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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 8R4F

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00454

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245560**
2.STATE VENDOR OR MEDICAID NO.
(L2) **767842800**

3. NAME AND ADDRESS OF FACILITY
(L3) **EDGEBROOK CARE CENTER**
(L4) **505 TROSKY ROAD WEST**
(L5) **EDGERTON, MN** (L6) **56128**

4. TYPE OF ACTION: **2** (L8)
1. Initial **2. Recertification**
3. Termination **4. CHOW**
5. Validation **6. Complaint**
7. On-Site Visit **9. Other**
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **07/29/2021** (L34)

8. ACCREDITATION STATUS: __ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

01 Hospital	**05 HHA**	**09 ESRD**	**13 PTIP**	**22 CLIA**
02 SNF/NF/Dual	**06 PRTF**	**10 NF**	**14 CORF**	
03 SNF/NF/Distinct	**07 X-Ray**	**11 ICF/IID**	**15 ASC**	
04 SNF	**08 OPT/SP**	**12 RHC**	**16 HOSPICE**	

FISCAL YEAR ENDING DATE: (L35)
12/31

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **56** (L18)
13.Total Certified Beds **56** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	56			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE Date :
Lois Boerboom, HFE NE II 09/22/2021 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 09/23/2021 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
____ 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :
_____

22. ORIGINAL DATE OF PARTICIPATION
06/01/1991
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00140
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Electronically delivered
August 23, 2021

Administrator
Edgebrook Care Center
505 Trosky Road West
Edgerton, MN 56128

RE: CCN: 245560
Cycle Start Date: July 29, 2021

Dear Administrator:

On July 29, 2021, a survey was completed at your facility by the Minnesota Department(s) of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

REMEDIES

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

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective September 22, 2021.

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

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective September 22, 2021. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective September 22, 2021.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for

new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

This Department is also recommending that CMS impose:

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

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $11,160; 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 September 22, 2021, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Edgebrook Care Center will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from September 22, 2021. 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" tag), and emergency preparedness deficiencies (those preceded by an “E” tag), i.e., the plan of correction should be directed to:

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by January 29, 2022 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:

Tamika.Brown@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 Tamika Brown, Principal Program

Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

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

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

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

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

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
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
	245560	A. BUILDING _____ B. WING _____	C 07/29/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDGEBROOK CARE CENTER	**505 TROSKY ROAD WEST EDGERTON, MN 56128**

(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 7/26/21 through 7/29/21, 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 007 SS=F	EP Program Patient Population CFR(s): 483.73(a)(3) §403.748(a)(3), §416.54(a)(3), §418.113(a)(3), §441.184(a)(3), §460.84(a)(3), §482.15(a)(3), §483.73(a)(3), §483.475(a)(3), §484.102(a)(3), §485.68(a)(3), §485.625(a)(3), §485.727(a)(3), §485.920(a)(3), §491.12(a)(3), §494.62(a)(3). [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following:] (3) Address [patient/client] population, including, but not limited to, persons at-risk; the type of services the [facility] has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans.**	E 007		9/10/21

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

Electronically Signed | 09/01/2021

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 007	Continued From page 1 *[For LTC facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do all of the following: (3) Address resident population, including, but not limited to, persons at-risk; the type of services the LTC facility has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans. *NOTE: ["Persons at risk" does not apply to: ASC, hospice, PACE, HHA, CORF, CMCH, RHC/FQHC, or ESRD facilities.] This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to address in their Emergency Preparedness Plan the patient population including, but not limited to, persons at-risk. This had the potential to effect all 43 current patients of the agency. Findings include: The agency's Emergency Preparedness Plan dated January 2021, did not address population, including but not limited to persons at-risk, the type of services the agency had the ability to provide in an emergency, and continuity of operations. During interview on 7/29/21, at 5:43 p.m. the agency's administrator confirmed she was unable to locate in the plan the population served, including, but not limited to, persons at-risk; the type of services the agency had the ability to	E 007	Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. For the purposes of any allegation that the center is not in substantial compliance with federal requirements of participation, this response and plan of correction constitutes the center□s allegation of compliance in accordance with section 7305 of the State Operations Manual. 1. Emergency plan was updated to include the current resident population including, but not limited to, persons at-risk.	

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E 007	Continued From page 2 provide in an emergency.	E 007	2. This had the potential to effect all residents. 3. Emergency plan was updated to include the current resident population including, but not limited to, persons at-risk this will be done by the administrator or designee. Emergency plan will be reviewed with any significant change and in resident population and annually. 4. Audits will be completed by the Quality Assurance Coordinator or designee weekly x 4 and every other week x 2 and monthly x 1. Audit results will be brought to the monthly QA meeting with appropriate follow up indicated to ensure solutions are sustained. 5. Completion date: September 10,2021	
E 024 SS=F	Policies/Procedures-Volunteers and Staffing CFR(s): 483.73(b)(6) §403.748(b)(6), §416.54(b)(5), §418.113(b)(4), §441.184(b)(6), §460.84(b)(7), §482.15(b)(6), §483.73(b)(6), §483.475(b)(6), §484.102(b)(5), §485.68(b)(4), §485.625(b)(6), §485.727(b)(4), §485.920(b)(5), §491.12(b)(4), §494.62(b)(5). [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:]	E 024		9/10/21

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E 024	Continued From page 3 (6) [or (4), (5), or (7) as noted above] The use of volunteers in an emergency or other emergency staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency. *[For RNHCIs at §403.748(b):] Policies and procedures. (6) The use of volunteers in an emergency and other emergency staffing strategies to address surge needs during an emergency. *[For Hospice at §418.113(b):] Policies and procedures. (4) The use of hospice employees in an emergency and other emergency staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to develop policy and procedure for the use of volunteers or other personnel in the facility during an emergency. This deficient practice had the potential to affect all 43 resident who currently resided in the facility. Findings include: Interview and document review on 7/29/21 at 5:52 p.m., with the administrator to review the facility's Emergency Policy and Procedure manual, dated January 2021. The administrator was unable to locate a policy for use of volunteers or other personnel in the facility during an emergency. The administrator confirmed the plan lacked	E 024	1. Emergency plan was updated to include the use of volunteers during an emergency. 2. This had the potential to effect all residents. 3. Emergency plan was updated to include the use of volunteer during an emergency. This will be done by the administrator or designee. Emergency plan will be reviewed with any significant change and annually. 4. Audits will be completed by the Quality Assurance Coordinator or designee weekly x 4 and every other week x 2 and monthly x 1. Audit results will be brought to the monthly QA meeting with	

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E 024	Continued From page 4 documentation of a policy for use of volunteers.	E 024	appropriate follow up indicated to ensure solutions are sustained. 5. Completion date: September 10,2021	
E 034 SS=F	Information on Occupancy/Needs CFR(s): 483.73(c)(7) §403.748(c)(7), §416.54(c)(7), §418.113(c)(7) §441.184(c)(7), §482.15(c)(7), §460.84(c)(7), §483.73(c)(7), §483.475(c)(7), §484.102(c)(6), §485.68(c)(5), §485.68(c)(5), §485.727(c)(5), §485.625(c)(7), §485.920(c)(7), §491.12(c)(5), §494.62(c)(7). [(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities]. The communication plan must include all of the following: (7) [(5) or (6)] A means of providing information about the [facility's] occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee. *[For ASCs at 416.54(c)]: (7) A means of providing information about the ASC's needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee. *[For Inpatient Hospice at §418.113(c):] (7) A means of providing information about the hospice's inpatient occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command	E 034		9/10/21

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E 034	Continued From page 5 Center, or designee. This REQUIREMENT is not met as evidenced by: Based on document review and interview, the facility failed to ensure the emergency preparedness communication plan included a procedure for sharing information on occupancy and the facility's ability to provide assistance to the authority having jurisdiction in the event of an emergency. This practice had the potential to affect all 43 patients currently residing in the facility. Findings include: During review of the Emergency Preparedness Plan dated January 2021, it was identified the plan lacked a policy and procedure that addressed how the facility would share occupancy needs and ability to provide assistance with outside resources during an emergency. Interview and document review on 7/29/21 at 6:00 p.m., with the administrator revealed the plan had no policies and procedures related to sharing occupancy needs or ability to provide assistance with outside resources during an emergency. The administrator identified that the facility would send information to all the providers in the area to alert what residents the facility could take on a regular basis, but confirmed there was nothing in the emergency preparedness plan that identified that.	E 034	1. Emergency plan was updated to include the use of communication methods during an emergency including, but not limited to sharing information to different authorities having jurisdiction during an emergency. 2. This had the potential to effect all residents. 3. Emergency plan was updated to include the use of communication methods during an emergency including, but not limited to sharing information to different authorities having jurisdiction during an emergency. This will be done by the administrator or designee. Emergency plan will be reviewed with any significant change and in resident population and annually. 4. Audits will be completed by the Quality Assurance Coordinator or designee weekly x 4 and every other week x 2 and monthly x 1. Audit results will be brought to the monthly QA meeting with appropriate follow up indicated to ensure solutions are sustained. 5. Completion date: September 10,2021	
E 035 SS=F	LTC and ICF/IID Sharing Plan with Patients CFR(s): 483.73(c)(8) §483.73(c)(8); §483.475(c)(8)	E 035		9/10/21

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E 035	Continued From page 6 *[For LTC Facilities at §483.73(c):] [(c) The LTC facility must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually. The communication plan must include all of the following:] *[For ICF/IIDs at §483.475(c):] [(c) The ICF/IID must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years. The communication plan must include all of the following:] (8) A method for sharing information from the emergency plan, that the facility has determined is appropriate, with residents [or clients] and their families or representatives. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure their emergency preparedness communication plan included a method for sharing information the facility has determined appropriate, with residents and their families or representatives. Findings include: Interview and document review on 7/29/21 at 6:10 p.m., with administrator identified that she believed the facility reviewed the emergency preparedness plan with families at family council however, was unsure if that was documented. She was unsure how the facility shared the information with the residents on the facilities emergency preparedness plan. The administrator	E 035	1. Emergency plan was updated to include the use of communication methods during an emergency including, but not limited to sharing information to resident, resident families or representatives during an emergency. 2. This had the potential to effect all residents. 3. Emergency plan was updated to include the use of communication methods during an emergency including, but not limited to sharing information to residents, resident families or representatives during an emergency. This will be done by the administrator or designee. Emergency plan will be reviewed with any significant change and	

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E 035	Continued From page 7 confirmed there was no plan that identified the method for sharing information with families or residents.	E 035	in resident population and annually. 4. Audits will be completed by the Quality Assurance Coordinator or designee weekly x 4 and every other week x 2 and monthly x 1. Audit results will be brought to the monthly QA meeting with appropriate follow up indicated to ensure solutions are sustained. 5. Completion date: September 10,2021	
E 037 SS=F	EP Training Program CFR(s): 483.73(d)(1) §403.748(d)(1), §416.54(d)(1), §418.113(d)(1), §441.184(d)(1), §460.84(d)(1), §482.15(d)(1), §483.73(d)(1), §483.475(d)(1), §484.102(d)(1), §485.68(d)(1), §485.625(d)(1), §485.727(d)(1), §485.920(d)(1), §486.360(d)(1), §491.12(d)(1). *[For RNCHIs at §403.748, ASCs at §416.54, Hospitals at §482.15, ICF/IIDs at §483.475, HHAs at §484.102, "Organizations" under §485.727, OPOs at §486.360, RHC/FQHCs at §491.12:] (1) Training program. The [facility] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the [facility] must conduct training on the updated policies and	E 037		9/22/21

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E 037	Continued From page 8 procedures. *[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles. (ii) Demonstrate staff knowledge of emergency procedures. (iii) Provide emergency preparedness training at least every 2 years. (iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others. (v) Maintain documentation of all emergency preparedness training. (vi) If the emergency preparedness policies and procedures are significantly updated, the hospice must conduct training on the updated policies and procedures. *[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) After initial training, provide emergency preparedness training every 2 years. (iii) Demonstrate staff knowledge of emergency procedures. (iv) Maintain documentation of all emergency	E 037		

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E 037	Continued From page 9 preparedness training. (v) If the emergency preparedness policies and procedures are significantly updated, the PRTF must conduct training on the updated policies and procedures. *[For PACE at §460.84(d):] (1) The PACE organization must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, contractors, participants, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Demonstrate staff knowledge of emergency procedures, including informing participants of what to do, where to go, and whom to contact in case of an emergency. (iv) Maintain documentation of all training. (v) If the emergency preparedness policies and procedures are significantly updated, the PACE must conduct training on the updated policies and procedures. *[For LTC Facilities at §483.73(d):] (1) Training Program. The LTC facility must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency	E 037		

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E 037	Continued From page 10 procedures. *[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following: (i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment. (v) If the emergency preparedness policies and procedures are significantly updated, the CORF must conduct training on the updated policies and procedures. *[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following: (i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at	E 037		

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E 037	Continued From page 11 least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the CAH must conduct training on the updated policies and procedures. *[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least every 2 years. This REQUIREMENT is not met as evidenced by: Based on document review and interview, the facility failed to provide appropriate training and testing of the emergency preparedness plan. This had the potential to affect all 43 residents and employed staff at the facility. . Findings include: The facilities Emergency Preparedness Program Plan, dated January 2021, lacked identification of a written plan for training and testing of the program. Interview and documentation review on 7/29/21 at 6:04 p.m., with administrator who reviewed the emergency preparedness plan identified that the maintenance director was to be responsible to sit	E 037	1. Emergency plan was updated to include yearly training and testing protocols of GSS policies and procedures during an emergency. 2. This had the potential to affect all residents. 3. Emergency plan was updated to include yearly training and testing protocols of GSS policies and procedures this will be done by the administrator or designee. Emergency plan will be reviewed with any significant change and in resident population and annually. The plan will be tested on 9/22 on changes to the emergency plan and annually or with significant changes. 4. Audits will be completed by the Quality	

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E 037	Continued From page 12 down with new employees and review the emergency preparedness book. The administrator revealed she had just started at the facility in January 2021, and was not aware of the training program. The facility provided no documentation of emergency preparedness training. The administrator identified for testing the facility had done 2 table tops however, she was unable to provide the documentation and analysis of a table top exercise. The administrator provided an old email from March 20, 2020 that identified a regional meeting at 2:30 to talk through a couple of scenarios to be considered as a quick table top exercise. There was no documentation to support that exercise occurred within the past year. The administrator then provided a blank infection control table top drill form dated for August 26, 2021 that had not taken place yet. Administrator was unaware if the facility had a COVID-19 outbreak within the last year which would have implemented their emergency plan satisfying some of the requirement. The administrator confirmed the facility lacked documentation that any testing of the plan had been completed.	E 037	Assurance Coordinator or designee weekly x 4 and every other week x 2 and monthly x 1. Audit results will be brought to the monthly QA meeting with appropriate follow up indicated to ensure solutions are sustained. 5. Completion date: September 22, 2021	
F 000	INITIAL COMMENTS On 7/26/21 through 7/29/21, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were found to be SUBSTANTIATED: H5560017C (MN72409) with a deficiency cited at F557.	F 000		

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F 000	Continued From page 13 The following complaints were found to be UNSUBSTANTIATED: H5560016C (MN67434) and H5560019C (MN73579). H5560018C (MN73481 & MN73484), was also UNSUBSTANTIATED, however, a related deficiency was cited at F607. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F 000		
F 557 SS=D	Respect, Dignity/Right to have Prsnl Property CFR(s): 483.10(e)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(2) The right to retain and use personal possessions, including furnishings, and clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents. This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to provide privacy for 1 of 1 resident (R1) after bathing in an undignified manner.	F 557	1. R1□s direct care staff were immediately reeducated on providing privacy during transportation after bathing. 2. Because all residents that require	9/10/21

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F 557	Continued From page 14 Findings include: Observation on 7/27/21 at 9:54 a.m., identified R1 was sitting on a chair used in the whirlpool tub. R1 was being pushed by staff to the whirlpool room with a large towel draped over him to be bathed. The towel did not completely cover R1 and R1's abdomen was visible on his side. Interview on 07/29/21 at 10:35 a.m. , with family member (FM)-A identified that R1 had been very self-conscious about his appearance and would have been very concerned about his abdomen being exposed. FM-A revealed prior to his admission, R1 was so shy about appearance, in the past, after a colostomy (tube leading from abdomen to a pouch affixed to the abdomen) R1 no longer wanted to go out of the house because he didn't want people to potentially see his pouch underneath his clothing. Interview on 07/29/21 at 11:00 a.m., with nursing assistant (NA)-A identified staff transport all the residents who required a total lift in the the whirlpool chair. Staff drape a towel over them when taking the resident down the hall to the whirlpool room. There were no robes routinely used. Interview on 07/29/21 03:35 p.m., with the director of nursing (DON) identified staff should provide for personal privacy when transporting residents to the whirlpool room. Review of the 9/08/20, Dressing and Undressing policy identified privacy should be provided during the dressing and undressing process.	F 557	assist while bathing have the potential to be affected, all staff will be reeducated with competency verification on how to transport residents in a dignified manner. 3. To ensure systemic changes staff involved will be educated on the GSS policy and procedure for providing privacy with cares by the DNS or designee. 4. Observation audits will be conducted by the Quality Assurance Coordinator or designee for (R1) and (2) other random residents for transporting the resident in a dignified manner audits will be done weekly x 4 and every other week x 2 and monthly x 1. Audit results will be brought to the monthly QA meeting with appropriate follow up indicated to ensure solutions are sustained. 5. Completion date: September 10, 2021	
F 607 SS=D	Develop/Implement Abuse/Neglect Policies	F 607		9/10/21

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F 607	Continued From page 15 CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to follow facility policy and procedure by notifying 1 of 1 resident (R95) family of an allegation of abuse. Findings include: Review of the 6/4/21 at 12:52 p.m., SA report identified an alleged staff-t- resident abuse directed toward R95. An unidentified reporter had contacted the local Sheriff's department on 6/2/21 at 4:07 p.m. to make the report. The reporter alleged nurse aide (NA)-F made a verbal comment to the reporter, "when the resident hits, he [NA-F] hits back". The sheriff's department contacted the facility on 6/3/21 to report the allegation and inform them they would be interviewing NA-F. Interview on 7/29/21 at 5:01 p.m., with the social services designee (SSD) identified she was contacted by the local Sheriff's department on 6/3/21 informing her they had received a report of	F 607	1. The center contacted the legal representative of Resident (R1) on July 29, 2021. Phone call was documented in the Interdisciplinary Progress (IDP) notes of the resident chart. 2. The center will review the medical records of all residents who have had a complaint or allegation of abuse in the last 30 days to ensure that there is documentation that any pertinent legal representatives have been contacted. If the documentation is found to be inadequate, then legal representatives will immediately be notified as needed. Any required actions will then be documented in the IDP notes. This process will be completed by 9/10/2021. 3. To ensure systemic changes staff involved will be educated on the GSS policy and procedure for abuse and neglect, specifically notification to family by the DNS or designee. 4. Audits for all residents with allegations	

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F 607	Continued From page 16 staff to resident abuse from an unidentified reporter on 6/2/21 at 4:07 p.m. The SSD notified administrative staff who immediately suspended NA-F pending investigation. The SSD identified R95 was assessed by nursing with no bruising or skin issues noted. Due to severe cognitive impairment, R95 had no recollection of any occurrence. Additional residents and staff who had worked with NA-F were interviewed for any concerns of abuse. All stated they had neither seen or heard NA-F being abusive in a physical or verbal manner. Interview on 7/29/21 at 5:55 p.m., with R95's family member, (FM)-A identified she was not aware of any allegation of abuse and denied receiving any notification of an investigation or concern by the facility. FM-A voiced her concern that R95 had possibly been abused and family had not received any notification. FM-A verified she was the first contact person and expected to be contacted with any concerns or issues related to R95. Interview on 7/29/21 at 6:04 p.m. with the SSD and director of nursing (DON) identified the normal procedure was to notify family members when the facility became aware of any incidents or allegations of resident abuse or neglect. The SSD stated she could not remember if R95's family had been contacted. Both the SSD and DON confirmed R95's family had not been notified of alleged incident. The DON stated they were going to contact the family immediately. Interview on 7/30/21 at 9:50 a.m. with R95's FM-B identified he expressed his concern regarding the facility's failure to notify family members of the alleged incident of abuse toward	F 607	of abuse will be conducted by the Social Services designee or other designee weekly x 4 and every other week x 2 and monthly x 1 to ensure residents legal representative was contacted when an allegation of abuse occurs. Audit results will be brought to the monthly QA meeting with appropriate follow up indicated to ensure solutions are sustained. 5. Completion date: September 10, 2021	

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F 607	Continued From page 17 R95. He confirmed the family had not received any notification from either the facility or law enforcement and were not aware of the incident until the call on 7/29/21 at 5:55 p.m. FM-B identified R95 was in the dying process, and the family's primary goal was for comfort and care. He stated if they had been aware of the allegation they would have moved R95 to a different location to ensure her comfort and safety. Review of the 12/23/20, Abuse and Neglect-Rehab/Skilled, Therapy and Rehab policy identified an allegation of abuse was to be reported to the family notifying them the facts of the situation. Staff were to inform family an investigation was in process and record that information.	F 607		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to implement 1 of 1 resident's (R7) identified care planned interventions to assist with Activities of Daily Living (ADL) for toileting and repositioning assistance. Findings include: R7's quarterly Minimum Data Set (MDS) dated 5/11/21, identified R7 had severe cognitive impairment with diagnoses which included:	F 677	1. The care plans for R7 was reviewed and updated for appropriate interventions. 2. All residents requiring assistance for toileting and repositioning were reviewed to ensure appropriate interventions are reviewed and in place, no other residents were identified. 3. All staff will received reeducation by 9/10/21 by the DNS regarding the expectations regarding the GSS policy and procedure for following care plans for toileting and repositioning by the DNS or	9/10/21

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F 677	Continued From page 18 degenerative disease of nervous system (affects balance, movement, talking, breathing, heart function), bullous pemphigoid (autoimmune skin conditions causing blisters often between skin folds or creases of skin), heart failure, dysphagia (difficulty swallowing), adjustment disorder, edema, atrial fibrillation, diabetes, and muscle weakness. R7's MDS identified R7 required ADL assistance of staff with dressing, grooming and transfers, and toileting. R7's Care Plan revised 5/18/21, identified R7 had bladder and bowel incontinence related being unable to safely transfer on and off the toilet with a total mechanical lift. R7 had a scheduled check and change toileting plan for every 2 hours and as needed. Staff were to offer R7 a bedpan during check and change times. Staff were to apply barrier ointment with brief changes as a preventative measure from moisture to the skin. R7 was at risk for pressure ulcer development related to limited mobility and incontinence with a history of stage 2 pressure ulcer development to her left and right buttocks. Staff were to reposition and offload R7 every 2 hours. Staff were to immediately notify the nurse of any new areas of skin breakdown noted during bath or daily cares. Observations on 7/28/21, from 7:24 a.m. through 10:34 a.m. of R7 revealed at: 1) 7:24 a.m., R7 buttocks was observed with assistance from nursing assistant (NA)-C during transfer from tub chair to wheelchair. NA-C dried area which was observed to have white macerated skin between her buttocks crease and coccyx area that had some peeling skin noted. 2) 7:29 a.m., R7 was assisted into wheelchair and taken to dining room for breakfast. 3) 7:51 a.m., R7 was in dining room eating her	F 677	designee. 4. Observation audits will be conducted by the Quality Assurance Coordinator or designee for (R7) and (2) other random residents with a care plan of toileting and repositioning to be completed weekly x 4 and every other week x 2 and monthly x 1 to ensure care plans are being followed. Audit results will be brought to the monthly QA meeting with appropriate follow up indicated to ensure solutions are sustained. 5. Completion date: September 10, 2021	

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F 677	Continued From page 19 breakfast independently. 4) 8:42 a.m., R7 was sleeping at dining room table with about 1/4 of her breakfast still on her plate. There are no staff observed to be cueing R7 to finish her meal. 5) 8:55 a.m., NA-D escorted R7 back to her room, pushed the bedside table in front of her wheelchair and set up a peg activity. The staff did not reposition R7 and exited the room. 6) 9:21 a.m., R7 was sleeping in her wheelchair in her room with the bedside table positioned in front of her. Observation and interview on 7/28/21, at 9:36 a.m., with registered nurse (RN)-E of R7 identified RN-E entered R7's room and completed a wound treatment on her left foot, 3rd digit. RN-E identified she was responsible for wound care in the facility and their monitoring. She completed weekly rounds. RN-E revealed R7 had no open areas on her bottom she was aware of. RN-E identified staff were to update her with any new skin concerns or open areas. She had not been updated on any skin concerns recently for R7. RN-E was advised of this surveyor's observation earlier that am. RN-E was unaware but stated she would assess the area when staff laid R7 down later to be check and changed. Further observations and subsequent interviews on 7/28/21, identified at: 1) 10:00 a.m., R7 still sitting in her wheelchair in her room. Licensed practical nurse (LPN)-A communicated with NA-D that R7 needed to lay down to be checked and changed and to notify RN-E when she is in bed.. 2) 10:34 a.m., NA-D and NA-E assisted R7 to lay down in her bed. R7 was observed to be	F 677		

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F 677	Continued From page 20	F 677		

incontinent of urine. NA-E stated staff were suppose to reposition R7 "every couple hours and check and change her that time". RN-E then entered R7's room and assessed R7's coccyx area. RN-E stated the areas on R7's buttocks crease measured 0.4 centimeters (CM) x 0.2 cm for the first identified area, and the second measured 1.7 cm x 0.5 cm. RN-E described the skin as moisture-associated skin damage from incontinence. RN-E revealed that R7 was on a check and change schedule every 2 hours and she would expect staff were to be following the plan of care to change R7's incontinent product and reposition R7 in order to prevent skin breakdown from moisture or potential pressure injury. R7 required assistance for both toileting and repositioning. RN-E identified random audits were to be completed. Staff nurses performing these audits would place a piece of paper under residents with a note to return to the nurse when found as a way of monitoring repositioning. RN-E was unsure when R7 had been included in this type of monitoring system.

Interview on 7/28/21 at 11:05 a.m., with NA-D identified they agreed it had been approximately 3 hours since R7 had last been repositioned after her morning bath.

Interview on 7/29/21 at 3:49 p.m., with director of nursing (DON) identified her expectation would be staff follow the individual plan of care for each resident and assist residents to perform ADL's. The DON revealed the charge was to be overseeing the direct care staff on the floor to ensure care plans are being followed and residents received assistance in performing ADL's to prevent skin breakdown. The DON confirmed she was responsible for oversight of

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F 677	Continued From page 21 the nursing department. Review of 12/11/20, Restorative-Identifying Decline in ADL's- Rehab/Skilled, Therapy and Rehab policy identified resident changes on MDS for decline in mobility, transfers, toileting would signal the need for intervention to improve function or slow decline. Staff were to consider transfer, mobility and toileting programs. When a resident decline was noted, staff were to update the care plan. and document interventions used. Staff were to be aware of the care plan interventions and understand them. Review of the 10/16/20, Care Plan-Rehab/Skilled policy identified the plan of care was to be modified to reflect the care currently required and needed for the resident to ensure the resident received those appropriate cares and services.	F 677		
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	F 692		9/10/21

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F 692	Continued From page 22 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 observation, interview, and document review, the facility failed to comprehensively assess, and implement interventions for 1 of 3 residents (R7) reviewed who had a significant weight loss. Findings Include: R7's 5/11/21, quarterly Minimum Data Set (MDS) identified R7 had severe cognitive impairment with diagnoses included degenerative disease of her nervous system, which affected her balance, movement, talking, breathing, and heart function., an auto-immune skin condition causing blisters often between skin folds or creases of the skin, heart failure, difficulty swallowing, edema, diabetes, and muscle weakness. R7's MDS identified R7 was independent with supervision with eating. R7 was identified to have had a weight loss of 5% or more in one month or 10% or more in 6 months with no physician-prescribed weight loss regimen. R7 was identified with weight of 187 pounds at that time. R7's previous MDS dated 3/2/21, identified R7 had no weight loss or gain and weighed 204 pounds. R7's Care Plan revised 5/18/21, identified R7 had nutritional problems or potential nutritional problems of requiring diet restrictions related to difficulty swallowing and diabetes. R7 was to be provided a diabetic diet with soft foods for easy chewing and swallowing. R7's goal was to	F 692	1. The care plans for R7 were reviewed and updated with interventions to prevent weight loss. All staff received education on 7/29/21 by the dietary manager regarding offering R7 the appropriate foods for her diet. 2. All residents who are at risk for weight loss have had their care plans evaluated to ensure appropriate interventions are in place by the registered dietitian. 3. All nurses will be provided with reeducation on assessing, notifying dietitian and implementing interventions for residents with significant weight loss by the dietitian or designee. 4. Audits will be conducted by the Quality Assurance Coordinator or designee for (R7) and (2) other random residents that have had significant weight loss to ensure assessments and interventions were completed and care planed. Audits will be done weekly x 4 and every other week x 2 and monthly x 1. Audit results will be brought to the monthly QA meeting with appropriate follow up indicated to ensure solutions are sustained. 5. Completion date: September 10, 2021	

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F 692	Continued From page 23	F 692		

average greater than 75% of her meal without choking through the review date. R7 required supervision with setup for meals and staff were to offer a diet as ordered by her physician. R12's care plan also included approaches to monitor her for problems with chewing and swallowing. Staff were to provide a therapeutic diet of a diabetic diet that was mechanical soft. R7 had a potential fluid deficit related to diuretic (medication to prevent edema from fluid overload) use. Staff were to obtain daily weights and offer R7 drinks of her choice during interactions.

Observation on 7/28/21, at 7:51 a.m. of R7 identified she was sitting in her wheelchair in the dining room at the table eating independently at breakfast. R7 had eggs, toast, coffee, juice, and water. R7 consumed approximately 50% of her breakfast meal served. No staff were observed to encourage her to finish her meal.

Review of R7's recorded weights identified R7 was weighed monthly. R7's weight in January was 204 lbs. By 7/23/21, R7 had a weight loss of 22 lbs and weighed 182 lbs. A 10.78 % severe weight loss.

Review of R7's Nutrition Report for average meal intake percentages identified she consumed between 38% to 79% of her meals, averaging 59% of food consumed.

R7's mini-nutritional assessments performed by the dietary manager (DM) identified on: 3/21/21, 5/18/21, and 7/27/21, R7 was noted to be at risk of malnutrition. She had moderate intake, a weight loss greater than 6.6 pounds, and severe dementia.

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F 692	Continued From page 24 Review of R7's dietary notes written by the DM from June through July of 2021, identified on: 1) 6/7/21, R7 had a weight change over 180 days of 10.7%. Staff were to continue R7 on diuretic therapies. 2) 6/23/21, R7 had a weight change over 180 days 12.7%. Action provider and nurses continue to monitor related to long history of edema. 3) 7/6/21, communication with R7, who identified she preferred tomato soup at every noon meal. Staff will continue to honor request. 4) 7/8/21, R7 had a weight change over 30 days 6.0% and over 180 days 12.2%. R7's meal intakes declined from 70%, to 60%,to 50%, and now to 40% over last month. R7 remained resistant to staff assistance. 5) 7/26/21, R7 had a weight change over 180 days of 10.7%. Staff were to continue to monitor and encourage R7 to eat independently since she was resistant to assistance. R7's 7/8/21, physician orders identified R7 had a diet of CCHO (consistent carbohydrate diet for diabetes) level 2 (dysphagia diet moist, soft foods to make chewing and swallowing easier) with regular fluids. Additionally R7 had an order for Arginade (nutritional supplement) twice a day for wound healing. Observation on 7/29/21 at 8:50 a.m., of R7 identified she was eating her breakfast at the dining room table independently. She had eggs, toast, coffee, milk, and juice. No staff were observed interacting with R7 during the observation. Interview on 7/29/21 at 9:26 a.m., with dietary manager (DM) identified most of R7's weight loss	F 692		

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she felt was a result of her use of a high dose of diuretics. She ate her meals independently. The DM offered staff assistance to R7 but R7 would refuse. The DM revealed R7 would only eat tomato soup at noon. When staff tried stopping the tomato soup and giving her other items, she stopped eating. The DM identified kitchen staff resumed providing the tomato soup daily at noon per her request but was unsure when that had occurred. The DM revealed she was not overly concerned about R7's weight as she had edema "all the time they are trying to get rid of it". The DM confirmed she was aware of R7's weight loss and had been monitoring it but had not reviewed existing interventions or implemented new interventions. If the DM saw weight loss she normally notified the registered dietician (RD) and would bring her findings to the interdisciplinary team meeting, at which time the nurse manager was to notify the physician. The DM confirmed that she had not notified the RD about R7's continued weight loss.

Interview on 7/29/21 at 9:13 a.m., with nursing assistant (NA)-B identified that R7 liked to go out for activities and had snacks at that time in the afternoon. R7 liked to drink her Dr. Pepper soda and she was independent with eating and drinking.

Interview on 7/29/21 at 1:27 p.m., with RN-C identified if nursing noted someone was not eating they would offer the food of their choice or maybe a malt or ice cream. The DM or RD would make recommendations to the physician (MD) for supplements if there was concern for weight loss.

Interview on 7/29/21 at 1:56 p.m., with the RD identified she would review once a month any

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residents she was notified of with weight loss. The DM was to have updated her while onsite at the facility or via email of any resident with weight loss or other concerns. When weight loss was identified, the RD would discuss the potential reason for the weight loss and initiate any new interventions. The RD revealed she was unsure how the weight loss concern had missed being identified and communicated for R7. The RD would expect to be notified of a significant weight loss by the DM as soon as possible.

Interview on 7/29/21 at 3:49 p.m., with director of nursing (DON) identified she would expect the DM to be monitoring residents weights and updating the RD if there had been identified weight loss for any resident. The DON further identified her expectation would be the DM would implement interventions when weight loss was identified. The DON confirmed the DM was to have contacted the MD to update them on a resident's weight loss but if there was a need for assistance, the nurse manager could also make the update to the MD.

Interview on 7/29/21 at 4:30 p.m., with registered nurse RN-B and the dietary manager (DM) identified they had discussed R7's weight loss at their interdisciplinary team meeting on 6/30/21 and again on 7/21/21. The DM and RN-B confirmed an intervention had not been implemented for R7's weight loss nor had the primary physician been updated following either meeting. The DM and RN-B agreed after identification and discussion of R7's weight loss on 6/30/21, and intervention should have been implemented and all parties notified.

Interview on 7/30/21 at 9:40 a.m., with R7's MD's

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F 692	Continued From page 27 medical assistant (MA), who spoke on behalf of the MD, identified there had been no fax communicating a concern for weight loss for R7 to the provider. The MA reported the MD would expect communication and notification in regards to changes in condition for any of the residents that he directed care for. Review of 12/11/20, Interact-Change in Condition Evaluation (CICE) policy identified the purpose was to improve communication between nursing staff and providers. Nursing staff are to check with other staff members who interact with the resident on a daily basis to obtain complete picture of the potential change in condition. Staff are then to initiate the CICE form and input pertinent data prior to contacting the physician. The form can also be used between shifts as a form of communication about a change in condition. The form is a working tool to ensure pertinent clinical data is obtained and relayed to the physician. The is also an alert on PCC resident dashboard that is associated with the change of condition evaluation. The eINTERACT Stop and Watch will show alerts created that need to be assessed and cleared after action is taken. A policy related to weight and nutritional monitoring was requested but not provided.	F 692		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary	F 761		9/17/21

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F 761	Continued From page 28 instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to appropriately secure 1 of 1 resident (R38) insulin pen when not in use by staff during administration. Findings include: Observation on 7/26/21 at 4:55 p.m., of registered nurse (RN)-D identified she collected supplies for a blood sugar (BS) check from the medication cart that was parked outside of R38's room on opposite side of hall. RN-D took supplies out of the drawer including R38's Novolog insulin pen. RN-D picked up all supplies needed to check R38's BS, and entered R38's room across the hall. RN-D left R38's insulin pen and needle for the pen on top of the medication cart unattended	F 761	1. All licensed nurses and TMAs will be educated on the correct procedure for storing medications including insulin pens according to the manufactures direction and GSS policy on 9/17/21. 2. All residents receiving medications and insulin have the potential to be affected. 3. To ensure systemic changes are made staff involved with medication storage will be educated on the GSS policy and procedure for medication storage by the DNS or designee on 9/17/21. 4. Observation audits will be conducted by the Quality Assurance Coordinator or designee for (R38) and (2) other random residents regarding medication storage when medications are being administered.	

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F 761	Continued From page 29 and RN-D returned to the medication cart verified the order, primed the insulin pen and drew up sliding scale of 4 units for BS of 221. Interview on 7/27/21 at 10:28 a.m., with RN-D identified she normally takes any insulin pens with her into the room but reported she was distracted by being observed. She revealed she was not concerned with leaving R38's medication unsecured as she thought most residents would be in the dining room for the evening meal at that time. She confirmed she was not to have left the insulin pen with needle unattended on top of the medication cart when she stepped away to obtain R38's BS. Interview on 7/29/21 at 3:49 p.m., with director of nursing (DON) identified medication should never be left unattended and should remain locked in the medication cart or in the medication room. A policy related to medication storage was requested but not provided by the end of the survey.	F 761	Audits will be done weekly x 4 and every other week x 2 and monthly x 1 to ensure medication is being stored properly. Audit results will be brought to the monthly QA meeting with appropriate follow up indicated to ensure solutions are sustained. 5. Completion date: September 17, 2021	
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention	F 880		9/22/21

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	245560	A. BUILDING _____ B. WING _____	C 07/29/2021

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F 880	Continued From page 30 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 (vi)The hand hygiene procedures to be followed	F 880		

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F 880	Continued From page 31 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 appropriate disinfection of 2 of 2 whirlpool tub aire-jet systems between resident use and utilized by 39 of 43 resident who resided in the facility. Findings include: Observation, interview, and document review on 7/28/21 at 9:17 a.m. , with trained medication aide (TMA)-A while cleaning and disinfecting the whirlpool tub identified TMA-A pushed the button labeled "disinfect" and held it for approximately 10 seconds until the solution flowed through the jets into the tub and the liquid level reached between the second and third jets from the tub well. TMA added more water, and used the long handled brush to scrub the entire tub surface. TMA-A identified the disinfecting solution must remain in contact for 30 seconds to allow for disinfection of the tub. After brushing the tub surfaces and bath chair, she drained the tub but did not rinse off the disinfecting solution. She identified the surface	F 880	1. All licensed nurses, TMA, and certified nursing assistants were educated on the GSS policy and procedure for disinfecting of surfaces according to the manufactures direction through written communication on 7/28/21. Timers were placed on 7/28/21 ensure proper disinfecting time occurs. 2. All resident have the potential to be affected by the practice; the policy has been reviewed and interventions put in place as needed. 3. A DPOC was conducted in which a Root Cause Analysis was completed which established our education to staff. To ensure systemic changes staff involved will be educated on the GSS policy and procedure for disinfecting the whirlpool tubs. Signage is posted on the tub itself and the timers have been placed in the tub room for staff to use to ensure timing	

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F 880	Continued From page 32 was to be "allowed to dry" to kill any bacteria left on the surface. In addition the tub door was opened and brushed with the wet brush and allowed to air dry. TMA-A stated the solution usually remained in the tub while she went to retrieve the next resident, but was unaware of any wet-contact time required to disinfect. A single page was posted on the wall beside the tub with a hand written note: "To Disinfect the tub, hold the Disinfect Button until solution is seen coming out of all the air jet and 1 to 1 1/2 gallons of disinfectant solution was in the foot well of the tub for "about 30 seconds". Staff were to allow the disinfectant to stay on the surface for 10 minutes. Following the 10 minute time, the solution was to be rinsed with the shower sprayer and the air blower was to be activated and run until clear water ran from all the jets. TMA-A confirmed she was not aware of the policy requiring 10 minute wet-contact time nor was she aware the tub was not being appropriately rinsed of chemical. Interview on 7/28/21 at 1:32 p.m., with of NA-B identified she also gave resident baths and provided training to new NAs on the bathing process. NA-B stated the process for disinfection was for the product used for disinfection of the whirlpool tub was run the solution into the tub and run the jets for 30 seconds until 1 -1.5 gallons of disinfectant solution was in the bottom of the tub. Staff were to then take the scrub brush and scrub all tub surfaces and chair, including the door seal, drain, and let the solution "sit" and air dry for 10-15 minutes. When this was finished, staff were to rinse the tub. Interview of NA-A on 7/28/21 at 1:59 p.m. identified she also occasionally provided resident tub baths. She identified following a bath, she	F 880	is accurate by the DNS or designee. 4. Observation audits will be conducted by the Quality Assurance Coordinator or designee to ensure length disinfect time is followed according to policy and manufacture direction. Audits will be done weekly x 4 and every other week x 2 and monthly x 1. Audit results will be brought to the monthly QA meeting with appropriate follow up indicated to ensure solutions are sustained. 5. Completion date: September 22, 2021	

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F 880	Continued From page 33	F 880		

would fill the tub well with the disinfectant solution and leave the disinfectant in the tub for 5-10 minutes. Then she would drain the well and use the hand sprayer to rinse and run the jets to clear the lines, then dry off the chair. NA-A identified "sometimes there was only 5 minutes of disinfectant contact time". NA-A identified she had not had a method to time the how long disinfectant remained in the tub well and was unaware the tub required a wet-contact time of 10 minutes to ensure appropriate disinfection.

Interview on 7/29/21 at 10:03 a.m. with the director of nursing (DON) identified her expectation that the whirlpool tubs were cleaned and disinfected according the policy and procedure and manufactures recommendation. As a certified Infection Preventionist (IP), she would consider an inappropriately disinfected tub as a potential source of infection. The DON identified she was aware of the signage posted beside the tub as a reminder, but was not aware of the failure to follow the process.

Review of the current, Penner Spa Aqua- Aire Sit-Bath System 6900 manual identified the system was to be cleaned and disinfected after every bath as follows:
1.) Close and lock the door.
2.) Press the Tub Fill Button and turn the Temperature Control Knob all the way to the left to its warmest level to heat the disinfectant solution and maximize its effectiveness.
3.) Remove any visible tissue, residue, or fluids from the tub by pressing the Shower Button and rinsing the inside tub surfaces with the shower sprayer.
4.) Press the Fill Button again to turn off the water. Allow the tub to drain, and place the drain

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F 880	Continued From page 34 plug over the drain. 5.) On the Aqua-Aire Tubs, press and hold the Disinfect Button located on the left side of the tub. As the button is held down, the properly mixed cleaning solution is running through the air injection system and out all of the air jets. Release the button after you see solution coming out of all the air jets and you have 1 to 1 1/2 gallons of disinfectant solution in the foot well of the tub. 6.) Using a long-handled brush, thoroughly scrub all interior surfaces of the tub with the solution that remains in the foot well of the tub. Let disinfectant stay on surface for 10 minutes (wet-contact time) or by the chemical disinfecting solution's instructions. 7.) Remove the plug from the drain. 8.) Rinse the tub ' s interior surfaces thoroughly with the shower sprayer. 9.) Press and hold the Rinse button located on the left side of the control panel until clear water runs from all the air jets. Then release the Rinse button. 10.) Finish rinsing the interior surfaces of the tub with the shower sprayer. 11.) Start the air blower by pushing the Aqua-Aire Button. Allow it to run for 30 seconds. 12.) Stop the Aqua-Aire blower by again pushing the Aqua-Aire button. 13.) Visibly check that the tub and the reservoir (if applicable) was effectively cleaned during the disinfecting procedure. If not, repeat the procedure. Review of the undated, current FAQ About Whirlpool Tub Cleaning and Disinfection using the Penner Classic Whirlpool disinfectant cleaner identified the solution required a wet-contact time to thoroughly disinfect the whirlpool tub. A 30	F 880		

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F 880	Continued From page 35 second wet-contact time would only allow for sanitation and would not ensure the tub had been appropriately disinfected to allow for pathogens to be reduced to a safe level (99.999% free).	F 880		

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	245560	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**07/28/2021**

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Edgebrook Care Center was found 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, the Health Care Facilities Code. Edgebrook Care Center is one-story in height, has a partial basement, and is fully sprinklered. The original building was built in 1968, with building additions in 1992 and 1997. All were determined to be of Type II(111) construction. Building 02 consists of the 2003 building addition, which includes a meeting room and offices. Building 02 is one-story in height, has no basement, is fully fire sprinkler protected and was determined to be of Type II(111) construction. Because the original building and the (3) addition are of the same type of construction and meet the construction type allowed for existing buildings, the facility was surveyed as one building. The building is protected by a full fire sprinkler system. The facility has a fire alarm system with full corridor smoke detection and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 56 beds and had a census of 43 at the time of the survey.	K 000		

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

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 The requirement at 42 CFR, Subpart 483.70(a) is MET.	K 000		