medication used to decrease the frequency of diarrhea) as needed four times daily was administered and documented as not effective on 10/5/22 and 10/6/22; administered with no effectiveness documented on 10/8/22; and administered and documented as effective on 10/11/22, 10/14/22,	F 684	assessments/care. Documentation for change of condition parameters will be provided to all LPNs and RNs. Verify weekly weights order in the EMR for each resident. Verify the weekly weight task carries over to the EMR care stream and NAR sheet. The DON or designee will monitor residents with change of conditions for assessments, progress notes, provider/family notifications, and interventions. Results will be brought to IDT and Quarter 2, 2023 QAPI for recommendations for ongoing monitoring. Audits will be completed with 2 random residents weekly for 6 weeks and then 1 resident randomly for 6 weeks.	

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F 684	Continued From page 9 10/15/22. - Gastrointestinal (GI) distress including nausea, vomiting or abdominal pain was documented on 10/11/22, 10/14/22, and 10/15/22. Specific symptom(s), severity or frequency were not documented. - Body aches or headaches on 10/6/22, 10/10/22, 10/14/22, and 10/15/22 were documented but specific symptom(s) were not. R53's pain rating was documented on 10/14/22 as #2/10, and on 10/15/22 was #5/10. R53 had received Acetaminophen 650 mg on 10/14/22 and 10/15/22. R53's Progress Notes dated 10/1/22 through 10/25/22, included the following: - On 10/6/22, R53 requested imodium for loose stools. Effectiveness was not documented. - On 10/11/22, R53 complained of sore throat, feeling tired and not able to smell very good. R53 was afebrile and had a negative rapid COVID test. - On 10/20/22, at 5:00 a.m. R53 had a low blood sugar of 31. Snacks were provided, and blood sugar recheck at 5:45 a.m. was 145. - On 10/20/22, at 2:05 p.m. note stating res is being transferred to hospital with diagnosis of sepsis. - On 10/20/22, at 2:06 p.m. change of condition note documented stating R53 was in the dining room for breakfast, then went back to room and resident started complaining of not feeling well. Vitals sign's were completed showing a BP: 100/83. R53 was having a difficult time with formulating words and sentences and had complaints of chest pain. Ambulance was called and R53 sent to the emergency department (ED).	F 684		

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F 684	Continued From page 10 R53's emergency department (ED) record dated 10/20/22, identified R53 presented to the ED for evaluation of increased fatigue and lethargy. The ED medical doctor (ED MD) identified R53 was ill-appearing, toxic appearing, was tachycardic with heart rate of 110-120, and shallow respirations at 30. Treatments included intravenous (IV) fluids, Levophed (IV medication used to treat life-threatening low blood pressure), panculture (testing of the blood, urine, sputum, or stool to identify infection), and IV antibiotics. The final diagnoses included sepsis due to unspecified organism, unspecified whether acute organ dysfunction present and the plan had been to transfer R53 to another facility for critical care management. R53's hospital progress notes identified the following: - 10/21/22, R53 presented to the ED due to feeling weak, lethargic, and decreased blood pressure. R53 had diarrhea for about a week, dysuria (painful urination), and abdominal pain. There was abnormal lab work and CT (medical imaging tests that take pictures of selected areas inside the body) scans. Diagnoses included septic shock due to a combination of UTI and colitis as well as acute kidney injury, anemia, low potassium, and low magnesium. At 6:25 p.m. the provider addend the progress note and included an additional diagnosis of acute respiratory failure with treatment including 12 liters of oxygen, additional antibiotic for potential atypical pneumonia and one dose of Lasix (medication used to prevent the body from absorbing too much salt and allows the salt to be passed out of the body through the urine). - 10/22/22, continue Levophed (medication used to treat life-threatening low blood pressure that	F 684		

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F 684	Continued From page 11 can occur with certain medical conditions), continue IV antibiotics and continue oral antibiotics. - 10/23/22, continue Levophed and antibiotics. At 5:34 p.m. the provider addend the progress note and identified throughout the day R53 had not produced any urine and required increased oxygen resulting in multiorgan system failure. - 10/24/22, R53 was non-responsive, on bipap (a type of ventilator that helps with breathing), not producing urine, was acidotic (a medical condition in which too much acid is produced in the body and/or the kidneys cannot remove enough acid through the urine. The medical condition may lead to confusion, shock or even death), had fluid overload and prognosis was very poor. The provider discussed with family and decided on comfort cares and no further escalation of treatment. R53's hospital discharge summary dated 10/25/22, identified R53 continued to decline and expired at 12:53 a.m. During interview on 1/12/23, at 7:43 p.m. registered nurse (RN)-A stated she was not familiar with R53. On 1/12/22, at 7:45 p.m. during joint interview with RN-C and RN-D, who is also the infection preventionist, RN-D stated R53 was sickly, was a drug seeker and always had something going on. RN-C stated R53 tested negative for COVID-19 on 10/11/22 and was monitored for GI issues on 10/11/22, 10/14/22, and 10/15/22. RN-C and RN-D stated staff should have further monitored and assessed R53 prior to going to the hospital. During interview on 1/12/23, at 8:02 p.m. nursing	F 684		

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F 684	Continued From page 12 assistant (NA)-E stated R53 had always been sick, had always complained of not feeling well and had diarrhea all the time. NA-E stated R53 had been confused the week before she went to the hospital. A few days prior to R53's transfer to the ED R53 became pale, yellowish in color, became weak and her ability declined from a 2-person stand-by-assist to a total mechanical lift. NA-E stated she reported R53's changes to the nurse. On 1/12/22, at 8:21 p.m. left a message requesting MD-A return call. During interview on 1/13/22, at 3:06 p.m. medical doctor (MD)-A stated R53 was a very complicated resident and had diagnoses including anemia, diabetes, thyroid disorder, and atrial fibrillation; all of which were stable at the time of R53's evaluation on 9/30/22. R53's exam had been non-specific (normal) and residents only symptoms were fatigue and feeling tired. When R53 was at baseline, R53 had been able to communicate her needs. MD-A stated she expected staff to assess R53, respond appropriately, and notify MD-A of any changes. MD-A stated she had been unable to find any communication (via fax, computer messages or phone calls) from the facility beginning after the 9/30/22 evaluation through the ED admit date of 10/20/22. MD-A stated she would expect the facility to notify herself or her nurse of any change in condition. - MD-A stated upon review of R53's emergency department (ED) note dated 10/20/22, R53 was hypertensive, tachycardic and was admitted to the hospital. The final diagnoses were Clostridioides difficile (C-diff) colitis (an infection	F 684		

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F 684	Continued From page 13 in the colon which symptoms including diarrhea, belly pain and fever) and septic shock (a life-threatening condition caused by an infection. Symptoms include low blood pressure, pale and cool arms and legs, chills, difficulty breathing, decreased urine output, mental confusion, and disorientation). MD-A stated R53 was admitted to the hospital and according to the hospital notes had declined quickly. Signs and symptoms of septic shock included any signs of infection, diarrhea, cellulitis, fever, tachycardia, an increase in blood pressure and then a drop in blood pressure. Further, MD-A stated the nurses should have assessed R53 and should have been able to tell something was wrong. R53's medical record did not identify comprehensive assessment(s) were completed after identification of R53's confusion, weakness, diarrhea and change in color, nor identify interventions implemented to stabilize R53's mental and physical status, or evidence of ongoing monitoring. Further, it was not evident the MD-A had been notified of the change in R53's cognition, mental status, or GI status. R36's quarterly Minimum Data Set (MDS) dated 11/3/22, identified R23 had moderate cognitive impairment, required supervision or setup for most activities of daily living (ADLs) and used a walker for mobility. R36's care plan dated 1/5/23, identified R36 had shortness of breath related to chronic obstructive pulmonary disease (COPD) and asthma and directed staff to monitor her shortness of breath and oxygen levels. R36 had short term memory problem and/or periods of confusion.	F 684		

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F 684	Continued From page 14 During observation and interview with R36 and family member (FM)-A on 1/9/23, at 12:10 p.m. R36 was sleeping soundly and did not respond to the knock on her door or her name being called. FM-A stated R36 had frequent periods where she was unresponsive and was unable to be aroused from sleep. R36 had frequent low oxygen saturations and was requiring oxygen more and more frequently. R36's Physician Orders dated 1/12/23, identified R36 received Ipratropium bromide nasal solution, xopenex inhaler, and Trelegy Ellipta for respiratory failure and COPD. R36 also received Xarelto (a medication to prevent blood clots). The physician orders did not identify the use of oxygen. R36's progress notes identified the following: -12/1/22, R36 felt weak and complained of no strength. She fell on to her left arm. Was alert and orientated and assisted up with assist of two staff. The doctor was notified of the fall. -12/11/22, R36 was confused and wandered into another resident's room. -12/16/22, R36 reported she had fallen off her toilet the day before and hit her head. R36 stated she had gotten herself up and did not notify anyone at the time of her fall. -12/17/22, R36's physician was notified of her reported fall. Orders were received to monitor her mental status. -12/18/22, R36 was very sleepy during the evening shift. Staff will continue to monitor for COVID-19 symptoms. Oxygen saturation was 92% on room air. -12/23/22, R36 was very sleepy through out the evening shift. FM-A requested staff assess her	F 684		

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F 684	Continued From page 15 vital signs. R36 oxygen saturation was 92% on room air. -12/27/22, R36 was on leave of absence (LOA) with FM-A. FM-A called the facility at 12:00 p.m. and again 2:30 p.m. to report he was unable to awaken R36. He was told to take R36 to her physician to be evaluated. -12/27/22, R36 went by ambulance while on LOA with family. Returned to the facility at 7:00 p.m. Direction to follow up with primary physician with no new orders. Will continue to monitor. -1/7/23, FM-A requested staff to assess R36 vital signs. Vital signs were taken and oxygen saturation was 80%. Oxygen was applied and oxygen saturation was rechecked 45 minutes later. Oxygen saturation was 89%. The medical record lacked evidence of further assessment for R36's unusual lethargy, confusion, abnormal oxygen saturations, and new utilization of PRN oxygen. During interview on 1/12/23, at 3:30 p.m. the director of nursing (DON) stated more assessment would be needed when R36 was difficult to arouse or when exhibits low oxygen saturations. The DON would expect further assessment and vital signs as well as report to next shift for ongoing assessments. R4's significant change MDS dated 10/26/22, identified R4 had moderate cognitive impairment, received antipsychotic, antianxiety and antidepressant medications on a daily basis, and required extensive assistance to complete activities of daily living (ADLs). The MDS outlined a section to record R4's mood. R4 was unable to be interviewed, however, staff assessment of R4's mood severity scored 3, as minimal. No	F 684		

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F 684	Continued From page 16	F 684		

hallucinations, rejection of care or behaviors were recorded and no change in R4's mood and behavior had occurred since her last assessment.

During interview on 1/9/23, at 2:40 p.m. R4 stated her feet were really swollen and she was concerned about it. She was not taking diuretic medications. The staff did have her elevate her feet in the afternoons. The swelling bothered her and her daughter had ordered some elastic stockings for her to try but they had not been delivered yet.

R4's progress notes identified the following:
-11/1/22, hospice note. Noted 3+ edema (swelling) to right lower leg and foot and 2+ to the left. Orders received to try Lasix (a diuretic medication to decrease fluid retention) 20 milligrams (mg) daily for seven days. Will reevaluate in seven days.
-12/9/22, hospice note. Gradual weight gain in past months. is back to her baseline weight of 190 to 200 pounds. R4 has significant edema to her feet. Encourage to elevate her legs.
-12/20/22, hospice note. R4 has 2-3+ edema to both feet. Encouraged to elevate during the day. She does have compression wraps on at this time.

R4's Physician Order Review, dated 11/15/22, identified R4's current signed orders. These included medications: Lasix (a diuretic medication) 20 mg every day for 5 days with start date 11/11/22 and end date 11/15/22, for localized edema.

R4's most recent Physician Progress Note, dated 11/15/22, identified the current visit was for medication recheck. The progress note lacked

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F 684	Continued From page 17 evidence R4's diuretic medication and edema had been addressed, or if the physician was aware the medication ordered for five days ended 11/15/22, with need for further evaluation. R4's weights were reviewed 10/1/22 through 1/10/23 and indicated the following: -10/14/22, R4's weight was 200 pounds. -10/26/22, R4's weight was 186 pounds. -11/23/22, R4's weight was 181.8 pounds. -12/4/22, R4's weight was 192 pounds. -1/4/23, R4's weight was 198 pounds -1/10/23, R4's weight was 182 pounds. ' The recorded weights identified R4 had a significant weight gain of 5% in less than a two week period between 11/23/22 and 12/4/22. R4's diuretic medication was ordered 11/11/22, with end date of 11/15/22, however, the medical record lacked evidence R4's weight gain was assessed after the discontinuation of the medication. When interviewed on 1/12/23, at 11:50 a.m. registered nurse (RN)-G stated the physician came to the facility to see patients. Medications were discussed verbally on rounds. R4 did have Lasix ordered for 5 days as recommended by hospice, as R4 had developed 2-3+ pedal edema in her lower extremities. The medication was for a limited time and then would be reevaluated. Staff did try to have R4 lie in a recliner with her feet elevated in the afternoon as an intervention for her edema. She was not aware R4 had a weight gain after the diuretic was stopped. The staff obtained the resident weights on their bath days but had difficulty with putting the information in the electronic medical record, so RN-G had to rely on staff verbal reports if they noticed resident	F 684		

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F 684	Continued From page 18 weight gains or losses. The unit has been actively weighing all the residents this week to obtain current weights and getting them documented in to the each residents medical records. RN-G had not done any type of assessment for R4 when her diuretic was discontinued because R4 was a hospice patient and she felt the hospice nurse should have assessed R4. R4's ten pound weight gain was not reported by the nursing assistants who did the weights and because they had not tracked resident weights in the computer the significant weight gain was missed. RN-G was not aware R4 had gained ten pounds in the two weeks after discontinuing her diuretic, but thought it could have been due to her increased appetite. When interviewed on 1/12/23, at 3:15 p.m. the DON stated when a resident was prescribed a diuretic medication she would like to see their weight come down and watch their fluid intake. The DON remembered R4 had been pretty fluffy and hospice was trying to get some of the fluid off for comfort. Staff would need to assess weights to find out if the diuretic ordered was effective and weights should be done weekly. The DON did not feel a ten pound weight gain in a two week period could be attributed to appetite alone. Assessments were expected to be conducted when needed, regardless if the resident was under hospice care. A policy on assessing for a change of condition was requested and not provided. The facility's Weight Monitoring Program policy dated 1/18/21, identified the purpose was to provide guidance to staff for monitoring weights to maintain or improve the overall health of	F 684		

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F 684	Continued From page 19 residents. The policy defined a medically significant weight gain as a weight gain of 5 or more pounds within one week could indicate a change in health status per the plan of care (i.e. diuretics, cortcosteroids, etc). Staff were directed to weigh residents weekly, as needed, or as ordered by the physician. Weight data would be assessed, tracked and entered into the electronic health record weekly. The physician would be contacted for any resident with a medically significant weight gain of 5 pounds or more.	F 684		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the	F 692	The resident has the right to have weight	2/16/23

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F 692	Continued From page 20 facility failed to implement and complete routine weight monitoring to ensure caloric needs were being met to prevent weight loss and promote health and failed to complete a comprehensive nutritional assessment for 1 of 1 resident (R36) reviewed with significant weight loss. Findings include: R36's quarterly Minimum Data Set (MDS) dated 11/3/22, identified R23 had moderate cognitive impairment, required supervision or setup for most activities of daily living (ADLs). R36's care plan dated 1/5/23, identified R36 had short term memory problem and/or periods of confusion. R36 was independent with eating. Staff were directed to monitor her weight weekly, and offer her food and drinks per her preference. On 1/9/23, at 12:10 p.m. R36 was observed sleeping soundly and did not respond to the knock on her door or her name being called. Family member (FM)-A stated R36 had frequent periods where she was unresponsive and was unable to be aroused from sleep. During continuous observation 7:00 a.m. through 8:40 a.m. on 1/11/23, R36 was observed sleeping soundly on her bed. Staff entered the room at 8:30 a.m. after knocking and placed R36's breakfast tray on her bedside table approximately four feet from the side of the bed and out of R36's reach. The unidentified staff made no attempt to awaken R36 to eat and left the room without speaking to R36. R36 remained sleeping on her bed and made no attempt to sit up or eat. R36's Physician Orders dated 1/12/23, identified	F 692	monitored and a comprehensive nutritional supplement to ensure caloric needs are being met. Residents are to be given appropriate treatment and services to maintain a healthy weight. R36 weight decreased from 126.8 lbs on 11/9/22 to 114 lbs on 1/10/23. R36 has frequent episodes of refusing meals and staying in bed for prolong periods of time. A care conference was held on 11/16/22 without mention of concerns for weight, nutritional intake, or episodes of prolonged periods in bed. The facility dietician will complete a comprehensive nutritional assessment. TRCC will reach out to family/PCP to discuss possible nutritional supplements. Will reweigh resident at next bath day and alert family and PCP changes. TRCC will implement a weekly weight committee to review all residents for weight gain/loss. Upon review, the weight committee will identify any residents with a 5 lbs weight change and refer to the facility dietician for a comprehensive nutritional assessment. All residents are at risk for nutritional and hydration deficit. Nurse Managers will review weights on all residents to see if others have had weight loss. Then they will inform physician, RD, and family if any are found. Nurse manager/dietary at care conferences will review weight gain/loss, nutritional status, preferences for waking for meals or having in room will be	

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F 692	Continued From page 21 R36 received a regular diet. A multi-vitamin was ordered daily, as well as vitamins C, D3 and an Occuvite vitamin daily. Nutritional supplements were not listed on R36's orders. R36's most recent dietary assessment dated 10/20/22, identified R36 was 64 inches in height and weight was 123.4 pounds from 5/25/22. Estimated daily nutrition needs were 56 grams of protein and 1290 calories. The dietary note identified R36 was at lower nutrition risk. R36's goal range for the next 90 days was 120-130 pounds. R36 was able to get adequate nutrition via meals and snacks offered. No new nutrition recommendations. Continue with current nutrition plan of care and contact dietitian with any nutritional concerns or questions. R36's progress notes identified the following: -12/7/22, R36 slept all shift. R36 did not eat supper as she was not alert enough. -12/9/22, care conference was held on 11/16/22. Reviewed information from the past quarter, including weights and meal intakes. No new concerns noted. Will continue with current plan of care and observe for changes. -12/31/22, R36 would not wake up to eat or take her medications. A record of R36 meal intakes was requested, however, was not received. R36's record of weights from May 25, 2022 through 1/10/22, identified the following: - 5/25/22, R36 weighed 123 pounds. -11/3/22, R36 weighed 125 pounds. -11/9/22, R36 weighed 126.8 pounds. -1/10/23, R36 weighed 114 pounds.	F 692	documented. These interventions will be care planned and communicated to clinical staff via care stream in EMR and NAR care sheets. Weekly weight review with MDS and Dietary manager to escalate to the dietician any weight gain/loss concerns. Weekly weight committee meetings will take place to audit 30 random residents and monitor for any weight loss/gain. The weight committee will reach out to the dietician for a comprehensive nutritional assessment. All clinical staff will be re-educated on completing weekly weights on bath days. Education on use of TRCC EMR system to enter weights will be completed. The DON or designee will monitor if weights, care conferences, care plans, and documentation are being followed. Random interviews with residents will also take place to see if weights are occurring. This will be done 3x/week for four weeks, 2x/week for four weeks and then 1x/week for weeks and then monthly. Results will be brought to IDT and Quarter 2, 2023 QAPI for recommendations for ongoing monitoring	

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F 692	Continued From page 22 R36's medical record lacked evidence of weekly weights as directed and did not identify any additional documentation. R36 demonstrated an unidentified weight loss of 12.8 pounds (10%) in the two months between 11/9/22 and 1/10/23. R36's medical record also lacked evidence of any nutritional assessments, evaluation of her oral intake at meals, or notification of the RD or R36's provider related to this unidentified significant weight loss. During interview on 1/12/23, at 11:50 a.m. RN-G stated weights were not being recorded in the resident's medical record. The bath aide obtained resident weights on their bath days but had trouble documenting in the new electronic medical record. The facility was currently educating the staff on how to enter data, like weights, into residents electronic records. RN-G just went by what was reported to her by the bath aide. RN-G was currently having the nursing assistants weigh all the residents in her unit so they could enter current weights in all the resident's medical records. When interviewed by telephone on 1/12/23, at 4:25 p.m. the registered dietitian (RD)-M stated he did come to the nursing facility periodically. RD-M completed resident dietary assessments based on the information he was given. When weights were not recorded RD-M emailed the resident's case manager for the information. When RD-M completed R36's dietary assessment on 10/5/22, he had notified the case manager via email he did not have a current weight, however did not receive a response. He completed the assessment using the weight he did have, from May 2022, five months previous. It was more limited but he wanted to do	F 692		

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F 692	Continued From page 23 something, rather than nothing. RD-M had her diagnoses list and her heights and the resident progress notes were reviewed to glean information. RD-M wondered if he should wait to do his assessment until he had a more current weight The weight from May was more limited but he wanted to do something and could not properly assess her nutritional status. RD-M did not complete the dietary section of resident MDS's and thought maybe RN-C completed them. RD-M only completed resident dietary assessments which were documented in the medical record under a progress note. R36's 10/5/22, progress note was the most recent dietary assessment completed and RD-M was unsure if any other dietary assessments were completed. He was not contacted further regarding concerns pertaining to R36. During interview on 1/12/13, at 4:40 p.m. the MDS coordinator, RN-C stated the dietitian wrote his dietary Cassessment in the resident's progress notes but did not complete any part of the MDS assessment or the Care Analysis Assessments (CAA). RN-C completed the dietary section of the MDS and the nutrition CAA. He had staff weigh R36 when he needed to enter her weight into the MDS, which was why R36 had weights documented on 11/3/22, and 11/9/22. During interview on 1/12/23, at 3:30 p.m. the director of nursing (DON) stated she would expect further assessment and vital signs as well as report to next shift for ongoing assessments. Resident weights should be done weekly. A policy for physician notification was requested, however, was not received.	F 692		

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F 692	Continued From page 24 The facility's Weight Monitoring Program policy dated 1/18/21, identified the purpose was to provide guidance to staff for monitoring weights to maintain or improve the overall health of residents. The policy defined a medically significant weight gain as a weight gain of 5 or more pounds within one week could indicate a change in health status per the plan of care (i.e. diuretics, corticosteroids, etc). Staff were directed to weigh residents weekly, as needed, or as ordered by the physician. Weight data would be assessed, tracked and entered into the electronic health record weekly. The physician would be contacted for any resident with a medically significant weight gain of 5 pounds or more.	F 692		
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical	F 756		2/16/23

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F 756	Continued From page 25 director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the consulting pharmacist (CP)-A failed to identify irregularities related to the use psychotropic medications for 1 of 5 residents (R4), the facility failed to ensure irregularities identified by CP-A were addressed timely by the medical provider for 1 of 5 residents (R4) and failed to ensure the medical provider documented a rationale for the extended use of an as needed (PRN) psychotropic medication for 2 of 3 residents (R20 R28) reviewed for unnecessary medications. Findings include: R4's significant change Minimum Data Set (MDS) dated 10/26/22, identified R4 had moderate cognitive impairment, consumed antipsychotic, antianxiety and antidepressant medications daily, and required extensive assistance to complete	F 756	The resident has the right to have medications, particularly psychotropic, reviewed by a pharmacist consultant. Residents have the right to have medication recommendations acted in a timely manner. Providers are to provide rationale for continuing medications with appropriate diagnoses. R4 had an order for Zyprexa that required clarification. Provider updated progress note to reflect order clarification of Zyprexa AM dose to 2.5mg po daily in morning. R20 Provider prescribing Ativan discontinued order on 1/31/23 due to lack of use.	

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F 756	Continued From page 26 activities of daily living (ADLs). The MDS outlined a section to record R4's mood. R4 was unable to be interviewed, however, staff assessment of R4's mood severity scored 3, as minimal. No hallucinations, rejection of care or behaviors were recorded and no change in R4's mood and behavior had occurred since her last assessment. R4's Physician Order Review, dated 9/20/22, identified R4's current signed orders. These included but was not limited to the following medication: Abilify (an antipsychotic medication) 2 milligrams (mg) by mouth (po) at bedtime, R4's Physician Progress Note, dated 10/18/22, identified R4 had a recent emergency room visit and had been given Zyprexa (antipsychotic medication). Staff reported R4 was like a different person when on the medication with improved mood and behavior. The physician indicated R4's Abilify would be discontinued and Zyprexa 5 milligrams at bedtime initiated. R4's Physician Order Review, dated 11/15/22, identified R4's current signed orders. These included medications but were not limited to: lorazepam (an antianxiety) 0.5 mg by mouth (po) every four hours as needed (PRN) with start date 10/19/22, and Zyprexa (an antipsychotic medication) 5 mg po at bedtime, with start date 10/18/22. The orders failed to identify an end date for the PRN lorazepam ordered, as required. R4's Pharmacy Summary Report dated 11/8/22, indicated irregularities were identified and to see report. The corresponding report titled Nursing Report for November 2022, directed nursing staff to address ASAP but no later than 7 days, R4's lorazepam 0.5 mg tablet. The report read PRN	F 756	R28 Provider prescribing Ativan documented 1/10/23 that PRN was needed to be continued for 6 months due to exit seeking behaviors. All residents may need irregularities in their medication regimens to be addressed. Review of the Drug Regimen Review policy by clinical staff and implementation of the process of managing the recommendations from West Pod to East Pod. Monthly review of psychotropic with PharmD and RN manager will take place with communication of review to primary care provider as needed. Other residents on a psychotropic medication scheduled or PRN will be audited for appropriate rationale and clear prescription directions. All clinical staff will be re-educated on Drug Regimen Review will take place at clinical team meeting on 2/10/23. Review of the process for sending out the DRR to primary care will be reviewed at this time. The DON or designee will monitor if DRR are completed and provider notifications/follow up is completed. This will be done 1x/week for 6 weeks, then monthly. Results will be brought to IDT and Quarter 2, 2023 QAPI for recommendations for ongoing monitoring	

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F 756	Continued From page 27 psychotropics were limited to a 14-day duration based on updated CMS guidance and rules, unless the prescriber chose to extend treatment by providing clinical rationale and documentation of intended duration. A recommendation was made to re-evaluate the appropriateness of continuing the current therapy. If treatment was to be continued add an appropriate stop date and document the duration of treatment and clinical evaluation/rationale of the resident. R4's most recent Physician Progress Note, dated 11/15/22, identified the current visit was for medication recheck. Staff reported R4 had been a little lethargic during the day and felt a decrease in her dose of Zyprexa would be beneficial. Staff reported R4's mood had been stable and no issues with mood swings, depression, or anxiety symptoms. R4 was tired during the day but had appropriate behaviors. The physician indicated R4's morning dose of Zyprexa would be decreased to 2.5 milligrams mg, however, R4 did not currently receive Zyprexa in the morning. R4's current order had been for Zyprexa 5 mg at bedtime only which was not changed or decreased. Further, the progress note lacked evidence the pharmacist recommendations made on 11/8/22, to evaluate R4's PRN lorazepam was brought to the physician's attention or addressed. R4's undated Face Sheet identified R4's current physician ordered medications. These included medications: Zyprexa 2.5 mg po in the morning, with start date 11/18/22, and Zyprexa 5 mg po at bedtime. R4 was currently receiving Zyprexa in the morning as well as her bedtime dosage. The medical record lacked documentation the physician had been contacted to confirm the increase to R4's Zyprexa by 2.5 mg daily was an	F 756		

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F 756	Continued From page 28 intentional increase in medication. R4's Pharmacy Summary Report dated 12/8/22, indicated no irregularities were identified, despite the previous month's recommendation regarding the PRN lorazepam had not yet been addressed and the recent conflicting increase of R4's antipsychotic medication Zyprexa. When interviewed on 1/12/22, at 11:50 a.m. registered nurse (RN)-G stated she had not received any pharmacy reports from the physician since September 2022. The pharmacy reports were physically brought over to the physician's office right after the CP's monthly visit and the physician would fax the signed forms to the facility after review. RN-G wished the process was more timely. The forms were brought to the physician office and the recommendations did not get addressed again until they were returned from the physician. At that time the nurse managers reviewed the forms to check if any medication or treatment changes were ordered. RN-G stated R4's pharmacy recommendations, as well as other residents, should be addressed in a more timely fashion. During interview on 1/12/23, at 1:36 p.m. CP-A stated he did not feel it was unusual for the physician's late response to his recommendations. The nursing staff was supposed to re-evaluate PRN psychotropic medications with the provider, for the required 14-day window. When a PRN psychotropic medication was first identified during monthly medication review, he would fill out a Consultant Pharmacist Medication Review form. CP-A filled out the form for R4 because the medication had a 14-day window and needed to be addressed.	F 756		

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F 756	Continued From page 29 CP-A did not typically reiterate previous recommendations month to month. CP-A remembered wondering about the increase with R4's Zyprexa but did not read the physician's progress note when the provider had initiated the increase. It was a small dose, so there was nothing to really trigger a recommendation from him. When interviewed on 1/12/23, at 3:15 p.m. the director of nursing (DON) stated the facility did not have a process to check if the physician had addressed monthly pharmacy recommendations. R20's significant change Minimum Data Set (MDS) dated 12/24/22, identified R20 had diagnoses that included major depressive disorder and generalized pain. R20 exhibited behaviors that included physical and verbal behaviors towards others and refusing cares. R20 received antianxiety medication 2 out of the 7 days of the assessment period. R20's physician orders dated 12/2/22, included an order for lorazepam (antianxiety, psychotropic medication) 1 mg by mouth two times per day as needed (PRN) due to disorientation, pain/anxiety from 12/2/22 to 3/20/23. R20's physician notes from 12/2/22 to 1/12/23, lacked documentation regarding R20's extended use of antianxiety medication and lacked documentation of contraindications for gradual dose reduction of lorazepam R20's Consultant Pharmacist's Medication	F 756		

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F 756	Continued From page 30 Review dated 12/8/22, identified R20 had an order for lorazepam 1 mg tablet 1 tablet by mouth twice daily PRN for anxiety. The pharmacist comments included: since this medication was used for a psychological condition and due to Centers for Medicare and Medicaid Services (CMS) guidelines, the PRN medication had to be re-evaluated within the first 14 days of starting. If the medication was to be continued a re-evaluation date was needed. On 12/20/22, the physician responded the medication was to be continued for 90 days. "Will have a routine visit in about 4 weeks". However, the form lack rationale/justification for continuation. R28's annual MDS dated 10/14/22, identified diagnoses that included dementia with behavioral disturbance, Alzheimer's disease, and paranoid personality disorder. R28 utilized antianxiety medications but did not exhibit behaviors during the assessment period. R28's Psychotropic Drug Use CAA dated 10/10/22, identified R28 was prescribed lorazepam 0.5 mg PRN daily due to a diagnoses of paranoid personality disorder. R28 did not utilize the medication during the assessment period. R28's physician orders dated 7/5/22, included an order for lorazepam 0.5 mg by mouth everyday PRN for anxiety from 7/5/22 to 7/10/23. Target behaviors: exit seeking, paranoid behaviors, confusion, being scared, and not sleeping. R28's physician notes from 7/6/22 to 12/17/22, lacked documentation regarding R28's extended use of PRN antianxiety medication and lacked documentation of contraindications for gradual	F 756		

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F 756	Continued From page 31 dose reduction of lorazepam. R28's Consultant Pharmacist's Medication Review dated 6/9/22, identified R28 had an order for lorazepam 0.5 mg tablet 1 tablet by mouth everyday PRN for anxiety. The pharmacist comments included: since this medication was used for a psychological condition and due to Centers for Medicare and Medicaid Services (CMS) guidelines, the PRN medication had to be re-evaluated within the first 14 days of starting. If the medication was to be continued a re-evaluation date was needed. On 6/21/22, the physician responded, "6 months". However, the form did not identify a justification for continued use. During an interview on 1/12/23, at 1:42 p.m. RN-A stated the interdisciplinary team (IDT) did not review PRN lorazepam administrations, documentation, nor physician progress notes prior to making GDR recommendations. The process was more of a discussion between the nurse manager and the consultant pharmacist than chart review to determine what was best for the resident. RN-A used to make sure the physician completed all documentation to ensure compliance with guidelines but the physician would not do it. Because of this, RN-A stated she gave up trying. However, RN-A had not brought this concern to administration to address. During a phone interview on 1/12/23, at 3:08 p.m. the consultant pharmacist stated he looked for the initial 14-day evaluation whenever a PRN psychotropic medication was started. Then, he would review if the resident was using the medication and how often. From there, if the resident had not used a medication for	F 756		

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F 756	Continued From page 32	F 756		

approximately 3 months, he would recommend the medication be discontinued. Sometimes, the consultant would review progress notes to make sure there was a rationale but the facility had implemented a new electronic medical record system, and "it was more of a process to look at progress notes". He usually visited with the nurse manager to determine a resident's chart included a rationale for use. During the IDT meeting, the team would review the residents who had MDS assessments that month; however, the team did not review administrations, documentation nor physician progress notes. The consultant pharmacist hoped the physician would provide a clear, concise documentation why a medication was ordered, but this was more of a nursing responsibility and his role was to review how often a medication was given. Once his recommendations were made, he did not review the following month to ensure it was addressed.

During an interview on 1/12/23, at 4:55 p.m. the director of nursing (DON) stated she was new to her role at the facility and was aware documentation for administration of a psychotropic medication needed to be more robust. She received emails with the pharmacist reviews, and they discussed potential GDR during IDT meetings she attended. Staff were expected to follow facility policy regarding documentation of non-pharmacological interventions attempted, what was effective or not and to determine patterns of use. The DON stated this information was needed to provide the IDT with the appropriate information to determine if the medication was an appropriate choice for the resident.

The facility policy Psychotropic Medications

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F 756	Continued From page 33 issued 10/1/15, identified physicians and other providers (nursing practitioners and physician assistants) would order psychotropic medications appropriately working with the interdisciplinary team to ensure appropriate use, evaluation, and monitoring. The policy further identified the consultant pharmacist would: 1. Monitor psychotropic drug use in the facility to ensure that medications were not used in excessive doses or for excessive duration, monthly basis. 2. Participate in the IDT quarterly review of residents on psychotropic medications. 3. Notify the physician and the nursing unit if a psychotropic medication was due for review. Additionally, the Physician would: 1. Order psychotropic medication only for the treatment of specific medical and/ or psychiatric conditions or when the medication meets the needs of the resident to alleviate significant distress for the resident not met by the use of non- pharmacologic approaches. 2. Document rationale and diagnosis for use and identify Target Behavior symptoms for the reason the medication is being used. 3. Document discussion with the resident and/or responsible party regarding the risk versus benefit of the use of these medications included in the discussion and documentation must be the presence of any black box warning or off label use of the medication affecting the prescribing of the medication to the resident. 4. Evaluate with the interdisciplinary team, effects, and side effects of psychoactive medications within one month of initiating, increasing, or decreasing dose and during routine visits thereafter. 5. Monitors the resident for lack of drug efficacy clinically and in discussions with the	F 756		

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F 756	Continued From page 34 interdisciplinary team within one month of initiating and during routine visits. 6. Attempt a gradual dose reduction (GDR) decrease or discontinuation of psychotropic medications after no more than 3 months unless clinically contraindicated. Gradual dose reduction must be attempted for 2 separate quarters (with at least one month between attempts). Gradual dose reduction must be attempted annually thereafter or as the resident's clinical condition warrants. 7. Review Sedative/ hypnotics quarterly for gradual dose reduction. GDR must be attempted quarterly unless clinically contraindicated. 8. New orders for PRN psychotropic medications will be time limited (i.e., times 2 weeks) and only for specific clearly documented circumstances. 9. Obtain psychiatric consultation as resident's clinical condition requires.	F 756		
F 758 SS=E	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs	F 758		2/16/23

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F 758	Continued From page 35 unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure a gradual dose reduction (GDR) was attempted and/or medical justification was provided to support an increase dosage of Zyprexa (an antipsychotic medication) for 1 of 5 residents (R4) reviewed and ensure as needed (PRN) psychotropic medication use was limited to	F 758	The resident has the right to be free from unneeded psychotropic medications or PRN medications. Residents have the right to not have PRNs given for staff convenience or without cause. Residents have the right to non-pharmacological interventions before use of PRN	

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F 758	Continued From page 36 14 days or medical justification was provided to support ongoing use for 1 of 5 residents (R4) who had PRN psychotropic medications ordered. The facility failed to provide evidence non-pharmacological interventions were provided prior to administration of as needed (PRN) psychotropic medication for 3 of 4 residents (R8, R28, R20). Findings include: R4's significant change Minimum Data Set (MDS) dated 10/26/22, identified R4 had moderate cognitive impairment, consumed antipsychotic, antianxiety and antidepressant medications on a daily basis, and required extensive assistance to complete activities of daily living (ADLs). The MDS outlined a section to record R4's mood. R4 was unable to be interviewed, however, staff assessment of R4's mood severity scored 3, as minimal. No hallucinations, rejection of care or behaviors were recorded and no change in R4's mood and behavior had occurred since her last assessment. R4's Physician Order Review, dated 9/20/22, identified R4's current signed orders. These included but were not limited to the following medication: Abilify (an antipsychotic medication) 2 milligrams (mg) by mouth (po) at bedtime, R4's Physician Progress Note, dated 10/18/22, identified R4 had a recent emergency room visit and had been given Zyprexa. Staff reported R4 was like a different person when on the medication with improved mood and behavior. The physician indicated R4's Abilify would be discontinued and Zyprexa 5 mg at bedtime initiated.	F 758	medications. Providers are to provide rationale for continuing any psychotropic medications with appropriate diagnoses. Providers are to provide rationale for continuation of any PRN medication every 14 days. R4 had an order for Zyprexa that needed clarification. Mills ARNP revised the order to read to start 2.5mg every am by mouth and continue 5mg every hs by mouth. R8 was prescribed a PRN antianxiety medication but did not carry a diagnoses or demonstrate behaviors that are consistent with needing the PRN, However, R8 was given the PRN medication on different occasions without documentation of behaviors or effectiveness of medications or non-pharmacological interventions. Comprehensive behavior assessment was completed with non-pharmacological interventions care planned. Staff was informed of the changes to care plan and what interventions could be utilized before using PRN medications. PharmD consultant and RN Managers reviewed medications on 1/19/23. Training for on going documentation of behaviors was completed for staff on 1/20/23. R20 received PRN medication without appropriate documentation of behaviors or response to PRN medications. Non-pharmacological interventions were not care planned or used at various times. Comprehensive behavior assessment was completed with non-pharmacological	

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F 758	Continued From page 37 R4's Pharmacy Summary Report dated 11/8/22, indicated irregularities were identified and to see report. The corresponding report titled Nursing Report for November 2022, directed nursing staff to address ASAP but no later than 7 days, R4's lorazepam 0.5 mg tablet. The report read PRN psychotropics were limited to a 14-day duration based on updated CMS guidance and rules, unless the prescriber chose to extend treatment by providing clinical rationale and documentation of intended duration. A recommendation was made to re-evaluate the appropriateness of continuing the current therapy. If treatment was to be continued add an appropriate stop date and document the duration of treatment and clinical evaluation/rationale of the resident. R4's Physician Order Review, dated 11/15/22, identified R4's current signed orders. These included but were not limited to the following medications: lorazepam (an antianxiety) 0.5 mg po every four hours PRN with start date 10/19/22, Zyprexa (an antipsychotic medication) 5 mg po at bedtime, with start date 10/18/22. The orders failed to identify an end date for the PRN lorazepam ordered, as required. R4's most recent Physician Progress Note, dated 11/15/22, identified the current visit was for medication recheck. Staff reported R4 had been a little lethargic during the day and felt a decrease in her daytime dose of Zyprexa would be beneficial. Staff reported R4's mood had been stable and no issues with mood swings, depression or anxiety symptoms. R4 was tired during the day but had appropriate behaviors. The physician indicated R4's morning dose of Zyprexa would be decreased to 2.5 mg, however,	F 758	interventions care planned. Staff was informed of the changes to care plan and what interventions could be utilized before using PRN medications. PharmD consultant and RN Managers reviewed medications on 1/19/23. Training for on going documentation of behaviors was completed for staff on 1/20/23. Resident was evaluated by mental health DNP and given medication management and diagnosis. R28 Comprehensive behavior assessment was completed with non-pharmacological interventions care planned. Staff was informed of the changes to care plan and what interventions could be utilized before using PRN medications. PharmD consultant and RN Managers reviewed medications on 1/19/23. Training for on going documentation of behaviors was completed for staff on 1/20/23. Any resident that may need psychotropic medication should have an evaluation by primary care or specialist provider face to face. TRCC has policy in place for psychotropic and PRN medication use in place. However, the process was not implemented. To ensure the process is implemented as designed, the following will take place: Use of the behavior tile in the EMR will be used to fully document behaviors and interventions. Comprehensive behavior assessment will be completed with non-pharmacological interventions care planned on any resident demonstrating behavior	

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F 758	Continued From page 38 R4 did not currently receive Zyprexa in the morning. R4's current order had been for Zyprexa 5 mg at bedtime only which was not changed or decreased. Further, the progress note lacked evidence the pharmacist recommendations made on 11/8/22, to evaluate R4's PRN lorazepam was brought to the physician's attention or addressed. R4's undated Face Sheet identified R4's current physician ordered medications. These included but were not limited to the following medications: Zyprexa 2.5 mg po in the morning, with start date 11/18/22, and Zyprexa 5 mg po at bedtime. R4 was currently receiving Zyprexa in the morning as well as her bedtime dosage. The medical record lacked documentation the physician had been contacted to confirm the increase to R4's Zyprexa by 2.5 mg daily was an intentional increase in medication. When interviewed on 1/12/23, at 11:50 a.m. registered nurse (RN)-G stated the physician came to the facility to see patients. Medications were discussed verbally on rounds. The physician had stopped R4's Abilify and started Zyprexa on 10/18/22. RN-G indicated she was unable to find documentation in R4's medical record to justify the increase in the Zyprexa in November and thought maybe the physician had noticed something with R4 that the facility staff had missed. RN-G reviewed the physician progress notes on 11/15/22, and verified R4's physician had dictated to decrease R4's Zyprexa, not increase the medication. RN-G had written the verbal order and transcribed the morning Zyprexa order to R4's medication administration record. RN-G indicated the nurses reviewed	F 758	concerns. Staff will be informed of the changes to care plan and what interventions could be utilized before using PRN medications. PharmD consultant and RN Managers will review psychotropic and PRN medications on a monthly bases. Training for on going documentation of behaviors was completed for staff on 1/20/23. Additional documentation on establishing patterns of behaviors and outcomes of intervention will be covered at clinical staff meeting on 2/10/23. Policy review for psychotropic medication use and PRN medication use will be covered at clinical staff meeting on 2/10/23. The DON or designee will monitor psychotropic medications, PRN medications and non-pharmacological interventions are being followed. Random observations and behavior and medication use audits for residents with psychotropic medications, PRN medications and behaviors will also take place to see if interventions as care planned are occurring. This will be done x 2 random residents/week for four weeks, x 1 random resident/week for four weeks then 1 random resident monthly. Results will be brought to IDT and Quarter 2, 2023 QAPI for recommendations for ongoing monitoring	

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F 758	Continued From page 39 resident behaviors quarterly by review of the nurse progress notes incidental charting and if a resident's behaviors changed it would be in the progress notes. RN-G was unable to find documentation to warrant an increase in R4's Zyprexa. RN-G stated she would review R4's increased Zyprexa dose next week when R4's physcian was at the facility for rounds. During telephone interview with the consulting pharmacist (CP)-A on 1/12/23, at 1:35 p.m. CP-A indicated it was not unusual for the medical provider to have a late response to his monthly recommendations. The nursing staff were suppose to evaluate his recommendations with the primary provider within 14 days. After that it could wait for 30 or 60 days for formal response documented by the physician. CP-A did not reiterate his former recommendations and it was just because of the 14 day window with the PRN psychotropic that he wanted his recommendations addressed for R4. CP-A had noted the increase Zyprexa in November, but it was a small dose and he had not read the physician progress notes and so had not addressed it during his monthly medication review. When interviewed on 1/12/23, at 3:15 p.m. the director of nursing (DON) stated she was aware behavior documentation in the facility's current electronic medical record system was a problem. The nurses were directed to do a weekly summary of behaviors and behavior audits. The documentation of behaviors would be needed before adjustment of resident medications. When R4's Zyprexa was increased, the nurse should have asked for an order clarification immediately.	F 758		

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F 758	Continued From page 40 R8's annual Minimum Data Set (MDS) dated 11/29/22, identified R8 had severe cognitive impairment and had diagnoses that included vascular dementia with behavioral disturbance. R8 utilized antianxiety (a type of psychotropic) medications but R8 did not exhibit behaviors during the assessment period. R8's Psychotropic Drug Use CAA dated 12/2/22, identified R8 utilized lorazepam (psychotropic medication used to treat anxiety) 0.5 milligram (mg) once daily as needed (PRN) after 2:00 p.m., if R8's scheduled dose of gabapentin (an anticonvulsant that was used with other medications to prevent and control seizures. It was also used to relieve nerve pain following shingles (a painful rash due to herpes zoster infection) in adults) did not help with target behaviors which included yelling, anxiety, refusing to eat, hitting at staff. No PRN doses were given during assessment period. R8's non-pharmacological interventions were as follows: 1:1, music, cinnamon toast, drink. Staff were directed to take things slow and speak softly to R8 during that time. R8 continued to have behaviors such as uncontrolled yelling which cannot be redirected and issues with bathing, hitting out at staff, and yelling. R8's care plan dated 1/4/23, identified R8 exhibited behaviors of yelling, hitting, and swearing. Staff were directed to use non-pharmacological interventions including: 1:1, music, cinnamon toast, food/drink, leave and reapproach. Staff were also directed to observe for changes and report. R8's undated, nursing assistant care sheet did	F 758		

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F 758	Continued From page 41 not identify R8 had any behaviors nor did it direct staff on R8's behavioral triggers or non-pharmacological interventions. R8's physician orders dated 3/2/22, included an order for lorazepam 0.5 mg by mouth once daily PRN from 3/22/22 to 2/2/23. Special instructions included: Never to be given before 1:00 p.m. dose of gabapentin. Utilize and document redirection interventions prior to giving lorazepam. R8's target behaviors included: yelling, banging on table, and hitting. R8's August 2022 Electronic Medication Administration Record (EMAR) identified R8 did not receive any PRN doses of lorazepam. R8's September 2022, EMAR identified the following: - On 9/5/22, at 3:48 p.m. R8 received 0.5 mg of lorazepam. The administration notes field identified the medication was administered due to "given as PRN". However, the notes did not identify any behaviors, or any non-pharmacological interventions attempted. Additionally, it identified the medication was not effective. - On 9/27/22, 4:17 p.m., R8 received 0.5 mg of lorazepam. The EMAR did not identify why the medication was administered nor non-pharmacological interventions were attempted prior to the administration. R8's October 2022, EMAR identified on 10/11/22, at 3:05 p.m. R8 received 0.5 mg of lorazepam. The EMAR did not identify why the medication was administered or if any non-pharmacological interventions were attempted prior to the administration.	F 758		

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F 758	Continued From page 42 R8's December 2022, EMAR identified on 12/5/22, at 11:57 a.m. R8 received 0.5 mg of lorazepam. The EMAR did not identify why the medication was administered nor non-pharmacological interventions were attempted prior to the administration. During an observation on 1/10/23, at 9:28 a.m. R8 was sitting in her wheelchair next to the medication cart. Licensed practical nurse (LPN)-C encouraged R8 to drink approximately 2 ounces (oz) of a supplement drink from a disposable plastic cup. LPN-C used a calm, reassuring voice. R8 drank the supplement drink, and no behaviors were exhibited. During an observation on 1/10/23, at 10:00 a.m. R8 sat at a table in the common area. R8 sat quietly and watched the other residents. Family member (FM)-A approached and greeted R8. R8 was calm and smiled. FM-A then assisted R8 to her room for a visit. During an interview on 1/11/23, at 10:20 a.m. nursing assistant (NA)-B stated when she worked with R8, R8 really didn't understand. R8 did not get mad or angry. R8 just didn't do anything when you asked her. NA-B did see R8 have behaviors in the morning once during morning cares. Staff just walked away and let R8 eat her breakfast, then R8 calmed down. The rest of the morning went fine. NA-B reiterated staff needed to stay calm and reapproach R8 when she was having a bad day. R8 was usually happy and smiling. R8 wasn't always able to make sense when she spoke, but she tried. During an interview on 1/11/23, at 5:19 p.m.	F 758		

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F 758	Continued From page 43 LPN-D stated R8's bath days were "really bad". R8 would yell and scream. Sometimes, R8 had to eat in the activity room because she was so upset. Staff never knew what R8 needed. Staff offered toileting or eating, but sometimes R8 just had to calm herself. These behaviors could last hours, minutes or not at all. LPN-D then stated R8 had an order for as needed lorazepam and LPN-D would speak with the other nurse and nursing assistants before giving it to make sure it was a good choice. LPN-D would then document all the non-pharmacological interventions staff had tried and would continue to monitor for effectiveness. However, LPN-D then stated she would forget to document in a progress note "most of the time". LPN-D would put a note in the EMAR when she administered the medication. For example, on 9/5/22, LPN-D stated she entered "for pain" on R8's lorazepam administration. LPN-D stated she had administered Tylenol as well because she "thought" R8 was having neck/shoulder pain and R8 wasn't able to tell her. R8 wouldn't calm down. However, LPN-D stated it had occurred four months prior and she could not identify what behaviors if any, R8 was exhibiting. LPN-D additionally could not identify what non-pharmacological interventions had been attempted prior to the lorazepam administration. LPN-D continued to state lorazepam was more for calming R8 down. Staff were not able to tell if it was pain or behaviors but if the Tylenol did not help R8's pain at least she would calm down. LPN-D then stated she knew she needed to do better documentation, but she was a new LPN and was learning every day. During an interview on 1/12/23, at 9:45 a.m. registered nurse (RN)-B stated behavior	F 758		

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F 758	Continued From page 44 monitoring needed to be documented on any resident that exhibited a behavior. Some common behaviors were yelling, hitting, and screaming. R8 did exhibit behaviors of yelling, screaming, and hitting. Staff were directed to provide cinnamon toast, distraction and sometimes she needed the quiet of her room. R8 also had a photo album that she liked to look at. However, sometimes the non-pharmacological interventions did not help, and she needed an as needed dose of lorazepam. However, lorazepam would only be given as a last resort when every other non-pharmacological intervention did not work. Staff were additionally directed to document the administration on the EMAR, document behaviors and interventions in the nursing progress notes, and document a follow up as well that identified if the medication was effective or not. During an interview on 1/12/23, at 1:29 p.m. RN-A stated R8 had scheduled lorazepam on her bath days, but sometimes bathing continued to be difficult for R8. R8 had an additional order for lorazepam 0.5 mg once daily PRN. Before this was to be given, staff were directed to provide non-pharmacological interventions such as cinnamon toast, minimal bath water, calm approaches, start with one nursing assistant and ask for help if needed, quiet places and 1:1. However, R8's exhibited behaviors and responses to non-pharmacological interventions were "all over the place". RN-A stated neither R8's EMAR, nor progress notes, identified why PRN medications were given nor did they identify what non-pharmacological interventions had been attempted prior to the administration. Staff were expected to document all interventions that were attempted in the nursing progress notes. Additionally, staff were expected to do a follow up	F 758		

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F 758	Continued From page 45 note that described the effectiveness of the medication. During an interview on 1/12/23, at 4:55 p.m. the director of nursing (DON) stated she had recently begun her role at the facility. She knew the interdisciplinary team (IDT) had a conversation about R8 and her medications because R8 yelled at night. The DON stated she needed to investigate to determine when R8 had received PRN lorazepam and why. Staff were expected to follow facility policy regarding documentation of non-pharmacological interventions attempted, what was effective or not and to determine patterns of use. The DON stated this information was needed to provide the IDT with the appropriate information to determine if the medication was an appropriate choice for R8. R28's annual MDS dated 10/4/22, identified a severe cognitive impairment and diagnoses that included dementia with behavioral disturbance, Alzheimer's disease, and paranoid personality disorder. R28 utilized antianxiety medications but did not exhibit behaviors during the assessment period. R28's Psychotropic Drug Use CAA dated 10/10/22, identified R28 was prescribed lorazepam 0.5 mg PRN daily due to a diagnoses of paranoid personality disorder. R28's target behaviors included: exiting seeking and paranoid behaviors. R28 did not utilize the medication during the assessment period. R28's care plan dated 12/29/22, identified R28 utilized antianxiety medication related to diagnosis of anxiety as exhibited by: exit seeking and wandering that was not redirectable. Staff	F 758		

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F 758	Continued From page 46 were directed to administer medications per order and observe for side effects, work with a psychiatric team, monitor mood and response to medications. R28's non-pharmacological interventions included: 1:1, offer food/drink and give a toy dog to distract. R28's undated, nursing assistant care sheet did identify R28 was an elopement risk but did not identify any other target behaviors nor directed staff on R28's behavioral triggers or non-pharmacological interventions. R28's physician orders dated 7/5/22, included an order for lorazepam 0.5 mg po everyday PRN anxiety from 7/5/22 to 7/10/23. Target behaviors: exit seeking, paranoid behaviors, confusion, being scared, and not sleeping. R28's September 2022 , EMAR identified the following: - On 9/4/22, at 1:22 a.m. R28 received 0.5 mg of lorazepam. R28's medical record did not identify why the medication was administered nor non-pharmacological interventions were attempted prior to the administration. - On 9/23/22, at 6:47 p.m. R28 received 0.5 mg of lorazepam. R28's medical record did not identify why the medication was administered nor non-pharmacological interventions were attempted prior to the administration. - On 9/30/22, at 7:31 p.m. R28 received 0.5 mg of lorazepam. R28's medical record did not identify why the medication was administered nor non-pharmacological interventions were attempted prior to the administration. R28's October 2022, EMAR identified R28 did not receive PRN lozepam	F 758		

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F 758	Continued From page 47 R28's November 2022, EMAR identified the following: - On 11/4/22, at 7:20 p.m. R28 received 0.5 mg of lorazepam. R28's medical record did not identify why the medication was administered nor non-pharmacological interventions were attempted prior to the administration. - On 11/5/22, at 7:26 p.m. R28 received 0.5 mg of lorazepam. R28's medical record did not identify why the medication was administered nor non-pharmacological interventions were attempted prior to the administration. - On 11/6/22, at 7:41 p.m. R28 received 0.5 mg of lorazepam. R28's medical record did not identify why the medication was administered nor non-pharmacological interventions were attempted prior to the administration. - On 11/9/22, at 4:04 a.m. R28 received 0.5 mg of lorazepam. R28's medical record did not identify why the medication was administered nor non-pharmacological interventions were attempted prior to the administration. - On 11/22/22, at 1:14 a.m. R28 received 0.5 mg of lorazepam. R28's medical record did not identify why the medication was administered nor non-pharmacological interventions were attempted prior to the administration. R28's December 2022, EMAR identified the following: - On 12/3/22, at 7:25 a.m. R28 received 0.5 mg of lorazepam. R28's medical record did not identify why the medication was administered nor non-pharmacological interventions were attempted prior to the administration. - On 12/4/22 at 7:26 a.m. R28 received 0.5 mg of lorazepam. R28's medical record did not identify why the medication was administered nor	F 758		

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F 758	Continued From page 48 non-pharmacological interventions were attempted prior to the administration. - On 12/12/22, at 7:24 a.m. R28 received 0.5 mg of lorazepam. R28's medical record did not identify why the medication was administered nor non-pharmacological interventions were attempted prior to the administration. - On 12/17/22, at 6:53 a.m. R28 received 0.5 mg of lorazepam. R28's medical record did not identify why the medication was administered nor non-pharmacological interventions were attempted prior to the administration. - On 12/20/22, at 3:24 a.m. R28 received 0.5 mg of lorazepam. R28's medical record did not identify why the medication was administered nor non-pharmacological interventions were attempted prior to the administration. - On 12/31/22 at 2:34 a.m. R28 received 0.5 mg of lorazepam. R28's medical record did not identify why the medication was administered nor non-pharmacological interventions were attempted prior to the administration. During an observation on 1/12/23, at 8:32 a.m. R28 was in the dining room. R28 was clean, well-groomed, and eating his breakfast. No behaviors were exhibited. During an interview on 1/12/23, at 9:48 a.m. RN-B stated R28 needed reorientation to the day of the week, time of day or where he was. Staff usually waited to give R28 lorazepam until the evening or night shift so R28 would get some sleep. R28 would often get up at night and eat snacks, but his blood sugar would be elevated in the morning. R28 could be restless and hard to redirect. R28 did wander but never entered other residents' rooms or attempted to hurt anyone. He would just have a lost look on his face.	F 758		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THIEF RIVER CARE CENTER	2001 EASTWOOD DRIVE THIEF RIVER FALLS, MN 56701

(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 758	Continued From page 49 During an interview on 1/12/23, at 1:29 p.m. RN-A stated neither R28's EMAR, nor progress notes identified why PRN medications were given nor did they identify what non-pharmacological interventions were attempted prior to the administration. During an interview on 1/12/23, at 4:55 p.m. DON stated staff were expected to follow facility policy regarding documentation of non-pharmacological interventions attempted, what was effective or not and to determine patterns of use. The DON stated this information was needed to provide the IDT with the appropriate information to determine if the medication was an appropriate choice for R28. R20's significant change MDS dated 12/24/22, identified R20 had no cognitive impairment and had diagnoses that included disorientation, major depression disorder, and amnesia. R20's Psychotropic Drug Use CAA dated 12/26/22, identified R20 was prescribed Melatonin 5 mg for insomnia. R20 reported sleeping "very little" during the night, documentation showed between 5-8 hours each night. R20 napped frequently throughout the day. R20 was prescribed duloxetine 20mg for depression. R20 reported feeling down/depressed and had chronic pain. R20 was very angry, swung out at staff, and refused staff to care for him. The CAA did not address R20's prescribed lorazepam 1 mg by mouth three times a day PRN. R20's care plan dated 12/28/22, identified R20 utilized antidepressant medication. R20's target	F 758		

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F 758	Continued From page 50 behaviors were refusal of care, hitting, yelling, swearing. Staff were directed to administer mediations per orders, monitor and document behaviors, complete assessments, make referrals as needed, meet with R20/family to address concerns, and offer activity. The care plan did not identify R20 was prescribed lorazepam PRN. R20's physician orders dated 12/2/22, included an order for lorazepam 1 mg by mouth two times per day PRN due to disorientation, pain/anxiety from 12/2/22 to 3/20/23. R20's December 2022 , EMAR identified the following: - On 12/3/22, at 7:57 a.m. R20 received 1 mg of lorazepam. R20's medical record did not identify why the medication was administered nor what non-pharmacological interventions were attempted prior to the administration. - On 12/3/22, at 8:56 p.m. R20 received 1 mg of lorazepam. R20's medical record did not identify why the medication was administered nor what non-pharmacological interventions were attempted prior to the administration. - On 12/4/22, at 9:19 a.m. R20 received 1 mg of lorazepam. R20's medical record did not identify why the medication was administered nor what non-pharmacological interventions were attempted prior to the administration. - On 12/4/22, at 10:59 p.m. R20 received 1 mg of lorazepam. R20's nursing progress note dated 12/4/22 at 10:59 p.m. identified R20 had received hydrocodone acetaminophen 5/325 mg at 8:00 a.m. and 8:00 p.m. for moderate pain in his left hip and lower extremities. R20 also received lorazepam PRN morning and evening for anxiety. This was effective in providing restful periods for	F 758		

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F 758	Continued From page 51 R20. However, the nursing progress note did not identify R20's exhibited behaviors nor the non-pharmacological interventions attempted prior to the administration. - On 12/5/22, at 9:30 a.m. R20 received 1 mg of lorazepam. R20's medical record did not identify why the medication was administered nor what non-pharmacological interventions were attempted prior to the administration. - On 12/6/22, at 4:29 a.m. R20 received 1 mg of lorazepam. R20's medical record did not identify why the medication was administered nor what non-pharmacological interventions were attempted prior to the administration. - On 12/7/22, at 7:28 p.m. R20 received 1 mg of lorazepam. R20's nursing progress note dated 12/7/2022, at 10:10 p.m. identified R20 was alert and oriented. R20's physician orders were updated with scheduled twice daily hydrocodone acetaminophen 10/325 mg for moderate pain in his left hip and lower extremity. Lorazepam 1 mg twice daily for anxiety. However, the nursing progress note did not identify R20's exhibited behaviors nor the non-pharmacological interventions attempted prior to the administration. - On 12/10/22, at 5:33 p.m. R20 received 1 mg of lorazepam. R20's nursing progress note dated 12/10/22, at 7:59 p.m. identified R20 was alert and oriented. Lorazepam 1 mg PRN for anxiety. However, the nursing progress note did not identify R20's exhibited behaviors nor the non-pharmacological interventions attempted prior to the administration. - On 12/21/22, at 7:41 a.m. R20 received 1 mg of lorazepam. R20's medical record did not identify why the medication was administered nor what non-pharmacological interventions were attempted prior to the administration.	F 758		

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F 758	Continued From page 52 - On 12/24/22, at 7:24 a.m. R20 received 1 mg of lorazepam. R20 received 1 mg of lorazepam. R20's medical record did not identify why the medication was administered nor what non-pharmacological interventions were attempted prior to the administration. - On 12/29/22, 11:17 a.m. R20 received 1 mg of lorazepam. R20 received 1 mg of lorazepam. R20's medical record did not identify why the medication was administered nor what non-pharmacological interventions were attempted prior to the administration. During an observation on 1/10/23, at 1:46 p.m. R20 was lying in bed with blankets covering to his neck. R20's eyes were closed and R20 was resting peacefully. During an observation on 1/12/23, at 8:00 a.m. NA-H entered R20's room and greeted R20. NA-H then asked R20 if he was ready to get up for the day. While NA-H began prepping for morning cares, she began speaking with R20 about his family, where they live and how the roads were that day. R20 stated it was hard for his kids to come, especially in winter when roads could be bad. NA-H then proceeded to assist R20 to dress for the day. NA-H gave verbal cues that allowed R20 to make choices, such as: can I help you roll to the other side? - At 8:08 a.m. R20 asked NA-H to just let him stay in bed because he was having pain. R20 stated sometimes you just need to lay still for a bit. NA-H assisted R20 to lie on his left side and covered him with a blanket. NA-H opened R20's window blinds, telling R20 he could watch the deer outside. NA-H ensured R20 had his call light and R20 told NA-H "thank you".	F 758		

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F 758	Continued From page 53 During an interview on 1/12/23, at 8:14 a.m. NA-H stated R20 could become very angry. R20's triggers included loud noises, tv, radio, and large groups of people talking. If people were talking in low voices around him, R20 would think they were talking about him. R20 would become angry if staff did not tell him what they were doing or not giving him options. NA-H then stated staff really needed to make it R20's idea to do something. Also, R20 liked to get dressed early and go back to bed to lie down, or he wouldn't cooperate with morning cares. When R20 did become angry, staff would just walk away and try again later. During an interview on 1/12/23, at 9:53 a.m. RN-B stated R20 was monitored for behaviors and had orders for lorazepam 1 mg twice daily PRN, but RN-B had never witnessed R20 receive lorazepam. During an interview on 1/12/23, at 1:42 p.m. RN-A stated neither R20's EMAR, nor progress notes, identified why PRN medications were given nor did they identify what non-pharmacological interventions had been attempted prior to the administration. During an interview on 1/12/23, at 4:55 p.m. DON stated staff were expected to follow facility policy regarding documentation of non-pharmacological interventions attempted, what was effective or not and to determine patterns of use. The DON stated this information was needed to provide the IDT with the appropriate information to determine if the medication was an appropriate choice for R20. The facility's Psychotropic Medications policy dated 10/1/15, identified the purpose was to	F 758		

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F 758	Continued From page 54 ensure the therapeutic use of and to minimize the risks associated with psychotropic medications. The facility would make every effort to comply with state and federal regulations related to the use of psychopharmacological medications to include regular review for continued need, appropriate dosage, side effects, risks and/or benefits. Efforts to reduce dosage or discontinue of psychopharmacological medications would be ongoing, as appropriate, for the clinical situation. New orders for PRN psychotropic medications would be time limited and only for specific clearly documented circumstances. The policy also identified physicians and other providers (nursing practitioners and physician assistants) would order psychotropic medications appropriately working with the interdisciplinary team to ensure appropriate use, evaluation, and monitoring. The policy directed nursing to: 1. Monitor psychotropic drug use daily, noting any adverse effects such as increased somnolence or functional decline. 2. Monitor for the presence of target behaviors on a daily basis, charting by exception (i.e., charting only when the behaviors are present). 3. Review the use of the medications with the physician and the interdisciplinary team on a quarterly basis to determine the continued presence of target behaviors and/or the presence of any adverse effects of the medication use. 4. Complete assessments on any resident on an antipsychotic medication, at least every 6 months, and changes would be reported to the physician. 5. Include specific target behaviors on the care plan.	F 758		
F 802 SS=F	Sufficient Dietary Support Personnel CFR(s): 483.60(a)(3)(b)	F 802		2/16/23

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F 802	Continued From page 55 §483.60(a) Staffing The facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.60(a)(3) Support staff. The facility must provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. §483.60(b) A member of the Food and Nutrition Services staff must participate on the interdisciplinary team as required in § 483.21(b)(2)(ii). This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure dietary staff had the appropriate competencies for obtaining dishwasher temperatures, to prevent potential cross-contamination which may result in foodborne illness. This had the potential to affect all 54 residents residing in the facility and staff who consumed food from the kitchen. Findings include: During the kitchen tour on 1/11/23, at 5:07 p.m. the dietary manager (DM) stated the dishwasher was recently serviced as the dishes were not drying fast enough. The DM stated the final rinse needed to reach 180 degrees Fahrenheit (F) or higher and the dishwasher was not reaching that	F 802	1. The facility created a policy and procedure for monitoring the gauges and temperature of each cycle and what to do if any cycle or gauge is not reaching the required temperature. The facility contracted with a service vendor to correct the issue related to the gauges not working reliably or consistently day to day. 2. All dietary staff have been educated on the policy and procedure effective 2/6/2023. New staff will be trained on the dishwasher policy in dietary department orientation. 3. The dietary manager will audit the dishwasher logs two times per week for 12 weeks to ensure staff are compliant with taking temperatures and ensuring	

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F 802	Continued From page 56 temperature (temp). There was a note attached to the dishwasher directing staff to check the temp after breakfast, after lunch and after dinner, however a temp log was not near the dishwasher. The DM stated she didn't know where the log was. During a joint interview with DM and the administrator on 1/11/23, at 5:45 p.m. the DM stated she had been working with the staff to check the temps three times daily, however staff were not completing the task due to staffing and competency issues. During interview on 1/12/23, at 7:07 a.m. CK-B stated all the dietary staff washed dishes. CK-B pointed to two gauges on the front of the machine and stated they were the only temps he would look at and would mark the temps on the paper log that was usually located next to the dishwasher, however he didn't know the purpose for logging the temps. CK-B pointed to the gauges towards the back and stated he did not know what the gauges were or what they were used for. CK-B was not aware of what the temp ranges should be, how often the temps should be checked or how to ensure the dishes were sanitized, however, CK-B stated he would tell the DM if there was a problem. CK-B stated he did not check the dishwasher temp and if the dishes looked clean and were hot, then they were clean. During interview on 1/12/23, at 7:11 a.m. dietary aide (DA)-E stated everyone was responsible for checking and marking the dishwasher temperatures, however, DA-E stated she was not familiar with the gauges on the dishwasher. If the dishes looked clean and were hot, then they were clean but did not know if the dishes were	F 802	temperatures meet required the requirements for each cycle. A designee based on position will audit the logs daily for 12 weeks.	

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F 802	Continued From page 57 sanitized. During follow up joint interview on 1/12/23, at 8:39 a.m. the DM stated staff should be checking and documenting the dishwasher temps on a log, but staff were not doing it. The administrator stated the staff did not have specific training related to the dishwasher including temperature expectations, frequency of temping, nor how to monitor the temp. During interview on 1/12/23, at 12:10 p.m. DA-F stated he would wash dirty dishes in the dishwasher but never checked the dishwasher temps, did not know how to check the temps, and was never instructed to do so. DA-F made sure the dishes were sanitized by making sure the detergent was full. The Dietary Aide Meeting minutes dated 11/26/21 indicated recording dish machine temps was discussed. The Dietary Aide Job Description dated 10/14/22, described the primary purpose of the job included performing dishwashing duties. Dietary staff training related to dishwasher temp monitoring was requested but was not provided.	F 802		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.	F 812		2/16/23

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F 812	Continued From page 58 (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure dietary staff were monitoring the dishwasher temperatures in 1 of 1 kitchen to prevent potential cross-contamination which may result in foodborne illness. This had potential to affect 54 residents residing in the facility and consumed food from the kitchen. Findings include: During the kitchen tour on 1/11/23, at 5:07 p.m. the dietary manager (DM) stated the dishwasher was recently serviced as the dishes were not drying fast enough. The final rinse needed to reach 180 degrees Fahrenheit (F) or higher and the dishwasher was not reaching that temperature. There was a note on the dishwasher directing staff to check the temperature after breakfast, after lunch and after dinner, however there was no temperature log near the dishwasher. The DM stated she didn't know where the log was. The DM stated if there were any problems with the equipment, she would tell	F 812	1. The facility created a policy and procedure for monitoring the gauges and temperature of each cycle and what to do if any cycle or gauge is not reaching the required temperature. The facility contracted with a service vendor to fix the gauges that were not working consistently day to day. On 2/3/23 the vendor determined the problem and corrected it. The work order will be kept in the survey compliance binder for evidence of correction. If the dishwasher is determined to not be reaching appropriate temperatures, the staff will alert the dietary manager immediately so a vendor can be called. 2. All dietary staff have been educated on the policy and procedure effective 2/6/2023. The staff will document the dishwasher temps 3 times per day. 3. The dietary manager or designee will complete a temperature audit of the dishwasher, using a disc to be placed inside the machine that will record the	

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F 812	Continued From page 59 the maintenance manager. Further, she was unable to find the test strips to check the dishwasher temperature. During observation on 1/11/23, at 5:07 p.m. after surveyor prompting, the DM ran a dish tray through the dishwasher and stated the rinse temperature was 180 F. During a joint interview with the DM and administrator on 1/11/23, at 5:45 p.m. the DM stated she did not have the dishwasher temperature logs and did not know when the last time the temperature were obtained. The DM was working with the staff to check the temperature three times daily, but the staff were not compliant with checking the temperature. If there was a concern, then staff were to fill out a form which then went to the maintenance manager. During interview on 1/11/23, at 6:02 p.m. the administrator stated the dishwasher booster was changed and tested good on 11/9/22, and was rechecked and working on 11/11/22. During interview on 1/12/23, at 7:07 a.m. CK-B stated all the dietary staff washed dishes. CK-B pointed to two gauges on the front of the machine and stated they were the only temperature he would look at and would mark the temperature on the paper log that was usually located next to the dishwasher, however he didn't know the purpose for logging the temperature. CK-B pointed to the gauges towards the back and stated he did not know what the gauges were or what they were used for. CK-B was not aware of what the temperature ranges should be, how often the temperature should be checked or how to ensure the dishes were sanitized, however, CK-B stated	F 812	temperature of the cycle to verify the temperature is meeting the requirements. This audit will be completed weekly for 12 weeks to ensure the dishwashing machine is working effectively.	

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F 812	Continued From page 60	F 812		

he would tell the DM if there was a problem. CK-B stated he did not check the dishwasher temperature and if the dishes looked clean and were hot, then they were clean.

During interview on 1/12/23, at 7:11 a.m. dietary aide (DA)-E stated everyone was responsible for checking and marking the dishwasher temperature, however, DA-E stated she didn't monitor any of the temperature and was not familiar with the gauges on the dishwasher. DA-E stated she did not know how to determine if the dishes were clean, and further stated if the dishes looked clean and were hot then they were clean but did not know if the dishes were sanitized.

During interview 1/12/23, at 7:35 a.m. after surveyor prompting, cook (CK)-B sent a tray through the dishwasher. CK-B did not attempt to check the rinse cycle temperature until prompted and then read the temperature from the two gauges on the front of the machine labeled wash tank and rinse tank. CK-B did not attempt to read the gauge in the back. After prompting, CK-B stated the gauge was hard to read. With further prompting, CK-B stated the gauge read 180 F. CK-B stated he didn't know what the gauges were for and had not been trained on how or why to read them. CK-B did not log the temperature anywhere.

Another joint interview with the administrator and the DM was conducted on 1/12/23, at 8:39 a.m. The DM stated staff should be checking and documenting the dishwasher temperature on a log, but staff were not doing it.

During interview on 1/12/23, at 12:10 p.m. DA-F

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F 812	Continued From page 61 stated he would wash dirty dishes in the dishwasher but never checked the dishwasher temperature, did not know how to check the temperatures, and was never instructed to do so. DA-F made sure the dishes were sanitized by making sure the detergent was full. Although, the dishwasher temperatures were within range on survey, the facility failed to ensure staff were following the facility process to check the dishwasher temperatures to ensure the dishwasher was running in a manner to sanitize the dishes. The Cleaning Dishes/Dish Machine policy dated 4/20/22, directed all flatware, dishware, serving dishes and cookware were to be cleaned, rinsed, and sanitized after each use. The dish machines were to be checked prior to meals to assure proper functioning and appropriate temperatures for cleaning and sanitizing. Staff were directed to follow the procedures for washing dishes including temperature verified and logged for each shift.	F 812		
F 867 SS=F	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input	F 867		2/16/23

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F 867	Continued From page 62 from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement. §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor performance indicators. §483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation. §483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events. §483.75(d) Program systematic analysis and systemic action. §483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained. §483.75(d)(2) The facility will develop and implement policies addressing:	F 867		

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F 867	Continued From page 63 (i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems; (ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and (iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained. §483.75(e) Program activities. §483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care. §483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility. §483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e). Improvement projects must include at least annually a project that focuses on high risk or	F 867		

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F 867	Continued From page 64 problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section. §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure its quality assessment and assurance (QAA)/Quality Assurance Process Improvement (QAPI) committee was effective in identifying and implementing appropriate action plans to correct quality deficiencies identified during the survey. The facility was aware of or should have been aware of as it was previously identified over previous surveys. This deficient practice had the potential to affect all 54 residents currently residing in the facility. Findings include: The Certification and Survey Provider Enhanced Reports (CASPER)-3 (assessment data is converted to quality measures (QM) to evaluate	F 867	The facility should have a process improvement program that monitors data and outcomes to better standards of care. The facility failed to ensure its quality assessment and assurance process improvement programs (QAA/QAPI). The facility should have been aware of the issues with its QAA/QAPI program previously identified over prior surveys. Revision of the QAPI program will include monthly meeting to discuss performance improvement projects, internal data (resident infections, staff illnesses, antibiotic utilization, therapy utilization, restorative program utilization, falls, and interventions implementation), performance around QIIP and PIPP,	

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F 867	Continued From page 65 nursing home's performance) dated 1/4/23, identified the following prior deficiencies by month and year: - F880, Infection Control was cited on 8/18 at a scope and severity of a D (isolated); 6/19 at a scope and severity at a D and on 8/21 at a scope and severity of a F (widespread) - F881, Antibiotic Stewardship Program was cited on 8/21, at a scope and severity of a F - F886, COVID-19 Testing-Residents and Staff was cited on 8/21, at a scope and severity of a F See also F880, Infection Prevention and Control: Based on observation, interview and document review the facility failed to ensure 5 of 5 employees, (licensed practical nurse (LPN)-A, dietary aide (DA)-D, activity aide (AA)-C, nursing assistant (NA)-D and LPN-B) were appropriately cleared to return to work following reports of potential symptoms of COVID-19; failed to initiate contact tracing or facility wide testing for COVID-19 following potential exposure from a staff who tested positive for COVID-19; failed to ensure 3 of 53 residents (R108, R29, R41) were isolated while presenting with symptoms of COVID-19; and failed to utilize appropriate protective equipment for 2 of 3 residents (R41, R50) when they were placed in isolation. In addition, the facility failed to ensure twelve employees (cook (CK)-A, activity director (AD)-A, DA-B, the director of nursing (DON), DA-C, assistant dietary manager (ADM)-A, DA-B, registered nurse (RN)-D, DA-D, NA-C, NA-A,NA-B) who were out ill with potentially communicable illness' were cleared to return to work: failed to to track resident symptoms of infection and implement an ongoing analysis of collected data to ensure patterns and trends were identified and acted upon to reduce the risk of	F 867	audits from EVS and Dietary. Additionally, audit reports from behavior management, psychotropic medication and PRN utilization, hospitalizations, readmissions, TRCC will utilize electronic data program Health Connex to monitor monthly performance on infection tracking, monitoring, testing, and treatment. Clinical Leadership have all been trained to enter resident/staff data into Health Connex. Action plans, SMART goals, PDSA will be put in place for areas of opportunity Development of a QA sub-committee that will meet monthly. This sub-committee will review the progress of the PIP and action plans of the QAPI. The sub-committee members will be: leadership/nursing on nights/EVS/dietary staff etc…they will conduct and review the following: MDH Pathway Resident interview QA Audits	

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F 867	Continued From page 66 disease spread within the facility as recommended by the Centers for Disease Control (CDC) guidance to prevent/or minimize the transmission of COVID-19. This resulted in a system wide failure in infection control procedures to prevent the spread of illness within the facility to vulnerable residents and the staff of the facility and resulted in an immediate jeopardy (IJ) which placed all 54 residents at a high likelihood to for serious illness and/or death by contracting a communicable disease, including but not limited to COVID-19. See also F881, Antibiotic Stewardship: Based on interview and document review, the facility failed to develop an antibiotic stewardship program which included implementation of protocols and a system to monitor antibiotic use to ensure appropriate antibiotics were utilized. In addition, the facility failed to ensure cultures were obtained for antibiotic use for 2 of 2 residents (R 23, R33) who were prescribed antibiotics for urinary tract infections (UTI). This deficient practice had the potential to affect all 54 residents who resided in the facility. See also F886, COVID- 19 Testing- Residents and Staff: Based on observation, interview and record review, the facility failed to ensure all staff were tested for COVID-19 during outbreak testing; and failed to test and/or implement confirmatory testing for symptomatic residents and staff, licensed practical nurse (LPN)-A, LPN-B, dietary aide (DA)-D, activity aide (AA)-C, nursing assistant (NA)-D, R108, R29 and R41, who were not tested or had an initial negative rapid antigen testing for COVID-19, per the Centers for Disease Control (CDC) guidance on testing protocols. This system wide breakdown	F 867		

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F 867	Continued From page 67 resulted in an immediate jeopardy (IJ) situation which had the high likelihood to cause serious illness and/or death to all 54 residents residing in the facility, along with staff and visitors. See F888: COVID-19 Vaccination of Facility Staff: Based on interview and document review, the facility failed to ensure 13 of 72 staff members (registered nurse (RN)-E, RN-F, licensed practical nurse (LPN)-E, dietary aide (DA)-C, DA-G. activity aide (AA)-D, director of human resources (DHR)-A, nursing assistant (NA)-B, NA-D, NA-J, NA-K, NA-L , NA-M) were vaccinated with a complete primary series of COVID-19 vaccine and/or had an approved or pending exemption on record. In addition, the facility failed to have a process for tracking and securely documenting the COVID-19 vaccination status for all staff and report accurate COVID-19 vaccination status of staff and related information as indicated by the Centers for Disease Control and Prevention's National Healthcare Safety Network (NHSN). This resulted in a vaccination rate of 81.94% which was greater than 10% from the data the facility had submitted to the National Healthcare Safety Network (NHSN) and had potential to affect all 54 residents in the facility. On 1/11/23, at 1:30 p.m. the administrator stated she was aware the employee vaccination logs and data were not up to date and felt registered nurse (RN)-D struggled with utilizing the computer to organize and track the needed information. QAPI Committee Agenda/Minutes were requested since the last standard survey exited on 8/19/22. Notes were received for the following quarterly meetings and identified the following:	F 867		

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F 867	Continued From page 68 - 1/26/22, failed to identify concerns related to infection control which were cited on the previous three annual surveys. It also, failed to address identified concerns from the last survey related to antibiotic stewardship and COVID-19 testing of residents and staff from the last standard survey exited 12/2/21. - 4/20/22, during the quarter from 1/1/22, through 3/31/22, there were 4 respiratory infections, 9 urinary tract infections (bladder infection) (UTI), 10 skin/wound infections, 30 gastrointestinal (stomach and intestines) (GI) infections (24 of which were in February 2022), and 4 other infections. The facility had COVID-19 in January 2022, and norovirus in February 2022. A root cause analysis (RCA) was done for the January 2022, COVID-19 outbreak and identified a staff member who normally worked on Evergreen Unit had family on the Blueberry Unit who tested positive for COVID-19. The identified 18 residents and 19 staff were positive for COVID-19. There was no other follow up from the COVID-19 outbreak. There were no comments or concerns brought up related to norovirus. - 7/27/22, during the quarter from 4/1/22, through 6/30/22, there were 9 respiratory infections, 14 UTIs, 2 skin/wound infections, 6 GI infections, and 4 other infections. There was no follow-up identified on meeting minutes regarding resident illnesses for the quarter. Staff Infection Surveillance Log from April 2022 identified 10 staff were ill of which 4 had diarrhea/vomiting (norovirus was questioned but lacked follow up), 3 complaints of headache, 2 with sore throats, and 1 with general not feeling well. Staff Infection Surveillance Log from May 2022 identified 3 staff	F 867		

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F 867	Continued From page 69 were ill of which 1 was fever, 1 was GI, and 1 was sent home not feeling well. The May illnesses lacked follow up. The Staff Infection Surveillance Log from June 2022 identified 4 illnesses of which 3 were GI and 1 sore throat. 1 of the GI illness identified COVID exposure and follow up PCR and antigen were negative. No other follow up was done on other illnesses. - 11/16/22, during the quarter from 7/1/22, through 9/30/22, there were 7 respiratory infections, 11 UTIs, 3 skin/wound infections, 2 GI infections, and 7 other infections. Follow-up was done on UTIs regarding treatments prior to receiving culture results and contacting provider to inform treatment was not needed, but noted the treatment continued. An improvement project was started regarding antibiotic usage in UTIs. No follow-up was identified for the other infections and did not address cause or spread of UTIs. The resident infections grid for previous quarters were unreliable. The infection grid did not identify the 30 GI illnesses from 1/31/22, through 3/31/22, and only identified 6 of 14 UTIs identified from 4/122, through 6/30/22. The provided QAPI Committee Agenda/Minutes did not identify a plan to ensure infections were investigated, tracked, trended, and analyzed appropriately, ensure appropriate antibiotic use; ensure staff had the necessary vaccination or exceptions and collected the necessary data to report accurately to Centers for Disease Control and Prevention's National Healthcare Safety Network (NHSN); when the facility staff had known there were issues with the infection control program. During an interview on 1/12/23, at 7:15 p.m. the	F 867		

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F 867	Continued From page 70 administrator stated when the QAA/QAPI committee picked a quality measure (QM) QM to work on for improvement they would review previous years surveys, CASPER-3, and corporate QM measures. When a high-risk area was discovered, the committee would work on an improvement project to improve quality of life for the residents. The administrator identified infection control was a high-risk area and there have been continued concerns with it over the past couple of years. An improvement project was not started because of frequent changes of leadership in the building. Because infection control was a high-risk area, an improvement measure should have been started for the benefit of the residents. The facility's QAPI policy dated 4/6/15 identified the facility would monitor and drawn data from previous surveys to conduct Performance Improvement Projects (PIPs) to improve care or services in areas that have been identified as a concern. These projects would concentrate on a particular problem in one area of the care center or care center wide.	F 867		
F 880 SS=L	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program.	F 880		2/16/23

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F 880	Continued From page 71 The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and	F 880		

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F 880	Continued From page 72 (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure 5 of 5 employees, (licensed practical nurse (LPN)-A, dietary aide (DA)-D, activity aide (AA)-C, nursing assistant (NA)-D and LPN-B) were appropriately cleared to return to work following reports of potential symptoms of COVID-19; failed to initate contact tracing or facility wide testing for COVID-19 following potential exposure from a staff who tested positive for COVID-19; failed to ensure 3 of 53 residents (R108, R29, R41) were isolated while presenting with symptoms of COVID-19; and failed to utilize appropriate protective equipment for 2 of 3 residents (R41, R50) when they were placed in isolation. In addition, the facility failed to ensure twelve employees (cook (CK)-A, activity director (AD)-A, DA-B, the director of nursing (DON), DA-C, assistant dietary manager (ADM)-A, DA-B, registered nurse (RN)-D, DA-D, NA-C, NA-A,NA-B) who were out ill with potentially communicable illness' were cleared to return to	F 880	TRCC goal is to minimize the risk of infection by following guidelines set by governing agencies. The DON or designee will review and revise policies/procedures related to infection control practice including use of gowns and resident quarantine practices. Signs were posted on R41 & R108 doors on how to use PPE. Reeducation to staff was done on the guidelines at time of survey and on 1/20/23. When to isolate/quarantine and what isolation precautions to use were also covered. Proper signage was put in place and available to each nursing unit. R 108, R 29, & R41 were placed in isolation and Covid testing protocol was started. Testing at Days 1, 3, 5, 5-7 days later and again 5-7 days later and 10 days of quarantine. PPE was placed outside of	

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THIEF RIVER CARE CENTER	2001 EASTWOOD DRIVE THIEF RIVER FALLS, MN 56701

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F 880	Continued From page 73 work: failed to to track resident symptoms of infection and implement an ongoing analysis of collected data to ensure patterns and trends were identified and acted upon to reduce the risk of disease spread within the facility as recommended by the Centers for Disease Control (CDC) guidance to prevent/or minimize the transmission of COVID-19. This resulted in a system wide failure in infection control procedures to prevent the spread of illness within the facility to vulnerable residents and the staff of the facility and resulted in an immediate jeopardy (IJ) which placed all 54 residents at a high likelihood to for serious illness and/or death by contracting a communicable disease, including but not limited to COVID-19. The IJ began on 12/20/22, when NA-D returned to work following COVID-19 symptoms on 12/19/22 and subsequently became positive on 12/21/22. Following the positive COVID-19 test result, the facility failed to conduct contact tracing or initate facility wide testing for COVID-19. The facility failed to isolate and implement transmission based precautions for R108, R29 and R41 when they displayed signs and symptoms of COVID-19. In addition, after the facility placed residents in isolation, staff were observed to not use the appropriate PPE. The administrator and DON were notified of the IJ on 1/11/23, at 2:00 p.m. The IJ was removed on 1/12/23, at 3:00 p.m. when the facility implemented actions to reduce/prevent the spread of illness, including COVID-19. However, noncompliance remained at the lower scope and severity, F, widespread, which indicated no actual harm with potential for more than minimal harm that was not IJ.	F 880	rooms with signage for type of isolation, PPE don and doffing, and notice to visitors and staff to see nursing prior to entering the first time. Staff were reeducated on PPE, types of isolation precautions, hand hygiene, covid testing, monitoring, and surveillance. Staff that were not cleared to return to work were interviewed by RN. The following inquiries were made: symptoms, start date, end date, work 48 hours prior to getting ill, and return to work date. The 5 staff were all listed as having GI symptoms in IPCO tracking book. 1- 1 staff- GI symptoms were a result of alcohol 2- 1- Reported URI symptoms- 1 had symptoms start during a prolonged vacation outside of state. Symptoms resolved prior to return to work- was tested for covid day of return 3- 1- reported URI- common cold per PCP 4- 1- headache and treated for chronic migraines at urgent care 5- 1- Diarrhea that is chronic for them (they are testing for auto-immune- like Chrons or UC). Re-educated staff on when/what to call in sick for. Reeducated on process of checking in daily to review symptom changes, resolution, and return to work and COVID testing upon return. Documentation of resident and employee illness, symptoms, testing, treatment, and return to work (for staff) will be conducted	

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F 880	Continued From page 74 Findings include: The Interim Infection Prevention and Control Recommendations for Healthcare Personnel (HCP) During the Coronavirus Disease 2019 (COVID-19) Pandemic, updated September 23, 2022, identified anyone with even mild symptoms of COVID-19, regardless of vaccination status, should receive a viral test for COVID-19 as soon as possible. Mild illness is defined as any various signs and symptoms of COVID-19 such as fever, cough, sore throat, malaise, headache, muscle pain, without shortness of breath, dyspnea or abnormal chest imaging. Moderate illness is defined as evidence of lower respiratory disease, by clinical assessment or imaging, and a saturation of oxygen of <94% on room air. CDC further indicated HCP with mild to moderate illness who are not moderately to severely immunocompromised could return to work after the following criteria have been met: At least 7 days have passed since symptoms first appeared if a negative viral test* is obtained within 48 hours prior to returning to work (or 10 days if testing is not performed or if a positive test at day 5-7), and At least 24 hours have passed since last fever without the use of fever-reducing medications, and Symptoms (e.g., cough, shortness of breath) have improved. Further, patients with symptoms of COVID-19 (even before results or diagnostic testing) should be placed in Transmission-Based Precautions. The decision to discontinue empiric transmission based precautions by excluding the diagnosis of a current COVID-19 infection for a patient with symptoms can be made based upon having negative results from at least one viral test. If	F 880	in the electronic data base, Health Connex. Either ICP trained RN will enter the data and follow those residents and staff, keeping the data base up to date. This can affect all residents at TRCC. The DON or designees will look if there are other residents that are need or are in quarantine or may have to be in quarantine and ensure that proper signage is on the door regarding PPE and isolation precautions. Monthly either ICP RN will analyze the data between staff and resident illness to identify correlation. The DON or designees will perform infection control and data base tracking audits to ensure that illness documentation and tracking, hand hygiene & PPE are being used properly and that quarantined residents remain in their rooms. Audits will be done 3x/week for four weeks, 2x week for 4 weeks and then weekly. Audit results will be brought to the QAPI committee and QA subcommittee meeting for further evaluation and recommendations.	

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F 880	Continued From page 75 using an antigen test, a negative result should be confirmed by either a negative molecular test or a second negative antigen test taken 48 hours after the first negative test. Patients with suspected or confirmed COVID-19 should be placed in a single person room and the door should be kept closed, if safe to do so. Healthcare workers who enter the patients rooms should adhere to standard precautions and use a NIOSH-approved particulate respirator with N95 filters or higher, gown, gloves, and eye protection (i.e., goggles or a face shield that covers the front and sides of the face). The CDC Symptoms of COVID-19, updated October 26, 2022, identified people with COVID-19 have had a wide range of symptoms reported-ranging from mild symptoms to severe illness. Symptoms may appear 2 to 14 days after exposure to the virus. Possible symptoms include: fever or chills, cough, shortness of breath, fatigue, muscle or body aches, headache, new loss of taste or smell, sore throat, congestion or runny nose, nausea or vomiting and diarrhea. Employee Illness Tracking The facility employee infection control logs for the month of December 2022, identified the following: Respiratory Illness - On 11/24/22, dietary aide (DA)-A tested positive for RSV. DA-A was not tested for COVID-19 illness. DA-A returned to work on 11/28/22. -On 12/4/22, licensed practical nurse (LPN)-A reported aching, sore throat, and headache. LPN-A was not tested for COVID-19 illness. LPN-A returned to work on 12/5/22. LPN-A was not tested for COVID-19 illness. LPN-A worked	F 880		

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F 880	Continued From page 76 12/5/22, 12/6/22 and 12/7/22. On 12/8/22, LPN-A tested positive for influenza B and was still not tested to rule out COVID-19. An analysis of potential contacts who may have been exposed or resolution of symptoms was not documented. -On 12/6/22, DA-D reported increase respiratory symptoms. DA-D was not tested for COVID-19 illness. DA-D returned to work on 12/21/22. -On 12/7/22, AA-C reported symptoms of aching and cough. AA-C was not tested for COVID-19 illness. AA-C returned to work on 12/12/22. -On 12/19/22, NA-D reported respiratory symptoms. NA-D was not tested for COVID-19 illness. NA-D returned to work on 12/20/22. On 12/21/22, NA-D reported illness and tested positive for COVID-19. Contact tracing and testing for COVID-19 to evaluate staff and residents potential exposure and limit the spread of the illness within the facility was not initiated, despite NA-D having worked providing direct care to residents the day prior to her positive test result. -On 12/24/22, LPN-B reported illness of headache and aching while working her shift. LPN-B tested positive for COVID-19 on 12/27/22. LPN-B returned to work on 12/29/22. Contact tracing and testing for COVID-19 to evaluate staff and residents potential exposure and limit the spread of the illness within the facility was not initiated, despite LPN-B having worked providing direct care to residents the day she began exhibiting symptoms of illness. Gastrointestinal Illness (GI) -On 12/8/22, cook (CK)-A reported diarrhea illness and went home. CK-A was not tested for COVID-19 illness. CK-A returned to work on 12/9/22. -On 12/8/22, activity director (AD)-A reported	F 880		

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F 880	Continued From page 77 nausea and went home. AD-A was not tested for COVID-19 illness. AD-A returned to work on 12/9/22. -On 12/8/22, dietary aide (DA)-B reported nausea, vomiting and diarrhea and went home. DA-B was not tested for COVID-19 illness. DA-B returned to work on 12/9/22 -On 12/9/22, the director of nursing (DON) reported diarrhea and headache. The DON was not tested for COVID-19 illness. The DON returned to work on 12/12/22. -On 12/9/22, DA-C reported GI symptoms. DA-C was not tested for COVID-19 illness. DA-C returned to work on 12/19/22. -On 12/9/22, assistant dietary manager (ADM)-A reported GI symptoms. ADM-A was not tested for COVID-19 illness. -On 12/12/22, DA-B reported GI symptoms. DA-B was not tested for COVID-19 illness. DA-B returned to work on 12/13/22. -On 12/14/22, registered nurse (RN)-D reported body aches, nausea and vomiting. RN-D did not test for COVID-19 illness. RN-D returned to work on 12/16/22 -On 12/21/22, DA-D reported GI symptoms. DA-D was not tested for COVID-19 illness. DA-D returned to work on 12/30/22 -On 12/27/22, nursing assistant (NA)-C reported vomiting and diarrhea. NA-C was not tested for COVID-19 illness. NA-C returned to work on 12/29/22 -On 12/28/22, NA-A reported nausea and dizziness. NA-A was not tested for COVID-19 illness. NA-A returned to work on 1/9/23. -On 12/29/22, NA-B reported nausea, vomiting and diarrhea. NA-B was not tested for COVID-19 illness. NA-B returned to work on 12/31/22.	F 880		

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F 880	Continued From page 78	F 880		

There was no evidence assessments were conducted to determine if employee illness could potentially be COVID-19 symptoms and require testing prior to return to work or if there were potential resident and staff exposures and a need to conduct contact or outbreak testing. The infection control logs lacked evidence the facility conducted a comprehensive analysis of the collected outcome surveillance data to determine if any of the infections identified were potentially related or corresponded with resident illness for the same month period. There was no evidence the facility had investigated the infections identified for potential causes and/or subsequent actions to reduce the risk of recurrence.

When interviewed on 1/10/23, at 2:15 p.m. LPN-A stated if an employee came to her with complaints of feeling sick she would ask them about their symptoms. If it was just sniffles or a little under the weather, she would not send them home. If they were really sick and they had coverage, she would send them home.

During interview on 1/10/23 at 2:35 p.m. NA-C stated she would not come to work if she felt sick. If NA-C was already working and started to feel sick, she would try to get someone to come in and replace her but if could not find anyone, she couldn't just go home. It depended on what her symptoms were and which of the nurses was working. If she was throwing up she would probably go home, but if was just feeling run down she would have to work out her shift.

When interviewed on 1/10/23, at 3:40 p.m. NA-D stated she was ill with COVID in December of 2022, and tested positive for COVID-19 on 12/21/22. The symptoms NA-D experienced

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F 880	Continued From page 79 during that illness were GI upset of nausea, vomiting and diarrhea. During interview on 1/11/23, at 10:30 a.m. LPN-B stated she was sick the day she worked on 12/24/22. LPN-B called the administrator that evening to let her know and did not work on 12/25/22 or 12/26/22. LPN-B tested positive on 12/27/22, as she knew she would as a family member in her home was ill with COVID-19 the week before. LPN-B returned to work on 12/29/22, when she was no longer feeling ill and it was five days since her symptoms first appeared. During interview on 1/10/23, at 10:20 a.m. RN-D, who was the infection preventionist, stated she saw the employees when they returned to work after having called in and none appeared ill. RN-D did not test the employees on their return to work. RN-D had known LPN-B had a family member who was ill with COVID-19 living in her home and reported not feeling well on 12/24/23; however, continued to work her entire shift. LPN-B did test positive on 12/27/22. The facility had not initiated any testing of potentially exposed residents or staff, as RN-D felt the doctors in the area believed people tested for COVID too often. RN-D was aware of the facility's policies for staff who had signs and symptoms of COVID-19 like illness (based on screening) and/or a temperature (100 degrees or higher) should not report to work until testing could be completed as well as contact tracing for potential exposures; however, the policies were written by the corporate office and did not necessarily reflect current practice. RN-D stated she visualized all the staff members LPN-B worked with when LPN-B was presenting with symptoms at work. The unidentified staff did not display any	F 880		

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F 880	Continued From page 80 symptoms of illness, so RN-D did not feel any COVID-19 testing was necessary, despite COVID-19 having asymptomatic transmission. RN-D saw DA-A on her return to work on 11/28/22, after testing positive for RSV on 11/24/22, and DA-A had no obvious symptoms of illness, and there were no other cases of RSV in the facility. The employees who reported symptoms of GI illness during the month of December were not tested for COVID-19 as their symptoms did not act like a COVID-19 illness. It depended on staff symptoms if they would need to test before returning to work after an illness. An interview was conducted with the DON and administrator on 11/10/22, at 3:30 p.m. The administrator stated if staff or residents displayed illness that could indicate a COVID-19 infection, the ill resident or staff were to isolate and COVID-19 testing would be done on day one, day three and day five of symptom onset. If the results were negative and the resident or staff was asymptomatic isolation was lifted. For contact tracing, the facility did outbreak testing with COVID-19 antigen tests. The facility had not completed an assessment to see if outbreak testing would be needed when LPN-B had tested positive as her positive test was more than 48 hours since she had last worked, despite having displayed symptoms of COVID-19 while at work on 12/24/22. The facility allowed staff to return to work in five to ten days of a positive COVID test, five days if emergency staffing, if they had improved symptoms and were fever free. They allowed LPN-B to return to work on 12/29/22, because they had used onset of symptoms 12/24/22, for the start of her illness. RESIDENT OBSERVATIONS:	F 880		

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F 880	Continued From page 81 During observation of R41 on 1/11/23, at 8:40 a.m. there was a sign on R41's door which directed staff/visitors to stop at nurses station prior to going into the room. An isolation cart was outside of the room. During observation of R41 on 1/11/23, at 8:51 a.m. R41's door was wide open and R41 was not in the room. During observation of R41 on 1/11/23, at 8:56 a.m. R41 was in the dining room and seated at a table in the far corner of the room approximately 10-12 feet (ft) from other residents. Nursing assistant (NA)-C was wearing a face mask and was seated next to R41 to assist R41 with eating. During observation of R41 on 1/11/23, at 8:58 a.m. activity aide (AA)-C wheeled R41 out of the dining room and into the hallway near the waterfall. R41 was not wearing a face mask. During observation on 1/11/23, at 9:06 a.m. R41 was seated in her wheelchair, was not wearing a face mask and was seated next to two unidentified residents in the hallway near the waterfall. During observation of R41 on 1/11/23, at 9:06 a.m. R41 was observed unmasked and seated in her wheelchair in the activity area. R41 stated she didn't feel well. R41 coughed several times. Licensed practical nurse (LPN)-C stated R41 could eat in the dining room as long as the resident wore a face mask and sat at the table in the far corner. LPN-C needed to give R41 a breathing treatment and started to wheel R41 out of the activity area. While LPN-C was wheeling	F 880		

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R41 down the hallway, LPN-C was interrupted and left R41 in the hallway. R41 was still unmasked.

During observation of R41 on 1/11/23, at 9:17 a.m. LPN-C returned to R41 and started wheeling R41 towards her room. LPN-C stated R41 should be wearing a face mask since she was in the hallway.

During observation on 1/11/23, at 9:21 a.m. LPN-C was standing next to R41, nurse prepped nebulizer equipment near R41 and then exited residents room. LPN-C did not put on personal protective equipment (PPE) prior to entering R41's room, and did not perform hand hygiene prior to entering or upon exiting the room. LPN-C re-entered R41's room wearing a face mask and carried gloves balled up in her left hand. LPN-C did not put on PPE or use hand sanitizer prior to entered R41's room. With bare hands, LPN-C prepped R41's nebulizer medication (inhaled medication used to reduce inflammation in the lungs or to open airways to improve breathing ability), and placed the face mask over R41's face, secured the elastic straps around R41's head and turned the machine on. LPN-C proceeded to clean and walk around the area near R41 while the nebulizer machine was bubbling and running. LPN-C maintained a distance between 2 feet and 8 feet from R41 during the entire time.

During observation at 9:28 a.m. NA-F entered R41's room, talked with LPN-C and then exited the room. Upon entering R41's room NA-F did not use hand sanitizer or put PPE on prior to entering room, use hand sanitizer upon exiting the room or to change face mask after exiting the

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F 880	Continued From page 83 room. During observation at 9:30 a.m. LPN-C continued to walk around R41's room. LPN-C leaned over R41 and stand face-to-face with R41 while R41's nebulizer was still running. LPN-C was wearing a face mask . LPN-C then removed R41's nebulizer mask, walked behind resident and turned nebulizer machine off. With bare hands, LPN-C carried the nebulizer mask into the bathroom. LPN-C exited the bathroom and walked to R41's side. LPN-C arranged R41's oxygen tubing, placed the nasal cannula on the resident's face and listened to her chest with a stethoscope. LPN-C was within one to two feet of R41 the entire time. Then LPN-C walked into the bathroom, washed hands, removed the face mask, exited R41's room and put on a clean face mask. LPN-C was in R41's room for a total of 8 minutes while in close proximity of R41 and only wearing a face mask. During interview on 1/11/23, at 9:28 a.m. NA-F stated despite there being a sign on the door and a cart outside R41's room she completely forgot to put on PPE prior to entering R41's room. During interview on 1/11/23, at 9:35 a.m. LPN-C stated R41 had a cough and tested negative for COVID-19 on 1/10/23. LPN-C stated R41 was on contact and droplet precautions due to R41's cough and R41 should wear a face mask when out of the room. Staff were supposed to wear on a gown, gloves and face mask when entering R41's room and the sign on the door identified that information. LPN-C did not wear a gown and gloves upon entering R41's room but should have. COVID-19 testing recommendations were to test on day 1, day 3 and day 5 before residents	F 880		

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F 880	Continued From page 84 were considered negative. Yesterday was R41's first test. LPN-C stated she did not think R41 would be considered free from COVID-19 after one negative test. When interviewed on 1/11/23, at 9:57 a.m. NA-G stated when she came to work that morning R41 had transmission based precautions (TBP) cart with PPE and a sign on the door directing staff to wear a gown, gloves, eye goggles and face mask when entering the room. Wearing PPE was used to help reduce the risk of spreading infections to other staff and residents. NA-G was initially told R41 had to stay in her room but then later was told the resident could go to the dining room for breakfast as long as she sat at the table furthest in the corner and away from other people. When NA-G wheeled R41 through the dining room R41 did not wear a face mask. During interview on 1/12/23, at 3:48 p.m. the director of nursing (DON) stated when a resident was on TBP the staff were expected to wear a gown, gloves, mask, and depending on the precaution would also expect staff to wear eye goggles, face shield or N95 mask. The staff would also be expected to use hand sanitizer prior to and upon exiting the residents room. That was the policy and staff knew and were expected to follow the policy. When interviewed on 1/11/23, at 10:34 a.m. LPN-B stated R50 started to complain of a sore throat and headache that morning. R50's first COVID-19 test that morning was negative; however, R50 was placed on isolation until confirmatory COVID-19 testing could be completed and her symptoms evaluated.	F 880		

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F 880	Continued From page 85 During observation of R50 on 1/11/23, at 10:50 a.m. housekeeper (HK)-A was cleaning R50's room while wearing a surgical face mask and gloves. R50's room had an isolation cart outside of her door and the door way to her room was clearly marked with a sign that indicated anyone who entered needed to observe transmission based precautions and put on a disposable gown, gloves, eye protection and face mask before entering the room. R50 was lying on her bed reading a magazine. The DON approached the room and asked HK-A to leave the room to talk with her. HK-A was instructed on contact precautions. HK-A removed and discarded her gloves in the garbage; however, continued to wear the same surgical mask. HK-A stated they were not told residents were placed in transmission based precautions. HK-A did not see the signs indicating the TBP on R50's door, as R50's door was open when she approached it. During observation odf R50 on 1/11/23, at 10:53 a.m. HK-B entered R50's room to deliver laundry. R50 was lying on her bed reading a magazine. HK-B wore a surgical face mask under her chin, that did not cover her mouth or nose. HK-B did not put on a gown, gloves or eye protection, and entered the room with clean laundry. HK-B delivered the resident's laundry, putting the clean clothes in the residents closet and exited the room; however, did not perform hand hygiene. HK-B stated the transmission based precaution sign hanging on R50's door and the isolation cart outside her door was set up just for visitors, if they were staying in the room for a long time. If the resident was being quarantined for COVID infection there would have been a large COVID sign on her door and in that case, she would not have entered the resident's room and just hung	F 880		

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F 880	Continued From page 86 the clean laundry outside her door for nursing staff to put away. HK-B knew her mask was to cover her nose and mouth. It kept sliding down and so she adjusted it back in place. Resident Illness Tracking Resident illness tracking logs for the month of November 2022, identified the following: Respiratory illness -On 11/4/22, R15 developed symptoms of lethargy, decrease oxygen saturation, cough and increase confusion. R15 received two antibiotics for treatment of pneumonia; however, sensitivities were not identified and COVID-19 testing was not conducted. -On 11/19/22, R34 developed symptoms of nasal drainage, cough, loss of taste and smell. R34 tested positive for COVID-19 on 11/22/22 and placed in isolation. -On 11/28/22, R38 was identified as positive for COVID-19 and placed in isolation. Urinary Tract Infections (UTI) -On 11/21/22, R3 developed a UTI. R3 received antibiotic treatment; however, sensitivities to see if the organism was sensitive to the antibiotic ordered, were not identified. -On 11/28/22, R38 developed a UTI. R38 received antibiotic treatment; however, sensitivities to see if the organism was sensitive to the antibiotic ordered, were not identified. Resident illness tracking logs for the month of December 2022, identified the following: Urinary Tract Infections (UTI)	F 880		

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F 880	Continued From page 87 The December 2022 Infection Surveillance Log (ISL) identified : -On 11/30/22, R23 developed a UTI -On 11/24/22, R3 developed a UTI. R3 received antibiotic treatment; however, sensitivities to see if the organism was sensitive to the antibiotic ordered, were not identified. -On 12/2/22, R35 developed a UTI. -On 12/6/22, R23 developed a UTI. R23 received antibiotic treatment; however, sensitivities to see if the organism was sensitive to the antibiotic ordered, were not identified. -On 12/8/22, R33 developed a UTI. R38 received antibiotic treatment; however, sensitivities to see if the organism was sensitive to the antibiotic ordered, were not identified. -On 12/8/22, R41 developed a UTI. R41 received antibiotic treatment; however, sensitivities to see if the organism was sensitive to the antibiotic ordered, were not identified -On 12/27/22, R23 developed a UTI. R23 received two different antibiotics for treatment; however, sensitivities to see if the organism was sensitive to the antibiotics ordered, were not identified The summary of December 2022 infection control log identified eight resident UTI's, 7 consisted of bacterial infections and 1 was contaminated but treated anyway. The infection control logs lacked evidence the facility conducted a comprehensive analysis of the collected outcome surveillance data to determine if any of the infections identified were potentially related or corresponded with staff illness for the same month period to initiate appropriate corrective action. There was no evidence the facility investigated the infections	F 880		

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F 880	Continued From page 88 identified for potential causes and/or subsequent actions to reduce the risk of reoccurrence. The following resident medical records in conjunction with the facility infection control logs identified the following: - Progress note (PN) dated 12/16/22, identified R108 developed decrease lung sounds and oxygen saturations of 70 to 80% with oxygen in place. R108 required hospitalization and returned with diagnosis of pneumonia with unknown origin. R108 was not identified on resident illness logs for surveillance when he presented with initial illness, or throughout his illness. R108 was not evaluated or tested for COVID-19 during the initial course of illness and was not isolated from other residents until COVID-19 testing could be completed to rule out the infectious illness. -PN dated 1/9/23, identified R29 developed symptoms of nausea and vomiting. A rapid COVID-19 test was performed and was negative. R29 was not listed on the resident illness tracking log for surveillance, nor placed on isolation pending a confirmatory test. -PN dated 1/4/23, identified R41 developed low grade temperature of 99. 5, oxygen saturation of 93% with supplemental oxygen at 2L/min, and complaints of not feeling well. A rapid COVID-19 test was performed and was negative. However, R41 was not listed on the resident illness tracking log. R41 remained symptomatic with cough and general malaise, no further COVID-19 test were performed and R41 was not placed into transmission based precautions as recommended by the Centers for Disease Control	F 880		

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F 880	Continued From page 89 (CDC) until facility was notified of surveyor concerns on 1/11/23. During interview on 1/10/23, at 10:20 a.m. RN-D stated the nursing staff were supposed to fill out a sick log form when residents had symptoms of illness and she would update her surveillance logs from those forms weekly. RN-D was notified R41 was tested for COVID-19 on 1/4/23, and was negative. R41 had nasal drainage and a cough when she had assisted her in the dining room on 1/6/23. RN-D then notified the charge nurse after wheeling R41 out of the dining room. Testing was usually done on day one, day three and day five for symptomatic staff and residents because of the potential incubation period of the illness. RN-D usually did the COVID-19 testing for residents but did not fill out the sheets for R41's follow up tests, so the required follow up testing was not completed. RN-D was not sure why R108 was not on the resident infection December 2022 logs, as R108 should have been, especially because of his emergency room visit and diagnosis of pneumonia. RN-D indicated it was important to be sure to include all ill resident and employees on the surveillance logs so you could track where they were, how the illness was going and if it was spreading. During interview on 1/10/23, at 4:00 p.m. registered nurse (RN)-A stated if a resident showed signs of COVID-19, they would isolate the resident and test with a rapid antigen test. If still showing symptoms they would retest the resident. They always notified RN-D when they tested a resident for COVID-19. R41 displayed a cough and low grade fever. R41 was tested on 1/4/23 and was negative for COVID-19. R41 still exhibited symptoms of cough and her oxygen	F 880		

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F 880	Continued From page 90 saturation was 95% at rest with supplemental oxygen. R41's cough was loose and in her chest, not in her lungs. RN-A had not personally done a repeat COVID test and would have to check with the nurses working on the floor if another test was needed. No second confirmatory testing was completed after the initial test was done on 1/4/23, despite her continued symptoms. R41 had not been isolated, although continued to exhibit symptoms of cough and shortness of breath. When interviewed on 1/11/23, at 8:30 a.m. RN-D stated some of the resident UTI infections should not have had an antibiotic ordered because no specific bacteria was cultured. RN-D looked for patterns and trends with the resident infections but could only find incontinence of urine and resisting staff assist with peri care after an incontinent episode as a common factor. There did not seem to be a common bacteria with the infections or in the same areas of the facility or she would have suspected staff as the source. RN-D did not document sensitivities to cultures or follow up to make sure the antibiotic ordered was effective against the identified organism. Some times the facility would get sensitivity results on cultures and sometimes they would not. In some instances the lab would not even do a sensitivity on a culture. RN-D stated she watched some staff complete peri care to ensure proper technique; however, had not documented audits formally. She had tried to start audit forms but staff had become angry with the audits and so they were not completed. RN-D did not identify if any concerns or training with peri care had been completed while performing audits. The facility's Coronavirus Prevention, Screening and Identification policy dated 10/9/22, indicated	F 880		

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F 880	Continued From page 91 If a resident exhibited any symptoms of respiratory infection, or other COVID-19 related symptoms the resident's provider would be notified immediately. Quarantine interventions and testing would be initiated. If initial test was negative, the resident would be encouraged to use mask and social distance. For residents with suspected or confirmed COVID; monitoring of vital signs and respiratory symptoms would be at least twice a day. and any vital sign changes would be identified and further licensed nurse assessment would occur. During an outbreak, any breach of Personal Protective Equipment (PPE) would be reported immediately to the supervisor or designee. Staff who had signs and symptoms of COVID-19 like illness (based on screening) and/or a temperature (100 degrees or higher) would not report to work until testing could be completed. Staff who had mild to moderate illness, who were not moderately to severely Immunocompromised, could return to work if at least 7 days if a negative antigen or PCR was obtained within 48 hours prior to returning to work or 10 days have passed since symptoms had first appeared, and at least 24 hours had passed since last fever without the use of fever-reducing medications, and symptoms (e.g., cough, shortness of breath) had improved. Staff who were asymptomatic throughout their infection and were not moderately to severely Immunocompromised could return to work if at least 7 days if a negative antigen or PCR was obtained within 48 hours prior to returning to work or after 10 days if testing was not performed. Staff who had a high risk exposure would have three viral tests for SARS-CoV-2 infection. testing would occur (as able) on day one (where day of exposure is day 0), day three, and day five. Care center would keep a list of any staff unprotected	F 880		

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F 880	Continued From page 92 exposure to COVID-19. The list would include all staff that interacted with the positive person from two days before symptoms started. For potential staff exposure, the facility would complete Assessment for Health Care Workers (HCW) Assessment for Health Care Workers Potentially Exposed to COVID-19 in Minnesota. Identify the risk level using assessment. Contact tracing may indicate low risk when there was no direct exposure to a COVID-19 infected person. Contact risk was identified as close (within 6 feet for 15 minutes or more, or within same living space) contact of person(s) with COVID-19 within 48 hours. Communicate the risk level to the staff with work-related recommendations. Recommendations would be followed for staff who had high-risk workplace exposure to COVID-19 and staff with household or intimate contacts who had confirmed or suspected COVID-19. The facility's policy Transmission Based Precautions dated 6/7/17, indicated transmission based precautions would be used when caring for residents who were documented or suspected to have communicable diseases or infections that could be transmitted to others. When transmission based precautions were implemented the IP nurse would ensure that PPE is maintained near or inside the resident's room and post the appropriate notice on the room door entrance and in the resident's chart so all personnel would be aware of the precautions before entering the room. Residents with symptoms consistent with norovirus would be placed on contact precautions for a minimum of 48 hours after the resolution of symptoms to prevent further exposure of susceptible residents.	F 880		

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F 880	Continued From page 93 The facility's policy Infection Prevention and Control Officer dated 5/8/17, indicated it was the IP nurse responsibility to establish infection prevention and control procedures for surveillance, identification, investigation, control and prevention of infections and communicable diseases for all persons providing services in the facility. The IP was directed to maintain an infection surveillance program with infection control log of incidents for both residents and staff, with documentation of analysis of tracking and trending and measures taken according to findings. The IJ that began on 12/20/22, was removed on 1/11/23, at 3:00 p.m. when it could be verified through observation, interview and record review the facility implemented actions to reduce/prevent the spread of infectious illness, including COVID-19, within the facility. The facility implemented the following: established a system to track all resident and employee illness', established a return to work after illness process, analyzed current infection control data; updated the staff screening process, assessed all residents for signs and symptoms of infection and isolated those that met the criteria for isolation and educated all staff on the the infection control policies and executions including: transmission based precautions, appropriate PPE use, signs and symptoms of COVID-19.	F 880		
F 881 SS=F	Antibiotic Stewardship Program CFR(s): 483.80(a)(3) §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at	F 881		2/16/23

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F 881	Continued From page 94 a minimum, the following elements: §483.80(a)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to develop an antibiotic stewardship program which included implementation of protocols and a system to monitor antibiotic use to ensure appropriate antibiotics were utilized. In addition, the facility failed to ensure cultures were obtained for antibiotic use for 2 of 2 residents (R23, R33) who were prescribed antibiotics for urinary tract infections (UTI). This deficient practice had the potential to affect all 54 residents who resided in the facility. Findings include: The facility form, Infection Surveillance Log from November through December 2022, tracked actual infections and antibiotic use. The form was organized with twelve columns which collected the following data: resident name, room number, physician, signs and symptoms, infection site, identified pathogen and date of test, risk factors/pertinent remarks/admit to hospital, date/type of antibiotic treatment, preventative measures/precautions/isolation, follow up/antibiotic effective/interventions effective/date resolved. The December 2022, Infection Surveillance Log and corresponding analysis identified eleven antibiotics were prescribed. Nine infections on the surveillance log did not identify culture and sensitivity results were identified to track.	F 881	TRCC lacked the foundation of an Antibiotic Stewardship Program failing to implement protocols and a system to monitor antibiotic use and ensure appropriate antibiotics are utilized. R33 Admitted from local assisted living on 12/8/22 in afternoon. At this time R33 was on day 4 of a 7-day course of Cipro. Urine culture was returned on 12/4/22 with mixed flora. Urine culture was not sent with resident. R23 Cultures obtained and noted the 12/22 culture that the sensitivity for both amoxicillin and doxycycline are appropriate treatments. Implementation of the McGeer protocol expanded to include UTI, URI, PNA, and skin infections to clinical nursing staff. This will be escalated to primary care providers for need of ATBs. Reeducated clinical staff on antibiotic stewardship program purpose. Review of antibiotic stewardship policy will be implemented and reviewed with staff. Antibiotic Stewardship letter to area medical providers from TRCC medical director, administrator, and DON will be mailed and sent to providers at residents' clinical and ED visits.	

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F 881	Continued From page 95 The analysis identified eight resident urinary tract infections (UTI)s in the month of December, six of which received antibiotic treatment. One resident infection was treated with more than one antibiotic at the same time for the same infection; however, it did not identify a rationale for the treatment of two antibiotics for the same infection. Further, the analysis identified antibiotic treatment for R33 with a potential urinary infection that produced mixed flora and was not positive for infection. R33 was prescribed Cipro (antibiotic), there was no evidence the antibiotic was reviewed and discontinued. There was no evidence any of the antibiotics were reviewed for appropriate use, nor were any culture sensitivities identified to demonstrate the organism was susceptible to the prescribed antibiotic. There was no evidence of any established criteria (i.e. McGeer, Loeb's) being used to determine the presence of infection before the antibiotics were initiated for resident UTI symptoms. On the back of the December 2022, surveillance log was a handwritten note, which registered nurse (RN)-D, who was also the infection control (IP) nurse, indicated was her written summary of the facility's December resident infections. The note identified there were eight UTI's, seven with bacterial infection and one that had a contaminant but was treated anyway. The report identified each resident along with their symptoms and prescribed antibiotic; however, lacked any information if a sensitivity was done and if the organism was susceptible to the prescribed antibiotic. There was no evidence of any established criteria being used or interventions implemented prior to the start of treatment, nor the date the symptoms resolved.	F 881	Implementation of Health Connex, electronic data base for tracking suspected illness, testing/ culture results, and antibiotic utilization. DON or designee will enter and monitor information will be entered in real time and analysis completed for monthly QA meetings and quarterly QAPI meetings. Either IPC RNs will audit progress notes, labs, and the information in the Health Connex data 3x/week for 4 weeks, 2x/week for 4 weeks, 1x/week for 4 weeks, then monthly and ongoing to review accurate infections, culture/sensitivity, and antibiotic utilization. Audits will be brought to QAPI for review and recommendations.	

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F 881	Continued From page 96 R23's undated Resident Face Sheet, identified an admission date of 8/18/21. Diagnoses included congestive heart failure, chronic obstructive pulmonary disease, diabetes, chronic kidney disease, polyp of corpus uteri, and urge incontinence. R23's nurse progress notes identified the following: -12/6/22, a verbal order was received to start Cipro (an antibiotic) 500 milligrams (mg) by mouth (po) two times per day (BID) for seven days. The culture showed Klebsiella pneumoniae infection and identified the organism as an abnormal result. The medical record lacked sensitivity for the organism being treated. -12/21/22, new orders received to start Augmentin (an antibiotic) 875-125 mg BID for seven days for urinary tract infection (UTI). -12/27/22, orders received to stop amoxicillin (an antibiotic) and start Doxycycline 100 mg BID until gone. The medical record lacked evidence of a culture or sensitivity to identify if the antibiotic ordered would be effective to treat the infection. R23's progress notes were reviewed 12/1/22 through 12/31/22, lacked any documentation of assessments, symptoms, or complaints of urinary tract infections. The medical record failed to identify if any non-pharmacological interventions were attempted, such as increase fluids. Laboratory documentation identified a urinalysis and culture was completed on 12/20/22. A sensitivity was recorded and did indicate the	F 881		

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F 881	Continued From page 97 organism was susceptible to the current antibiotic treatment. The medical record lacked urinalysis, cultures or sensitivities for the treated UTI infections on 12/6/22 and 12/27/22. R33's undated Resident Face Sheet, identified an admission date of 12/8/22. Diagnoses included hydronephrosis, hematuria, cystitis, abnormal uterine and vaginal bleeding and stress urinary incontinence. R33's Outpatient Medication Orders, dated 12/5/22, indicated Cipro (an antibiotic) 500 milligrams (mg) two times per day. R33's Family Medicine Clinic Note dated 12/5/22, identified R33 had been seen in the emergency department on 12/4/22, and was started on an antibiotic for an urinary tract infection (UTI). R33's medical record was reviewed and lacked evidence of a urinalysis, culture or sensitivity results (a laboratory test to identify infective germs and which antibiotics were effective for treatment), however, the December Resident Infection Surveillance Log identified R33 had symptoms of lethargy, confusion and behaviors and received Cipro antibiotic treatment two times per day (BID) for seven days for a UTI. The organism was identified as mixed microflora. (indicated at least 2 organisms present and does not meet the criteria for a positive urine culture. Urine cultures that contain more than one organism are usually considered a contaminated specimen.) R33's Medication Administration Record dated December 2022, identified R33 received Cipro 500 mg BID from 12/8/22 through 12/15/22.	F 881		

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F 881	Continued From page 98 R33's progress notes and physician communication notes were reviewed 12/8/22 through 1/10/23, and lacked evidence the physician was notified of the culture results and inappropriate antibiotic treatment. Further, the progress notes lacked documentation of assessments, symptoms, or complaints of urinary tract infection and failed to identify non-pharmacological interventions attempted, such as increase in fluids. On 1/12/22, at 2:00 p.m. RN-D, the IP, stated if an antibiotic was ordered and it was identified the infection was not appropriate to treat with an antibiotic, the resident usually had already completed the treatment by the time the facility received the culture results. The area physicians did not usually wait for the culture results before treating. RN-D looked at resident culture and sensitivities, and at times looked them up in the resident clinic notes. The physicians were the problem, as they did not wait for the results before ordering antibiotics. Sometimes the lab would send the culture and sensitivities to the facility following urinalysis and sometimes they did not. Sometimes the lab would not even do a sensitivity on the cultures. RN-D tried to get the nurses to try to increase fluids and other interventions for three days prior to calling to obtain a urinalysis and was trying to get the nurses to use the SBAR (situation, background, assessment and recommendation format to facilitate prompt and appropriate communication) forms for notifying the physicians of possible resident infections, or Loeb's or the McGeer criteria, but it was only as good as what the nurses were putting in the medical record for her	F 881		

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F 881	Continued From page 99 to review. RN-D checked the report log daily to see if any residents had started an antibiotic treatment and frequently the culture and sensitivity would not be back. RN-D was unsure what could be done, and felt maybe the facility should hold the antibiotic until the culture and sensitivity was received. That way RN-D would be able to pull it all together in a SBAR form to fax to the physician. RN-D did not have any documentation culture or sensitivities were received or reviewed by the facility for resident infections that were treated with antibiotics and did not have documentation of physician notifications. During interview on 1/12/23, at 5:30 p.m. the director of nursing (DON) stated RN-D, the IP should be documenting sensitivities and compare and analyze resident antibiotic use. RN-D should notify the physician if an antibiotic was felt to be inappropriate. The facility should be using an antibiotic use criteria such as McGeer to determine the need for treatment. She planned to revamp the whole infection control program. The facility's policy Antibiotic Stewardship Program dated 7/1/19, indicated the care center would establish and antibiotic stewardship team that would be accountable for antibiotic stewardship activities. The team would implement antibiotic use protocol and criteria, review infections and monitor antibiotic use patterns, review reports on number of antibiotics prescribed and the number of residents treated each month, quarter, and year. Review reports on the number of residents on antibiotics that did not meet criteria for active infection, and review trends of antibiotic use, overuse and trends of resistance. Direct care nurse, charge nurse or IP	F 881		

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F 881	Continued From page 100 nurse would communicate with the prescribing physician if an antibiotic was ordered outside of criteria. The pharmacy consultant would review antibiotic usage data each month and make recommendations as needed. The medical director would review antibiotic use and resistance data at Quality Assurance Performance Improvement (QAPI) meetings or as needed. The facility would use McGeer's, Loeb's, or The National Healthcare and Safety Network (NHSN) criteria for assessing resident for infections. The facility would assess appropriate diagnostic testing such as cultures for various infections and evaluate the appropriateness of antibiotic therapy per laboratory results. The direct care nurse, charge nurse and/or IP nurse would screen antibiotic orders for appropriate agent selection and would communicate with the prescriber and make recommendations if indicated. The direct care nurse and prescriber would conduct an antibiotic review process after an antibiotic was started for all antibiotics prescribed. When culture results were received the nurse would contact the prescriber to review the results to ensure follow up on appropriate antibiotic therapy. The IP nurse would be responsible for ensuring the facility infection and multi-drug resistant surveillance was being done by the nursing staff. The IP nurse would be responsible to interpret data and do action responses as needed. The IP nurse would review if appropriate tests/cultures were obtained for the antibiotic order.	F 881		
F 882 SS=F	Infection Preventionist Qualifications/Role CFR(s): 483.80(b)(1)-(4) §483.80(b) Infection preventionist The facility must designate one or more	F 882		2/16/23

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F 882	Continued From page 101 individual(s) as the infection preventionist(s) (IP) (s) who are responsible for the facility's IPCP. The IP must: §483.80(b)(1) Have primary professional training in nursing, medical technology, microbiology, epidemiology, or other related field; §483.80(b)(2) Be qualified by education, training, experience or certification; §483.80(b)(3) Work at least part-time at the facility; and §483.80(b)(4) Have completed specialized training in infection prevention and control. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility infection preventionist (IP) failed to adequately assesses, develop, implement, monitor, and manage the infection prevention and control program. This had the potential to affect all 54 residents residing in the facility including staff and visitors. Findings include See also F880, Infection Prevention and Control: Based on observation, interview and document review the facility failed to ensure 5 of 5 employees, (licensed practical nurse (LPN)-A, dietary aide (DA)-D, activity aide (AA)-C, nursing assistant (NA)-D and LPN-B) were appropriately cleared to return to work following reports of potential symptoms of COVID-19; failed to initiate contact tracing or facility wide testing for COVID-19 following potential exposure from a staff who tested positive for COVID-19; failed to	F 882	TRCC's IPCO did not complete duties and task as directed. The IPCO failed to monitor, track, investigate, or assess risk of communicable illness at TRCC for staff and residents. Residents affected during survey include R108, R29, & R41. 5 staff were not tested as they met criteria for possible covid illness or communicable disease symptoms and were assessed by IPCO to return to work. Currently TRCC has 2 RNs that completed with the CDC Infection Preventionist certification since survey on 1/13/2023. 1 RN Infection Preventionist consultant completing audit for infection control at TRCC and work plan forthcoming. The DON or designee will monitor Health Connex for documentation and if illnesses	

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F 882	Continued From page 102 ensure 3 of 53 residents (R108, R29, R41) were isolated while presenting with symptoms of COVID-19; and failed to utilize appropriate protective equipment for 2 of 3 residents (R41, R50) when they were placed in isolation. In addition, the facility failed to ensure twelve employees (cook (CK)-A, activity director (AD)-A, DA-B, the director of nursing (DON), DA-C, assistant dietary manager (ADM)-A, DA-B, registered nurse (RN)-D, DA-D, NA-C, NA-A,NA-B) who were out ill with potentially communicable illness' were cleared to return to work: failed to to track resident symptoms of infection and implement an ongoing analysis of collected data to ensure patterns and trends were identified and acted upon to reduce the risk of disease spread within the facility as recommended by the Centers for Disease Control (CDC) guidance to prevent/or minimize the transmission of COVID-19. This resulted in a system wide failure in infection control procedures to prevent the spread of illness within the facility to vulnerable residents and the staff of the facility and resulted in an immediate jeopardy (IJ) which placed all 54 residents at a high likelihood to for serious illness and/or death by contracting a communicable disease, including but not limited to COVID-19. During interview on 1/10/23, at 10:20 a.m. RN-D, who was the IP, stated she saw the employees when they returned to work after having called in and none appeared ill. RN-D did not test the employees on their return to work. RN-D had known LPN-B had a family member who was ill with COVID-19 living in her home and reported not feeling well on 12/24/23; however, continued to work her entire shift. LPN-B did test positive on 12/27/22. The facility had not initiated any	F 882	are being monitored. This will be done 3x/week for four weeks, 2x/week for four weeks and then 1x/week for weeks and then monthly. Results will be brought to IDT and Quarter 2, 2023 QAPI for recommendations for ongoing monitoring. Infection Preventionist Consultant will provide monitoring monthly to the 2 trained RNs for effective CDC training and understanding.	

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F 882	Continued From page 103 testing of potentially exposed residents or staff, as RN-D felt the doctors in the area believed people tested for COVID too often. RN-D was aware of the facility's policies for staff who had signs and symptoms of COVID-19 like illness (based on screening) and/or a temperature (100 degrees or higher) should not report to work until testing could be completed as well as contact tracing for potential exposures; however, the policies were written by the corporate office and did not necessarily reflect current practice. RN-D stated she visualized all the staff members LPN-B worked with when LPN-B was presenting with symptoms at work. The unidentified staff did not display any symptoms of illness, so RN-D did not feel any COVID-19 testing was necessary, despite COVID-19 having asymptomatic transmission. RN-D saw DA-A on her return to work on 11/28/22, after testing positive for RSV on 11/24/22, and DA-A had no obvious symptoms of illness, and there were no other cases of RSV in the facility. The employees who reported symptoms of GI illness during the month of December were not tested for COVID-19 as their symptoms did not act like a COVID-19 illness. It depended on staff symptoms if they would need to test before returning to work after an illness. See also F881, Antibiotic Stewardship: Based on interview and document review, the facility failed to develop an antibiotic stewardship program which included implementation of protocols and a system to monitor antibiotic use to ensure appropriate antibiotics were utilized. In addition, the facility failed to ensure cultures were obtained for antibiotic use for 2 of 2 residents (R 23, R33) who were prescribed antibiotics for urinary tract infections (UTI). This deficient practice had the	F 882		

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F 882	Continued From page 104 potential to affect all 54 residents who resided in the facility. When interviewed on 1/11/23, at 8:30 a.m. RN-D, who was the IP stated some of the resident UTI infections should not have had an antibiotic ordered because no specific bacteria was cultured. RN-D looked for patterns and trends with the resident infections but could only find incontinence of urine and resisting staff assist with peri care after an incontinent episode as a common factor. There did not seem to be a common bacteria with the infections or in the same areas of the facility or she would have suspected staff as the source. RN-D did not document sensitivities to cultures or follow up to make sure the antibiotic ordered was effective against the identified organism. Some times the facility would get sensitivity results on cultures and sometimes they would not. In some instances the lab would not even do a sensitivity on a culture. RN-D stated she watched some staff complete peri care to ensure proper technique; however, had not documented audits formally. She had tried to start audit forms but staff had become angry with the audits and so they were not completed. RN-D did not identify if any concerns or training with peri care had been completed while performing audits. During interview on 1/12/23, at 5:30 p.m. the director of nursing (DON) stated RN-D, the IP should be documenting sensitivities and compare and analyze resident antibiotic use. RN-D should notify the physician if an antibiotic was felt to be inappropriate. The facility should be using an antibiotic use criteria such as McGeer to determine the need for treatment.	F 882		

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F 882	Continued From page 105 See also F886, COVID- 19 Testing- Residents and Staff: Based on observation, interview and record review, the facility failed to ensure all staff were tested for COVID-19 during outbreak testing; and failed to test and/or implement confirmatory testing for symptomatic residents and staff, licensed practical nurse (LPN)-A, LPN-B, dietary aide (DA)-D, activity aide (AA)-C, nursing assistant (NA)-D, R108, R29 and R41, who were not tested or had an initial negative rapid antigen testing for COVID-19, per the Centers for Disease Control (CDC) guidance on testing protocols. This system wide breakdown resulted in an immediate jeopardy (IJ) situation which had the high likelihood to cause serious illness and/or death to all 54 residents residing in the facility, along with staff and visitors. During interview on 1/10/22, at 10:15 a.m. RN-D, who was the IP, stated the facility conducted outbreak testing 11/23/22 through 12/5/22, after two residents tested positive for COVID-19 in the facility. Staff were notified of the facility test dates and were expected to test prior to working. RN-D went on the nursing floor and reminded staff who had not tested to do so, but they refused to test. The facility policy to send the staff home if they refused to test was not enforced because the facility would not have enough staff to care for their residents. Some staff who did not test during the outbreak testing were still permitted to work. RN-D stated she notified the administrator of staff non-compliance with testing; however, felt she would not have the back up to enforce staff to not work if do not test. See F888: COVID-19 Vaccination of Facility Staff: Based on interview and document review, the facility failed to ensure 13 of 72 staff members	F 882		

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F 882	Continued From page 106 (registered nurse (RN)-E, RN-F, licensed practical nurse (LPN)-E, dietary aide (DA)-C, DA-G. activity aide (AA)-D, director of human resources (DHR)-A, nursing assistant (NA)-B, NA-D, NA-J, NA-K, NA-L , NA-M) were vaccinated with a complete primary series of COVID-19 vaccine and/or had an approved or pending exemption on record. In addition, the facility failed to have a process for tracking and securely documenting the COVID-19 vaccination status for all staff and report accurate COVID-19 vaccination status of staff and related information as indicated by the Centers for Disease Control and Prevention's National Healthcare Safety Network (NHSN). This resulted in a vaccination rate of 81.94% which was greater than 10% from the data the facility had submitted to the National Healthcare Safety Network (NHSN) and had potential to affect all 54 residents in the facility. A joint interview with the administrator and RN-D was conducted on 1/11/23, at 1:30 p.m. The administrator stated DHR-A was to add the names of the new hires with a sheet regarding their vaccination status and put these on a vaccination log list. The facility struggled to keep the list up to date. RN-D identified when she got the sheets from DHR-A she looked in MIIC to verify the employee's vaccination status and had even tried to get the information from the local clinic's electronic health record, but at times had difficulty finding the information. The administrator stated she was monitoring the new hires to be sure they completed exemption forms if they were not up to date with their COVID-19 vaccinations. The administrator stated she was aware the employee vaccination logs and the NHSN data was not up to date due to the difficulty keeping the employee logs up to date and current. The	F 882		

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F 882	Continued From page 107 administrator felt RN-D struggled with utilizing the computer to organize and track the needed information. During interview on 1/12/23, at 5:30 p.m. DON stated she planned to revamp the whole infection control program. The facility Infection Prevention and Control Officer 5/8/17, identified St. Francis Health Services (SFHS) will designate one or more individuals as the Infection Prevention and Control Officer (IPCO) who will be responsible for the care center ' s Infection Prevention and Control Program (IPCP). The care center IPCO will have completed specialized training in infection prevention and control and professional training in nursing, medical technology, microbiology, epidemiology or related field. The IPCO will have the following organizational responsibilities: a. Coordinate the development and monitoring of the facility ' s established Infection Prevention and Control policies and practices, b. Establish Infection Prevention and Control procedures for surveillance, identification, investigation, control, and prevention of infections and communicable diseases, for all persons providing services in the facility, c. Identify and implement basic infection control measures (e.g. hand hygiene and standard precautions), transmission-based precautions for identified potentially communicable infections, and isolation procedures as appropriate, d. Implement Antibiotic Stewardship program that includes antibiotic use protocols and a system to monitor ABI use and resistance data, e. Implement outbreak control and preparedness planning procedures,	F 882		

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F 882	Continued From page 108 f. Report required diseases to public health authorities, g. Maintain an Infection Surveillance program with Infection Control Log of incidents for both residents and staff, with documentation of analysis of tracking and trending and measures taken according to findings, h. Promote Infection prevention, and responsibility of care during Care Transitions, i. Serve as a member of and bring reports on the IPCP to the facility ' s QAPI Committee. The IPCO will have the following resident care responsibilities: a. Maintain a resident health program that includes Tb screening, Influenza and Pneumovac immunizations, and tracking of infections. b. Ensure resident care equipment is cleaned and disinfected according to Centers for Disease Control and Prevention (CDC) and manufacturer guidelines. c. Monitor resident infection control care practices. The IPCO will have the following personnel responsibilities: a. Ensure implementation of the employee health program that includes: i. Employee TB program, ii. Employee immunization program, iii. Employee infectious illness guidelines, iv. Employee exposure plan. b. Provide required health care staff orientation and annual in-service training on infection control, including bloodborne pathogens and use of personal protective equipment (PPE), c. Provide educational materials for residents, families and providers	F 882		

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F 882	Continued From page 109 d. Ensure linen handling procedures comply with infection control practices.	F 882		
F 886 SS=L	COVID-19 Testing-Residents & Staff CFR(s): 483.80 (h)(1)-(6) §483.80 (h) COVID-19 Testing. The LTC facility must test residents and facility staff, including individuals providing services under arrangement and volunteers, for COVID-19. At a minimum, for all residents and facility staff, including individuals providing services under arrangement and volunteers, the LTC facility must: §483.80 (h)((1) Conduct testing based on parameters set forth by the Secretary, including but not limited to: (i) Testing frequency; (ii) The identification of any individual specified in this paragraph diagnosed with COVID-19 in the facility; (iii) The identification of any individual specified in this paragraph with symptoms consistent with COVID-19 or with known or suspected exposure to COVID-19; (iv) The criteria for conducting testing of asymptomatic individuals specified in this paragraph, such as the positivity rate of COVID-19 in a county; (v) The response time for test results; and (vi) Other factors specified by the Secretary that help identify and prevent the transmission of COVID-19. §483.80 (h)((2) Conduct testing in a manner that is consistent with current standards of practice for conducting COVID-19 tests;	F 886		2/16/23

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F 886	Continued From page 110 §483.80 (h)((3) For each instance of testing: (i) Document that testing was completed and the results of each staff test; and (ii) Document in the resident records that testing was offered, completed (as appropriate to the resident's testing status), and the results of each test. §483.80 (h)((4) Upon the identification of an individual specified in this paragraph with symptoms consistent with COVID-19, or who tests positive for COVID-19, take actions to prevent the transmission of COVID-19. §483.80 (h)((5) Have procedures for addressing residents and staff, including individuals providing services under arrangement and volunteers, who refuse testing or are unable to be tested. §483.80 (h)((6) When necessary, such as in emergencies due to testing supply shortages, contact state and local health departments to assist in testing efforts, such as obtaining testing supplies or processing test results. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure all staff were tested for COVID-19 during outbreak testing; and failed to test and/or implement confirmatory testing for symptomatic residents and staff, licensed practical nurse (LPN)-A, LPN-B, dietary aide (DA)-D, activity aide (AA)-C, nursing assistant (NA)-D, R108, R29 and R41, who were not tested or had an initial negative rapid antigen testing for COVID-19, per the Centers for Disease Control (CDC) guidance on testing	F 886	TRCC did not complete covid monitoring and testing as recommended by the CDC. The facility failed to monitor, track, investigate, or assess risk of communicable illness at TRCC for staff and residents. Residents affected during survey include R108, R29, & R41. Staff were not tested as they met criteria for possible covid illness or communicable disease symptoms and were assessed by IPCO to return to work.	

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F 886	Continued From page 111 protocols. This system wide breakdown resulted in an immediate jeopardy (IJ) situation which had the high likelihood to cause serious illness and/or death to all 54 residents residing in the facility, along with staff and visitors. The IJ began on 11/23/22, when the facility identified an outbreak of COVID-19 in November and failed to ensure all staff were tested according to CDC outbreak testing requirements. The facility failed to provide evidence 34 staff who worked during outbreak were tested. In addition, the facility failed to initially test or provide a confirmatory test for residents and/or staff who exhibited or reported symptoms of COVID-19 and were tested with antigen tests. The administrator and the director of nursing (DON) were notified of the IJ on 1/10/23, at 2:00 p.m. The immediate jeopardy was removed on 1/11/23, at 3:00 p.m. when the facility implemented interventions to ensure all staff would be tested according to CDC guidelines; however, noncompliance remained at the lower scope and severity level of F, widespread, which indicated no actual harm with potential for more than minimal harm that was not immediate jeopardy. Findings include: The CDC guidance Interim Infection Prevention and Control Recommendations for Healthcare Personnel (HCP) During the Coronavirus Diseases 2019 (COVID-19) Pandemic updated 9/23/22, indicated for nursing homes, a single new case of SARS-CoV-2 infection in any HCP or resident should be evaluated to determine if others in the facility could have been exposed. The approach to an outbreak investigation could involve either contact tracing or a broad-based	F 886	R 108, R 29, & R41 were placed in isolation and Covid testing protocol was started. Testing at Days 1, 3, 5, 5-7 days later and again 5-7 days later and 10 days of quarantine. PPE was placed outside of rooms with signage for type of isolation, PPE don and doffing, and notice to visitors and staff to see nursing prior to entering the first time. Staff were reeducated on PPE, types of isolation precautions, hand hygiene, covid testing, monitoring, and surveillance. Testing of all residents and current staff for covid outbreak testing started on 1/11 as day 1 and followed the day 3, day 5, 5-7 days after and again 5-7 days after to end on 1/30. Results were recorded in Health Connex for tracking purpose. Reeducated staff on Covid signs and symptoms, self-surveillance/check in daily and temperature taking, PPE don and doff, transmission precautions, hand hygiene, antibiotic stewardship program, employee infectious illness guidelines, and infection surveillance. Reeducated on process of checking in daily to review symptom changes, resolution, and return to work and COVID testing upon return. Also reeducated that Covid testing is mandatory prior to starting a shift if returning from illness, symptom development, or outbreak testing. The DON or designee will audit if symptomatic staff or residents were tested for COVID-19 by reviewing call in slips,	

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F 886	Continued From page 112 approach; however, a broad-based (e.g., unit, floor, or other specific area(s) of the facility) approach is preferred if all potential contacts could not be identified or managed with contact tracing or if contact tracing failed to halt transmission. Perform testing for all residents and HCP identified as close contacts or on the affected unit(s) if using a broad-based approach, regardless of vaccination status. Testing is recommended immediately (but not earlier than 24 hours after the exposure) and, if negative, again 48 hours after the first negative test and, if negative, again 48 hours after the second negative test. This will typically be at day 1 (where day of exposure is day 0), day 3, and day 5. The CDC guidance Interim Guidance for Managing Healthcare Personnel with SARS-CoV-2 (COVID-19) Infection or Exposure to SARS-CoV-2 updated 9/23/22 indicated when testing a person with symptoms of COVID-19, negative results from at least one viral test indicate that the person most likely does not have an active SARS-CoV-2 infection at the time the sample was collected. If using an antigen test, a negative result should be confirmed by either a negative NAAT (molecular) or second negative antigen test taken 48 hours after the first negative test. HCP who are not symptomatic could return to work after results are negative from at least two consecutive respiratory specimens collected 48 hours apart (total of two negative specimens) tested using an antigen test or NAAT. STAFF OUTBREAK TESTING: The facility's undated staff line testing forms identified outbreak testing began on 11/23/22, and the facility was testing three times weekly	F 886	staff self-screening sheets, reviewing surveillance line list for staff/residents and by doing a chart review on residents. This will be done 3x/week for four weeks, 2x/week for four weeks and then 1x/week for four weeks and then monthly. Results will be brought to IDT and Quarter 2, 2023 QAPI for recommendations for ongoing monitoring.	

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F 886	Continued From page 113 through 12/5/22. The staff line testing form and corresponding working schedules for November 23, 2022 through 12/9/22, identified the following: - On 11/23/22, the facility began their first week of outbreak testing for all staff and residents in the facility following two residents who tested positive for COVID-19. The facility scheduled the first week of testing for staff on 11/23/22, 11/25/22, and 11/28/22. Of the 76 staff listed on the testing logs, 21 staff tested negative on 11/23/22, two staff were not eligible to be tested and the remaining 53 staff did not have test results recorded. On 11/25/22, 10 staff tested negative for COVID-19, two staff were ineligible for testing and 64 staff did not have test results recorded. On 11/28/22, 18 staff tested negative for COVID-19, two staff were ineligible to test and 56 staff did not have test results recorded. - On 11/29/22, the facility began their second week of outbreak testing for COVID-19. The facility scheduled the second week of testing staff on 11/29/22, 12/1/22, and 12/5/22. On 11/29/22, of the 82 staff listed on the testing logs, 14 staff tested negative on 11/29/22, two were ineligible to test, and 64 staff did not have test results recorded. On 12/1/22, 22 staff tested negative, two were ineligible to test and 58 staff did not have test results recorded. On 12/5/22, 25 staff tested negative for COVID-19, two staff were ineligible to test and 55 staff did not have test results recorded. The facility time sheets during the entire outbreak period identified 34 of the facility staff worked in the facility during the outbreak period 11/23/22, through 12/5/22, without having completed any of the required outbreak testing.	F 886		

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F 886	Continued From page 114 During interview on 1/10/22, at 10:15 a.m. registered nurse (RN)-D, who was also the infection prevention (IP) nurse, stated the facility conducted outbreak testing 11/23/22 through 12/5/22, after two residents tested positive for COVID-19 in the facility. Staff were notified of the facility test dates and were expected to test prior to working. RN-D went on the nursing floor and reminded staff who had not tested to do so, but they refused to test. The facility policy to send the staff home if they refused to test was not enforced because the facility would not have enough staff to care for their residents. Some staff who did not test during the outbreak testing were still permitted to work. RN-D stated she notified the administrator of staff non-compliance with testing; however, felt she would not have the back up to enforce staff to not work if do not test. - LPN-B had a family member who was ill with COVID-19 living in her home and reported not feeling well on 12/24/22; however, continued to work her entire shift and tested positive on 12/27/22. The facility did not initiate any testing of potentially exposed residents or staff, as RN-D thought the doctors in the area felt people tested for COVID to often. RN-D was aware of the facility's policy's regarding COVID-19 testing; however, the policies were written by the corporate office and did not necessarily reflect current practice. RN-D had observed the staff LPN-B worked with and they did not display any symptoms of illness, and didn't feel testing them was necessary. When interviewed on 1/10/22, at 3:30 p.m. the administrator stated when outbreak testing, the facility would conduct antigen testing three times	F 886		

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F 886	Continued From page 115 a week for two weeks. If any COVID positive tests were obtained the start cycle of testing would start over, until no new positive tests were obtained. The facility would stop testing and consider the outbreak resolved when no new positive tests were documented for two weeks. The administrator was not sure how the facility determined the outbreak had resolved when all the employees had not tested as required. All staff were notified by mass text to comply with outbreak testing and assumed they were compliant. If staff did not work on the scheduled test dates, they could test prior to their next scheduled shift. The administrator was not aware any staff were refusing to test. The facility expected all staff to test prior to working with residents when in outbreak status. The administrator did not think this was enforced but it was the expectation. If staff displayed illness that could indicate a COVID-19 infection, the ill staff was to isolate and COVID-19 testing would be done on day one, day three and day five of symptom onset. If results of the testing was negative and the staff was asymptomatic, isolation was lifted. The facility had not initiated outbreak testing when LPN-B had tested positive as her positive test was more than 48 hours since she had last worked, despite having displayed symptoms of COVID-19 while at work on 12/24/22. During interview on 1/11/23, at 8:51 a.m. LPN-C stated outbreak testing was done two times per week. LPN-C may have forgotten to get tested during the outbreak as required. No one ever stated a test was needed to be done before the start of the shift. Sometimes RN-D would remind staff to come and test but LPN-C was already working on the floor by then. If LPN-C	F 886		

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F 886	Continued From page 116 remembered to test she did so. LPN-C was not aware of any consequences if staff did not test as required. When interviewed on 1/11/23, at 9:15 a.m. NA-G stated facility outbreak testing was done sometimes two times per week and sometimes three times per week. NA-G tested when she was told to test. NA-G did not think the last round of facility testing was for everyone to test, just some of the staff, as not all of the staff were exposed to the COVID positive resident. On 1/11/23, at 10:30 a.m. LPN-B stated the staff did have to test for COVID-19 during the outbreak starting 11/23/22. The testing was done one or two times per week or if you lived a distance from the facility, staff just had to test prior to start of their shift. When interviewed on 1/11/23, at 10:50 a.m. NA-H stated facility outbreak testing was conducted two times per week. NA-H did not come in for the testing but did a rapid antigen test prior to starting her shift. The nurse on the duty did the test and gave the results to RN-D. RN-D did not always document all the staff COVID antigen tests, but NA-H knew she tested when required. During interview on 1/11/23, at 9:55 a.m. the administrator stated she was not aware so many of the facility staff had not tested during the outbreak testing that was conducted 11/23/22 through 12/5/22, and thought the facility compliance had improved. The administrator did not know why the untested staff were allowed to work and felt the facility needed to do a better job with their COVID-19 testing. The expectation was a list would be made of all the staff who had	F 886		

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F 886	Continued From page 117 not tested and a plan to see who had not been tested and how it would get done prior to their next scheduled shifts. TESTING WITH SYMPTOMS: Staff: The facility staff infection control logs for the month of December 2022, identified the following: -On 12/4/22, licensed practical nurse (LPN)-A reported aching, sore throat, and headache. LPN-A was not tested for COVID-19 illness. LPN-A returned to work on 12/5/22. LPN-A worked 12/5/22, 12/6/22 and 12/7/22. On 12/8/22, LPN-A tested positive for influenza B. LPN-A was not tested for COVID-19. LPN-A returned to work on 12/10/22. -On 12/6/22, DA-D reported increase respiratory symptoms. DA-D returned to work on 12/21/22. A COVID-19 test was not documented prior to return to work. -On 12/7/22, AA-C reported symptoms of aching and cough. AA-C was not tested for COVID-19. AA-C returned to work on 12/12/22. -On 12/19/22, NA-D reported respiratory symptoms. NA-D was not tested for COVID-19. NA-D returned to work on 12/20/22. On 12/21/22, NA-D reported illness and tested positive for COVID-19. -On 12/24/22, LPN-B reported illness of headache and aching while working her shift. LPN-B tested positive for COVID-19 on 12/27/22. LPN-B returned to work on 12/29/22. There was no evidence an assessment was conducted to determine potential resident and staff exposures or if there were a need to conduct	F 886		

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F 886	Continued From page 118	F 886		

contact or outbreak testing based on the positive staff results.

Residents:

-Progress note (PN) on 12/16/22, identified R108 developed decrease lung sounds and oxygen saturations of 70 to 80% with oxygen in place. R108 required hospitalization and returned with a diagnosis of pneumonia with unknown origin. R108 was not evaluated or tested for COVID-19 during the initial course of illness to rule out COVID-19.

-PN on 1/9/23, identified R29 developed symptoms of nausea and vomiting. A rapid antigen COVID-19 test was performed and was negative. The medical record lacked documentation of a secondary test performed to confirm the negative finding.

-PN on 1/4/23, identified R41 developed a low grade temperature of 99. 5 F, oxygen saturation of 93% with supplemental oxygen at 2L/min, and had complaints of not feeling well. A rapid antigen COVID-19 test was performed and was negative. On 1/10/23, R41 was observed symptomatic with cough and general malaise and out with other residents; however, no further COVID-19 tests had been conducted.

During interview on 1/10/22, at 10:15 a.m. registered nurse RN-D, the IP nurse, was notified R41 was tested for COVID-19 on 1/4/23, and was negative. RN-D was not sure why further follow up testing for COVID-19 was not done for R41. RN-D assisted R41 in the dining room on 1/6/23, and observed R41 with nasal drainage and was coughing, so she wheeled her out of the dining

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F 886	Continued From page 119 room and notified the charge nurse. Testing was usually done on day one, day three and day five for symptomatic staff and residents because of the potential incubation period of the illness. RN-D usually did the COVID testing for residents but had not filled out the sheets for R41's follow up tests .The sheets were completed so the required follow up testing can be completed. When interviewed on 1/10/22, at 3:30 p.m. the administrator stated if residents displayed illness that could indicate a COVID-19 infection, the ill resident was to isolate and COVID-19 testing would be done on day one, day three and day five of symptom onset. If results of the testing was negative and the resident was asymptomatic isolation was lifted. During interview on 1/10/23, at 4:00 p.m. registered nurse (RN)-A stated if a resident showed signs of COVID-19, they would isolate the resident and test with a rapid antigen test. If still showing symptoms they would retest the resident. They always notified RN-D when they tested a resident for COVID-19. R41 displayed a cough and low grade fever. R41 was tested on 1/4/23, and was negative for COVID-19. R41 still exhibited symptoms of cough and her oxygen saturation was 95% at rest with supplemental oxygen, but the cough was loose and in the chest, not in the lungs. RN-A had not personally done a repeat COVID test and would have to check with the nurses working on the floor if another test was needed. No second confirmatory testing was completed after the initial test was done on 1/4/23, despite R41's continued symptoms. The facility's Coronavirus Prevention, Screening	F 886		

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F 886	Continued From page 120 and Identification policy dated 10/9/22, indicated If a resident exhibited any symptoms of respiratory infection, or other COVID-19 related symptoms the resident's provider would be notified immediately. Quarantine interventions and testing would be initiated. If initial test was negative, the resident would be encouraged to use mask and social distance. Staff who had signs and symptoms of COVID-19 like illness (based on screening) and/or a temperature (100 degrees or higher) would not report to work until testing can be completed. Staff who had mild to moderate illness who were not moderately to severely Immunocompromised, could return to work if at least 7 days if a negative antigen or reverse transcription polymerase chain reaction (PCR) was obtained within 48 hours prior to returning to work or 10 days have passed since symptoms had first appeared, and at least 24 hours had passed since last fever without the use of fever-reducing medications, and symptoms (e.g., cough, shortness of breath) had improved. Staff who were asymptomatic throughout their infection and were not moderately to severely Immunocompromised could return to work if at least 7 days if a negative antigen or PCR was obtained within 48 hours prior to returning to work or after 10 days if testing was not performed. Staff who had a high risk exposure would have three viral tests for SARS-CoV-2 infection. testing would occur (as able) on day one (where day of exposure is day 0), day three, and day five. Care center would keep a list of any staff unprotected exposure to COVID-19. The list would include all staff that interacted with the positive person from two days before symptoms started. For potential staff exposure, the facility would complete Assessment for Health Care Workers (HCW) Assessment for Health Care Workers Potentially	F 886		

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F 886	Continued From page 121 Exposed to COVID-19 in Minnesota. Identify the risk level using assessment. Contact tracing may indicate low risk when there was no direct exposure to a COVID-19 infected person. Contact risk was identified as close (within 6 feet for 15 minutes or more, or within same living space) contact of person(s) with COVID-19 within 48 hours. Communicate the risk level to the staff with work-related recommendations. Recommendations would be followed for staff who had high-risk workplace exposure to COVID-19 and staff with household or intimate contacts who had confirmed or suspected COVID-19. The facility's policy COVID-19 Testing, dated 9/29/22, indicated COVID-19 testing strategies would be implemented to assist with identification and mitigation of spread of COVID-19 illness. The care center would test residents and staff based on parameters defined by the Center for Medicare and Medicaid Services (CMS), the Minnesota Department of Health (MDH) and the CDC. Symptomatic residents or staff would be tested. If newly identified COVID-19 positive staff or resident were identified all staff and residents would be tested, regardless of vaccination status. Any care center staff who refused to test would not be allowed to work within the care center. An employee must be tested prior to returning to work. Positive results from antigen tests are highly accurate, but there would be a chance of false negatives. A negative rapid antigen test may need to be confirmed using a RT-PCR test, especially if the result of the antigen test was inconsistent with the clinical symptoms. Individuals who have signs and symptoms must be tested on days one, three and five for COVID-19. If positive results the employee must	F 886		

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F 886	Continued From page 122 be removed from the care center and may remain out for up to ten days from the beginning of symptoms. Residents with signs and symptoms must be tested and if positive test, quarantine for ten days. All residents and staff with exposure should be tested immediately and all staff and residents that tested negative should be retested every five to seven days until testing identified no new cases of COVID-19 infection among staff or residents. Care centers will complete testing according to MDH, CDC and CMS guidelines. For symptomatic residents and staff, the date and time of identification of symptoms, when testing was conducted and the results and the actions the care center took based on the results would be documented. The facility would document the actions taken for residents and staff who refuse testing. The IJ which began on 11/23/22, was removed on 1/11/23, at 3:00 p.m. when it could be verified through interview and document review the facility implemented housewide COVID-19 testing in accordance with CDC guidance, including performing confirmatory testing on symptomatic antigen negative residents and staff. Education was provided to all employees on current and updated COVID-19 protocols for testing.	F 886		
F 888 SS=C	COVID-19 Vaccination of Facility Staff CFR(s): 483.80(i)(1)-(3)(i)-(x) §483.80(i) COVID-19 Vaccination of facility staff. The facility must develop and implement policies and procedures to ensure that all staff are fully vaccinated for COVID-19. For purposes of this section, staff are considered fully vaccinated if it has been 2 weeks or more since they completed	F 888		2/16/23

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F 888	Continued From page 123	F 888		

a primary vaccination series for COVID-19. The completion of a primary vaccination series for COVID-19 is defined here as the administration of a single-dose vaccine, or the administration of all required doses of a multi-dose vaccine.

§483.80(i)(1) Regardless of clinical responsibility or resident contact, the policies and procedures must apply to the following facility staff, who provide any care, treatment, or other services for the facility and/or its residents:
(i) Facility employees;
(ii) Licensed practitioners;
(iii) Students, trainees, and volunteers; and
(iv) Individuals who provide care, treatment, or other services for the facility and/or its residents, under contract or by other arrangement.

§483.80(i)(2) The policies and procedures of this section do not apply to the following facility staff:
(i) Staff who exclusively provide telehealth or telemedicine services outside of the facility setting and who do not have any direct contact with residents and other staff specified in paragraph (i)(1) of this section; and
(ii) Staff who provide support services for the facility that are performed exclusively outside of the facility setting and who do not have any direct contact with residents and other staff specified in paragraph (i)(1) of this section.

§483.80(i)(3) The policies and procedures must include, at a minimum, the following components:
(i) A process for ensuring all staff specified in paragraph (i)(1) of this section (except for those staff who have pending requests for, or who have been granted, exemptions to the vaccination requirements of this section, or those staff for

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F 888	Continued From page 124 whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations) have received, at a minimum, a single-dose COVID-19 vaccine, or the first dose of the primary vaccination series for a multi-dose COVID-19 vaccine prior to staff providing any care, treatment, or other services for the facility and/or its residents; (iii) A process for ensuring the implementation of additional precautions, intended to mitigate the transmission and spread of COVID-19, for all staff who are not fully vaccinated for COVID-19; (iv) A process for tracking and securely documenting the COVID-19 vaccination status of all staff specified in paragraph (i)(1) of this section; (v) A process for tracking and securely documenting the COVID-19 vaccination status of any staff who have obtained any booster doses as recommended by the CDC; (vi) A process by which staff may request an exemption from the staff COVID-19 vaccination requirements based on an applicable Federal law; (vii) A process for tracking and securely documenting information provided by those staff who have requested, and for whom the facility has granted, an exemption from the staff COVID-19 vaccination requirements; (viii) A process for ensuring that all documentation, which confirms recognized clinical contraindications to COVID-19 vaccines and which supports staff requests for medical exemptions from vaccination, has been signed and dated by a licensed practitioner, who is not the individual requesting the exemption, and who is acting within their respective scope of practice as defined by, and in accordance with, all	F 888		

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F 888	Continued From page 125 applicable State and local laws, and for further ensuring that such documentation contains: (A) All information specifying which of the authorized COVID-19 vaccines are clinically contraindicated for the staff member to receive and the recognized clinical reasons for the contraindications; and (B) A statement by the authenticating practitioner recommending that the staff member be exempted from the facility's COVID-19 vaccination requirements for staff based on the recognized clinical contraindications; (ix) A process for ensuring the tracking and secure documentation of the vaccination status of staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations, including, but not limited to, individuals with acute illness secondary to COVID-19, and individuals who received monoclonal antibodies or convalescent plasma for COVID-19 treatment; and (x) Contingency plans for staff who are not fully vaccinated for COVID-19. Effective 60 Days After Publication: §483.80(i)(3)(ii) A process for ensuring that all staff specified in paragraph (i)(1) of this section are fully vaccinated for COVID-19, except for those staff who have been granted exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations; This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure 13 of 72 staff members	F 888	TRCC did not complete covid vaccination monitoring/documentation. The facility	

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F 888	Continued From page 126 (registered nurse (RN)-E, RN-F, licensed practical nurse (LPN)-E, dietary aide (DA)-C, DA-G. activity aide (AA)-D, director of human resources (DHR)-A, nursing assistant (NA)-B, NA-D, NA-J, NA-K, NA-L , NA-M) were vaccinated with a complete primary series of COVID-19 vaccine and/or had an approved or pending exemption on record. In addition, the facility failed to have a process for tracking and securely documenting the COVID-19 vaccination status for all staff and report accurate COVID-19 vaccination status of staff and related information as indicated by the Centers for Disease Control and Prevention's National Healthcare Safety Network (NHSN). This resulted in a vaccination rate of 81.94% which was greater than 10% from the data the facility had submitted to the National Healthcare Safety Network (NHSN) and had potential to affect all 54 residents in the facility. Findings include: During the recertification survey, from 1/9/23 to 1/12/23, evidence of staff vaccinations was requested. An untitled Staff COVID Vaccine Status listing dated 9/18/22, provided by registered nurse (RN)-D, the infection preventionist (IP), demonstrated all staff member's vaccination status with completed primary series date(s), and any provided booster doses of COVID-19 vaccines. Exempt staff members were identified with an E by their name. This listing identified a total of 72 staff members and four contracted staff members. Thirteen staff members, RN-E, RN-F, LPN-E, DA-C, DA-G. AA-D, DHR-A, NA-B, NA-D, NA-J, NA-K, NA-L and NA-M were not listed on the staff vaccination log at all. Further, the thirteen staff members were not included with the staff who had filed and	F 888	failed to monitor, track, and obtain exemption or document covid vaccination status for 13:72 staff. Documentation of new staff vaccination status after 10/22 failed to upon TRCC's policy of Mandatory COVID Immunization. Employees without updated covid vaccination status were updated in Human Resources records and will be updated in Health Connex when records are shared by HR to the DON. Updating all incoming staff's vaccination status is being completed by Director of HR. These reports are then given to the DON or designee to enter into Health Connex employee file. Additionally, to protect staff that are unvaccinated or not up to date on covid boosters policy was implemented for isolation for any resident demonstrating symptoms. PPE was placed outside of rooms with signage for type of isolation, PPE don and doffing, and notice to visitors and staff to see nursing prior to entering the first time. Staff were reeducated on PPE, types of isolation precautions, hand hygiene, covid testing, monitoring, and surveillance. Reeducated staff on Covid signs and symptoms, self-surveillance/check in daily and temperature taking, PPE don and doff, transmission precautions, hand hygiene, antibiotic stewardship program, employee infectious illness guidelines, and infection surveillance. Reeducated on process of checking in daily to review	

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F 888	Continued From page 127 approved exemptions. The vaccination data reported to NHSN for the week ending 12/18/22, indicated the facility reported staff completed vaccination rate as 70%, which reflected greater than 10% difference from the facility's actual staff vaccination rate of 81.94%. During interview on 1/10/23, at 11:45 a.m. RN-D, the infection control nurse (IP) stated she was not sure what the vaccination or exemption status was for DA-G and NA-M, as they were hired in September 2022, and she had not gotten the information from them. RN-D stated she should have known their status and would check the Minnesota Immunization Information Connection (MIIC) to get that information. On 1/10/23, at 4:00 p.m. RN-D provided seven employee MIIC reports. The reports included vaccination status for DA-G. and NA-M, both of whom were not up to date with the COVID-19 vaccinations. RN-D did not answer when asked if she had informed consent from the employees to access their MIIC report data and was unable to provide a release of information from the employees. A joint interview with the administrator and RN-D was conducted on 1/11/23, at 1:30 p.m. The administrator stated DHR-A was to add the names of the new hires with a sheet regarding their vaccination status and put these on a vaccination log list. The facility struggled to keep the list up to date. RN-D identified when she got the sheets from DHR-A she looked in MIIC to verify the employee's vaccination status and even tried to get the private employee information from	F 888	symptom changes, resolution, and return to work and COVID testing upon return. The DON or designee will monitor covid vaccination status with updated new employee list and covid vaccination status form weekly. These new employees will then be entered into Health Connex. The DON or designee will audit all incoming employees in Health Connex. This will be done 3x/week for four weeks, 2x/week for four weeks and then 1x/week for weeks and then monthly. Results will be brought to IDT and Quarter 2, 2023 QAPI for recommendations for ongoing monitoring.	

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F 888	Continued From page 128 the local clinics electronic health record but at times had difficulty finding the information. The administrator stated she was monitoring the new hires to be sure they completed exemption forms if they were not up to date with their COVID-19 vaccinations. The administrator stated she was aware the employee vaccination logs and the NHSN data was not up to date due to the difficulty keeping the employee logs up to date and current. The administrator felt RN-D struggled with utilizing the computer to organize and track the needed information. The facility's undated Mandatory COVID Immunization policy indicated the policy required employees to receive the COVID-19 vaccine or obtain a documented exemption as a condition of employment as mandated by federal regulations. All employees must provide written documentation to Human Resources demonstrating they had been fully vaccinated or obtained a religious or medical exemption as an accommodation. Initial failure of any employee to receive a COVID-19 vaccination or submit a Request for Exemption form by the deadline would result in the employee being placed on unpaid suspension for up to 14 days so that the employee could come into compliance.	F 888		

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 01/10/2023. At the time of this survey, the Thief River Care Center was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		02/06/2023

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

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K 000	Continued From page 1 Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. The Thief River Care Center is a 1-story building with no basement that was built in 2011 and was determined to be of Type II(000) construction. This facility is fully protected throughout by an automatic fire sprinkler system and has a fire alarm system with smoke detection in the corridors and spaces open to the corridors, that is monitored for automatic fire department notification. The facility is protected throughout by a complete fire sprinkler system. The facility also has smoke detection throughout the corridors and	K 000		

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K 000	Continued From page 2 spaces open to the corridors. The facility has a capacity of 70 beds and had a census of 56 at the time of the survey. The requirements at 42 CFR, Subpart 483.70(a), are NOT MET as evidenced by:	K 000		
K 291 SS=C	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 documentation review and staff interview the facility failed to maintain emergency lighting system per NFPA 101 (2012 edition), Life Safety Code, sections 19.2.9.1 and 7.9.3.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 01/10/2023, between 09:30am and 12:30pm, it was revealed by a review of available documentation that inspection documentation for the battery operated emergency lighting throughout the facility was not complete. The documentation failed to indicate which dates the emergency lights where tested for the 30 minutes duration and which dates the emergency lighting was tested for the required 90 minutes. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 291	1. The facility will document that all battery operating emergency lighting will be tested for 30 minutes monthly and 90 minutes annually. The 90 minute annual test will be completed by February 10, 2023. 2. The environmental services supervisor and assistant will receive education on the facility's emergency lights testing policy, which includes the requirement for 90 minute testing each year. 3. The Administrator will audit the emergency lighting logs monthly for 3 months to ensure compliance is sustained. 4. The environmental services director is responsible for the corrective actions and maintaining compliance.	2/16/23

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K 353 SS=E	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 spacing between storage and the sprinkler system per NFPA 101 (2012 edition), Life Safety Code, Section 9.7.5, NFPA 25 (2011 edition), Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, Section 5.2.1.2, and NFPA 13 (2010 edition), Standard for the Installation of Sprinkler Systems, Sections 8.6.5.3.2 and 8.15.9. These deficient findings could a patterned impact on the residents within the facility. Findings include: On 01/10/2023, between 0930am and 12:30pmpm, it was revealed by observation that	K 353	1. The environmental services director relocated items from the dry and cold pantry area to comply with the required 18 inches clearance from the sprinkler heads. 2. The environmental services director or designee will inspect other areas of the facility where storage has the potential of being within 18 inches of the sprinkler heads and verify other storage spaces are in compliance with the regulation. 3. The environmental services director or designee will complete weekly inspections of the dry and cold pantry to ensure compliance is sustained. Audits will be completed weekly for twelve	2/16/23

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K 353	Continued From page 4 storage materials had been placed on a storage rack, bringing the storage materials within the required 18 inch clearance area under the sprinkler heads. These obstructions were found in: 1) Pantry Dry Storage Room 2) Pantry - Cold Storage An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K 353	weeks. 4. The Environmental services is responsible for the corrective actions and maintaining compliance.	
K 372 SS=F	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain their smoke barrier per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.7.1, 19.3.7.3, 8.5.2.2, and 8.5.6.5. This deficient finding could have a widespread impact on the residents within the facility. Findings include:	K 372	1. The environmental services director sealed the fire barrier identified during the inspection on 1/11/2023. 2. If any contractor working on the TRCC campus has the need for penetrating through the smoke barrier, the area will be completed immediately after the contractors work is finished. The	2/16/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245252	A. BUILDING **02 - THEIF RIVER CARE CENTER NEW BLDG** B. WING _____	**01/10/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THIEF RIVER CARE CENTER	**2001 EASTWOOD DRIVE** **THIEF RIVER FALLS, MN 56701**

(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 372	Continued From page 5 On 01/10/2023 between 9:30am and 12:30pm, it was revealed by observation that there was a penetration running from one smoke compartment to another above doors between Blueberry Pod and the Link hallway. An interview with Maintenance Director verified this deficient finding at the time of discovery	K 372	inspection will take place specifically to look at the smoke barrier and ensure there is no penetration of the smoke barrier. 3. For any contractor who requires access through any smoke barrier, the environmental services director will complete an inspection of the smoke barrier area and document his findings on an audit form and make corrections as necessary. One audit will be completed each time a contractor has access to upstairs and will continue for 6 months. 4. The environmental services director is responsible for corrective actions and monitoring of compliance.	
K 511 SS=D	Utilities - Gas and Electric CFR(s): NFPA 101 Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to secure electrical panels per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.3.2.2.1.3. This deficient finding could have an isolated impact on the residents within	K 511	1. The environmental services director immediately locked the electrical panel identified during the inspection. 2. The environmental services director will inspect all electrical panels throughout	2/16/23

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K 511	Continued From page 6 the facility. Findings include: On 01/10/2023, between 0930am and 1230pm, it was revealed by observation that the electrical panel located in the maintenance/service hallway was not locked. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 511	the facility to ensure they are secured properly. The environmental services director has sole possession for the keys to lock the electrical panels. 3. The environmental services assistant will complete weekly audits of one electrical panel selected at random to verify compliance. Any electrical work done within the facility by an outside contractor will be reviewed to ensure the electrical panels are secure. Both of these inspections will be documented on an audit form for 3 months. 4. The environmental services director will be responsible for corrective actions and ongoing compliance.	
K 712 SS=C	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to conduct fire drills under varied times and conditions per NFPA 101 (2012 edition), Life Safety Code, sections 19.7.1.6, 4.7.4, and 4.6.1.1. This	K 712	1. The environmental services director will vary fire drill times based on a scheduled created by the Administrator. The schedule will ensure drills are completed at least one shift per quarter to	2/16/23

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K 712	Continued From page 7 deficient finding could have a widespread impact on the residents within the facility. Findings include: 1. On 01/10/2023, between 9:30am and 12:30pm, it was revealed by a review of available documentation that fire drills did not meet the varying time requirement: A) first shift - 02/21/2022 at 1:53pm, 05/31/2022 at 1:12pm and on 08/31/2022 at 1:25pm B) second shift - 06/30/2022 at 9:30pm, 08/31/2021 at 9:00pm, and 12/30/2022 at 9:15pm. C) third shift - 04/30/22 at 10:30pm, 07/31/2022 at 10:45pm and 10/31/2022 at 10:45pm. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 712	maintain compliance but also to ensure varied times occur to prevent predictability. Only the environmental services supervisor and the Administrator are aware of the schedule. 2. The environmental services supervisor will follow the schedule for fire drills for the year to prevent reoccurrence of this deficiency. 3. The Administrator will complete a monthly audit to verify the drills meet one shift per quarter but also varied for 3 months. 4. The environmental services supervisor is responsible for the corrective actions and monitoring of compliance.	
K 901 SS=F	Fundamentals - Building System Categories CFR(s): NFPA 101 Fundamentals - Building System Categories Building systems are designed to meet Category 1 through 4 requirements as detailed in NFPA 99. Categories are determined by a formal and documented risk assessment procedure performed by qualified personnel. Chapter 4 (NFPA 99)	K 901		2/16/23

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K 901	Continued From page 8 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility has failed to provide a complete facility Risk Assessment per NFPA 99 (2012 edition), Health Care Facilities Code, section 4.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 01/10/2023, 09:30am and 12:30pm, it was revealed during documentation review and an interview with the Environmental Services that the utility risk assessment document could not be provided at the time of the survey An interview with the Maintenance Director verified this deficient finding at the time of discovery	K 901	1. The environmental services director will complete the utilities risk assessment no later than 2/10/2023. The risk assessment will be maintained in the emergency preparedness/life safety book. 2. The environmental services supervisor and the administrator will be educated on the facility policy for completing the utilities risk assessment annually. 3. The risk assessment will be added to the safety committee agenda to complete annually. 4. The environmental services supervisor is responsible for compliance and ongoing monitoring.	
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36	K 918		2/16/23

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K 918	Continued From page 9 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to test and inspect the generator per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.4.4.1.1.4, and NFPA 110 (2010 edition), Standard for Emergency and Standby Power Systems, section 8.3.8 and 8.4.7. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 01/10/2023, between 0930am and 1230pm, it was revealed by a review of available documentation of the emergency generator maintenance and testing the annual generator inspections were not performed. The last	K 918	1. The environmental services supervisor will contract with the emergency generator vendor to complete the required load testing of the emergency generator for four hours continuously. The contractor is scheduled to conduct the facility testing on 2/8/23. 2. The environmental services supervisor will be educated on the requirement for 4 hour continuous testing every 36 months. 3. The contractor has been scheduled for the next inspection which will occur in January, 2026. The facility created a new form to include the 36 month testing requirement that will be kept inside the inspection binder.	

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K 918	Continued From page 10 available document state an annual inspection date of 04/13/2018. An interview with Maintenance Director and Administrator verified this deficient finding at the time of discovery.	K 918	4. The environmental services supervisor is responsible for compliance and monitoring.	

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
January 27, 2023

Administrator
Thief River Care Center
2001 Eastwood Drive
Thief River Falls, MN 56701

Re: State Nursing Home Licensing Orders
Event ID: 8R3E11

Dear Administrator:

The above facility was surveyed on January 9, 2023 through January 12, 2023 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

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

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

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

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

Jen Bahr, RN, Unit Supervisor
Bemidji District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
705 5th Street NW, Suite A
Bemidji, Minnesota 56601-2933
Email: Jennifer.bahr@state.mn.us
Office: (218) 308-2104 Mobile: (218) 368-3683

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

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00448	A. BUILDING: _____ B. WING _____	C 01/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THIEF RIVER CARE CENTER	2001 EASTWOOD DRIVE THIEF RIVER FALLS, MN 56701

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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 1/9/23, through 1/12/23, a licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found NOT in compliance with the MN State Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you have reviewed	2 000		

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2 000	Continued From page 1 these orders and identify the date when they will be completed. The following complaint was found to be UNSUBSTANTIATED: H52527245C (MN87187). The following complaint was found to be SUBSTANTIATED: H52527244C (MN89806), however no licensing orders were issued. 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	2 000		

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2 000	Continued From page 2 corrected prior to electronically submitting to the Minnesota Department of Health. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 255	MN Rule 4658.0070 Quality Assessment and Assurance Committee A nursing home must maintain a quality assessment and assurance committee consisting of the administrator, the director of nursing services, the medical director or other physician designated by the medical director, and at least three other members of the nursing home's staff, representing disciplines directly involved in resident care. The quality assessment and assurance committee must identify issues with respect to which quality assurance activities are necessary and develop and implement appropriate plans of action to correct identified quality deficiencies. The committee must address, at a minimum, incident and accident reporting, infection control, and medications and pharmacy services. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure its quality assessment and assurance (QAA)/Quality Assurance Process Improvement (QAPI) committee was effective in identifying and implementing appropriate action	2 255	corrected	2/16/23

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2 255	Continued From page 3 plans to correct quality deficiencies identified during the survey. The facility was aware of or should have been aware of as it was previously identified over previous surveys. This deficient practice had the potential to affect all 54 residents currently residing in the facility. Findings include: The Certification and Survey Provider Enhanced Reports (CASPER)-3 (assessment data is converted to quality measures (QM) to evaluate nursing home's performance) dated 1/4/23, identified the following prior deficiencies by month and year: - F880, Infection Control was cited on 8/18 at a scope and severity of a D (isolated); 6/19 at a scope and severity at a D and on 8/21 at a scope and severity of a F (widespread) - F881, Antibiotic Stewardship Program was cited on 8/21, at a scope and severity of a F - F886, COVID-19 Testing-Residents and Staff was cited on 8/21, at a scope and severity of a F See also F880, Infection Prevention and Control: Based on observation, interview and document review the facility failed to ensure 5 of 5 employees, (licensed practical nurse (LPN)-A, dietary aide (DA)-D, activity aide (AA)-C, nursing assistant (NA)-D and LPN-B) were appropriately cleared to return to work following reports of potential symptoms of COVID-19; failed to initiate contact tracing or facility wide testing for COVID-19 following potential exposure from a staff who tested positive for COVID-19; failed to ensure 3 of 53 residents (R108, R29, R41) were isolated while presenting with symptoms of COVID-19; and failed to utilize appropriate protective equipment for 2 of 3 residents (R41, R50) when they were placed in isolation. In	2 255		

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2 255	Continued From page 4 addition, the facility failed to ensure twelve employees (cook (CK)-A, activity director (AD)-A, DA-B, the director of nursing (DON), DA-C, assistant dietary manager (ADM)-A, DA-B, registered nurse (RN)-D, DA-D, NA-C, NA-A,NA-B) who were out ill with potentially communicable illness' were cleared to return to work: failed to to track resident symptoms of infection and implement an ongoing analysis of collected data to ensure patterns and trends were identified and acted upon to reduce the risk of disease spread within the facility as recommended by the Centers for Disease Control (CDC) guidance to prevent/or minimize the transmission of COVID-19. This resulted in a system wide failure in infection control procedures to prevent the spread of illness within the facility to vulnerable residents and the staff of the facility and resulted in an immediate jeopardy (IJ) which placed all 54 residents at a high likelihood to for serious illness and/or death by contracting a communicable disease, including but not limited to COVID-19. See also F881, Antibiotic Stewardship: Based on interview and document review, the facility failed to develop an antibiotic stewardship program which included implementation of protocols and a system to monitor antibiotic use to ensure appropriate antibiotics were utilized. In addition, the facility failed to ensure cultures were obtained for antibiotic use for 2 of 2 residents (R 23, R33) who were prescribed antibiotics for urinary tract infections (UTI). This deficient practice had the potential to affect all 54 residents who resided in the facility. See also F886, COVID- 19 Testing- Residents and Staff: Based on observation, interview and record review, the facility failed to ensure all staff	2 255		

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2 255	Continued From page 5 were tested for COVID-19 during outbreak testing; and failed to test and/or implement confirmatory testing for symptomatic residents and staff, licensed practical nurse (LPN)-A, LPN-B, dietary aide (DA)-D, activity aide (AA)-C, nursing assistant (NA)-D, R108, R29 and R41, who were not tested or had an initial negative rapid antigen testing for COVID-19, per the Centers for Disease Control (CDC) guidance on testing protocols. This system wide breakdown resulted in an immediate jeopardy (IJ) situation which had the high likelihood to cause serious illness and/or death to all 54 residents residing in the facility, along with staff and visitors. See also F888: COVID-19 Vaccination of Facility Staff: Based on interview and document review, the facility failed to ensure 13 of 72 staff members (registered nurse (RN)-E, RN-F, licensed practical nurse (LPN)-E, dietary aide (DA)-C, DA-G. activity aide (AA)-D, director of human resources (DHR)-A, nursing assistant (NA)-B, NA-D, NA-J, NA-K, NA-L , NA-M) were vaccinated with a complete primary series of COVID-19 vaccine and/or had an approved or pending exemption on record. In addition, the facility failed to have a process for tracking and securely documenting the COVID-19 vaccination status for all staff and report accurate COVID-19 vaccination status of staff and related information as indicated by the Centers for Disease Control and Prevention's National Healthcare Safety Network (NHSN). This resulted in a vaccination rate of 81.94% which was greater than 10% from the data the facility had submitted to the National Healthcare Safety Network (NHSN) and had potential to affect all 54 residents in the facility. On 1/11/23, at 1:30 p.m. the administrator stated she was aware the employee vaccination logs	2 255		

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2 255	Continued From page 6 and data were not up to date and felt registered nurse (RN)-D struggled with utilizing the computer to organize and track the needed information. QAPI Committee Agenda/Minutes were requested since the last standard survey exited on 8/19/22. Notes were received for the following quarterly meetings and identified the following: - 1/26/22, failed to identify concerns related to infection control which were cited on the previous three annual surveys. It also, failed to address identified concerns from the last survey related to antibiotic stewardship and COVID-19 testing of residents and staff from the last standard survey exited 12/2/21. - 4/20/22, during the quarter from 1/1/22, through 3/31/22, there were 4 respiratory infections, 9 urinary tract infections (bladder infection) (UTI), 10 skin/wound infections, 30 gastrointestinal (stomach and intestines) (GI) infections (24 of which were in February 2022), and 4 other infections. The facility had COVID-19 in January 2022, and norovirus in February 2022. A root cause analysis (RCA) was done for the January 2022, COVID-19 outbreak and identified a staff member who normally worked on Evergreen Unit had family on the Blueberry Unit who tested positive for COVID-19. The identified 18 residents and 19 staff were positive for COVID-19. There was no other follow up from the COVID-19 outbreak. There were no comments or concerns brought up related to norovirus. - 7/27/22, during the quarter from 4/1/22, through 6/30/22, there were 9 respiratory infections, 14 UTIs, 2 skin/wound infections, 6 GI infections, and 4 other infections. There was no follow-up	2 255		

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2 255	Continued From page 7 identified on meeting minutes regarding resident illnesses for the quarter. Staff Infection Surveillance Log from April 2022 identified 10 staff were ill of which 4 had diarrhea/vomiting (norovirus was questioned but lacked follow up), 3 complaints of headache, 2 with sore throats, and 1 with general not feeling well. Staff Infection Surveillance Log from May 2022 identified 3 staff were ill of which 1 was fever, 1 was GI, and 1 was sent home not feeling well. The May illnesses lacked follow up. The Staff Infection Surveillance Log from June 2022 identified 4 illnesses of which 3 were GI and 1 sore throat. 1 of the GI illness identified COVID exposure and follow up PCR and antigen were negative. No other follow up was done on other illnesses. - 11/16/22, during the quarter from 7/1/22, through 9/30/22, there were 7 respiratory infections, 11 UTIs, 3 skin/wound infections, 2 GI infections, and 7 other infections. Follow-up was done on UTIs regarding treatments prior to receiving culture results and contacting provider to inform treatment was not needed, but noted the treatment continued. An improvement project was started regarding antibiotic usage in UTIs. No follow-up was identified for the other infections and did not address cause or spread of UTIs. The resident infections grid for previous quarters were unreliable. The infection grid did not identify the 30 GI illnesses from 1/31/22, through 3/31/22, and only identified 6 of 14 UTIs identified from 4/122, through 6/30/22. The provided QAPI Committee Agenda/Minutes did not identify a plan to ensure infections were investigated, tracked, trended, and analyzed appropriately, ensure appropriate antibiotic use; ensure staff had the necessary vaccination or exceptions and collected the necessary data to	2 255		

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2 255	Continued From page 8 report accurately to Centers for Disease Control and Prevention's National Healthcare Safety Network (NHSN); when the facility staff had known there were issues with the infection control program. During an interview on 1/12/23, at 7:15 p.m. the administrator stated when the QAA/QAPI committee picked a quality measure (QM) QM to work on for improvement they would review previous years surveys, CASPER-3, and corporate QM measures. When a high-risk area was discovered, the committee would work on an improvement project to improve quality of life for the residents. The administrator identified infection control was a high-risk area and there have been continued concerns with it over the past couple of years. An improvement project was not started because of frequent changes of leadership in the building. Because infection control was a high-risk area, an improvement measure should have been started for the benefit of the residents. The facility's QAPI policy dated 4/6/15, identified the facility would monitor and drawn data from previous surveys to conduct Performance Improvement Projects (PIPs) to improve care or services in areas that have been identified as a concern. These projects would concentrate on a particular problem in one area of the care center or care center wide. Suggested Method of Correction: The administrator could work with the DON or designee, medical director, and governing body to update polices and procedures, identify issues and develop improvement plans, for known sytem issues. The administrator and DON could audit cares to ensure resident needs are met, audit	2 255		

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2 255	Continued From page 9 charts for delinquencies and report results to the quality committee. Time Period for Correction: Twenty-one (21) days.	2 255		
2 302	MN State Statute 144.6503 Alzheimer's disease or related disorder train ALZHEIMER'S DISEASE OR RELATED DISORDER TRAINING: MN St. Statute 144.6503 (a) If a nursing facility serves persons with Alzheimer's disease or related disorders, whether in a segregated or general unit, the facility's direct care staff and their supervisors must be trained in dementia care. (b) Areas of required training include: (1) an explanation of Alzheimer's disease and related disorders; (2) assistance with activities of daily living; (3) problem solving with challenging behaviors; and (4) communication skills. (c) The facility shall provide to consumers in written or electronic form a description of the training program, the categories of employees trained, the frequency of training, and the basic topics covered. (d) The facility shall document compliance with this section. This MN Requirement is not met as evidenced	2 302		2/16/23

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2 302	Continued From page 10 by: Based on interview and document review the facility failed to ensure 1 of 8 staff (registered nurse (RN)-A) received dementia or Alzheimer's training upon hire and annually according to MN St. Statue 144.6503. Findings include: During record review of Alzheimer's disease or related disorder training that encompassed explanation of Alzheimer's disease and related disorders, assistance with activities of daily living, problem solving with challenging behaviors, and communication skills identified RN-A had not received annual dementia or Alzheimer's training. RN-A's training record (undated) lacked evidence of explanation of Alzheimer's disease and related disorders, assistance with activities of daily living, problem solving with challenging behaviors, and communication skills. During interview on 1/12/23, at 3:25 p.m RN-A stated she completed all of her dementia and Alzheimer's Educare training when she was rehired to the facility in the fall of 2021. RN-A stated the Educare training's pop up automatically and did not have any assigned to her. During interview on 1/12/23, at 3:52 p.m. the director of nursing (DON) stated nursing staff were required to have yearly dementia or Alzheimer's training. The DON reviewed RN-A's Educare transcript and stated RN-A's dementia and Alzheimer's training were past due and not current within the last year as required. The facilities Alzheimer's Disease or Related Disorder Training reviewed/revised 4/6/15, defined the purpose was to ensure care center	2 302	Corrected	

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2 302	Continued From page 11 direct care staff and their supervisors would provide thoughtful and skillful care for residents with dementias as required by MN State Statute 144.6503. The policy directed the facility would provide training upon hire and annually. SUGGESTED METHOD OF CORRECTION: The DON or designee could develop, review, and/or revise policies and procedures to ensure training for Alzheimer's was communicated to the consumer. In addition, the DON or designee could ensure the training for Alzheimer's was completed for all staff. The Director of Nursing or designee could educate all appropriate staff on the policies and procedures. The Director of Nursing or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 302		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed.	2 830		2/16/23

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2 830	Continued From page 12 This MN Requirement is not met as evidenced by: Based on observation, interview, and document review the facility to comprehensively assess, develop interventions and ensure consistent clinical monitoring was completed for 3 of 3 residents (R53, R36, R4) who had experienced a change in condition. This resulted in actual harm for R53, who was hospitalized with sepsis and expired. Findings include: R53's quarterly Minimum Data Set (MDS) dated 8/9/22, identified R53 was cognitively intact, diagnosis included diabetes mellitus type 2, and required assist with activities of daily living (ADL's). R53's undated face sheet, identified diagnoses including history of clostridium difficile (C.diff - an infection in the colon which symptoms including diarrhea, belly pain and fever), diarrhea and nausea with vomiting. R53's care plan dated 4/26/22, directed staff to monitor R53 for changes in abilities, report loose foul-smelling stools and to monitor stool consistency. R53's Medication Administration Record (MAR) dated 10/1/22 through 10/30/22, identified the following: - Staff monitored R53's daily fluid restriction of 1200-1400 cc although the total daily fluid intake was not documented. - R53's daily weight was documented all but four days and ranged from 203 lbs on 10/1/22, to	2 830	Corrected	

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2 830	Continued From page 13 207.5 lbs on 10/19/22. On 10/1/22 through 10/9/22, and on 10/11/22, R53's vital signs (blood pressure, pulse, oxygen saturation (O2 sats), respirations and temperature) was documented at least once daily. Staff had not documented vital signs from 10/9/22, 10/10/22, or 10/12/22 through 10/20/22. 10/1/22 evening shift: 124/86, R20, O2 sats 97% RA, P88, T 97.7F 10/2/22 evening shift: 105/63, R20, 99% RA, P88, T 98.6F 10/3/22 evening shift: 94/72, morning shift: 130/66, R20, 99% RA, P 97, T 97.5F, 10/4/22 evening shift: 141/88, R20,99% RA, P 92, T 97.2F, 10/5/22 evening shift: 125/76. R20, 99% RA, P113, T 97.8F, 10/6/22 evening shift 112/80. R20, 93% RA, P93, T 98.2F, 10/7/22 evening shift 121/64, R18, 91% RA, P 100, T 97.7F, 10/8/22 evening shift 115/71, R20, 97% RA, P84, T 97.9F, 10/11/22 morning shift: 130/84, other VS not documented - R53's blood pressure was not documented on 10/9/22, 10/10/22 or 10/12/22 through 10/20/22. - R53's Respirations were not documented from 10/9/22 through 10/20/22. - R53's O2 sats were not documented from 10/9/22 through 10/20/22 - R53's pulse or temperature were not documented from 10/9/22 through 10/20/22. - Medication(s) including Loperamide (medication	2 830		

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2 830	Continued From page 14 used to decrease the frequency of diarrhea) as needed four times daily was administered and documented as not effective on 10/5/22 and 10/6/22; administered with no effectiveness documented on 10/8/22; and administered and documented as effective on 10/11/22, 10/14/22, 10/15/22. - Gastrointestinal (GI) distress including nausea, vomiting or abdominal pain was documented on 10/11/22, 10/14/22, and 10/15/22. Specific symptom(s), severity or frequency were not documented. - Body aches or headaches on 10/6/22, 10/10/22, 10/14/22, and 10/15/22 were documented but specific symptom(s) were not. R53's pain rating was documented on 10/14/22 as #2/10, and on 10/15/22 was #5/10. R53 had received Acetaminophen 650 mg on 10/14/22 and 10/15/22. R53's Progress Notes dated 10/1/22 through 10/25/22, included the following: - On 10/6/22, R53 requested imodium for loose stools. Effectiveness was not documented. - On 10/11/22, R53 complained of sore throat, feeling tired and not able to smell very good. R53 was afebrile and had a negative rapid COVID test. - On 10/20/22, at 5:00 a.m. R53 had a low blood sugar of 31. Snacks were provided, and blood sugar recheck at 5:45 a.m. was 145. - On 10/20/22, at 2:05 p.m. note stating res is being transferred to hospital with diagnosis of sepsis. - On 10/20/22, at 2:06 p.m. change of condition note documented stating R53 was in the dining room for breakfast, then went back to room and resident started complaining of not feeling well. Vitals sign's were completed showing a BP:	2 830		

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2 830	Continued From page 15 100/83. R53 was having a difficult time with formulating words and sentences and had complaints of chest pain. Ambulance was called and R53 sent to the emergency department (ED). R53's emergency department (ED) record dated 10/20/22, identified R53 presented to the ED for evaluation of increased fatigue and lethargy. The ED medical doctor (ED MD) identified R53 was ill-appearing, toxic appearing, was tachycardic with heart rate of 110-120, and shallow respirations at 30. Treatments included intravenous (IV) fluids, Levophed (IV medication used to treat life-threatening low blood pressure), panculture (testing of the blood, urine, sputum, or stool to identify infection), and IV antibiotics. The final diagnoses included sepsis due to unspecified organism, unspecified whether acute organ dysfunction present and the plan had been to transfer R53 to another facility for critical care management. R53's hospital progress notes identified the following: - 10/21/22, R53 presented to the ED due to feeling weak, lethargic, and decreased blood pressure. R53 had diarrhea for about a week, dysuria (painful urination), and abdominal pain. There was abnormal lab work and CT (medical imaging tests that take pictures of selected areas inside the body) scans. Diagnoses included septic shock due to a combination of UTI and colitis as well as acute kidney injury, anemia, low potassium, and low magnesium. At 6:25 p.m. the provider addend the progress note and included an additional diagnosis of acute respiratory failure with treatment including 12 liters of oxygen, additional antibiotic for potential atypical pneumonia and one dose of Lasix (medication used to prevent the body from absorbing too	2 830		

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2 830	Continued From page 16 much salt and allows the salt to be passed out of the body through the urine). - 10/22/22, continue Levophed (medication used to treat life-threatening low blood pressure that can occur with certain medical conditions), continue IV antibiotics and continue oral antibiotics. - 10/23/22, continue Levophed and antibiotics. At 5:34 p.m. the provider addend the progress note and identified throughout the day R53 had not produced any urine and required increased oxygen resulting in multiorgan system failure. - 10/24/22, R53 was non-responsive, on bipap (a type of ventilator that helps with breathing), not producing urine, was acidotic (a medical condition in which too much acid is produced in the body and/or the kidneys cannot remove enough acid through the urine. The medical condition may lead to confusion, shock or even death), had fluid overload and prognosis was very poor. The provider discussed with family and decided on comfort cares and no further escalation of treatment. R53's hospital discharge summary dated 10/25/22, identified R53 continued to decline and expired at 12:53 a.m. During interview on 1/12/23, at 7:43 p.m. registered nurse (RN)-A stated she was not familiar with R53. On 1/12/22, at 7:45 p.m. during joint interview with RN-C and RN-D, who is also the infection preventionist, RN-D stated R53 was sickly, was a drug seeker and always had something going on. RN-C stated R53 tested negative for COVID-19 on 10/11/22 and was monitored for GI issues on 10/11/22, 10/14/22, and 10/15/22. RN-C and RN-D stated staff should have further monitored	2 830		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 17 and assessed R53 prior to going to the hospital. During interview on 1/12/23, at 8:02 p.m. nursing assistant (NA)-E stated R53 had always been sick, had always complained of not feeling well and had diarrhea all the time. NA-E stated R53 had been confused the week before she went to the hospital. A few days prior to R53's transfer to the ED R53 became pale, yellowish in color, became weak and her ability declined from a 2-person stand-by-assist to a total mechanical lift. NA-E stated she reported R53's changes to the nurse. On 1/12/22, at 8:21 p.m. left a message requesting MD-A return call. During interview on 1/13/22, at 3:06 p.m. medical doctor (MD)-A stated R53 was a very complicated resident and had diagnoses including anemia, diabetes, thyroid disorder, and atrial fibrillation; all of which were stable at the time of R53's evaluation on 9/30/22. R53's exam had been non-specific (normal) and residents only symptoms were fatigue and feeling tired. When R53 was at baseline, R53 had been able to communicate her needs. MD-A stated she expected staff to assess R53, respond appropriately, and notify MD-A of any changes. MD-A stated she had been unable to find any communication (via fax, computer messages or phone calls) from the facility beginning after the 9/30/22 evaluation through the ED admit date of 10/20/22. MD-A stated she would expect the facility to notify herself or her nurse of any change in condition. - MD-A stated upon review of R53's emergency department (ED) note dated 10/20/22, R53 was hypertensive, tachycardic and was admitted to	2 830		

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2 830	Continued From page 18 the hospital. The final diagnoses were Clostridioides difficile (C-diff) colitis (an infection in the colon which symptoms including diarrhea, belly pain and fever) and septic shock (a life-threatening condition caused by an infection. Symptoms include low blood pressure, pale and cool arms and legs, chills, difficulty breathing, decreased urine output, mental confusion, and disorientation). MD-A stated R53 was admitted to the hospital and according to the hospital notes had declined quickly. Signs and symptoms of septic shock included any signs of infection, diarrhea, cellulitis, fever, tachycardia, an increase in blood pressure and then a drop in blood pressure. Further, MD-A stated the nurses should have assessed R53 and should have been able to tell something was wrong. R53's medical record did not identify comprehensive assessment(s) were completed after identification of R53's confusion, weakness, diarrhea and change in color, nor identify interventions implemented to stabilize R53's mental and physical status, or evidence of ongoing monitoring. Further, it was not evident the MD-A had been notified of the change in R53's cognition, mental status, or GI status. R36's quarterly Minimum Data Set (MDS) dated 11/3/22, identified R23 had moderate cognitive impairment, required supervision or setup for most activities of daily living (ADLs) and used a walker for mobility. R36's care plan dated 1/5/23, identified R36 had shortness of breath related to chronic obstructive pulmonary disease (COPD) and asthma and directed staff to monitor her shortness of breath and oxygen levels. R36 had short term memory problem and/or periods of confusion.	2 830		

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2 830	Continued From page 19 During observation and interview with R36 and family member (FM)-A on 1/9/23, at 12:10 p.m. R36 was sleeping soundly and did not respond to the knock on her door or her name being called. FM-A stated R36 had frequent periods where she was unresponsive and was unable to be aroused from sleep. R36 had frequent low oxygen saturations and was requiring oxygen more and more frequently. R36's Physician Orders dated 1/12/23, identified R36 received Ipratropium bromide nasal solution, xopenex inhaler, and Trelegy Ellipta for respiratory failure and COPD. R36 also received Xarelto (a medication to prevent blood clots). The physician orders did not identify the use of oxygen. R36's progress notes identified the following: -12/1/22, R36 felt weak and complained of no strength. She fell on to her left arm. Was alert and orientated and assisted up with assist of two staff. The doctor was notified of the fall. -12/11/22, R36 was confused and wandered into another resident's room. -12/16/22, R36 reported she had fallen off her toilet the day before and hit her head. R36 stated she had gotten herself up and did not notify anyone at the time of her fall. -12/17/22, R36's physician was notified of her reported fall. Orders were received to monitor her mental status. -12/18/22, R36 was very sleepy during the evening shift. Staff will continue to monitor for COVID-19 symptoms. Oxygen saturation was 92% on room air. -12/23/22, R36 was very sleepy through out the evening shift. FM-A requested staff assess her vital signs. R36 oxygen saturation was 92% on	2 830		

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2 830	Continued From page 20 room air. -12/27/22, R36 was on leave of absence (LOA) with FM-A. FM-A called the facility at 12:00 p.m. and again 2:30 p.m. to report he was unable to awaken R36. He was told to take R36 to her physician to be evaluated. -12/27/22, R36 went by ambulance while on LOA with family. Returned to the facility at 7:00 p.m. Direction to follow up with primary physician with no new orders. Will continue to monitor. -1/7/23, FM-A requested staff to assess R36 vital signs. Vital signs were taken and oxygen saturation was 80%. Oxygen was applied and oxygen saturation was rechecked 45 minutes later. Oxygen saturation was 89%. The medical record lacked evidence of further assessment for R36's unusual lethargy, confusion, abnormal oxygen saturations, and new utilization of PRN oxygen. During interview on 1/12/23, at 3:30 p.m. the director of nursing (DON) stated more assessment would be needed when R36 was difficult to arouse or when exhibits low oxygen saturations. The DON would expect further assessment and vital signs as well as report to next shift for ongoing assessments. R4's significant change MDS dated 10/26/22, identified R4 had moderate cognitive impairment, received antipsychotic, antianxiety and antidepressant medications on a daily basis, and required extensive assistance to complete activities of daily living (ADLs). The MDS outlined a section to record R4's mood. R4 was unable to be interviewed, however, staff assessment of R4's mood severity scored 3, as minimal. No hallucinations, rejection of care or behaviors were recorded and no change in R4's mood and	2 830		

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2 830	Continued From page 21 behavior had occurred since her last assessment. During interview on 1/9/23, at 2:40 p.m. R4 stated her feet were really swollen and she was concerned about it. She was not taking diuretic medications. The staff did have her elevate her feet in the afternoons. The swelling bothered her and her daughter had ordered some elastic stockings for her to try but they had not been delivered yet. R4's progress notes identified the following: -11/1/22, hospice note. Noted 3+ edema (swelling) to right lower leg and foot and 2+ to the left. Orders received to try Lasix (a diuretic medication to decrease fluid retention) 20 milligrams (mg) daily for seven days. Will reevaluate in seven days. -12/9/22, hospice note. Gradual weight gain in past months. is back to her baseline weight of 190 to 200 pounds. R4 has significant edema to her feet. Encourage to elevate her legs. -12/20/22, hospice note. R4 has 2-3+ edema to both feet. Encouraged to elevate during the day. She does have compression wraps on at this time. R4's Physician Order Review, dated 11/15/22, identified R4's current signed orders. These included medications: Lasix (a diuretic medication) 20 mg every day for 5 days with start date 11/11/22 and end date 11/15/22, for localized edema. R4's most recent Physician Progress Note, dated 11/15/22, identified the current visit was for medication recheck. The progress note lacked evidence R4's diuretic medication and edema had been addressed, or if the physician was aware the medication ordered for five days ended	2 830		

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2 830	Continued From page 22 11/15/22, with need for further evaluation. R4's weights were reviewed 10/1/22 through 1/10/23 and indicated the following: -10/14/22, R4's weight was 200 pounds. -10/26/22, R4's weight was 186 pounds. -11/23/22, R4's weight was 181.8 pounds. -12/4/22, R4's weight was 192 pounds. -1/4/23, R4's weight was 198 pounds -1/10/23, R4's weight was 182 pounds. ' The recorded weights identified R4 had a significant weight gain of 5% in less than a two week period between 11/23/22 and 12/4/22. R4's diuretic medication was ordered 11/11/22, with end date of 11/15/22, however, the medical record lacked evidence R4's weight gain was assessed after the discontinuation of the medication. When interviewed on 1/12/23, at 11:50 a.m. registered nurse (RN)-G stated the physician came to the facility to see patients. Medications were discussed verbally on rounds. R4 did have Lasix ordered for 5 days as recommended by hospice, as R4 had developed 2-3+ pedal edema in her lower extremities. The medication was for a limited time and then would be reevaluated. Staff did try to have R4 lie in a recliner with her feet elevated in the afternoon as an intervention for her edema. She was not aware R4 had a weight gain after the diuretic was stopped. The staff obtained the resident weights on their bath days but had difficulty with putting the information in the electronic medical record, so RN-G had to rely on staff verbal reports if they noticed resident weight gains or losses. The unit has been actively weighing all the residents this week to obtain current weights and getting them documented in to the each residents medical records. RN-G had	2 830		

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2 830	Continued From page 23 not done any type of assessment for R4 when her diuretic was discontinued because R4 was a hospice patient and she felt the hospice nurse should have assessed R4. R4's ten pound weight gain was not reported by the nursing assistants who did the weights and because they had not tracked resident weights in the computer the significant weight gain was missed. RN-G was not aware R4 had gained ten pounds in the two weeks after discontinuing her diuretic, but thought it could have been due to her increased appetite. When interviewed on 1/12/23, at 3:15 p.m. the DON stated when a resident was prescribed a diuretic medication she would like to see their weight come down and watch their fluid intake. The DON remembered R4 had been pretty fluffy and hospice was trying to get some of the fluid off for comfort. Staff would need to assess weights to find out if the diuretic ordered was effective and weights should be done weekly. The DON did not feel a ten pound weight gain in a two week period could be attributed to appetite alone. Assessments were expected to be conducted when needed, regardless if the resident was under hospice care. A policy on assessing for a change of condition was requested and not provided. The facility's Weight Monitoring Program policy dated 1/18/21, identified the purpose was to provide guidance to staff for monitoring weights to maintain or improve the overall health of residents. The policy defined a medically significant weight gain as a weight gain of 5 or more pounds within one week could indicate a change in health status per the plan of care (i.e. diuretics, cortcosteroids, etc). Staff were directed	2 830		

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2 830	Continued From page 24 to weigh residents weekly, as needed, or as ordered by the physician. Weight data would be assessed, tracked and entered into the electronic health record weekly. The physician would be contacted for any resident with a medically significant weight gain of 5 pounds or more. SUGGESTED METHOD OF CORRECTION: The DON or designee could review policies/procedures for identfiying, assessing and notifying the MD when a change of condition is identfiied. In addition the DON or designeed could develop a system to monitor weights when medication affecting wight are discontinued. The DON or designee could educate all appropriate staff new process' and audit for compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		
2 915	MN Rule 4658.0525 Subp. 6 A Rehab - ADLs Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that: A. a resident is given the appropriate treatments and services to maintain or improve abilities in activities of daily living unless deterioration is a normal or characteristic part of the resident's condition. For purposes of this part, activities of daily living includes the resident's ability to: (1) bathe, dress, and groom; (2) transfer and ambulate; (3) use the toilet; (4) eat; and (5) use speech, language, or other functional communication systems; and	2 915		2/16/23

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2 915	Continued From page 25 This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to assist with ambulation for 1 of 3 residents (R47) reviewed for activities of daily living (ADL). Findings include: R47's quarterly Minimum Data Set (MDS) dated 12/15/22, identified R47 was cognitively intact and required assist of two staff for activities of daily living including transfers and did not walk in the room or corridor. R47 used a wheelchair for locomotion and had no functional limitation in range of motion of the upper or lower extremities. Diagnoses included acute transverse myelitis (a demyelinating disease of central nervous system), and transient ischemic attack (commonly called a mini-stroke; a temporary blockage of blood flow to the brain). R47's care plan dated 6/15/22, directed staff to ambulate R47 to the dining room with assist of 1 or 2 staff and walker three times daily. The facility undated nurse aide care sheet directed staff to walk R47 daily. R47's therapy orders were requested and not received. The facility Therapy Lite Assessment (Therapy and Restorative Minutes) Results dated 11/10/22 through 1/2/23, identified R47's total walking minutes and total walking distance was "0". The restorative therapy orders were requested but not provided.	2 915	Corrected	

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2 915	Continued From page 26 During interview on 1/9/23, at 1:44 p.m. R47 stated she was recently discharged from therapy and wanted staff to walk with her to lunch. R47 stated the last time she walked was on 1/6/22. During interview on 1/12/23, at 12:23 p.m. the physical therapist (PT) stated when R47 was discharged from therapy, orders were written for nursing staff to ambulate R47 to meals. The orders were written for nursing staff to complete the task because she knew the restorative nurses were not always working. The PT stated the nursing staff knew and should be walking R47. During interview on 1/12/23, at 1:40 p.m. nursing assistant (NA)-B stated staff were supposed to walk with R47 every day to lunch. NA-B did not walk R47 because the resident was not on her care group. During interview on 1/12/23, at 1:51 p.m. NA-G stated R47 was on her care group and did walk a few steps to and from the bed and wheelchair but did not walk to the bathroom or elsewhere in the room or outside of her room. It was on the care sheet to walk R47 every day but did not identify the frequency or distance and R47 did not ask, nor had she offered to walk R47 farther. During interview on 1/12/23, 2:14 p.m. NA-I stated R47 wanted to walk to get stronger and the last time NA-I walked with R47 was on 1/6/23, to the dining room for evening meal. During interview on 1/12/23, at 2:19 p.m. registered nurse (RN)-A stated she or another staff updated resident care plans and NA care sheets. Nursing staff were aware they were supposed to walk R47 to meals. RN-A stated she	2 915		

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2 915	Continued From page 27 expected staff to ambulate R47 as ordered by therapy and per the NA care sheet. During interview on 1/12/23, at 3:52 p.m. the director of nursing (DON) stated R47 recently was discharged from therapy with orders for staff to ambulate resident to meals. Staff was supposed to ambulate resident 1 to 3 times per day and she expected staff to complete the task. The facility's undated Walk to Dine Ambulation Program identified the program to promote a more homelike and enhanced dining experience for residents, meanwhile maintaining their strength and ambulation abilities. The program included resident encouragement to walk, staff monitoring of distance and/or time walked, monitoring participation and if declined, offering another time during the day. SUGGESTED METHOD FOR CORRECTION: The DON could review and revise as necessary the policies and procedures regarding the need for assistance with restorative rehabilitative services. The DON or designee (s) could provide training for all appropriate staff on these policies and procedures and importance of documentation. The DON or designee (s) could monitor to assure all residents are receiving adequate and appropriate care. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 915		
2 965	MN Rule 4658.0600 Subp. 2 Dietary Service -Nutritional Status	2 965		2/16/23

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2 965	Continued From page 28 Subpart. 2. Nutritional status. The nursing home must ensure that a resident is offered a diet which supplies the caloric and nutrient needs as determined by the comprehensive resident assessment. Substitutes of similar nutritive value must be offered to residents who refuse food served. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to implement and complete routine weight monitoring to ensure caloric needs were being met to prevent weight loss and promote health and failed to complete a comprehensive nutritional assessment for 1 of 1 resident (R36) reviewed with significant weight loss. Findings include: R36's quarterly Minimum Data Set (MDS) dated 11/3/22, identified R23 had moderate cognitive impairment, required supervision or setup for most activities of daily living (ADLs). R36's care plan dated 1/5/23, identified R36 had short term memory problem and/or periods of confusion. R36 was independent with eating. Staff were directed to monitor her weight weekly, and offer her food and drinks per her preference. On 1/9/23, at 12:10 p.m. R36 was observed sleeping soundly and did not respond to the knock on her door or her name being called. Family member (FM)-A stated R36 had frequent periods where she was unresponsive and was unable to be aroused from sleep.	2 965	Corrected	

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2 965	Continued From page 29 During continuous observation 7:00 a.m. through 8:40 a.m. on 1/11/23, R36 was observed sleeping soundly on her bed. Staff entered the room at 8:30 a.m. after knocking and placed R36's breakfast tray on her bedside table approximately four feet from the side of the bed and out of R36's reach. The unidentified staff made no attempt to awaken R36 to eat and left the room without speaking to R36. R36 remained sleeping on her bed and made no attempt to sit up or eat. R36's Physician Orders dated 1/12/23, identified R36 received a regular diet. A multi-vitamin was ordered daily, as well as vitamins C, D3 and an Occuvite vitamin daily. Nutritional supplements were not listed on R36's orders. R36's most recent dietary assessment dated 10/20/22, identified R36 was 64 inches in height and weight was 123.4 pounds from 5/25/22. Estimated daily nutrition needs were 56 grams of protein and 1290 calories. The dietary note identified R36 was at lower nutrition risk. R36's goal range for the next 90 days was 120-130 pounds. R36 was able to get adequate nutrition via meals and snacks offered. No new nutrition recommendations. Continue with current nutrition plan of care and contact dietitian with any nutritional concerns or questions. R36's progress notes identified the following: -12/7/22, R36 slept all shift. R36 did not eat supper as she was not alert enough. -12/9/22, care conference was held on 11/16/22. Reviewed information from the past quarter, including weights and meal intakes. No new concerns noted. Will continue with current plan of care and observe for changes. -12/31/22, R36 would not wake up to eat or take	2 965		

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THIEF RIVER CARE CENTER	2001 EASTWOOD DRIVE THIEF RIVER FALLS, MN 56701

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 965	Continued From page 30 her medications. A record of R36 meal intakes was requested, however, was not received. R36's record of weights from May 25, 2022 through 1/10/22, identified the following: - 5/25/22, R36 weighed 123 pounds. -11/3/22, R36 weighed 125 pounds. -11/9/22, R36 weighed 126.8 pounds. -1/10/23, R36 weighed 114 pounds. R36's medical record lacked evidence of weekly weights as directed and did not identify any additional documentation. R36 demonstrated an unidentified weight loss of 12.8 pounds (10%) in the two months between 11/9/22 and 1/10/23. R36's medical record also lacked evidence of any nutritional assessments, evaluation of her oral intake at meals, or notification of the RD or R36's provider related to this unidentified significant weight loss. During interview on 1/12/23, at 11:50 a.m. RN-G stated weights were not being recorded in the resident's medical record. The bath aide obtained resident weights on their bath days but had trouble documenting in the new electronic medical record. The facility was currently educating the staff on how to enter data, like weights, into residents electronic records. RN-G just went by what was reported to her by the bath aide. RN-G was currently having the nursing assistants weigh all the residents in her unit so they could enter current weights in all the resident's medical records. When interviewed by telephone on 1/12/23, at 4:25 p.m. the registered dietitian (RD)-M stated he did come to the nursing facility periodically.	2 965		

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2 965	Continued From page 31 RD-M completed resident dietary assessments based on the information he was given. When weights were not recorded RD-M emailed the resident's case manager for the information. When RD-M completed R36's dietary assessment on 10/5/22, he had notified the case manager via email he did not have a current weight, however did not receive a response. He completed the assessment using the weight he did have, from May 2022, five months previous. It was more limited but he wanted to do something, rather than nothing. RD-M had her diagnoses list and her heights and the resident progress notes were reviewed to glean information. RD-M wondered if he should wait to do his assessment until he had a more current weight The weight from May was more limited but he wanted to do something and could not properly assess her nutritional status. RD-M did not complete the dietary section of resident MDS's and thought maybe RN-C completed them. RD-M only completed resident dietary assessments which were documented in the medical record under a progress note. R36's 10/5/22, progress note was the most recent dietary assessment completed and RD-M was unsure if any other dietary assessments were completed. He was not contacted further regarding concerns pertaining to R36. During interview on 1/12/13, at 4:40 p.m. the MDS coordinator, RN-C stated the dietitian wrote his dietary Cassessment in the resident's progress notes but did not complete any part of the MDS assessment or the Care Analysis Assessments (CAA). RN-C completed the dietary section of the MDS and the nutrition CAA. He had staff weigh R36 when he needed to enter her weight into the MDS, which was why R36 had weights documented on 11/3/22, and 11/9/22.	2 965		

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2 965	Continued From page 32 During interview on 1/12/23, at 3:30 p.m. the director of nursing (DON) stated she would expect further assessment and vital signs as well as report to next shift for ongoing assessments. Resident weights should be done weekly. A policy for physician notification was requested, however, was not received. SUGGESTED METHOD OF CORRECTION: The registered dietician (RD) or DON could develop, review, and/or revise policies and procedures to ensure residents who experience weight loss or who are at risk for weight loss are identified. The RD or DON or designee could educate all appropriate staff on the policies and procedures. The RD or DON or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 965		
21015	MN Rule 4658.0610 Subp. 7 Dietary Staff Requirements- Sanitary conditi Subp. 7. Sanitary conditions. Sanitary procedures and conditions must be maintained in the operation of the dietary department at all times. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure dietary staff were monitoring the dishwasher temperatures in 1 of 1 kitchens to prevent potential	21015	Corrected	2/16/23

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21015	Continued From page 33 cross-contamination which may result in foodborne illness. This had potential to affect 54 residents residing in the facility and consumed food from the kitchen. Findings include: During the kitchen tour on 1/11/23, at 5:07 p.m. the dietary manager (DM) stated the dishwasher was recently serviced as the dishes were not drying fast enough. The final rinse needed to reach 180 degrees Fahrenheit (F) or higher and the dishwasher was not reaching that temperature. There was a note on the dishwasher directing staff to check the temperature after breakfast, after lunch and after dinner, however there was no temperature log near the dishwasher. The DM stated she didn't know where the log was. The DM stated if there were any problems with the equipment, she would tell the maintenance manager. Further, she was unable to find the test strips to check the dishwasher temperature. During observation on 1/11/23, at 5:07 p.m. after surveyor prompting, the DM ran a dish tray through the dishwasher and stated the rinse temperature was 180 F. During a joint interview with the DM and administrator on 1/11/23, at 5:45 p.m. the DM stated she did not have the dishwasher temperature logs and did not know when the last time the temperature were obtained. The DM was working with the staff to check the temperature three times daily, but the staff were not compliant with checking the temperature. If there was a concern, then staff were to fill out a form which then went to the maintenance manager.	21015		

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21015	Continued From page 34 During interview on 1/11/23, at 6:02 p.m. the administrator stated the dishwasher booster was changed and tested good on 11/9/22, and was rechecked and working on 11/11/22. During interview on 1/12/23, at 7:07 a.m. CK-B stated all the dietary staff washed dishes. CK-B pointed to two gauges on the front of the machine and stated they were the only temperature he would look at and would mark the temperature on the paper log that was usually located next to the dishwasher, however he didn't know the purpose for logging the temperature. CK-B pointed to the gauges towards the back and stated he did not know what the gauges were or what they were used for. CK-B was not aware of what the temperature ranges should be, how often the temperature should be checked or how to ensure the dishes were sanitized, however, CK-B stated he would tell the DM if there was a problem. CK-B stated he did not check the dishwasher temperature and if the dishes looked clean and were hot, then they were clean. During interview on 1/12/23, at 7:11 a.m. dietary aide (DA)-E stated everyone was responsible for checking and marking the dishwasher temperature, however, DA-E stated she didn't monitor any of the temperature and was not familiar with the gauges on the dishwasher. DA-E stated she did not know how to determine if the dishes were clean, and further stated if the dishes looked clean and were hot then they were clean but did not know if the dishes were sanitized. During interview at 7:35 a.m. after surveyor prompting, cook (CK)-B sent a tray through the dishwasher. CK-B did not attempt to check the rinse cycle temperature until prompted and then	21015		

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21015	Continued From page 35 read the temperature from the two gauges on the front of the machine labeled wash tank and rinse tank. CK-B did not attempt to read the gauge in the back. After prompting, CK-B stated the gauge was hard to read. With further prompting, CK-B stated the gauge read 180 F. CK-B stated he didn't know what the gauges were for and had not been trained on how or why to read them. CK-B did not log the temperature anywhere. Another joint interview with the administrator and the DM was conducted on 1/12/23, at 8:39 a.m. The DM stated staff should be checking and documenting the dishwasher temperature on a log, but staff were not doing it. During interview on 1/12/23, at 12:10 p.m. DA-F stated he would wash dirty dishes in the dishwasher but never checked the dishwasher temperature, did not know how to check the temperatures, and was never instructed to do so. DA-F made sure the dishes were sanitized by making sure the detergent was full. Although, the dishwasher temperatures were within range on survey, the facility failed to ensure staff were following the facility process to check the dishwasher temperatures to ensure the dishwasher was running in a manner to sanitize the dishes. The Cleaning Dishes/Dish Machine policy dated 4/20/22, directed all flatware, dishware, serving dishes and cookware were to be cleaned, rinsed, and sanitized after each use. The dish machines were to be checked prior to meals to assure proper functioning and appropriate temperatures for cleaning and sanitizing. Staff were directed to follow the procedures for washing dishes including temperature verified and logged for	21015		

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21015	Continued From page 36 each shift. SUGGESTED METHOD OF CORRECTION: The registered dietician, or the administrator could review policies and educate staff in kitchen of proper cleaning techniques and monitoring of equipment. And follow up with competencies. Then audit for compliance TIME PERIOD FOR CORRECTION: Twenty One (21) days	21015		
21390	MN Rule 4658.0800 Subp. 4 A-I Infection Control Subp. 4. Policies and procedures. The infection control program must include policies and procedures which provide for the following: A. surveillance based on systematic data collection to identify nosocomial infections in residents; B. a system for detection, investigation, and control of outbreaks of infectious diseases; C. isolation and precautions systems to reduce risk of transmission of infectious agents; D. in-service education in infection prevention and control; E. a resident health program including an immunization program, a tuberculosis program as defined in part 4658.0810, and policies and procedures of resident care practices to assist in the prevention and treatment of infections; F. the development and implementation of employee health policies and infection control practices, including a tuberculosis program as defined in part 4658.0815; G. a system for reviewing antibiotic use; H. a system for review and evaluation of products which affect infection control, such as	21390		2/16/23

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21390	Continued From page 37 disinfectants, antiseptics, gloves, and incontinence products; and l. methods for maintaining awareness of current standards of practice in infection control. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure 5 of 5 employees, (licensed practical nurse (LPN)-A, dietary aide (DA)-D, activity aide (AA)-C, nursing assistant (NA)-D and LPN-B) were appropriately cleared to return to work following reports of potential symptoms of COVID-19; failed to initate contact tracing or facility wide testing for COVID-19 following potential exposure from a staff who tested positive for COVID-19; failed to ensure 3 of 53 residents (R108, R29, R41) were isolated while presenting with symptoms of COVID-19; and failed to utilize appropriate protective equipment for 2 of 3 residents (R41, R50) when they were placed in isolation. In addition, the facility failed to ensure twelve employees (cook (CK)-A, activity director (AD)-A, DA-B, the director of nursing (DON), DA-C, assistant dietary manager (ADM)-A, DA-B, registered nurse (RN)-D, DA-D, NA-C, NA-A,NA-B) who were out ill with potentially communicable illness' were cleared to return to work: failed to to track resident symptoms of infection and implement an ongoing analysis of collected data to ensure patterns and trends were identified and acted upon to reduce the risk of disease spread within the facility as recommended by the Centers for Disease Control (CDC) guidance to prevent/or minimize the transmission of COVID-19. This resulted in a system wide failure in infection control procedures for all 54 residents residing in the	21390	Corrected	

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21390	Continued From page 38 facility. Findings include: The Interim Infection Prevention and Control Recommendations for Healthcare Personnel (HCP) During the Coronavirus Disease 2019 (COVID-19) Pandemic, updated September 23, 2022, identified anyone with even mild symptoms of COVID-19, regardless of vaccination status, should receive a viral test for COVID-19 as soon as possible. Mild illness is defined as any various signs and symptoms of COVID-19 such as fever, cough, sore throat, malaise, headache, muscle pain, without shortness of breath, dyspnea or abnormal chest imaging. Moderate illness is defined as evidence of lower respiratory disease, by clinical assessment or imaging, and a saturation of oxygen of <94% on room air. CDC further indicated HCP with mild to moderate illness who are not moderately to severely immunocompromised could return to work after the following criteria have been met: At least 7 days have passed since symptoms first appeared if a negative viral test* is obtained within 48 hours prior to returning to work (or 10 days if testing is not performed or if a positive test at day 5-7), and At least 24 hours have passed since last fever without the use of fever-reducing medications, and Symptoms (e.g., cough, shortness of breath) have improved. Further, patients with symptoms of COVID-19 (even before results or diagnostic testing) should be placed in Transmission-Based Precautions. The decision to discontinue empiric transmission based precautions by excluding the diagnosis of a current COVID-19 infection for a patient with symptoms can be made based upon having	21390		

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21390	Continued From page 39 negative results from at least one viral test. If using an antigen test, a negative result should be confirmed by either a negative molecular test or a second negative antigen test taken 48 hours after the first negative test. Patients with suspected or confirmed COVID-19 should be placed in a single person room and the door should be kept closed, if safe to do so. Healthcare workers who enter the patients rooms should adhere to standard precautions and use a NIOSH-approved particulate respirator with N95 filters or higher, gown, gloves, and eye protection (i.e., goggles or a face shield that covers the front and sides of the face). The CDC Symptoms of COVID-19, updated October 26, 2022, identified people with COVID-19 have had a wide range of symptoms reported-ranging from mild symptoms to severe illness. Symptoms may appear 2 to 14 days after exposure to the virus. Possible symptoms include: fever or chills, cough, shortness of breath, fatigue, muscle or body aches, headache, new loss of taste or smell, sore throat, congestion or runny nose, nausea or vomiting and diarrhea. Employee Illness Tracking The facility employee infection control logs for the month of December 2022, identified the following: Respiratory Illness - On 11/24/22, dietary aide (DA)-A tested positive for RSV. DA-A was not tested for COVID-19 illness. DA-A returned to work on 11/28/22. -On 12/4/22, licensed practical nurse (LPN)-A reported aching, sore throat, and headache. LPN-A was not tested for COVID-19 illness. LPN-A returned to work on 12/5/22. LPN-A was not tested for COVID-19 illness. LPN-A worked	21390		

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21390	Continued From page 40 12/5/22, 12/6/22 and 12/7/22. On 12/8/22, LPN-A tested positive for influenza B and was still not tested to rule out COVID-19. An analysis of potential contacts who may have been exposed or resolution of symptoms was not documented. -On 12/6/22, DA-D reported increase respiratory symptoms. DA-D was not tested for COVID-19 illness. DA-D returned to work on 12/21/22. -On 12/7/22, AA-C reported symptoms of aching and cough. AA-C was not tested for COVID-19 illness. AA-C returned to work on 12/12/22. -On 12/19/22, NA-D reported respiratory symptoms. NA-D was not tested for COVID-19 illness. NA-D returned to work on 12/20/22. On 12/21/22, NA-D reported illness and tested positive for COVID-19. Contact tracing and testing for COVID-19 to evaluate staff and residents potential exposure and limit the spread of the illness within the facility was not initiated, despite NA-D having worked providing direct care to residents the day prior to her positive test result. -On 12/24/22, LPN-B reported illness of headache and aching while working her shift. LPN-B tested positive for COVID-19 on 12/27/22. LPN-B returned to work on 12/29/22. Contact tracing and testing for COVID-19 to evaluate staff and residents potential exposure and limit the spread of the illness within the facility was not initiated, despite LPN-B having worked providing direct care to residents the day she began exhibiting symptoms of illness. Gastrointestinal Illness (GI) -On 12/8/22, cook (CK)-A reported diarrhea illness and went home. CK-A was not tested for COVID-19 illness. CK-A returned to work on 12/9/22. -On 12/8/22, activity director (AD)-A reported nausea and went home. AD-A was not tested for	21390		

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21390	Continued From page 41 COVID-19 illness. AD-A returned to work on 12/9/22. -On 12/8/22, dietary aide (DA)-B reported nausea, vomiting and diarrhea and went home. DA-B was not tested for COVID-19 illness. DA-B returned to work on 12/9/22 -On 12/9/22, the director of nursing (DON) reported diarrhea and headache. The DON was not tested for COVID-19 illness. The DON returned to work on 12/12/22. -On 12/9/22, DA-C reported GI symptoms. DA-C was not tested for COVID-19 illness. DA-C returned to work on 12/19/22. -On 12/9/22, assistant dietary manager (ADM)-A reported GI symptoms. ADM-A was not tested for COVID-19 illness. -On 12/12/22, DA-B reported GI symptoms. DA-B was not tested for COVID-19 illness. DA-B returned to work on 12/13/22. -On 12/14/22, registered nurse (RN)-D reported body aches, nausea and vomiting. RN-D did not test for COVID-19 illness. RN-D returned to work on 12/16/22 -On 12/21/22, DA-D reported GI symptoms. DA-D was not tested for COVID-19 illness. DA-D returned to work on 12/30/22 -On 12/27/22, nursing assistant (NA)-C reported vomiting and diarrhea. NA-C was not tested for COVID-19 illness. NA-C returned to work on 12/29/22 -On 12/28/22, NA-A reported nausea and dizziness. NA-A was not tested for COVID-19 illness. NA-A returned to work on 1/9/23. -On 12/29/22, NA-B reported nausea, vomiting and diarrhea. NA-B was not tested for COVID-19 illness. NA-B returned to work on 12/31/22. There was no evidence assessments were conducted to determine if employee illness could	21390		

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21390	Continued From page 42 potentially be COVID-19 symptoms and require testing prior to return to work or if there were potential resident and staff exposures and a need to conduct contact or outbreak testing. The infection control logs lacked evidence the facility conducted a comprehensive analysis of the collected outcome surveillance data to determine if any of the infections identified were potentially related or corresponded with resident illness for the same month period. There was no evidence the facility had investigated the infections identified for potential causes and/or subsequent actions to reduce the risk of recurrence. When interviewed on 1/10/23, at 2:15 p.m. LPN-A stated if an employee came to her with complaints of feeling sick she would ask them about their symptoms. If it was just sniffles or a little under the weather, she would not send them home. If they were really sick and they had coverage, she would send them home. During interview on 1/10/23 at 2:35 p.m. NA-C stated she would not come to work if she felt sick. If NA-C was already working and started to feel sick, she would try to get someone to come in and replace her but if could not find anyone, she couldn't just go home. It depended on what her symptoms were and which of the nurses was working. If she was throwing up she would probably go home, but if was just feeling run down she would have to work out her shift. When interviewed on 1/10/23, at 3:40 p.m. NA-D stated she was ill with COVID in December of 2022, and tested positive for COVID-19 on 12/21/22. The symptoms NA-D experienced during that illness were GI upset of nausea, vomiting and diarrhea.	21390		

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THIEF RIVER CARE CENTER	2001 EASTWOOD DRIVE THIEF RIVER FALLS, MN 56701

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21390	Continued From page 43 During interview on 1/11/23, at 10:30 a.m. LPN-B stated she was sick the day she worked on 12/24/22. LPN-B called the administrator that evening to let her know and did not work on 12/25/22 or 12/26/22. LPN-B tested positive on 12/27/22, as she knew she would as a family member in her home was ill with COVID-19 the week before. LPN-B returned to work on 12/29/22, when she was no longer feeling ill and it was five days since her symptoms first appeared. During interview on 1/10/23, at 10:20 a.m. RN-D, who was the infection preventionist, stated she saw the employees when they returned to work after having called in and none appeared ill. RN-D did not test the employees on their return to work. RN-D had known LPN-B had a family member who was ill with COVID-19 living in her home and reported not feeling well on 12/24/23; however, continued to work her entire shift. LPN-B did test positive on 12/27/22. The facility had not initiated any testing of potentially exposed residents or staff, as RN-D felt the doctors in the area believed people tested for COVID too often. RN-D was aware of the facility's policies for staff who had signs and symptoms of COVID-19 like illness (based on screening) and/or a temperature (100 degrees or higher) should not report to work until testing could be completed as well as contact tracing for potential exposures; however, the policies were written by the corporate office and did not necessarily reflect current practice. RN-D stated she visualized all the staff members LPN-B worked with when LPN-B was presenting with symptoms at work. The unidentified staff did not display any symptoms of illness, so RN-D did not feel any COVID-19 testing was necessary, despite COVID-19 having asymptomatic transmission. RN-D saw DA-A on her return to work on	21390		

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21390	Continued From page 44 11/28/22, after testing positive for RSV on 11/24/22, and DA-A had no obvious symptoms of illness, and there were no other cases of RSV in the facility. The employees who reported symptoms of GI illness during the month of December were not tested for COVID-19 as their symptoms did not act like a COVID-19 illness. It depended on staff symptoms if they would need to test before returning to work after an illness. An interview was conducted with the DON and administrator on 11/10/22, at 3:30 p.m. The administrator stated if staff or residents displayed illness that could indicate a COVID-19 infection, the ill resident or staff were to isolate and COVID-19 testing would be done on day one, day three and day five of symptom onset. If the results were negative and the resident or staff was asymptomatic isolation was lifted. For contact tracing, the facility did outbreak testing with COVID-19 antigen tests. The facility had not completed an assessment to see if outbreak testing would be needed when LPN-B had tested positive as her positive test was more than 48 hours since she had last worked, despite having displayed symptoms of COVID-19 while at work on 12/24/22. The facility allowed staff to return to work in five to ten days of a positive COVID test, five days if emergency staffing, if they had improved symptoms and were fever free. They allowed LPN-B to return to work on 12/29/22, because they had used onset of symptoms 12/24/22, for the start of her illness. RESIDENT OBSERVATIONS: During observation of R41 on 1/11/23, at 8:40 a.m. there was a sign on R41's door which directed staff/visitors to stop at nurses station prior to going into the room. An isolation cart was	21390		

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21390	Continued From page 45 outside of the room. During observation of R41 on 1/11/23, at 8:51 a.m. R41's door was wide open and R41 was not in the room. During observation of R41 on 1/11/23, at 8:56 a.m. R41 was in the dining room and seated at a table in the far corner of the room approximately 10-12 feet (ft) from other residents. Nursing assistant (NA)-C was wearing a face mask and was seated next to R41 to assist R41 with eating. During observation of R41 on 1/11/23, at 8:58 a.m. activity aide (AA)-C wheeled R41 out of the dining room and into the hallway near the waterfall. R41 was not wearing a face mask. During observation on 1/11/23, at 9:06 a.m. R41 was seated in her wheelchair, was not wearing a face mask and was seated next to two unidentified residents in the hallway near the waterfall. During observation of R41 on 1/11/23, at 9:06 a.m. R41 was observed unmasked and seated in her wheelchair in the activity area. R41 stated she didn't feel well. R41 coughed several times. Licensed practical nurse (LPN)-C stated R41 could eat in the dining room as long as the resident wore a face mask and sat at the table in the far corner. LPN-C needed to give R41 a breathing treatment and started to wheel R41 out of the activity area. While LPN-C was wheeling R41 down the hallway, LPN-C was interrupted and left R41 in the hallway. R41 was still unmasked. During observation of R41 on 1/11/23, at 9:17 a.m. LPN-C returned to R41 and started wheeling	21390		

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21390	Continued From page 46 R41 towards her room. LPN-C stated R41 should be wearing a face mask since she was in the hallway. During observation on 1/11/23, at 9:21 a.m. LPN-C was standing next to R41, nurse prepped nebulizer equipment near R41 and then exited residents room. LPN-C did not put on personal protective equipment (PPE) prior to entering R41's room, and did not perform hand hygiene prior to entering or upon exiting the room. LPN-C re-entered R41's room wearing a face mask and carried gloves balled up in her left hand. LPN-C did not put on PPE or use hand sanitizer prior to entered R41's room. With bare hands, LPN-C prepped R41's nebulizer medication (inhaled medication used to reduce inflammation in the lungs or to open airways to improve breathing ability), and placed the face mask over R41's face, secured the elastic straps around R41's head and turned the machine on. LPN-C proceeded to clean and walk around the area near R41 while the nebulizer machine was bubbling and running. LPN-C maintained a distance between 2 feet and 8 feet from R41 during the entire time. During observation at 9:28 a.m. NA-F entered R41's room, talked with LPN-C and then exited the room. Upon entering R41's room NA-F did not use hand sanitizer or put PPE on prior to entering room, use hand sanitizer upon exiting the room or to change face mask after exiting the room. During observation at 9:30 a.m. LPN-C continued to walk around R41's room. LPN-C leaned over R41 and stand face-to-face with R41 while R41's nebulizer was still running. LPN-C was wearing a face mask . LPN-C then removed R41's nebulizer	21390		

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21390	Continued From page 47 mask, walked behind resident and turned nebulizer machine off. With bare hands, LPN-C carried the nebulizer mask into the bathroom. LPN-C exited the bathroom and walked to R41's side. LPN-C arranged R41's oxygen tubing, placed the nasal cannula on the resident's face and listened to her chest with a stethoscope. LPN-C was within one to two feet of R41 the entire time. Then LPN-C walked into the bathroom, washed hands, removed the face mask, exited R41's room and put on a clean face mask. LPN-C was in R41's room for a total of 8 minutes while in close proximity of R41 and only wearing a face mask. During interview on 1/11/23, at 9:28 a.m. NA-F stated despite there being a sign on the door and a cart outside R41's room she completely forgot to put on PPE prior to entering R41's room. During interview on 1/11/23, at 9:35 a.m. LPN-C stated R41 had a cough and tested negative for COVID-19 on 1/10/23. LPN-C stated R41 was on contact and droplet precautions due to R41's cough and R41 should wear a face mask when out of the room. Staff were supposed to wear on a gown, gloves and face mask when entering R41's room and the sign on the door identified that information. LPN-C did not wear a gown and gloves upon entering R41's room but should have. COVID-19 testing recommendations were to test on day 1, day 3 and day 5 before residents were considered negative. Yesterday was R41's first test. LPN-C stated she did not think R41 would be considered free from COVID-19 after one negative test. When interviewed on 1/11/23, at 9:57 a.m. NA-G stated when she came to work that morning R41 had transmission based precautions (TBP) cart	21390		

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21390	Continued From page 48 with PPE and a sign on the door directing staff to wear a gown, gloves, eye goggles and face mask when entering the room. Wearing PPE was used to help reduce the risk of spreading infections to other staff and residents. NA-G was initially told R41 had to stay in her room but then later was told the resident could go to the dining room for breakfast as long as she sat at the table furthest in the corner and away from other people. When NA-G wheeled R41 through the dining room R41 did not wear a face mask. During interview on 1/12/23, at 3:48 p.m. the director of nursing (DON) stated when a resident was on TBP the staff were expected to wear a gown, gloves, mask, and depending on the precaution would also expect staff to wear eye goggles, face shield or N95 mask. The staff would also be expected to use hand sanitizer prior to and upon exiting the residents room. That was the policy and staff knew and were expected to follow the policy. When interviewed on 1/11/23, at 10:34 a.m. LPN-B stated R50 started to complain of a sore throat and headache that morning. R50's first COVID-19 test that morning was negative; however, R50 was placed on isolation until confirmatory COVID-19 testing could be completed and her symptoms evaluated. During observation of R50 on 1/11/23, at 10:50 a.m. housekeeper (HK)-A was cleaning R50's room while wearing a surgical face mask and gloves. R50's room had an isolation cart outside of her door and the door way to her room was clearly marked with a sign that indicated anyone who entered needed to observe transmission based precautions and put on a disposable gown, gloves, eye protection and face mask before	21390		

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21390	Continued From page 49 entering the room. R50 was lying on her bed reading a magazine. The DON approached the room and asked HK-A to leave the room to talk with her. HK-A was instructed on contact precautions. HK-A removed and discarded her gloves in the garbage; however, continued to wear the same surgical mask. HK-A stated they were not told residents were placed in transmission based precautions. HK-A did not see the signs indicating the TBP on R50's door, as R50's door was open when she approached it. During observation odf R50 on 1/11/23, at 10:53 a.m. HK-B entered R50's room to deliver laundry. R50 was lying on her bed reading a magazine. HK-B wore a surgical face mask under her chin, that did not cover her mouth or nose. HK-B did not put on a gown, gloves or eye protection, and entered the room with clean laundry. HK-B delivered the resident's laundry, putting the clean clothes in the residents closet and exited the room; however, did not perform hand hygiene. HK-B stated the transmission based precaution sign hanging on R50's door and the isolation cart outside her door was set up just for visitors, if they were staying in the room for a long time. If the resident was being quarantined for COVID infection there would have been a large COVID sign on her door and in that case, she would not have entered the resident's room and just hung the clean laundry outside her door for nursing staff to put away. HK-B knew her mask was to cover her nose and mouth. It kept sliding down and so she adjusted it back in place. Resident Illness Tracking Resident illness tracking logs for the month of November 2022, identified the following:	21390		

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21390	Continued From page 50 Respiratory illness -On 11/4/22, R15 developed symptoms of lethargy, decrease oxygen saturation, cough and increase confusion. R15 received two antibiotics for treatment of pneumonia; however, sensitivities were not identified and COVID-19 testing was not conducted. -On 11/19/22, R34 developed symptoms of nasal drainage, cough, loss of taste and smell. R34 tested positive for COVID-19 on 11/22/22 and placed in isolation. -On 11/28/22, R38 was identified as positive for COVID-19 and placed in isolation. Urinary Tract Infections (UTI) -On 11/21/22, R3 developed a UTI. R3 received antibiotic treatment; however, sensitivities to see if the organism was sensitive to the antibiotic ordered, were not identified. -On 11/28/22, R38 developed a UTI. R38 received antibiotic treatment; however, sensitivities to see if the organism was sensitive to the antibiotic ordered, were not identified. Resident illness tracking logs for the month of December 2022, identified the following: Urinary Tract Infections (UTI) The December 2022 Infection Surveillance Log (ISL) identified : -On 11/30/22, R23 developed a UTI -On 11/24/22, R3 developed a UTI. R3 received antibiotic treatment; however, sensitivities to see if the organism was sensitive to the antibiotic ordered, were not identified. -On 12/2/22, R35 developed a UTI. -On 12/6/22, R23 developed a UTI. R23 received antibiotic treatment; however, sensitivities to see if the organism was sensitive to the antibiotic	21390		

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21390	Continued From page 51 ordered, were not identified. -On 12/8/22, R33 developed a UTI. R38 received antibiotic treatment; however, sensitivities to see if the organism was sensitive to the antibiotic ordered, were not identified. -On 12/8/22, R41 developed a UTI. R41 received antibiotic treatment; however, sensitivities to see if the organism was sensitive to the antibiotic ordered, were not identified -On 12/27/22, R23 developed a UTI. R23 received two different antibiotics for treatment; however, sensitivities to see if the organism was sensitive to the antibiotics ordered, were not identified The summary of December 2022 infection control log identified eight resident UTI's, 7 consisted of bacterial infections and 1 was contaminated but treated anyway. The infection control logs lacked evidence the facility conducted a comprehensive analysis of the collected outcome surveillance data to determine if any of the infections identified were potentially related or corresponded with staff illness for the same month period to initiate appropriate corrective action. There was no evidence the facility investigated the infections identified for potential causes and/or subsequent actions to reduce the risk of reoccurrence. The following resident medical records in conjunction with the facility infection control logs identified the following: - Progress note (PN) dated 12/16/22, identified R108 developed decrease lung sounds and oxygen saturations of 70 to 80% with oxygen in place. R108 required hospitalization and returned with diagnosis of pneumonia with	21390		

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21390	Continued From page 52 unknown origin. R108 was not identified on resident illness logs for surveillance when he presented with initial illness, or throughout his illness. R108 was not evaluated or tested for COVID-19 during the initial course of illness and was not isolated from other residents until COVID-19 testing could be completed to rule out the infectious illness. -PN dated 1/9/23, identified R29 developed symptoms of nausea and vomiting. A rapid COVID-19 test was performed and was negative. R29 was not listed on the resident illness tracking log for surveillance, nor placed on isolation pending a confirmatory test. -PN dated 1/4/23, identified R41 developed low grade temperature of 99. 5, oxygen saturation of 93% with supplemental oxygen at 2L/min, and complaints of not feeling well. A rapid COVID-19 test was performed and was negative. However, R41 was not listed on the resident illness tracking log. R41 remained symptomatic with cough and general malaise, no further COVID-19 test were performed and R41 was not placed into transmission based precautions as recommended by the Centers for Disease Control (CDC) until facility was notified of surveyor concerns on 1/11/23. During interview on 1/10/23, at 10:20 a.m. RN-D stated the nursing staff were supposed to fill out a sick log form when residents had symptoms of illness and she would update her surveillance logs from those forms weekly. RN-D was notified R41 was tested for COVID-19 on 1/4/23, and was negative. R41 had nasal drainage and a cough when she had assisted her in the dining room on 1/6/23. RN-D then notified the charge nurse after wheeling R41 out of the dining room. Testing was	21390		

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21390	Continued From page 53 usually done on day one, day three and day five for symptomatic staff and residents because of the potential incubation period of the illness. RN-D usually did the COVID-19 testing for residents but did not fill out the sheets for R41's follow up tests, so the required follow up testing was not completed. RN-D was not sure why R108 was not on the resident infection December 2022 logs, as R108 should have been, especially because of his emergency room visit and diagnosis of pneumonia. RN-D indicated it was important to be sure to include all ill resident and employees on the surveillance logs so you could track where they were, how the illness was going and if it was spreading. During interview on 1/10/23, at 4:00 p.m. registered nurse (RN)-A stated if a resident showed signs of COVID-19, they would isolate the resident and test with a rapid antigen test. If still showing symptoms they would retest the resident. They always notified RN-D when they tested a resident for COVID-19. R41 displayed a cough and low grade fever. R41 was tested on 1/4/23 and was negative for COVID-19. R41 still exhibited symptoms of cough and her oxygen saturation was 95% at rest with supplemental oxygen. R41's cough was loose and in her chest, not in her lungs. RN-A had not personally done a repeat COVID test and would have to check with the nurses working on the floor if another test was needed. No second confirmatory testing was completed after the initial test was done on 1/4/23, despite her continued symptoms. R41 had not been isolated, although continued to exhibit symptoms of cough and shortness of breath. When interviewed on 1/11/23, at 8:30 a.m. RN-D stated some of the resident UTI infections should not have had an antibiotic ordered because no	21390		

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21390	Continued From page 54 specific bacteria was cultured. RN-D looked for patterns and trends with the resident infections but could only find incontinence of urine and resisting staff assist with peri care after an incontinent episode as a common factor. There did not seem to be a common bacteria with the infections or in the same areas of the facility or she would have suspected staff as the source. RN-D did not document sensitivities to cultures or follow up to make sure the antibiotic ordered was effective against the identified organism. Some times the facility would get sensitivity results on cultures and sometimes they would not. In some instances the lab would not even do a sensitivity on a culture. RN-D stated she watched some staff complete peri care to ensure proper technique; however, had not documented audits formally. She had tried to start audit forms but staff had become angry with the audits and so they were not completed. RN-D did not identify if any concerns or training with peri care had been completed while performing audits. The facility's Coronavirus Prevention, Screening and Identification policy dated 10/9/22, indicated If a resident exhibited any symptoms of respiratory infection, or other COVID-19 related symptoms the resident's provider would be notified immediately. Quarantine interventions and testing would be initiated. If initial test was negative, the resident would be encouraged to use mask and social distance. For residents with suspected or confirmed COVID; monitoring of vital signs and respiratory symptoms would be at least twice a day. and any vital sign changes would be identified and further licensed nurse assessment would occur. During an outbreak, any breach of Personal Protective Equipment (PPE) would be reported immediately to the supervisor or designee. Staff who had signs and	21390		

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21390	Continued From page 55 symptoms of COVID-19 like illness (based on screening) and/or a temperature (100 degrees or higher) would not report to work until testing could be completed. Staff who had mild to moderate illness, who were not moderately to severely Immunocompromised, could return to work if at least 7 days if a negative antigen or PCR was obtained within 48 hours prior to returning to work or 10 days have passed since symptoms had first appeared, and at least 24 hours had passed since last fever without the use of fever-reducing medications, and symptoms (e.g., cough, shortness of breath) had improved. Staff who were asymptomatic throughout their infection and were not moderately to severely Immunocompromised could return to work if at least 7 days if a negative antigen or PCR was obtained within 48 hours prior to returning to work or after 10 days if testing was not performed. Staff who had a high risk exposure would have three viral tests for SARS-CoV-2 infection. testing would occur (as able) on day one (where day of exposure is day 0), day three, and day five. Care center would keep a list of any staff unprotected exposure to COVID-19. The list would include all staff that interacted with the positive person from two days before symptoms started. For potential staff exposure, the facility would complete Assessment for Health Care Workers (HCW) Assessment for Health Care Workers Potentially Exposed to COVID-19 in Minnesota. Identify the risk level using assessment. Contact tracing may indicate low risk when there was no direct exposure to a COVID-19 infected person. Contact risk was identified as close (within 6 feet for 15 minutes or more, or within same living space) contact of person(s) with COVID-19 within 48 hours. Communicate the risk level to the staff with work-related recommendations. Recommendations would be followed for staff	21390		

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21390	Continued From page 56 who had high-risk workplace exposure to COVID-19 and staff with household or intimate contacts who had confirmed or suspected COVID-19. The facility's policy Transmission Based Precautions dated 6/7/17, indicated transmission based precautions would be used when caring for residents who were documented or suspected to have communicable diseases or infections that could be transmitted to others. When transmission based precautions were implemented the IP nurse would ensure that PPE is maintained near or inside the resident's room and post the appropriate notice on the room door entrance and in the resident's chart so all personnel would be aware of the precautions before entering the room. Residents with symptoms consistent with norovirus would be placed on contact precautions for a minimum of 48 hours after the resolution of symptoms to prevent further exposure of susceptible residents. The facility's policy Infection Prevention and Control Officer dated 5/8/17, indicated it was the IP nurse responsibility to establish infection prevention and control procedures for surveillance, identification, investigation, control and prevention of infections and communicable diseases for all persons providing services in the facility. The IP was directed to maintain an infection surveillance program with infection control log of incidents for both residents and staff, with documentation of analysis of tracking and trending and measures taken according to findings. SUGGESTED METHOD OF CORRECTION: The DON or designee could review their infection control program, to ensure policies and	21390		

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21390	Continued From page 57 procedures are established to include the analysis of collected data, appropriate RTW and appropriate isolation and PPE use inservice staff regarding policy and procedure, and audit to ensure compliance. Review at QAA meetings. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21390		
21530	MN Rule 4658.1310 A.B.C Drug Regimen Review A. The drug regimen of each resident must be reviewed at least monthly by a pharmacist currently licensed by the Board of Pharmacy. This review must be done in accordance with Appendix N of the State Operations Manual, Surveyor Procedures for Pharmaceutical Service Requirements in Long-Term Care, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system. It is not subject to frequent change. B. The pharmacist must report any irregularities to the director of nursing services and the attending physician, and these reports must be acted upon by the time of the next physician visit, or sooner, if indicated by the pharmacist. For purposes of this part, "acted upon" means the acceptance or rejection of the report and the signing or initialing by the director of nursing services and the attending physician. C. If the attending physician does not concur with the pharmacist's recommendation, or does not provide adequate justification, and the pharmacist believes the resident's quality of life is being adversely affected, the pharmacist must refer the matter to the medical director for review if the medical director is not the attending	21530		2/16/23

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21530	Continued From page 58 physician. If the medical director determines that the attending physician does not have adequate justification for the order and if the attending physician does not change the order, the matter must be referred for review to the quality assessment and assurance committee required by part 4658.0070. If the attending physician is the medical director, the consulting pharmacist must refer the matter directly to the quality assessment and assurance committee. This MN Requirement is not met as evidenced by: Based on interview and document review, the consulting pharmacist (CP)-A failed to identify irregularities related to the use psychotropic medications for 1 of 5 residents (R4), the facility failed to ensure irregularities identified by CP-A were addressed timely by the medical provider for 1 of 5 residents (R4) and failed to ensure the medical provider documented a rationale for the extended use of an as needed (PRN) psychotropic medication for 2 of 3 residents (R20 R28) reviewed for unnecessary medications. Findings include: R4's significant change Minimum Data Set (MDS) dated 10/26/22, identified R4 had moderate cognitive impairment, consumed antipsychotic, antianxiety and antidepressant medications daily, and required extensive assistance to complete activities of daily living (ADLs). The MDS outlined a section to record R4's mood. R4 was unable to be interviewed, however, staff assessment of R4's mood severity scored 3, as minimal. No hallucinations, rejection of care or behaviors were recorded and no change in R4's mood and behavior had occurred since her last assessment.	21530	Corrected	

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21530	Continued From page 59 R4's Physician Order Review, dated 9/20/22, identified R4's current signed orders. These included but was not limited to the following medication: Abilify (an antipsychotic medication) 2 milligrams (mg) by mouth (po) at bedtime, R4's Physician Progress Note, dated 10/18/22, identified R4 had a recent emergency room visit and had been given Zyprexa (antipsychotic medication). Staff reported R4 was like a different person when on the medication with improved mood and behavior. The physician indicated R4's Abilify would be discontinued and Zyprexa 5 milligrams at bedtime initiated. R4's Physician Order Review, dated 11/15/22, identified R4's current signed orders. These included medications but were not limited to: lorazepam (an antianxiety) 0.5 mg by mouth (po) every four hours as needed (PRN) with start date 10/19/22, and Zyprexa (an antipsychotic medication) 5 mg po at bedtime, with start date 10/18/22. The orders failed to identify an end date for the PRN lorazepam ordered, as required. R4's Pharmacy Summary Report dated 11/8/22, indicated irregularities were identified and to see report. The corresponding report titled Nursing Report for November 2022, directed nursing staff to address ASAP but no later than 7 days, R4's lorazepam 0.5 mg tablet. The report read PRN psychotropics were limited to a 14-day duration based on updated CMS guidance and rules, unless the prescriber chose to extend treatment by providing clinical rationale and documentation of intended duration. A recommendation was made to re-evaluate the appropriateness of continuing the current therapy. If treatment was to be continued add an appropriate stop date and	21530		

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21530	Continued From page 60 document the duration of treatment and clinical evaluation/rationale of the resident. R4's most recent Physician Progress Note, dated 11/15/22, identified the current visit was for medication recheck. Staff reported R4 had been a little lethargic during the day and felt a decrease in her dose of Zyprexa would be beneficial. Staff reported R4's mood had been stable and no issues with mood swings, depression, or anxiety symptoms. R4 was tired during the day but had appropriate behaviors. The physician indicated R4's morning dose of Zyprexa would be decreased to 2.5 milligrams mg, however, R4 did not currently receive Zyprexa in the morning. R4's current order had been for Zyprexa 5 mg at bedtime only which was not changed or decreased. Further, the progress note lacked evidence the pharmacist recommendations made on 11/8/22, to evaluate R4's PRN lorazepam was brought to the physician's attention or addressed. R4's undated Face Sheet identified R4's current physician ordered medications. These included medications: Zyprexa 2.5 mg po in the morning, with start date 11/18/22, and Zyprexa 5 mg po at bedtime. R4 was currently receiving Zyprexa in the morning as well as her bedtime dosage. The medical record lacked documentation the physician had been contacted to confirm the increase to R4's Zyprexa by 2.5 mg daily was an intentional increase in medication. R4's Pharmacy Summary Report dated 12/8/22, indicated no irregularities were identified, despite the previous month's recommendation regarding the PRN lorazepam had not yet been addressed and the recent conflicting increase of R4's antipsychotic medication Zyprexa.	21530		

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21530	Continued From page 61 When interviewed on 1/12/22, at 11:50 a.m. registered nurse (RN)-G stated she had not received any pharmacy reports from the physician since September 2022. The pharmacy reports were physically brought over to the physician's office right after the CP's monthly visit and the physician would fax the signed forms to the facility after review. RN-G wished the process was more timely. The forms were brought to the physician office and the recommendations did not get addressed again until they were returned from the physician. At that time the nurse managers reviewed the forms to check if any medication or treatment changes were ordered. RN-G stated R4's pharmacy recommendations, as well as other residents, should be addressed in a more timely fashion. During interview on 1/12/23, at 1:36 p.m. CP-A stated he did not feel it was unusual for the physician's late response to his recommendations. The nursing staff was supposed to re-evaluate PRN psychotropic medications with the provider, for the required 14-day window. When a PRN psychotropic medication was first identified during monthly medication review, he would fill out a Consultant Pharmacist Medication Review form. CP-A filled out the form for R4 because the medication had a 14-day window and needed to be addressed. CP-A did not typically reiterate previous recommendations month to month. CP-A remembered wondering about the increase with R4's Zyprexa but did not read the physician's progress note when the provider had initiated the increase. It was a small dose, so there was nothing to really trigger a recommendation from him. When interviewed on 1/12/23, at 3:15 p.m. the	21530		

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21530	Continued From page 62 director of nursing (DON) stated the facility did not have a process to check if the physician had addressed monthly pharmacy recommendations. R20's significant change Minimum Data Set (MDS) dated 12/24/22, identified R20 had diagnoses that included major depressive disorder and generalized pain. R20 exhibited behaviors that included physical and verbal behaviors towards others and refusing cares. R20 received antianxiety medication 2 out of the 7 days of the assessment period. R20's physician orders dated 12/2/22, included an order for lorazepam (antianxiety, psychotropic medication) 1 mg by mouth two times per day as needed (PRN) due to disorientation, pain/anxiety from 12/2/22 to 3/20/23. R20's physician notes from 12/2/22 to 1/12/23, lacked documentation regarding R20's extended use of antianxiety medication and lacked documentation of contraindications for gradual dose reduction of lorazepam R20's Consultant Pharmacist's Medication Review dated 12/8/22, identified R20 had an order for lorazepam 1 mg tablet 1 tablet by mouth twice daily PRN for anxiety. The pharmacist comments included: since this medication was used for a psychological condition and due to Centers for Medicare and Medicaid Services (CMS) guidelines, the PRN medication had to be re-evaluated within the first 14 days of starting. If the medication was to be continued a re-evaluation date was needed. On 12/20/22, the physician responded the medication was to be continued for 90 days. "Will have a routine visit in about 4 weeks". However, the form lack rationale/justification for continuation.	21530		

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21530	Continued From page 63 R28's annual MDS dated 10/14/22, identified diagnoses that included dementia with behavioral disturbance, Alzheimer's disease, and paranoid personality disorder. R28 utilized antianxiety medications but did not exhibit behaviors during the assessment period. R28's Psychotropic Drug Use CAA dated 10/10/22, identified R28 was prescribed lorazepam 0.5 mg PRN daily due to a diagnoses of paranoid personality disorder. R28 did not utilize the medication during the assessment period. R28's physician orders dated 7/5/22, included an order for lorazepam 0.5 mg by mouth everyday PRN for anxiety from 7/5/22 to 7/10/23. Target behaviors: exit seeking, paranoid behaviors, confusion, being scared, and not sleeping. R28's physician notes from 7/6/22 to 12/17/22, lacked documentation regarding R28's extended use of PRN antianxiety medication and lacked documentation of contraindications for gradual dose reduction of lorazepam. R28's Consultant Pharmacist's Medication Review dated 6/9/22, identified R28 had an order for lorazepam 0.5 mg tablet 1 tablet by mouth everyday PRN for anxiety. The pharmacist comments included: since this medication was used for a psychological condition and due to Centers for Medicare and Medicaid Services (CMS) guidelines, the PRN medication had to be re-evaluated within the first 14 days of starting. If the medication was to be continued a re-evaluation date was needed. On 6/21/22, the physician responded, "6 months". However, the form did not identify a justification for continued	21530		

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21530	Continued From page 64 use. During an interview on 1/12/23, at 1:42 p.m. RN-A stated the interdisciplinary team (IDT) did not review PRN lorazepam administrations, documentation, nor physician progress notes prior to making GDR recommendations. The process was more of a discussion between the nurse manager and the consultant pharmacist than chart review to determine what was best for the resident. RN-A used to make sure the physician completed all documentation to ensure compliance with guidelines but the physician would not do it. Because of this, RN-A stated she gave up trying. However, RN-A had not brought this concern to administration to address. During a phone interview on 1/12/23, at 3:08 p.m. CP-A stated he looked for the initial 14-day evaluation whenever a PRN psychotropic medication was started. Then, he would review if the resident was using the medication and how often. From there, if the resident had not used a medication for approximately 3 months, he would recommend the medication be discontinued. Sometimes, the consultant would review progress notes to make sure there was a rationale but the facility had implemented a new electronic medical record system, and "it was more of a process to look at progress notes". He usually visited with the nurse manager to determine a resident's chart included a rationale for use. During the IDT meeting, the team would review the residents who had MDS assessments that month; however, the team did not review administrations, documentation nor physician progress notes. The consultant pharmacist hoped the physician would provide a clear, concise documentation why a medication was ordered, but this was more of a nursing responsibility and his role was to review	21530		

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21530	Continued From page 65 how often a medication was given. Once his recommendations were made, he did not review the following month to ensure it was addressed. During an interview on 1/12/23, at 4:55 p.m. the director of nursing (DON) stated she was new to her role at the facility and was aware documentation for administration of a psychotropic medication needed to be more robust. She received emails with the pharmacist reviews, and they discussed potential GDR during IDT meetings she attended. Staff were expected to follow facility policy regarding documentation of non-pharmacological interventions attempted, what was effective or not and to determine patterns of use. The DON stated this information was needed to provide the IDT with the appropriate information to determine if the medication was an appropriate choice for the resident. The facility policy Psychotropic Medications issued 10/1/15, identified physicians and other providers (nursing practitioners and physician assistants) would order psychotropic medications appropriately working with the interdisciplinary team to ensure appropriate use, evaluation, and monitoring. The policy further identified the consultant pharmacist would: 1. Monitor psychotropic drug use in the facility to ensure that medications were not used in excessive doses or for excessive duration, monthly basis. 2. Participate in the IDT quarterly review of residents on psychotropic medications. 3. Notify the physician and the nursing unit if a psychotropic medication was due for review. Additionally, the Physician would: 1. Order psychotropic medication only for the treatment of specific medical and/ or psychiatric	21530		

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21530	Continued From page 66 conditions or when the medication meets the needs of the resident to alleviate significant distress for the resident not met by the use of non- pharmacologic approaches. 2. Document rationale and diagnosis for use and identify Target Behavior symptoms for the reason the medication is being used. 3. Document discussion with the resident and/or responsible party regarding the risk versus benefit of the use of these medications included in the discussion and documentation must be the presence of any black box warning or off label use of the medication affecting the prescribing of the medication to the resident. 4. Evaluate with the interdisciplinary team, effects, and side effects of psychoactive medications within one month of initiating, increasing, or decreasing dose and during routine visits thereafter. 5. Monitors the resident for lack of drug efficacy clinically and in discussions with the interdisciplinary team within one month of initiating and during routine visits. 6. Attempt a gradual dose reduction (GDR) decrease or discontinuation of psychotropic medications after no more than 3 months unless clinically contraindicated. Gradual dose reduction must be attempted for 2 separate quarters (with at least one month between attempts). Gradual dose reduction must be attempted annually thereafter or as the resident's clinical condition warrants. 7. Review Sedative/ hypnotics quarterly for gradual dose reduction. GDR must be attempted quarterly unless clinically contraindicated. 8. New orders for PRN psychotropic medications will be time limited (i.e., times 2 weeks) and only for specific clearly documented circumstances. 9. Obtain psychiatric consultation as resident's clinical condition requires.	21530		

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21530	Continued From page 67 SUGGESTED METHOD OF CORRECTION: The DON/ Consulting Pharmacist or designee could review and revise policies and procedures for pharmacy reviews and irregularities. The director of nursing or designee could develop a system to educate staff and develop a monitoring system to ensure pharmacy reviews are timely and irregularities are being acted upon. The quality assurance committee could monitor these measures to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) days	21530		
21535	MN Rule4658.1315 Subp.1 ABCD Unnecessary Drug Usage; General Subpart 1. General. A resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used: A. in excessive dose, including duplicate drug therapy; B. for excessive duration; C. without adequate indications for its use; or D. in the presence of adverse consequences which indicate the dose should be reduced or discontinued. In addition to the drug regimen review required in part 4658.1310, the nursing home must comply with provisions in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (1) found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is	21535		2/16/23

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21535	Continued From page 68 available through the Minitex interlibrary loan system and the State Law Library. It is not subject to frequent change. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure a gradual dose reduction (GDR) was attempted and/or medical justification was provided to support an increase dosage of Zyprexa (an antipsychotic medication) for 1 of 5 residents (R4) reviewed and ensure as needed (PRN) psychotropic medication use was limited to 14 days or medical justification was provided to support ongoing use for 1 of 5 residents (R4) who had PRN psychotropic medications ordered. The facility failed to provide evidence non-pharmacological interventions were provided prior to administration of as needed (PRN) psychotropic medication for 3 of 4 residents (R8, R28, R20). Findings include: R4's significant change Minimum Data Set (MDS) dated 10/26/22, identified R4 had moderate cognitive impairment, consumed antipsychotic, antianxiety and antidepressant medications on a daily basis, and required extensive assistance to complete activities of daily living (ADLs). The MDS outlined a section to record R4's mood. R4 was unable to be interviewed, however, staff assessment of R4's mood severity scored 3, as minimal. No hallucinations, rejection of care or behaviors were recorded and no change in R4's mood and behavior had occurred since her last assessment. R4's Physician Order Review, dated 9/20/22,	21535	Corrected	

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21535	Continued From page 69 identified R4's current signed orders. These included but were not limited to the following medication: Abilify (an antipsychotic medication) 2 milligrams (mg) by mouth (po) at bedtime, R4's Physician Progress Note, dated 10/18/22, identified R4 had a recent emergency room visit and had been given Zyprexa. Staff reported R4 was like a different person when on the medication with improved mood and behavior. The physician indicated R4's Abilify would be discontinued and Zyprexa 5 mg at bedtime initiated. R4's Pharmacy Summary Report dated 11/8/22, indicated irregularities were identified and to see report. The corresponding report titled Nursing Report for November 2022, directed nursing staff to address ASAP but no later than 7 days, R4's lorazepam 0.5 mg tablet. The report read PRN psychotropic's were limited to a 14-day duration based on updated CMS guidance and rules, unless the prescriber chose to extend treatment by providing clinical rationale and documentation of intended duration. A recommendation was made to re-evaluate the appropriateness of continuing the current therapy. If treatment was to be continued add an appropriate stop date and document the duration of treatment and clinical evaluation/rationale of the resident. R4's Physician Order Review, dated 11/15/22, identified R4's current signed orders. These included but were not limited to the following medications: lorazepam (an antianxiety) 0.5 mg po every four hours PRN with start date 10/19/22, Zyprexa (an antipsychotic medication) 5 mg po at bedtime, with start date 10/18/22. The orders failed to identify an end date for the PRN lorazepam ordered, as required.	21535		

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21535	Continued From page 70 R4's most recent Physician Progress Note, dated 11/15/22, identified the current visit was for medication recheck. Staff reported R4 had been a little lethargic during the day and felt a decrease in her daytime dose of Zyprexa would be beneficial. Staff reported R4's mood had been stable and no issues with mood swings, depression or anxiety symptoms. R4 was tired during the day but had appropriate behaviors. The physician indicated R4's morning dose of Zyprexa would be decreased to 2.5 mg, however, R4 did not currently receive Zyprexa in the morning. R4's current order had been for Zyprexa 5 mg at bedtime only which was not changed or decreased. Further, the progress note lacked evidence the pharmacist recommendations made on 11/8/22, to evaluate R4's PRN lorazepam was brought to the physician's attention or addressed. R4's undated Face Sheet identified R4's current physician ordered medications. These included but were not limited to the following medications: Zyprexa 2.5 mg po in the morning, with start date 11/18/22, and Zyprexa 5 mg po at bedtime. R4 was currently receiving Zyprexa in the morning as well as her bedtime dosage. The medical record lacked documentation the physician had been contacted to confirm the increase to R4's Zyprexa by 2.5 mg daily was an intentional increase in medication. When interviewed on 1/12/23, at 11:50 a.m. registered nurse (RN)-G stated the physician came to the facility to see patients. Medications were discussed verbally on rounds. The physician had stopped R4's Abilify and started Zyprexa on 10/18/22. RN-G indicated she was	21535		

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21535	Continued From page 71 unable to find documentation in R4's medical record to justify the increase in the Zyprexa in November and thought maybe the physician had noticed something with R4 that the facility staff had missed. RN-G reviewed the physician progress notes on 11/15/22, and verified R4's physician had dictated to decrease R4's Zyprexa, not increase the medication. RN-G had written the verbal order and transcribed the morning Zyprexa order to R4's medication administration record. RN-G indicated the nurses reviewed resident behaviors quarterly by review of the nurse progress notes incidental charting and if a resident's behaviors changed it would be in the progress notes. RN-G was unable to find documentation to warrant an increase in R4's Zyprexa. RN-G stated she would review R4's increased Zyprexa dose next week when R4's physician was at the facility for rounds. During telephone interview with the consulting pharmacist (CP)-A on 1/12/23, at 1:35 p.m. CP-A indicated it was not unusual for the medical provider to have a late response to his monthly recommendations. The nursing staff were suppose to evaluate his recommendations with the primary provider within 14 days. After that it could wait for 30 or 60 days for formal response documented by the physician. CP-A did not reiterate his former recommendations and it was just because of the 14 day window with the PRN psychotropic that he wanted his recommendations addressed for R4. CP-A had noted the increase Zyprexa in November, but it was a small dose and he had not read the physician progress notes and so had not addressed it during his monthly medication review. When interviewed on 1/12/23, at 3:15 p.m. the	21535		

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21535	Continued From page 72 director of nursing (DON) stated she was aware behavior documentation in the facility's current electronic medical record system was a problem. The nurses were directed to do a weekly summary of behaviors and behavior audits. The documentation of behaviors would be needed before adjustment of resident medications. When R4's Zyprexa was increased, the nurse should have asked for an order clarification immediately. R8's annual Minimum Data Set (MDS) dated 11/29/22, identified R8 had severe cognitive impairment and had diagnoses that included vascular dementia with behavioral disturbance. R8 utilized antianxiety (a type of psychotropic) medications but R8 did not exhibit behaviors during the assessment period. R8's Psychotropic Drug Use CAA dated 12/2/22, identified R8 utilized lorazepam (psychotropic medication used to treat anxiety) 0.5 milligram (mg) once daily as needed (PRN) after 2:00 p.m., if R8's scheduled dose of gabapentin (an anticonvulsant that was used with other medications to prevent and control seizures. It was also used to relieve nerve pain following shingles (a painful rash due to herpes zoster infection) in adults) did not help with target behaviors which included yelling, anxiety, refusing to eat, hitting at staff. No PRN doses were given during assessment period. R8's non-pharmacological interventions were as follows: 1:1, music, cinnamon toast, drink. Staff were directed to take things slow and speak softly to R8 during that time. R8 continued to have behaviors such as uncontrolled yelling which cannot be redirected and issues with bathing, hitting out at staff, and yelling. R8's care plan dated 1/4/23, identified R8	21535		

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21535	Continued From page 73 exhibited behaviors of yelling, hitting, and swearing. Staff were directed to use non-pharmacological interventions including: 1:1, music, cinnamon toast, food/drink, leave and reapproach. Staff were also directed to observe for changes and report. R8's undated, nursing assistant care sheet did not identify R8 had any behaviors nor did it direct staff on R8's behavioral triggers or non-pharmacological interventions. R8's physician orders dated 3/2/22, included an order for lorazepam 0.5 mg by mouth once daily PRN from 3/22/22 to 2/2/23. Special instructions included: Never to be given before 1:00 p.m. dose of gabapentin. Utilize and document redirection interventions prior to giving lorazepam. R8's target behaviors included: yelling, banging on table, and hitting. R8's August 2022 Electronic Medication Administration Record (EMAR) identified R8 did not receive any PRN doses of lorazepam. R8's September 2022, EMAR identified the following: - On 9/5/22, at 3:48 p.m. R8 received 0.5 mg of lorazepam. The administration notes field identified the medication was administered due to "given as PRN". However, the notes did not identify any behaviors, or any non-pharmacological interventions attempted. Additionally, it identified the medication was not effective. - On 9/27/22, 4:17 p.m., R8 received 0.5 mg of lorazepam. The EMAR did not identify why the medication was administered nor non-pharmacological interventions were attempted prior to the administration.	21535		

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21535	Continued From page 74 R8's October 2022, EMAR identified on 10/11/22, at 3:05 p.m. R8 received 0.5 mg of lorazepam. The EMAR did not identify why the medication was administered or if any non-pharmacological interventions were attempted prior to the administration. R8's December 2022, EMAR identified on 12/5/22, at 11:57 a.m. R8 received 0.5 mg of lorazepam. The EMAR did not identify why the medication was administered nor non-pharmacological interventions were attempted prior to the administration. During an observation on 1/10/23, at 9:28 a.m. R8 was sitting in her wheelchair next to the medication cart. Licensed practical nurse (LPN)-C encouraged R8 to drink approximately 2 ounces (oz) of a supplement drink from a disposable plastic cup. LPN-C used a calm, reassuring voice. R8 drank the supplement drink, and no behaviors were exhibited. During an observation on 1/10/23, at 10:00 a.m. R8 sat at a table in the common area. R8 sat quietly and watched the other residents. Family member (FM)-A approached and greeted R8. R8 was calm and smiled. FM-A then assisted R8 to her room for a visit. During an interview on 1/11/23, at 10:20 a.m. nursing assistant (NA)-B stated when she worked with R8, R8 really didn't understand. R8 did not get mad or angry. R8 just didn't do anything when you asked her. NA-B did see R8 have behaviors in the morning once during morning cares. Staff just walked away and let R8 eat her breakfast, then R8 calmed down. The rest of the morning went fine. NA-B reiterated staff needed to stay	21535		

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21535	Continued From page 75 calm and reapproach R8 when she was having a bad day. R8 was usually happy and smiling. R8 wasn't always able to make sense when she spoke, but she tried. During an interview on 1/11/23, at 5:19 p.m. LPN-D stated R8's bath days were "really bad". R8 would yell and scream. Sometimes, R8 had to eat in the activity room because she was so upset. Staff never knew what R8 needed. Staff offered toileting or eating, but sometimes R8 just had to calm herself. These behaviors could last hours, minutes or not at all. LPN-D then stated R8 had an order for as needed lorazepam and LPN-D would speak with the other nurse and nursing assistants before giving it to make sure it was a good choice. LPN-D would then document all the non-pharmacological interventions staff had tried and would continue to monitor for effectiveness. However, LPN-D then stated she would forget to document in a progress note "most of the time". LPN-D would put a note in the EMAR when she administered the medication. For example, on 9/5/22, LPN-D stated she entered "for pain" on R8's lorazepam administration. LPN-D stated she had administered Tylenol as well because she "thought" R8 was having neck/shoulder pain and R8 wasn't able to tell her. R8 wouldn't calm down. However, LPN-D stated it had occurred four months prior and she could not identify what behaviors if any, R8 was exhibiting. LPN-D additionally could not identify what non-pharmacological interventions had been attempted prior to the lorazepam administration. LPN-D continued to state lorazepam was more for calming R8 down. Staff were not able to tell if it was pain or behaviors but if the Tylenol did not help R8's pain at least she would calm down. LPN-D then stated she knew she needed to do	21535		

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21535	Continued From page 76 better documentation, but she was a new LPN and was learning every day. During an interview on 1/12/23, at 9:45 a.m. registered nurse (RN)-B stated behavior monitoring needed to be documented on any resident that exhibited a behavior. Some common behaviors were yelling, hitting, and screaming. R8 did exhibit behaviors of yelling, screaming, and hitting. Staff were directed to provide cinnamon toast, distraction and sometimes she needed the quiet of her room. R8 also had a photo album that she liked to look at. However, sometimes the non-pharmacological interventions did not help, and she needed an as needed dose of lorazepam. However, lorazepam would only be given as a last resort when every other non-pharmacological intervention did not work. Staff were additionally directed to document the administration on the EMAR, document behaviors and interventions in the nursing progress notes, and document a follow up as well that identified if the medication was effective or not. During an interview on 1/12/23, at 1:29 p.m. RN-A stated R8 had scheduled lorazepam on her bath days, but sometimes bathing continued to be difficult for R8. R8 had an additional order for lorazepam 0.5 mg once daily PRN. Before this was to be given, staff were directed to provide non-pharmacological interventions such as cinnamon toast, minimal bath water, calm approaches, start with one nursing assistant and ask for help if needed, quiet places and 1:1. However, R8's exhibited behaviors and responses to non-pharmacological interventions were "all over the place". RN-A stated neither R8's EMAR, nor progress notes, identified why PRN medications were given nor did they identify what non-pharmacological interventions had been	21535		

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21535	Continued From page 77 attempted prior to the administration. Staff were expected to document all interventions that were attempted in the nursing progress notes. Additionally, staff were expected to do a follow up note that described the effectiveness of the medication. During an interview on 1/12/23, at 4:55 p.m. the director of nursing (DON) stated she had recently begun her role at the facility. She knew the interdisciplinary team (IDT) had a conversation about R8 and her medications because R8 yelled at night. The DON stated she needed to investigate to determine when R8 had received PRN lorazepam and why. Staff were expected to follow facility policy regarding documentation of non-pharmacological interventions attempted, what was effective or not and to determine patterns of use. The DON stated this information was needed to provide the IDT with the appropriate information to determine if the medication was an appropriate choice for R8. R28's annual MDS dated 10/4/22, identified a severe cognitive impairment and diagnoses that included dementia with behavioral disturbance, Alzheimer's disease, and paranoid personality disorder. R28 utilized antianxiety medications but did not exhibit behaviors during the assessment period. R28's Psychotropic Drug Use CAA dated 10/10/22, identified R28 was prescribed lorazepam 0.5 mg PRN daily due to a diagnoses of paranoid personality disorder. R28's target behaviors included: exiting seeking and paranoid behaviors. R28 did not utilize the medication during the assessment period. R28's care plan dated 12/29/22, identified R28	21535		

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21535	Continued From page 78 utilized antianxiety medication related to diagnosis of anxiety as exhibited by: exit seeking and wandering that was not redirectable. Staff were directed to administer medications per order and observe for side effects, work with a psychiatric team, monitor mood and response to medications. R28's non-pharmacological interventions included: 1:1, offer food/drink and give a toy dog to distract. R28's undated, nursing assistant care sheet did identify R28 was an elopement risk but did not identify any other target behaviors nor directed staff on R28's behavioral triggers or non-pharmacological interventions. R28's physician orders dated 7/5/22, included an order for lorazepam 0.5 mg po everyday PRN anxiety from 7/5/22 to 7/10/23. Target behaviors: exit seeking, paranoid behaviors, confusion, being scared, and not sleeping. R28's September 2022 , EMAR identified the following: - On 9/4/22, at 1:22 a.m. R28 received 0.5 mg of lorazepam. R28's medical record did not identify why the medication was administered nor non-pharmacological interventions were attempted prior to the administration. - On 9/23/22, at 6:47 p.m. R28 received 0.5 mg of lorazepam. R28's medical record did not identify why the medication was administered nor non-pharmacological interventions were attempted prior to the administration. - On 9/30/22, at 7:31 p.m. R28 received 0.5 mg of lorazepam. R28's medical record did not identify why the medication was administered nor non-pharmacological interventions were attempted prior to the administration.	21535		

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21535	Continued From page 79 R28's October 2022, EMAR identified R28 did not receive PRN lorazepam R28's November 2022, EMAR identified the following: - On 11/4/22, at 7:20 p.m. R28 received 0.5 mg of lorazepam. R28's medical record did not identify why the medication was administered nor non-pharmacological interventions were attempted prior to the administration. - On 11/5/22, at 7:26 p.m. R28 received 0.5 mg of lorazepam. R28's medical record did not identify why the medication was administered nor non-pharmacological interventions were attempted prior to the administration. - On 11/6/22, at 7:41 p.m. R28 received 0.5 mg of lorazepam. R28's medical record did not identify why the medication was administered nor non-pharmacological interventions were attempted prior to the administration. - On 11/9/22, at 4:04 a.m. R28 received 0.5 mg of lorazepam. R28's medical record did not identify why the medication was administered nor non-pharmacological interventions were attempted prior to the administration. - On 11/22/22, at 1:14 a.m. R28 received 0.5 mg of lorazepam. R28's medical record did not identify why the medication was administered nor non-pharmacological interventions were attempted prior to the administration. R28's December 2022, EMAR identified the following: - On 12/3/22, at 7:25 a.m. R28 received 0.5 mg of lorazepam. R28's medical record did not identify why the medication was administered nor non-pharmacological interventions were attempted prior to the administration. - On 12/4/22 at 7:26 a.m. R28 received 0.5 mg of lorazepam. R28's medical record did not identify	21535		

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	00448	A. BUILDING: _____ B. WING _____	C 01/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THIEF RIVER CARE CENTER	2001 EASTWOOD DRIVE THIEF RIVER FALLS, MN 56701

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21535	Continued From page 80 why the medication was administered nor non-pharmacological interventions were attempted prior to the administration. - On 12/12/22, at 7:24 a.m. R28 received 0.5 mg of lorazepam. R28's medical record did not identify why the medication was administered nor non-pharmacological interventions were attempted prior to the administration. - On 12/17/22, at 6:53 a.m. R28 received 0.5 mg of lorazepam. R28's medical record did not identify why the medication was administered nor non-pharmacological interventions were attempted prior to the administration. - On 12/20/22, at 3:24 a.m. R28 received 0.5 mg of lorazepam. R28's medical record did not identify why the medication was administered nor non-pharmacological interventions were attempted prior to the administration. - On 12/31/22 at 2:34 a.m. R28 received 0.5 mg of lorazepam. R28's medical record did not identify why the medication was administered nor non-pharmacological interventions were attempted prior to the administration. During an observation on 1/12/23, at 8:32 a.m. R28 was in the dining room. R28 was clean, well-groomed, and eating his breakfast. No behaviors were exhibited. During an interview on 1/12/23, at 9:48 a.m. RN-B stated R28 needed reorientation to the day of the week, time of day or where he was. Staff usually waited to give R28 lorazepam until the evening or night shift so R28 would get some sleep. R28 would often get up at night and eat snacks, but his blood sugar would be elevated in the morning. R28 could be restless and hard to redirect. R28 did wander but never entered other residents' rooms or attempted to hurt anyone. He would just have a lost look on his face.	21535		

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21535	Continued From page 81 During an interview on 1/12/23, at 1:29 p.m. RN-A stated neither R28's EMAR, nor progress notes identified why PRN medications were given nor did they identify what non-pharmacological interventions were attempted prior to the administration. During an interview on 1/12/23, at 4:55 p.m. DON stated staff were expected to follow facility policy regarding documentation of non-pharmacological interventions attempted, what was effective or not and to determine patterns of use. The DON stated this information was needed to provide the IDT with the appropriate information to determine if the medication was an appropriate choice for R28. R20's significant change MDS dated 12/24/22, identified R20 had no cognitive impairment and had diagnoses that included disorientation, major depression disorder, and amnesia. R20's Psychotropic Drug Use CAA dated 12/26/22, identified R20 was prescribed Melatonin 5 mg for insomnia. R20 reported sleeping "very little" during the night, documentation showed between 5-8 hours each night. R20 napped frequently throughout the day. R20 was prescribed duloxetine 20mg for depression. R20 reported feeling down/depressed and had chronic pain. R20 was very angry, swung out at staff, and refused staff to care for him. The CAA did not address R20's prescribed lorazepam 1 mg by mouth three times a day PRN. R20's care plan dated 12/28/22, identified R20 utilized antidepressant medication. R20's target behaviors were refusal of care, hitting, yelling,	21535		

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21535	Continued From page 82 swearing. Staff were directed to administer mediations per orders, monitor and document behaviors, complete assessments, make referrals as needed, meet with R20/family to address concerns, and offer activity. The care plan did not identify R20 was prescribed lorazepam PRN. R20's physician orders dated 12/2/22, included an order for lorazepam 1 mg by mouth two times per day PRN due to disorientation, pain/anxiety from 12/2/22 to 3/20/23. R20's December 2022 , EMAR identified the following: - On 12/3/22, at 7:57 a.m. R20 received 1 mg of lorazepam. R20's medical record did not identify why the medication was administered nor what non-pharmacological interventions were attempted prior to the administration. - On 12/3/22, at 8:56 p.m. R20 received 1 mg of lorazepam. R20's medical record did not identify why the medication was administered nor what non-pharmacological interventions were attempted prior to the administration. - On 12/4/22, at 9:19 a.m. R20 received 1 mg of lorazepam. R20's medical record did not identify why the medication was administered nor what non-pharmacological interventions were attempted prior to the administration. - On 12/4/22, at 10:59 p.m. R20 received 1 mg of lorazepam. R20's nursing progress note dated 12/4/22 at 10:59 p.m. identified R20 had received hydrocodone acetaminophen 5/325 mg at 8:00 a.m. and 8:00 p.m. for moderate pain in his left hip and lower extremities. R20 also received lorazepam PRN morning and evening for anxiety. This was effective in providing restful periods for R20. However, the nursing progress note did not identify R20's exhibited behaviors nor the	21535		

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21535	Continued From page 83 non-pharmacological interventions attempted prior to the administration. - On 12/5/22, at 9:30 a.m. R20 received 1 mg of lorazepam. R20's medical record did not identify why the medication was administered nor what non-pharmacological interventions were attempted prior to the administration. - On 12/6/22, at 4:29 a.m. R20 received 1 mg of lorazepam. R20's medical record did not identify why the medication was administered nor what non-pharmacological interventions were attempted prior to the administration. - On 12/7/22, at 7:28 p.m. R20 received 1 mg of lorazepam. R20's nursing progress note dated 12/7/2022, at 10:10 p.m. identified R20 was alert and oriented. R20's physician orders were updated with scheduled twice daily hydrocodone acetaminophen 10/325 mg for moderate pain in his left hip and lower extremity. Lorazepam 1 mg twice daily for anxiety. However, the nursing progress note did not identify R20's exhibited behaviors nor the non-pharmacological interventions attempted prior to the administration. - On 12/10/22, at 5:33 p.m. R20 received 1 mg of lorazepam. R20's nursing progress note dated 12/10/22, at 7:59 p.m. identified R20 was alert and oriented. Lorazepam 1 mg PRN for anxiety. However, the nursing progress note did not identify R20's exhibited behaviors nor the non-pharmacological interventions attempted prior to the administration. - On 12/21/22, at 7:41 a.m. R20 received 1 mg of lorazepam. R20's medical record did not identify why the medication was administered nor what non-pharmacological interventions were attempted prior to the administration. - On 12/24/22, at 7:24 a.m. R20 received 1 mg of lorazepam. R20 received 1 mg of lorazepam. R20's medical record did not identify why the	21535		

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21535	Continued From page 84 medication was administered nor what non-pharmacological interventions were attempted prior to the administration. - On 12/29/22, 11:17 a.m. R20 received 1 mg of lorazepam. R20 received 1 mg of lorazepam. R20's medical record did not identify why the medication was administered nor what non-pharmacological interventions were attempted prior to the administration. During an observation on 1/10/23, at 1:46 p.m. R20 was lying in bed with blankets covering to his neck. R20's eyes were closed and R20 was resting peacefully. During an observation on 1/12/23, at 8:00 a.m. NA-H entered R20's room and greeted R20. NA-H then asked R20 if he was ready to get up for the day. While NA-H began prepping for morning cares, she began speaking with R20 about his family, where they live and how the roads were that day. R20 stated it was hard for his kids to come, especially in winter when roads could be bad. NA-H then proceeded to assist R20 to dress for the day. NA-H gave verbal cues that allowed R20 to make choices, such as: can I help you roll to the other side? - At 8:08 a.m. R20 asked NA-H to just let him stay in bed because he was having pain. R20 stated sometimes you just need to lay still for a bit. NA-H assisted R20 to lie on his left side and covered him with a blanket. NA-H opened R20's window blinds, telling R20 he could watch the deer outside. NA-H ensured R20 had his call light and R20 told NA-H "thank you". During an interview on 1/12/23, at 8:14 a.m. NA-H stated R20 could become very angry. R20's triggers included loud noises, tv, radio, and large groups of people talking. If people were talking in	21535		

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21535	Continued From page 85 low voices around him, R20 would think they were talking about him. R20 would become angry if staff did not tell him what they were doing or not giving him options. NA-H then stated staff really needed to make it R20's idea to do something. Also, R20 liked to get dressed early and go back to bed to lie down, or he wouldn't cooperate with morning cares. When R20 did become angry, staff would just walk away and try again later. During an interview on 1/12/23, at 9:53 a.m. RN-B stated R20 was monitored for behaviors and had orders for lorazepam 1 mg twice daily PRN, but RN-B had never witnessed R20 receive lorazepam. During an interview on 1/12/23, at 1:42 p.m. RN-A stated neither R20's EMAR, nor progress notes, identified why PRN medications were given nor did they identify what non-pharmacological interventions had been attempted prior to the administration. During an interview on 1/12/23, at 4:55 p.m. DON stated staff were expected to follow facility policy regarding documentation of non-pharmacological interventions attempted, what was effective or not and to determine patterns of use. The DON stated this information was needed to provide the IDT with the appropriate information to determine if the medication was an appropriate choice for R20. The facility's Psychotropic Medications policy dated 10/1/15, identified the purpose was to ensure the therapeutic use of and to minimize the risks associated with psychotropic medications. The facility would make every effort to comply with state and federal regulations related to the use of psychopharmacological medications to	21535		

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21535	Continued From page 86 include regular review for continued need, appropriate dosage, side effects, risks and/or benefits. Efforts to reduce dosage or discontinue of psychopharmacological medications would be ongoing, as appropriate, for the clinical situation. New orders for PRN psychotropic medications would be time limited and only for specific clearly documented circumstances. The policy also identified physicians and other providers (nursing practitioners and physician assistants) would order psychotropic medications appropriately working with the interdisciplinary team to ensure appropriate use, evaluation, and monitoring. The policy directed nursing to: 1. Monitor psychotropic drug use daily, noting any adverse effects such as increased somnolence or functional decline. 2. Monitor for the presence of target behaviors on a daily basis, charting by exception (i.e., charting only when the behaviors are present). 3. Review the use of the medications with the physician and the interdisciplinary team on a quarterly basis to determine the continued presence of target behaviors and/or the presence of any adverse effects of the medication use. 4. Complete assessments on any resident on an antipsychotic medication, at least every 6 months, and changes would be reported to the physician. 5. Include specific target behaviors on the care plan. SUGGESTED METHOD OF CORRECTION: The DON or designee could develop, review, and/or revise policies and procedures to ensure GRD's or justification of continued use of scheudled and PRN medications. In addition, assure non homological interventions were provided prior to administering PRN medication. Document the results of the PRN medications. The DON or	21535		

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21535	Continued From page 87 designee could educate all appropriate staff on the policies and procedures. The DON or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twent - One (21) Days	21535		