



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
August 19, 2024

Administrator
St Anthony Park Home Inc
2237 Commonwealth Avenue
Saint Paul, MN 55108

RE: CCN: 245063
Cycle Start Date: August 7, 2024

Dear Administrator:

On August 7, 2024, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Pete Cole, RN Regional Operations Supervisor
Metro Team C District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
625 Robert Street N
P.O. Box 64975
Saint Paul, Minnesota 55164-0975
Email: peter.cole@state.mn.us
Office/Mobile: (651) 249-1724

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

If substantial compliance has been achieved, certification of your facility in the Medicare and/or

Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

If substantial compliance with the regulations is not verified by November 7, 2024 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by February 7, 2025 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

INFORMAL DISPUTE RESOLUTION (IDR) / 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/lrc_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

St Anthony Park Home Inc

August 19, 2024

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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:

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

Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in black ink, appearing to read 'M. Poepping', with a stylized, cursive script.

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

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

PRINTED: 09/01/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245063	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 08/07/2024
NAME OF PROVIDER OR SUPPLIER ST ANTHONY PARK HOME INC			STREET ADDRESS, CITY, STATE, ZIP CODE 2237 COMMONWEALTH AVENUE SAINT PAUL, MN 55108		
(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 8/5/24 - 8/7/24, a survey for compliance with Appendix Z, Emergency Preparedness Requirements for Long Term Care facilities, §483.73 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 036 SS=F	EP Training and Testing CFR(s): 483.73(d) §403.748(d), §416.54(d), §418.113(d), §441.184(d), §460.84(d), §482.15(d), §483.73(d), §483.475(d), §484.102(d), §485.68(d), §485.542(d), §485.625(d), §485.727(d), §485.920(d), §486.360(d), §491.12(d), §494.62(d). *[For RNCHIs at §403.748, ASCs at §416.54, Hospice at §418.113, PRTFs at §441.184, PACE at §460.84, Hospitals at §482.15, HHAs at §484.102, CORFs at §485.68, REHs at §485.542, CAHs at §486.625, "Organizations" under 485.727, CMHCs at §485.920, OPOs at §486.360, and RHC/FHQs at §491.12:] (d) Training and testing. The [facility] must develop and maintain an emergency preparedness	E 036			9/17/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		08/29/2024

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 036	Continued From page 1 training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. *[For LTC facilities at §483.73(d):] (d) Training and testing. The LTC facility must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually. *[For ICF/IIDs at §483.475(d):] Training and testing. The ICF/IID must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. The ICF/IID must meet the requirements for evacuation drills and training at §483.470(i). *[For ESRD Facilities at §494.62(d):] Training, testing, and orientation. The dialysis facility must develop and maintain an emergency	E 036			

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E 036	Continued From page 2 preparedness training, testing and patient orientation program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training, testing and orientation program must be evaluated and updated at every 2 years. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to develop and maintain an emergency preparedness training and testing program that is based on the facility's emergency plan, risk assessment, policies and procedures, and communication plan to ensure compliance with the requirements of this section. This had the potential to affect all 80 residents currently residing in the facility, along with staff and volunteers who work in the facility. Findings include: See E0037: The facility failed to provide staff emergency preparedness training at least annually which was based on the facility emergency preparedness plan (EPP). See E0039: The facility failed to provide staff emergency preparedness training at least annually which was based on the facility EPP.	E 036	It is the policy of St Anthony Park Home to follow all Federal, State, and local guidelines, laws, regulations and statutes. This plan of correction is not to be construed as an admission of deficient practice by the facility administrator, employees, agents, or other individuals. The response to the alleged deficient practice cited in this statement of deficiencies does not constitute agreement with citations. The preparation, submission and implementation of this plan of correction will serve as our credible allegation of compliance. 1)What corrective actions(s) will be accomplished for those residents found to have been affected by the deficient practice. The facilities Disaster Training policy and Emergency Management Plan was updated and reviewed during the Facilities August QAPI meeting on 8/20/2024. The August review and update was within one year of the previous review and update. 2)How you will identify other residents having the potential to be affected by the		

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E 036	Continued From page 3	E 036	same deficient practice and what corrective action will be taken. All residents had the potential to be affected by this deficient practice. All staff were educated on this policy on September 5, 2024. 3)What measures will be put in place or what systemic changes will you make to ensure that the deficient practice does not recur. To ensure systemic changes are sustained, the organization' s Emergency Management Plan policy was reviewed during August 20, 2024, QAPI meeting and is current. The Facility leverages TELS for tracking EMP and TELS was updated to reflect the September 17, 2024, Tabletop exercise and annually thereafter. All staff will be educated on this policy on September 5, 2024. 4)How the corrective actions(s) will be monitored to ensure deficient practice will not recur, i.e., what quality assurance program will be put into practice. Audit of September 17, 2024, Tabletop exercise will be completed during September 2024 QAPI meeting. Will review the findings at QAPI to ensure compliance. 5)Administrator and/or designee will ensure compliance. The date of compliance is 9/17/2024.		
E 037 SS=F	EP Training Program CFR(s): 483.73(d)(1)	E 037			9/5/24

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E 037	Continued From page 4 §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), §485.542(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, REHs at §485.542, "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 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	E 037			

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E 037	Continued From page 5 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 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	E 037			

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E 037	Continued From page 6 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 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	E 037			

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E 037	Continued From page 7 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 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			E 037			

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E 037	Continued From page 8 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 interview and document review, the facility failed to ensure training in the facility' comprehensive Emergency Preparedness Plan (EPP) was provided upon hire and annually to existing employees and volunteers. The lack of facility-specific training in their EPP had the potential to affect all 80 residents who currently resided in the facility, along with staff and volunteers who work in the facility. Findings include: A review of the facility's emergency preparedness (EP) plan revised 7/24, lacked documentation of staff's initial and annual EP training during the past year. During interview on 8/6/24 at 12:21 p.m., activities (A)-A staff stated if a resident refused to leave during an evacuation, "I would go to the nurse on the floor," but denied receiving specific training regarding evacuation. During interview on 8/6/24 at 12:28 p.m., nursing assistant (NA)-E stated there was a recent fire drill due to a burning piece of toast and endorsed receiving education on safety drills and severe	E 037	1)What corrective actions(s) will be accomplished for those residents found to have been affected by the deficient practice. Annual EMP training will be conducted on Sept 4, 2024 emphasizing the facilities Emergency Management Policy's. The new employee onboarding process was evaluated and updated to reflect more comprehensive training on the facilities emergency management plan. 2)How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. All residents had the potential to be affected by this deficient practice. The new employee onboarding process was evaluated and updated to reflect more comprehensive training on the facilities emergency management plan. 3)What measures will be put in place or what systemic changes will you make to ensure that the deficient practice does not recur.		

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NAME OF PROVIDER OR SUPPLIER ST ANTHONY PARK HOME INC			STREET ADDRESS, CITY, STATE, ZIP CODE 2237 COMMONWEALTH AVENUE SAINT PAUL, MN 55108		
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E 037	Continued From page 9 weather. NA-E could not recall any training provided by the facility on evacuation but stated if a resident refused to leave during an evacuation, "we have to do something to get them to leave." NA-E stated they would first talk to the resident and then go to the nurse for help. During interview on 8/6/24 at 12:32 p.m., licensed practical nurse (LPN)-B was unsure if there had been training specifically related to evacuation but stated, "I'm sure it was in the initial training, which was a lot of information." LPN-B stated if a resident refused to leave during an evacuation, the priority would be to get the resident to safety. LPN-B stated they would contact other staff to re-approach and contact the supervisor in charge for further direction. LPN-B stated there was a policy book to reference for emergencies at the nurse's desk they could utilize as well. During interview on 8/6/24 at 12:45 p.m., registered nurse (RN)-D could not recall training or education regarding evacuation. RN-D confirmed having fire and severe weather safety training. RN-D stated they would contact family for assistance or the director of nursing (DON) if a resident refused to leave during an evacuation. A request for documentation of completed emergency preparedness training given to staff during the last year was requested and not received. During interview on 8/7/24 at 2:13 p.m., The administrator verified there was not annual training for staff on the facility EPP and stated it was "something I am working on." The administrator stated the facility had recently reviewed and updated the signature page in the	E 037	To ensure systemic changes are sustained, the organization's Emergency Management Plan policy was reviewed during the August 20, 2024, QAPI meeting and is current. The Facility leverages TELS for tracking EMP and the date was updated to reflect annual table top exercises annually. All staff will be educated on this policy September 4, 2024. 4)How the corrective actions(s) will be monitored to ensure deficient practice will not recur, i.e., what quality assurance program will be put into practice. An audit of all employee training and updated new employee onboarding EMP training will be audited during the September 2024 QAPI meeting. Will review the findings at QAPI to ensure compliance. 5) Administrator and/or designee will ensure compliance. The date of compliance is 9/05/2024.		

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E 037	Continued From page 10	E 037			
E 039 SS=F	EP Testing Requirements CFR(s): 483.73(d)(2) §416.54(d)(2), §418.113(d)(2), §441.184(d)(2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2), §483.475(d)(2), §484.102(d)(2), §485.68(d)(2), §485.542(d)(2), §485.625(d)(2), §485.727(d)(2), §485.920(d)(2), §491.12(d)(2), §494.62(d)(2). *[For ASCs at §416.54, CORFs at §485.68, REHs at §485.542, OPO, "Organizations" under §485.727, CMHCs at §485.920, RHCs/FQHCs at §491.12, and ESRD Facilities at §494.62]: (2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following: (i) Participate in a full-scale exercise that is community-based every 2 years; or (A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or (B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event. (ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of	E 039			9/17/24

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E 039	Continued From page 11 this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed. *[For Hospices at 418.113(d):] (2) Testing for hospices that provide care in the patient's home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the following: (i) Participate in a full-scale exercise that is community based every 2 years; or (A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full scale community-based exercise or individual facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited	E 039			

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E 039	Continued From page 12 to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (3) Testing for hospices that provide inpatient care directly. The hospice must conduct exercises to test the emergency plan twice per year. The hospice must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual facility-based functional exercise; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospice is exempt from engaging in its next required full-scale community based or facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop led by a facilitator that includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to	E 039			

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E 039	Continued From page 13 challenge an emergency plan. (iii) Analyze the hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the hospice's emergency plan, as needed. *[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):] (2) Testing. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the [PRTF, Hospital, CAH] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency	E 039			

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E 039	Continued From page 14 plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the [facility's] emergency plan, as needed. *[For PACE at §460.84(d):] (2) Testing. The PACE organization must conduct exercises to test the emergency plan at least annually. The PACE organization must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the PACE experiences an actual natural or man-made emergency that requires activation of the emergency plan, the PACE is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.	E 039			

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E 039	Continued From page 15 (iii) Analyze the PACE's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the PACE's emergency plan, as needed. *[For LTC Facilities at §483.73(d):] (2) The [LTC facility] must conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The [LTC facility, ICF/IID] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. (B) If the [LTC facility] facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required a full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [LTC facility] facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the	E 039			

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E 039	Continued From page 16 [LTC facility] facility's emergency plan, as needed. *[For ICF/IIDs at §483.475(d)]: (2) Testing. The ICF/IID must conduct exercises to test the emergency plan at least twice per year. The ICF/IID must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or. (B) If the ICF/IID experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID is exempt from engaging in its next required full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the ICF/IID's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID's emergency plan, as needed. *[For HHAs at §484.102] (d)(2) Testing. The HHA must conduct exercises to test the emergency plan at	E 039			

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E 039	Continued From page 17 least annually. The HHA must do the following: (i) Participate in a full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise every 2 years; or. (B) If the HHA experiences an actual natural or man-made emergency that requires activation of the emergency plan, the HHA is exempt from engaging in its next required full-scale community-based or individual, facility based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the HHA's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the HHA's emergency plan, as needed. *[For OPOs at §486.360] (d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the	E 039			

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E 039	Continued From page 18 following: (i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. If the OPO experiences an actual natural or man-made emergency that requires activation of the emergency plan, the OPO is exempt from engaging in its next required testing exercise following the onset of the emergency event. (ii) Analyze the OPO's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. *[RNCHIs at §403.748]: (d)(2) Testing. The RNHCI must conduct exercises to test the emergency plan. The RNHCI must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the RNHCI's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the RNHCI's emergency plan, as needed. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to complete a full-scale community and/or individual facility based exercise to test their emergency preparedness program during	E 039	1)What corrective actions(s) will be accomplished for those residents found to have been affected by the deficient practice.		

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E 039	Continued From page 19 the past year. This had the potential to affect all 80 residents who currently resided in the facility, along with staff and volunteers who work in the facility. Findings include: A review of the facility's emergency preparedness plan (EPP) last reviewed 7/24, lacked documentation of a full-scale community and/or individual facility based exercise to test their EPP. During interview on 8/7/24 at 2:13 p.m., the administrator stated there was a thunderstorm warning that occurred, and the director of nursing (DON) got staff's signatures to count towards an all-hazards-type exercise. The administrator verified there was not an after-action report (AAR) available that demonstrated the staff's strengths during the exercise or to reflect on areas for improvement. The administrator verified there was no community-based or tabletop exercise with AAR to meet the requirements. The administrator stated the facility recently joined the Metro Health & Medical Preparedness Coalition and signed up for a community based exercise through the coalition in September, 2024. An email correspondence dated 8/6/24, indicated the administrator received an invitation from the regional healthcare preparedness coordinator at Hennepin Healthcare for an annual community-based exercise opportunity dated 9/17/24.	E 039	Per surveyor writeup in facility 2567 Facility is registered to participate in the full-scale community-based exercise sponsored by Metro Health Medical Preparedness Coalition on September 17, 2024. In addition, an after action report (AAR) was completed for the July 10, 2024, severe weather all hazards exercise. 2)How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. All residents had the potential to be affected by this deficient practice. Per surveyor writeup in facility 2567 Facility is registered to participate in the full-scale community-based exercise sponsored by Metro Health Medical Preparedness Coalition on September 17, 2024. 3)What measures will be put in place or what systemic changes will you make to ensure that the deficient practice does not recur. To ensure systemic changes are sustained, the organization's Emergency Management Plan policy has been reviewed and is current. The facility is scheduled to participate in a full-scale community-based exercise on September 17, 2024. An entry into TELS was entered in 2025 as a reminder and will be tracked using the QAPI process. 4)How the corrective actions(s) will be monitored to ensure deficient practice will not recur, i.e., what quality assurance		

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E 039	Continued From page 20	E 039	program will be put into practice. The full-scale community-based exercise results will be audited at the facilities September QAPI meeting to ensure its all-hazards type exercises are in compliance.		
F 000	INITIAL COMMENTS On 8/5/24 to 8/7/24, a standard recertification survey was conducted by surveyors from the Minnesota Department of Health (MDH). In addition, complaint investigations were also completed. Your facility was found not in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. In addition to the recertification survey, the following complaints were reviewed with no deficiency issued. H50636482C (MN00105311) H50636224C (MN00105091) H50636503C (MN00105012) H50636504C (MN00104098) H50636502C (MN00103235) H50636501C (MN00103146) H50636506C (MN00103134) H50636507C (MN00098507) H50636500C (MN00098733) The following complaints were reviewed with deficient practices identified related to survey findings.	F 000	5) Administrator and/or designee will ensure compliance. The date of compliance is 9/17/2024.		

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F 000	Continued From page 21 H50636505C (MN00105028) non-compliance cited at F677 H50636568C (MN00105432) non-compliance cited at F677 H50636721C (MN00105515) non-compliance cited at F609 The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F 000			
F 550 SS=E	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal	F 550			9/5/24

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F 550	Continued From page 22 access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure resident's needs were addressed in a respectful and dignified manner when a resident (R34) used a call light for help. Additionally, the facility failed to ensure all staff knock on individual resident bedroom doors and introduce themselves prior to entry for 3 residents (R68, R76, R74). Furthermore, the facility failed to provide a dignified dining experience for 3 residents (R21, R31, R68). Findings include:	F 550	1)What corrective actions(s) will be accomplished for those residents found to have been affected by the deficient practice. No lasting effect noted related to call light wait times for R34 affected resident were interviewed to ensure his needs are being met. No lasting effect noted related to failure to knock on door for R68, R76, and R74. Affected residents were interviewed to ensure their right to privacy is being met.		

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F 550	Continued From page 23 Call Lights R34's quarterly Minimum Data Set (MDS) dated 6/3/24, indicated intact cognition and diagnoses of hemiplegia (one-side paralysis) and hemiparesis (weakness or the inability to move on one side of the body) after a stroke and high blood pressure. R34's care plan dated 8/30/23, indicated he was dependent on staff/volunteers/family for meeting his emotional, intellectual, physical, and social needs related to his tendency to not seek out activities. The care plan also identified R34's activities of daily living (ADL) self-care needs related to his left-sided weakness, including an assist of one staff person to transfer with an "EZ stand medium harness". During continuous observation on 8/6/24 between 12:51 p.m. and 1:24 p.m., two call lights were on in the same hallway with an alarm sounding. - At 12:55 p.m., R34's call light was noted to be on as indicated by the light on above his door, however the alarm was not sounding. - At 12:58 p.m., registered nurses (RN)-D and RN-F were standing in front of the medication carts in the dining area when R34 was heard calling, "hello" from his room. - At 12:59 p.m., nursing assistant (NA)-C exited a room in the same hallway as R34's room with meal trays in hand and walked towards the dining area. RN-F walked towards R34's room but turned and knocked to go into a different room to assist another resident. - At 1:00 p.m., RN-D approached the room where the first call light was observed to be on, knocked and entered the room and turned the call light off. - At 1:01 p.m., RN-D exited the room with a meal	F 550	No lasting effect noted related to their dining experience for R68, R21, and R31. R21, R31 and R68 will be served in a more dignified manner. 2)How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. All residents have the potential to be affected by the deficient practices. Staff educated on resident rights and dignity. 3)What measures will be put in place or what systemic changes will you make to ensure that the deficient practice does not recur. Call Light - The organization's policy on answering the call light dated 10/18/22 was reviewed and updated to reflect guidance to staff to answer the resident call light within a reasonable time. Staff educated on timeliness to answer call lights, privacy and dignity. Staff re-educated on call light response policy. Door Knocking ☐ The organization's policy on Dignity was reviewed and is up to date. Staff educated on expectation that staff knock, introduce self and task wait for permission to enter residents' room. Dining ☐ Staff educated on serving patients in a dignified manner. 4)How the corrective actions(s) will be monitored to ensure deficient practice will not recur, i.e., what quality assurance program will be put into practice. Call light times, door knocking, and		

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F 550	Continued From page 24 tray. R34's call light remained unchanged. - At 1:02 p.m., the assistant director of nursing (ADON) walked out from behind the nurse's station, into the dining area and down the hallway where R34's room was. The ADON turned into the tub/shower room. R34's call light remained unchanged. - At 1:03 p.m., RN-D was standing at the medication cart in the dining room. - At 1:05 p.m., NA-B walked down the hallway and into the room RN-F was in. - At 1:07 p.m., the call light alarm box at the nurse's station displayed the text, "W226 NORMAL" and was alarming with sound. It did not display a duration the call light had been on for. - At 1:08 p.m., RN-F exited the room and walked away from R34's and into the dining area. - At 1:11 p.m., RN-F walked down the hallway towards R34's room and entered another resident's room without a call light on. - At 1:12 p.m., RN-F exited the room and performed hand hygiene. RN-F walked down the hallway towards R34's room and entered a different resident's room without a call light on. RN-D was standing at the medication cart in the dining area. - At 1:13 p.m., RN-F exited the room with the resident and walked to the dining area. RN-F performed hand hygiene at the medication cart. R34's call light remained unchanged. - At 1:14 p.m., R34 stated in an interview he turned his call light on at 12:51 p.m. because he wanted to transfer into his recliner. He stated he needed staff assistance and the "EZ Stand" to transfer. R34 stated he experienced long call light wait times "most of the time" and stated, "it's getting old." - At 1:18 p.m., RN-F walked down the hallway	F 550	dignified dining will be audited 3x per week x 1 month, 2 x per week x 2 weeks and weekly for 2 weeks. Audit review and analysis will be brought to QAPI to determine ongoing frequency and duration of audits. 5) Director of Nursing and/or designee will ensure compliance. The date of compliance is September 5, 2024		

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F 550	Continued From page 25 with a medication cup in hand towards R34's room. RN-F entered another resident's room that had a call light on. - At 1:19 p.m., RN-F exited the room and walked down the hallway towards the dining area. R34's call light remained unchanged. - At 1:21 p.m., NA-C walked down the hallway with another unidentified resident and entered a different room. - At 1:22 p.m., NA-C stopped into a room with a call light on near R34's room. - At 1:23 p.m., NA-C answered R34's call light request. - At 1:28 p.m., NA-C pushed R34 down the hallway in his wheelchair and into the tub/shower room. During interview on 8/6/24 at 1:37 p.m., RN-D stated the goal is to keep the call light wait time under 20 minutes but understood that "a lot of residents" required two staff for assistance. RN-D verified waiting 30 minutes was "pushing it" and stated the floor was "pretty full census wise" so it could be a strain. During interview on 8/6/24 at 3:04 p.m., the ADON stated, "I do expect there would be someone to answer the call light, even if you can't help them, to acknowledge them and see what they need." The ADON confirmed 30 minutes was "too extended" and expected the call light to be answered sooner. The ADON expected any staff, from activities to housekeeping to "all my nursing staff", to address a call light if passing by. The ADON stated the risks of not answering a call light in a timely manner included the risk of incontinence, bowel incontinence, and a potential for unsafe self-transfers, although the ADON didn't believe R34 would attempt to self-transfer.	F 550			

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F 550	Continued From page 26 During interview on 8/7/24 at 11:52 a.m., the director of nursing (DON) stated it was "disappointing" to hear about a call light being on for 30 minutes and stated the expectation was for it to be answered in a "reasonable" time and suggested 10 minutes as a reasonable time. The DON stated the facility attempts to staff up during the day shift to accommodate resident needs. The DON verified concern for dignity with the extended call light wait time and expected all staff, including nurses, to answer call lights. A facility policy titled Answer the Call Light dated 10/18/22, indicated its purpose was to ensure timely responses to the resident's requests and needs. The policy guided staff to answer the resident call system immediately. A facility policy titled Dignity dated 12/8/21, indicated each resident should be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, and feels of self-worth and self-esteem. The policy indicated residents were treated with dignity and respect at all times and the facility culture supported dignity and respect for residents by honoring resident goals, choices, preferences, values and beliefs. Dignified Dining R31's significant change Minimum Data Set (MDS) assessment, dated 4/23/24, indicated R31	F 550			

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F 550	Continued From page 27 had severely impaired cognition with no hallucinations, or delusions. Further indicated R31 was dependent on staff for all activities of daily living (ADLs) including eating. R21's quarterly MDS assessment, dated 6/11/24, indicated R21 had severely impaired cognition with no hallucinations, or delusions. Further indicated R21 was dependent on staff for all activities of daily living (ADLs) including eating. R68's quarterly MDS assessment, dated 7/15/24, indicated R68 had severely impaired cognition with no hallucinations or delusions. Further indicated R68 was dependent on staff for all activities of daily living (ADLs) including eating. On 8/06/24 at 8:42 a.m., a table of three residents were seated in wheelchairs at a table. One resident was sitting with her eyes closed with an almost empty plate of food in front of her. The second resident was being assisted by a staff member to eat. R31 was the third resident at the table. Directly in front of R31, on the table, sat a hard plastic tray that contained on it, a warming plate with a cover, bowl with a plastic cover along with covered drinks. R31 was intermittently yelling out which caused other residents to look over at her. R31 continued to sit at the table with a clothes protector on with the covered food tray in front of her. No staff were interacting with R31. At 8:56 a.m., staff sat next to R31, uncovered the food in front of her and started to feed her (14 minutes after observation started). R31's food was left on the hard plastic tray during the meal. R31 stopped yelling out when staff started to assist her with her breakfast. During observation on 8/6/24 at 12:18 p.m., two	F 550			

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F 550	Continued From page 28 lunch carts were brought to 2nd floor and delivered to the 2nd floor dining room by unknown dietary staff. Each lunch cart was an enclosed metal cart on wheels with slots, that held hard plastic trays that contained resident meals. Each slot could hold two hard plastic trays which could be slid from the front or back of the approximately 6-foot metal cart. The hard plastic trays each contained a paper slip that identified who the meal was intended for, a plate of food that was sitting on a plate warmer and was covered with a hard plastic dome shaped lid. The tray contained a set of silverware along with a napkin. Staff would grab the trays from the lunch cart, add the drinks that were requested from a different cart and deliver the entire tray to residents sitting at the table. Staff would leave the food and drinks on the hard plastic tray that contained the entire meal including the drinks and silverware. At 12:22 p.m., R31, R21 and R68 were observed to be seated at the same table. R31 and R21's lunch trays were set in front of them (just the way trays sent up from the kitchen). At 12:23 p.m., R68's tray was set in front of him. Staff proceed to get drinks for all the trays and set them in front of R31, R21 and R68 on the hard plastic trays. At 12:30 p.m., staff sat next to R31 to assist her to eat. At 12:35 p.m., a second staff sat next to R68 to assist him to eat (13 minutes after the food had been placed in front of him). At 12:38 p.m. a third staff sat next to R21 to assist her to eat (16 minutes after her food had been sitting in front her). R21, R31 and R68 were non-interviewable as unable to answer questions.	F 550			

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F 550	Continued From page 29 During an interview on 8/06/24 at 2:04 p.m., nursing assistant (NA)-C stated meal trays are not handed out in a certain order, and "we just make sure residents get the right tray." NA-C verified they do not take food off the hard plastic trays to serve the residents. NA-C verified that some residents must wait to be assisted with their meals. During an interview on 8/06/24 at 2:14 p.m., NA-B stated that each staff passes out their own resident trays. NA-B stated that after all the trays are handed out to residents then they assist residents who need help. NA-B verified that residents may have to wait a little while for assistance with their meals as they have other to help and must pass out other trays. NA-B verified the plates and drinks are not removed from the plastic trays when they are served to residents as it makes serving easier. During an interview on 8/07/24 at 11:09 a.m., NA-D stated that residents in the dining room are served first, then room trays are delivered and then residents who need assistance are assisted. NA-D stated all meals are served on the hard plastic trays to residents and "have always done that," adding it makes it easier to clean up. During an interview on 8/07/24 at 11:18 a.m., registered nurse (RN)-C stated that meal trays are not served in any order but "we try to serve independent people first, then those who need supervision and then those who we assist last." RN-C stated there is no assigned seating in the dining room but try to have resident who need supervision or assistance sit together. RN-C stated, "trays are left underneath the meals."	F 550			

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F 550	Continued From page 30 On 8/07/2024 at 1:38 p.m., assistant director of nursing (ADON) stated meal trays are not served in a certain order and there is no assigned seating. ADON verified that meals are served to residents on the hard plastic trays (food items are not removed and placed directly on the table) stating, "there is not a reason why we do that It is easier to carry." On 8/07/2024 at 2:11 p.m., director of nursing (DON) verified there is no specific reason that meals are served on hard plastic trays to residents. DON stated residents should be served meals at the same time and staff should be able to assist when meals are served. NOT KNOCKING ON RESIDENTS' DOOR PRIOR TO ENTERING R68's quarterly MDS assessment, dated 7/15/24, indicated R68 had severely impaired cognition with no hallucinations or delusions with an admission date of 1/16/24. R76's admission MDS assessment, dated 6/24/24, indicated R76 has moderately impaired cognition with no hallucinations or delusions with an admission date of 6/18/24. R74's admission MDS assessment, dated 6/7/24, indicated R74 had severely impaired cognition with no hallucinations or delusions with an admission date of 6/3/24. During observation on 8/06/24 between 10:30 a.m. and 10:55 a.m., nursing assistant (NA)-B entering R68's room numerous times without	F 550			

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F 550	Continued From page 31 knocking or announcing self. NA-B was also observed entering R76's room, during that time, without knocking, announcing self, or talking with R76 prior to entering room. During interview at 8/6/24 at 11:01 a.m., NA-B verified that they entered R68's numerous times within the last 30 minutes without knocking or announcing self. R68 stated, "I am very busy but should've knocked." NA-B couldn't count how many times she had been in and out of R68's room without knocking but stating, "a lot." NA-B verified they entered R76 room without knocking as "she could see me in the hallway, and I was talking to her." NA-B verified they should always knock before entering a resident's room as "it is a privacy and dignity thing to knock on a door prior to entering rooms. " On 8/07/24 at 10:10 a.m., housekeeper (HSK)-A was observed opening R74's room door and entering R74's room without knocking or announcing self. On 8/7/24 at 10:12 a.m., HSK-A verified they had delivered soap to R74's room. HSK-A verified they had not knocked or announce themselves prior to opening R74's door and entering room. HSK-A stated, "I thought they were sleeping.". HSK-A further indicated, "you should always knock because you are entering their room." On 8/07/24 at 10:14 a.m., R74 was observed to be lying in bed. R74 answered questions mumbled and non-sensical. On 8/07/24 at 10:16 a.m., R68 did not respond when asked questions. During interview on 8/07/2024 at 1:38 p.m.,	F 550			

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F 550	Continued From page 32 assistant director of nursing (ADON) stated it is expected to knock prior to entering a resident's room and should be done all the time. ADON stated, "we should treat everyone like humans ...we a lot of people have dementia, and we don't want to scare them ...it's just the right thing to do." During interview on 8/07/2024 at 2:11 p.m., with director of nursing (DON) stated it is expected that staff either knock or announce themselves by saying hello announce. DON stated this is "for dignity and alert them so don't startle them." A facility policy titled Dignity, dated 12/8/21, indicated "residents are treated with dignity and respect at all times." Further indicated, "residents are provided with a dignified dining experience."	F 550			
F 582 SS=D	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each	F 582			9/5/24

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F 582	Continued From page 33 resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide a Skilled Nursing Facility Advanced Beneficiary Notice (SNFABN; CMS-10055) upon the termination of Medicare A coverage for 1 of 3 residents (R74) reviewed who	F 582	1)What corrective actions(s) will be accomplished for those residents found to have been affected by the deficient practice. R74 was provided a SNFABN;		

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F 582	Continued From page 34 remained in the nursing home after Medicare A coverage ended. Findings include: R74's Prospective Payment System (PPS) Part A Discharge (End of Stay) Minimum Data Set (MDS) dated 7/23/24, indicated he was discharged from Medicare Part A services on 7/23/24 and had intact cognition with diagnoses of Alzheimer's disease (a type of dementia that affects memory, thinking, and behavior) and depression. Under Point Click Care's (PCC) census header, Medicare Part A was identified as R74's primary payer on 6/3/24. Private pay was identified as R74's primary payer on 7/24/24. A Notice of Medicare Non-Coverage (NOMNC) form indicated, "a final day of skilled nursing services will be provided on 7/23/24 due to decrease of tube feeding. On 7/26/24, this client's family member(FM)/power of attorney (POA) was informed of this decision. Client unable to sign due to cognitive impairment. Family wants client remain in this facility for LTC at this time, while pursuing Part B or MA coverage for additional therapy services." The form lacked signature or date by resident or his representative. There was a handwritten note below the signature line that read, "Multiple attempts made for pt's FM/POA to sign NOMNC (7/23/24, 7/22/24, 7/23/24, and 7/24/24). POA demo's lack of understanding of this document and frequently moves onto other unrelated subjects during conversation. POA has been informed of the right to appeal but has not provided a decision at this time." The form was signed and dated by the occupational therapist	F 582	CMS-10055 form on 08/27/2024. 2)How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. All residents whose skilled services under Medicare A ended and remained in the facility have the potential to be affected by the deficient practice. All other like residents in the past 30 days were reviewed to ensure they received a SNFABN if needed on 08/27/2024. 3)What measures will be put in place or what systemic changes will you make to ensure that the deficient practice does not recur. Facility staff responsible for issuing SNFABN; CMS-10055 notices have been re-educated on facility policy for Medicare Beneficiary Liability Notices. Education on beneficiary notices occurred on 08/27/2024. 4)How the corrective actions(s) will be monitored to ensure deficient practice will not recur. SNFABN□s will be audited 1x per week x 2 months. Audit review and analysis will be brought to QAPI to determine ongoing frequency and duration of audits. 5)Director of Rehabilitation and/or designee will ensure compliance. The date of compliance is September 5, 2024		

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F 582	Continued From page 35 (OT) and therapy program manager on 7/24/24. R74's electronic health record (EHR) lacked documentation of discussion with R74 and/or representative about NOMNC or covered services prior to 8/7/24. A progress note dated 8/7/24, indicated social services spoke to R74's family member and the awareness of the cost per day of services. The progress note documented that R74's family member "cannot afford that". During interview on 8/7/24 at 1:39 p.m., the OT reviewed verified being responsible for providing NOMNCs and Skilled Nursing Facility Advance Beneficiary Notice of Non-coverage forms (SNF ABNs). The OT reviewed therapy records for R74 and verified R74's Medicare Part A skilled coverage ended on 7/23/24 and the final day skilled services were given was on 7/23/24. The OT recalled having an initial conversation about R74's non-coverage on 7/19/24. The OT stated there were multiple conversations with R74's POA about the NOMNC but the POA declined to sign the form. The OT was unable to locate documentation of such conversations and stated, "I don't see any supporting documentation aside from what I have on the NOMNC." Additionally, the OT stated no SNF-ABN was provided to R74 or his representative because the regional director of the consultant therapy company reported NOMNCs were for skilled stays and ABNs were for therapy services and not room and board. The OT stated it was a "rare occasion" in which they would provide both forms. The OT verbalized they did not believe a SNF ABN form needed to be given to R74 after he discharged from Medicare Part A services.	F 582			

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F 582	Continued From page 36 A facility policy titled Medicare Reimbursement Resource Manual Beneficiary Liability Notices dated 2021, indicated it was the policy of the organization to follow Medicare SNF Part A rules and regulations for advance beneficiary non-coverage notices by issuing the correct form in a timely manner. Under the procedure header, the policy guided staff to issue a non-coverage notice in advance of the anticipated last covered day when a resident was nearing discharge, would no longer meet clinical coverage criteria, or had exhausted the MA authorized length of stay. Furthermore, the policy guided staff to provide the SNF ABN (Advance Beneficiary) (CMS 100055) before providing care or services that do not meet Medicare coverage criteria. The policy provided an example of a resident being covered by Medicare Part A but staying in the facility for "custodial care". The policy provided a hyperlink for SNF ABN instructions. The policy indicated the NOMNC should be delivered at least two days prior to the last covered day and ensure that the beneficiary or legal representative signs and dates the NOMNC or telephone a beneficiary's legal representative to advise them when services would no longer be covered. The policy indicated if staff telephoned the beneficiary's legal representative, staff should confirm the telephone contact by sending a written notice in the mail on the same date, and if direct contact could not be made, a notice should be sent via registered mail and a dated copy of the notice should be placed in the medical record.	F 582			
F 585 SS=D	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances.	F 585		9/5/24	

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F 585	Continued From page 37 §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her	F 585			

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F 585	Continued From page 38 grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued;	F 585			

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F 585	Continued From page 39 (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to respond to and resolve a report of missing clothing for 1 of 1 residents (R182) reviewed for grievances. Findings include: R182's quarterly minimum assessment data (MDS) indicated, R182 had severe cognitive impairment, no behaviors, hallucinations, or delusions. R182 had limited range of motion in one side of her body, was dependent with grooming, toileting, dressing, and transfers. R182 was unable to ambulate, needed help to set up her meals, and was able to propel her wheelchair. R182's Clinical Diagnosis record printed 8/7/24, indicated diagnosis of hemiplegia and hemiparesis (paralysis and weakness of one side of the body) following cerebral infarction (stroke) affecting left non-dominant side (area of damaged tissue on the brain), lymphedema (swelling due to build-up of lymph fluid in the body), vascular dementia (problems with reasoning, planning, judgement, memory, and			F 585	1)What corrective actions(s) will be accomplished for those residents found to have been affected by the deficient practice. R182 discharged on 6/19/24 2)How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. All residents have the potential to be affected by the deficient practice. The review of all grievances from the past 30 days have been resolved and communicated to the submitter. 3)What measures will be put in place or what systemic changes will you make to ensure that the deficient practice does not recur. The use of a Lost Item Form was introduced for use anytime a resident, family, or staff member notes a missing clothing article or personal item. The Lost Item Form includes a section		

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F 585	Continued From page 40 other thought processes caused by brain damage from impaired blood flow to the brain), essential hypertension (an abnormally high blood pressure that's not the result of a medical condition) , neuralgia (pain caused by damaged or irritated nerves) , chronic pulmonary embolism (condition caused by a blood clot blocking the pulmonary artery, reduces blood flow and increases pressure in the lungs), chronic pain syndrome, and major depressive disorder. R182's progress note dated 11/21/23 at 2:32 p.m., by a licensed practical nurse (LPN)-C indicated "the resident is complaining of her missing dresses." Facility's grievance log for 2023 lacked documentation of a grievance filed on behalf of R182 regarding the missing clothing. During interview on 8/7/24 at 1:46 p.m., social worker (SW) stated when a resident reports a missing item, staff look in the residents' room and call the laundry. SW stated, sometimes they will call me or the administrator. The family will file a grievance form. SW stated we usually find the clothes and if we can't find the items, we call the family and let them know. SW stated, the administrator is in charge and directs the director of nursing (DON) and SW if any further action is necessary. During interview on 8/7/24 at 1:24 p.m., administrator stated, typically missing items are brought up to the nurse's attention. The nurses search the resident's room and call the laundry. This information would be discussed during the daily IDT meeting [Monday-Friday]. Depending on the item it will be assigned to the appropriate	F 585	documenting the manner in which follow up is managed and communicated. Education provided to staff and where to locate the form. 4)How the corrective actions(s) will be monitored to ensure deficient practice will not recur, i.e., what quality assurance program will be put into practice. Will be audited 1x per week x 2 months. Audit review and analysis will be brought to QAPI to determine ongoing frequency and duration of audits. 5)The Administrator or designee is responsible for ensuring compliance. The date of compliance is September 5, 2024		

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F 585	Continued From page 41 department and be followed up. During the weekend, concerns are brought up to the nurse in charge, and depending on the seriousness of the concern they will contact the DON or the administrator. Administrator was not aware a progress note was made indicating R182 reported missing dresses. Administrator stated grievance forms sometimes are part of the process to report missing personal items. Administrator stated grievance forms were available to staff, residents, and families. The facility's policy titled Filling Grievances/Complaints dated 12/14/21, indicated "Any resident, family member, or appointed resident representative may file a grievance or complaint concerning care, treatment, behavior of residents, staff members, theft of property, or any other concerns regarding his or her stay at the facility. The facility's policy titled Staff Responsibility Grievances/Complaints dated 10/28/21, indicated "staff members are encouraged to guide residents about where and how to file a grievance and/or complaint when the resident believes his/her rights have been violated." Additionally, policy indicated: Any allege abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, must be reported to the administrator immediately, but no later than 2 hours after the allegation is made if the events that cause the allegations involve abuse or result in serious bodily injury, or no later than 24 hours if the events that cause the allegations do not involve abuse and do not result in serious bodily injury.	F 585			
F 609 SS=D	Reporting of Alleged Violations	F 609			9/5/24

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F 609	Continued From page 42 CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure allegations of potential abuse were reported in a timely manner to the state agency (SA) for 1 of 1 residents (R21) whose allegations were reviewed. Findings include:	F 609	1)What corrective actions(s) will be accomplished for those residents found to have been affected by the deficient practice. It is the policy of this nursing facility that allegations of abuse, neglect, exploitation, or mistreatment are reported		

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F 609	Continued From page 43 R21's quarterly Minimum Data Set (MDS) dated 6/11/24, identified R21 had severely impaired cognition with no hallucinations or delusions, and was dependent on staff for all activities of daily living (ADLs) including bed mobility and transfers. R21's care plan, printed 8/7/24, identified R21 transferred with a Hoyer (mechanical lift) and assist of 2 staff. In addition, R21 was "unable to adequately verbalize her needs, Speech is nonsensical, disorganized and unintelligible when she speaks." Furthermore, the care plan identified, "my safety is at risk and there is potential for abuse due to: Cognitive Impairment, Dementia, or poor decision making." R21's progress note dated 8/1/24, identified the following entry: "Residents son flagged writer to come to his mom's room He said "there's a bruise here, has anyone reported it", it's probably from the Hoyer but I wanted you to see it. He showed me a very faint discoloration on L chest below her breast. Will monitor." R21's progress notes from 8/1/24 to 8/7/24 reviewed and lacked evidence of any other progress notes monitoring bruise mentioned. A Skin and Wound Evaluation, dated 8/5/24, identified a bruise on "left chest." Exact date of bruise was noted as "8/1/24" and area was measured as followed: Area: "35.0 cm (centimeters)2[squared]" Length: "9.3 cm" Width: 5.9 cm: A section on the bottom of the assessment indicated, "son reported faded bruise on left chest. Will continue to monitor." Notifications completed: a radio-button answered:	F 609	immediately. The incident for R21 was reported to the Minnesota Department of Health on August 7, 2024. The facility investigated and determined there was no evidence of abuse. 2)How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. All residents have the potential to be affected by the deficient practice. Reviewed risk management reports for injuries of unknown origins for the past month to ensure no other incidents were missed from a reporting standpoint. 3)What measures will be put in place or what systemic changes will you make to ensure that the deficient practice does not recur. The facility will conduct reeducation on abuse, neglect, and risk management reporting. This includes reporting potential abuse or neglect immediately to administrator and DON. Concerns provided by staff at the facility regarding resident safety, abuse or neglect will be investigated by the Administrator and DON. 4)How the corrective actions(s) will be monitored to ensure deficient practice will not recur, i.e., what quality assurance program will be put into practice. Social Services or designee will conduct audits of self-reports 1x per week x 2 months. Audit review and analysis will be brought to QAPI to determine ongoing		

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F 609	Continued From page 44 resident/responsible party notified. During an interview on 8/06/24 at 3:07 p.m., family member (FM)-A stated he reported the bruise on R21's chest to the nurse on 8/1/24. FM-A stated they are concerned that staff "aren't gentle" and if "I don't advocate for her, she will be neglected." FM-A stated the bruise on R21's chest was reported to FM-A from the hospice nurse on 7/31/24 and stated that no staff from the facility reported the bruise to FM-A. FM-A stated, "I get really worried as staff isn't equipped to handle this population, they aren't trained, they bring in agency staff who don't know anyone and don't care, they just flop them around and not gentle." R21's medical record was reviewed and lacked any evidence the allegation of potential abuse or neglect had been reported to the State Agency (SA). During interview on 8/07/24 at 11:18 a.m., registered nurse (RN)-C indicated that a bruise with unknown origin would be entered into the risk management section of the electronic medical record (EMR). RN-C verified R21's bruise was not entered into the risk management section of the (EMR). RN-C verified the provider should be notified of all injuries of unknown origin and that had not occurred with R21's bruise. RN-C verified R21's bruise was not being monitored in the skin/wound tab section and verified that is the other area that it may be monitored. RN-C verified the EMR lacked evidence of monitoring R21's bruise. During interview on 8/07/2024 at 1:38 p.m., assistant director of nursing (ADON) verified that	F 609	frequency and duration of audits. 5)The Administrator or designee is responsible for ensuring compliance. Date of compliance will be September 5, 2024.		

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F 609	Continued From page 45 she along with other leadership are responsible for filing "reports to the state." ADON verified that she did not assess R21's bruise and did not know if it was a "reportable event." During an interview on 8/07/2024 at 2:11 p.m., director of nursing (DON) verified she was aware of the R21's bruise on 8/5/24 "after the wound care nurse took a picture of it." DON verified the bruise was not reported to the SA despite it being of unknown origin the location of the bruise being under the resident's breast. DON verified she has not assessed the bruise and the bruise was not assessed by the wound care nurse until 5 days after the entry of the progress note on 8/1/24. DON verified that a bruise could lighten and shrink in size significantly in that time frame. DON stated, "the bruise might have been caused by the Hoyer." DON verified, after review, that R21's bruise should have been reported to SA and investigated to determine the cause. A policy titled Abuse, Neglect, Exploitation or Misappropriation -Reporting and Investigating, dated 3/22/23, was provided. Document indicated, "All reports of resident abuse (including injuries of unkonwn origin), neglect, exploitation, or theft/misappropriation of resident property are reported to local, state and federal agencies (as required by current regulations) and throroughly investigated by facility management."	F 609			
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;	F 677			9/5/24

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F 677	Continued From page 46 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to ensure routine personal care (i.e., incontinent cares, nail care) were provided for 2 of 3 residents (R6, R31) reviewed for dependent activities of daily living (ADL's). Findings include: R6 R6's significant change Minimum Data Set (MDS), dated 6/14/24, identified R6 had moderate cognitive impairment but demonstrated no delusional thinking. Further, the MDS outlined R6 was dependent on staff for most personal hygiene needs and was not diabetic. On 8/5/24 at 1:47 p.m., R6 was observed seated in a recliner chair while in his room. R6 had long fingernails present on both hands, with the nail edge both having a dark-colored debris present and being several millimeters (mm) long on multiple nails. R6 was questioned on his nail care and who, if anyone, helps him with it. R6 looked at his nails and expressed aloud, "My nails need to be clipped." R6 stated he used to clip them himself, however, had lost the clippers awhile back. R6 stated the staff helped him with showers on a weekly basis but nobody from the care center, to his recall, had asked him about clipping his nails in the past few weeks. R6's care plan, dated 7/2024, identified R6 had an ADL self-care deficit due to post-polio syndrome and impaired mentation. The care plan directed, "PERSONAL HYGIENE/ORAL CARE:	F 677	1)What corrective actions(s) will be accomplished for those residents found to have been affected by the deficient practice. R6 and R31 tasks tab have been updated with ADL assistance with grooming on nail care and personal hygiene. 2)How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. All residents have the potential to be affected by the deficient practice. An audit of all residents' fingernails was performed. Nails were trimmed as needed. Staff were educated on the importance of good personal hygiene and following care plans related to incontinence and ADL care needs. 3)What measures will be put in place or what systemic changes will you make to ensure that the deficient practice does not recur. Nursing staff educated on ADL Policy and the need to ensure nail care is offered and personal hygiene care plans are followed. 4)How the corrective actions(s) will be monitored to ensure deficient practice will not recur, i.e., what quality assurance program will be put into practice. Audits completed 1x per week x 1 month and 2x per month for 1 month.		

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F 677	Continued From page 47 Requires assistance of 1." The care plan lacked any information on nail care (i.e., preferred length, clipping frequency). On 8/6/24 at 9:40 a.m., R6 was observed again seated in his recliner chair. R6's fingernails remained long and soiled as had been observed the day prior. R6's Weekly Skin Review Assessment, dated 8/3/24, identified R6 had no skin issues along with dictation, "[R6] had shower. skin check completed with no new skin issue noted." The completed evaluation lacked evidence if nail care had been offered, provided or refused. Further, R6's medical record, including progress notes, lacked evidence nail care had been done, offered or refused within the last week despite R6 having long, potentially soiled nails present. When interviewed on 8/6/24 at 10:02 a.m., nursing assistant (NA)-F stated they had worked with R6 multiple times prior and described him as needing "total help" with cares and hygiene. NA-F stated R6 rarely, if ever, refused care and the NA's would be responsible to help him complete nail care with his showers. NA-F stated if nail care was refused, then the nurse should be told and they likely charted it but the NA charting didn't have spacing to record such. At 10:06 a.m., NA-F observed R6's nails while licensed practical nurse (LPN)-B was present in the room helping R6's roommate. NA-F verified R6's nails were long adding, "They need to be trimmed and cleaned." NA-F stated it looked as it had "been awhile" since nail care was last done and verified R6 was unable to clip his own adding, "He's total [care] and we have to do everything for him." NA-F stated they had never seen or heard of R6 having	F 677	Audit review and analysis will be brought to QAPI to determine ongoing frequency and duration of audits. 5)The DON or designee will be responsible for compliance to ensure residents receive the necessary ADL services. The date of compliance is September 5, 2024		

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F 677	Continued From page 48 his own clippers before. On 8/6/24 at 10:20 a.m., LPN-B was interviewed. LPN-B was questioned on R6's fingernails adding aloud, "I noticed that [just prior]." LPN-B stated the nails appeared like they'd been cut and expressed, "I will cut them." LPN-B stated nail care, including cleaning and clipping, should be done on scheduled bath days adding the care center had recently switched to a new form (i.e., Weekly Skin Review) which not longer asked about nail care so it was maybe being missed by staff. LPN-B verified R6's nail length and condition adding, "That is the longest I've seen them." LPN-B stated R6's nails "grow fast" and the length of them appeared it had been "well over a week" since they were last clipped. LPN-B stated R6 was not a diabetic and the NA could help him with clipping, too, if needed. Further, LPN-B stated there was no current place to record nail care being done or offered, but they verified nail care should be completed regularly as long nails could break off, create injury, or "promote infection." When interviewed on 8/6/24 at 11:32 a.m., registered nurse (RN)-E stated the care center had recently changed with "UDAs [assessments]" and no longer had nail care recorded on the weekly skin review. However, RN-E stated nail care should be completed with bathing adding, "That's always been the expectation." RN-E stated if nail care was refused, then the nurse should record such in the progress notes after re-approaching the resident; however, RN-E verified the medical record lacked evidence of such. RN-E stated nails should be clipped and kept clean so R6 didn't hurt himself or others with them.	F 677			

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F 677	Continued From page 49 A provided Fingernails/Toenails, Care Of policy, dated 2022, identified nail care included daily cleaning and regular trimming adding, "Proper nail care can aid in the prevention of skin problems around the nail bed." The policy directed nail care should be recorded in the medical record, including if offered and refused. R31 R31's quarterly Minimum Data Set (MDS), dated 7/23/24, indicated R31 had severely impaired cognition with no hallucinations or delusions. Diagnoses included: dementia (loss of memory, language, problem,-solving and other thinking abilities that are severe enough to interfere with daily life), anxiety, depression, other frontotemporal neurocognitive disorder (progressive disease of the brain involving frontal and temporal lobes of the brain; can also be referred to as frontotemporal dementia), and polyosteoarthritis (type of arthritis that involves five or more joints at the same time). In addition, R31 was dependent on staff for all ADLs including bed mobility and all hygiene needs. In section H: Bladder and Bowel: section H0300 Urinary Continence: R31 was coded as "Always incontinent (no episodes of continent voiding)," and in section H0400: Bowel Continence: R31 was coded as "Always incontinent (no episodes of continent bowel movements)." R31's care plan, printed 8/6/24, indicated R31 has "functional bladder and blower incontinent r/t [related to] severe cognitive impairment d/t [due to] dx [diagnosis] of Frontotemporal Dementia" with the following interventions: - "BRIEF USE: The resident uses disposable XL			F 677			

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F 677	Continued From page 50 yellow briefs, Change per schedule and prn [as needed]." - "INCONTINENT: Check/change 2-3 hours and as required for incontinent. Wash, rinse and dry perineum. Change clothing PRN after incontinent episodes." Care plan further indicated, "ADL self-care needs total assist of one secondary to advanced dementia" with the following interventions: - "PERSONAL HYGIENE/ORAL CARE: The resident is totally dependent on (1) staff for personal hygiene and oral care." - TOILET USE: The resident is not toileted. Dignity protocol every 2-3 hours." R31's progress notes, dated 7/9/24 to 8/7/24, were reviewed. Progress notes lacked evidence of R31 refusing staff assistance or documentation of any behaviors. R31's Kardex, printed 8/7/24, indicated R31 required assistance of 1-2 [staff] for bed mobility and to be repositioned every 2-3 hours. Furthermore, the document identified R31 as "Incontinent: Check/change 2-3 hours and as required for incontinence. Wash, rinse and dry perineum. Change clothing PRN after incontinence episodes." During continual observation on 8/06/24: -8:42 a.m., R31 was observed to be seated at the dining room table in her wheelchair, facing the television with two other residents at the table with her breakfast tray in front of her. -8:56 a.m., R31 was assisted with her breakfast -9:34 a.m., R31 continues to sit in the dining room in the same position and a group activity was starting. -10:23 a.m., R31 continues to sit in her	F 677			

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F 677	Continued From page 51 wheelchair in the same spot she had breakfast in. R31 has not moved from the location. -11:15 a.m., R31 continues to be seated in her wheelchair in the dining room, in the same position and location. -11:39 a.m., R31 continues to be seated in her wheelchair in the dining room, in the same position and location. -12:15 p.m., R31 continues to be seated in her wheelchair in the same position, in the same location she has been in since observation began. -12:22 p.m., R31's meal is placed in front of her on the table. -12:30 p.m., staff sit next to R31 to assist with her meal. -1:54 p.m., R31 remains seated in the dining room, has not been repositioned or brought back to her room. -2:14 p.m., R31 remains in the dining room. R31 has been in the same location, in the same position (5 hours 32 minutes after observation began). -3:06 p.m., R31 was observed lying in bed. During interview on 8/06/24 at 2:04 p.m., nursing assistant (NA)-C stated the expectation is to check and change a resident that is incontinent is every 2 hours along with repositioning them. NA-C verified they have not repositioned or changed R31 "since this morning before breakfast." NA-C verified this was over two hours. NA-C stated, "I haven't had a chance because I have a lot of work to do. We are short staffed." NA-C stated they were going to work on it now and verified they are working with R31 today. During interview on 8/06/24 at 2:14 p.m., NA-B stated it is expected to reposition, "check and	F 677			

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F 677	Continued From page 52 change" any resident that is incontinent every 2 hours. NA-B stated they helped transfer R31 this morning prior to breakfast. NA-B stated they have not assisted R31 with any cares, repositioning, or transfers since before breakfast. During interview on 8/06/24 at 3:36 p.m., NA-C stated that after talking with surveyor they brought R31 to their room, transferred her to bed and provided incontinent cares. NA-C verified that R31 had been incontinent of urine and a small amount of bowel movement. During interview on 8/07/2024 at 1:38 p.m., assistant director of nursing (ADON) stated the expectation is residents who are incontinent of bowel and bladder need to be checked and changed every 2-3 hours along with repositioned. ADON stated, "it would be based on the residents care plan." During interview on 8/07/2024 at 2:11 p.m., director of nursing (DON) stated the expectation for residents who are incontinent is "they are checked and changed every 2-3 hours or what the care plan says." DON stated it is important to do to offload residents to reduce pressure and to ensure they are clean and dry. A policy titled Activities of Daily Living (ADLs), Supporting, dated 12/7/21, indicated, "residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene."	F 677			
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii)	F 686			9/5/24

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F 686	Continued From page 53 §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure assessed and care-planned interventions for preventative skin care were consistently implemented for 1 of 1 residents (R31) reviewed for pressure ulcers. Findings include: R31's quarterly Minimum Data Set (MDS) dated 7/23/24, indicated R31 had severely impaired cognition with no hallucinations or delusions. Diagnoses included: dementia (loss of memory, language, problem,-solving and other thinking abilities that are severe enough to interfere with daily life), anxiety, depression, other frontotemporal neurocognitive disorder (progressive disease of the brain involving frontal and temporal lobes of the brain; can also be referred to as frontotemporal dementia), and polyosteoarthritis (type of arthritis that involves five or more joints at the same time). In addition, R31 was dependent on staff for all ADLs including bed mobility and all hygiene needs. In section H:	F 686	1)What corrective actions(s) will be accomplished for those residents found to have been affected by the deficient practice. R31 plan of care reviewed, and skin assessment performed with no evidence of pressure injury noted on August 12, 2024. 2)How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. All residents who are on a repositioning schedule have the potential to be affected by the deficient practice and plan of care will be reviewed and updated as needed. 3)What measures will be put in place or what systemic changes will you make to ensure that the deficient practice does not recur.		

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F 686	Continued From page 54 Bladder and Bowel: section H0300 Urinary Continence: R31 was coded as "Always incontinent (no episodes of continent voiding)," and in section H0400: Bowel Continence: R31 was coded as "Always incontinent (no episodes of continent bowel movements)." In Section M: Skin Condition: M0150 risk of pressure ulcers: R31 was identified at risk for developing pressure ulcers. R31's care plan, printed 8/6/24, indicated R31 "has potential impairment to skin integrity r/t [related to] incontinence, immobility, impaired cognition, and history of pressure ulcer right heel," with the following interventions: -"reposition q[every] 2-3 hrs [hours] R31's care plan further indicated R21 has "functional bladder and blower incontinent r/t [related to] severe cognitive impairment d/t [due to] dx [diagnosis] of Frontotemporal Dementia" with the following interventions: - "BRIEF USE: The resident uses disposable XL yellow briefs, Change per schedule and prn [as needed]." - "INCONTINENT: Check/change 2-3 hours and as required for incontinent. Wash, rinse and dry perineum. Change clothing PRN after incontinent episodes." Care plan further indicated, "ADL self-care needs total assist of one secondary to advanced dementia" with the following interventions: - "PERSONAL HYGIENE/ORAL CARE: The resident is totally dependent on (1) staff for personal hygiene and oral care." -"TOILET USE: The resident is not toileted. Dignity protocol every 2-3 hours." R31's progress notes, dated 7/9/24 to 8/7/24,	F 686	Nursing staff educated on following resident plan of care, importance of repositioning schedule and skin policy. Repositioning policy reviewed and remained current. 4)How the corrective actions(s) will be monitored to ensure deficient practice will not recur, i.e., what quality assurance program will be put into practice. Audits completed related to resident repositioning 1x per week for 1 month and 2x month for 1 months. Audit review and analysis will be brought to QAPI to determine ongoing frequency and duration of audits. 5)Director of Nursing and/or designee will ensure compliance. The date of compliance is September 5, 2024		

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F 686	Continued From page 55 were reviewed. Progress notes lacked evidence of R31 refusing staff assistance or documentation of any behaviors. R31's Kardex, printed 8/7/24, indicated R31 required assistance of 1-2 [staff] for bed mobility and to be repositioned every 2-3 hours. Furthermore, document identified R31 as "Incontinent: Check/change 2-3 hours and as required for incontinence. Wash, rinse and dry perineum. Change clothing PRN after incontinence episodes." During continual observation on 8/06/24: -8:42 a.m., R31 was observed to be seated at the dining room table in her wheelchair, facing the television with two other residents at the table with her breakfast tray in front of her. -8:56 a.m., R31 was assisted with her breakfast -9:34 a.m., R31 continues to sit in the dining room in the same position and a group activity was starting. -10:23 a.m., R31 continues to sit in her wheelchair in the same spot she had breakfast in. R31 has not moved from the location. -11:15 a.m., R31 continues to be seated in her wheelchair in the dining room, in the same position and location. -11:39 a.m., R31 continues to be seated in her wheelchair in the dining room, in the same position and location. -12:15 p.m., R31 continues to be seated in her wheelchair in the same position, in the same location she has been in since observation began. -12:22 p.m., R31's meal is placed in front of her on the table. -12:30 p.m., staff sit next to R31 to assist with her meal.	F 686			

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F 686	Continued From page 56 -1:54 p.m., R31 remains seated in the dining room, has not been repositioned or brought back to her room. -2:14 p.m., R31 remains in the dining room. R31 has been in the same location, in the same position (5 hours 32 minutes after observation began). -3:06 p.m., R31 was observed lying in bed. During interview on 8/06/24 at 2:04 p.m., nursing assistant (NA)-C stated the expectation is to check and change a resident that is incontinent is every 2 hours along with reposition them. NA-C verified they have not repositioned or changed R31 "since this morning before breakfast." NA-C verified this over two hours. NA-C stated, "I haven't had a chance because I have a lot of work to do. We are short staffed." NA-C stated they were going to work on it now and verified they are working with R31 today. During interview on 8/06/24 at 2:14 p.m., NA-B stated it is expected to reposition, and "check and change" any resident that is incontinent every 2 hours. NA-B stated they helped transfer R31 this morning prior to breakfast. NA-B stated they have not assisted R31 with any cares, repositioning, or transfers since before breakfast. During interview on 8/06/24 at 3:36 p.m., NA-C stated that after talking with surveyor they brought R31 to their room, transferred her to bed and provided incontinent cares. NA-C verified that R31 had been incontinent of urine and a small amount of bowel movement. During interview on 8/07/2024 at 1:38 p.m., assistant director of nursing (ADON) stated the expectation is residents who are incontinent of	F 686			

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F 686	Continued From page 57 bowel and bladder need to be checked and changed every 2-3 hours along with repositioned. ADON stated, "it would be based on the residents care plan." During interview on 8/07/2024 at 2:11 p.m., director of nursing (DON) stated the expectation for residents who need to be repositioned and are incontinent is "they are checked and changed every 2-3 hours or what the care plan says." DON stated it is important to do to offload residents to reduce pressure and to ensure they are clean and dry. A policy titled Prevention of Pressure Injuries, dated 9/29/21, indicated "reposition all residents with or at risk of pressure injuries on an individualized schedule, as determined by the interdisciplinary care team."	F 686			
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure behaviors of potential wandering were comprehensively assessed and, if needed, interventions placed to ensure safety and prevent elopement for 1 of 1 residents (R330); and failed to ensure fall	F 689	1)What corrective actions(s) will be accomplished for those residents found to have been affected by the deficient practice. R330 was admitted recently and reassessed for elopement risk. R330 was		9/5/24

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F 689	Continued From page 58 interventions were implemented to prevent fall and injury for 1 of 3 residents (R64) reviewed for falls and accidents. Findings include: R330 R330's Nurse Admission/Readmission 05212021 - V15, dated 7/31/24, identified R330 admitted to the care center from the hospital. R330 was recorded as being alert to person and time, however, not to place or aware of her clinical situation with an option being checked, "Short term memory loss." The evaluation concluded with a section labeled, "Admission Summary," which outlined, " ... alert and oriented X2 with forgetfulness ... assist of one with cares ... ". On 8/5/24 at 2:35 p.m., R330 was observed lying on her bed while in her room which was at the end of a hallway next to a stairwell. R330 smiled at the surveyor upon entrance to the room and expressed aloud, "You remember me?!" R330 added, "I'm your first cousin!" R330 stated she had been at the care center "just a few days." R330 had flip-flop style shoes in place on her feet, however, did not have any visible wanderguard devices (alerts when attempting to leave an area or building) on her person. Immediately following, at 2:39 p.m., registered nurse (RN)-B was interviewed and stated R6 was "very confused." RN-B stated R6 could "fool you" for awhile but had impaired cognition adding it had been like that since she admitted. R330's initial Elopement Risk Evaluation - V2, dated 8/2/24, identified R330 was non-ambulatory or able to self propel her wheelchair, did not have	F 689	given a wander guard on 8/23/24 and care plan was updated. Was on Q30 min checks prior to receiving wander guard. ADLs and care plan updated to reflect current status for R64 2)How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. All residents who are prone to wandering or falls have the potential to be affected by the deficient practice. Plans of care will be reviewed and updated as needed. 3)What measures will be put in place or what systemic changes will you make to ensure that the deficient practice does not recur. Wander and Elopement: Elopement policy will be updated, and staff educated that when wandering is newly noted the DON or ADON will be notified in a reasonable time and will update the care plan to reflect the new wandering with appropriate interventions (Q30 min checks or other appropriate intervention). The assigned floor nurse will communicate to all staff working with residents of the new behavior and interventions to implement. Interventions/Falls: Administrator and DON educated on the importance of ensuring an intervention is put into place in a timely manner following any report of a fall. 4)How the corrective actions(s) will be		

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F 689	Continued From page 59 a history of exit-seeking, and had not eloped or attempted to elope from the facility since the previous observation. The option to select which read, "3. Resident is a new admit," was left unchecked. The evaluation determined R330 was at low-risk for elopement and listed spacing to record what, if any, interventions were implemented including a personal safety alarm, exit alarm, or visual barriers. However, these were all left unchecked. The evaluated concluded, "Was the care plan: Initiated [marked]." However, R330's progress note, dated 8/3/24 at 2:03 p.m., identified R330 was seen wandering on another floor looking for the bathroom. The note outlined, "During breakfast, Staff was unable to locate resident on her floor and found resident on the first floor, towards the front entrance, sitting on the couch [sic]. It appears as if resident did not remember how to get back to her floor. Resident was redirected." The note lacked what, if any, interventions to reduce the risk of wandering and/or subsequent potential elopement were placed or offered. When interviewed on 8/6/24 at 9:52 a.m., nursing assistant (NA)-G stated they had worked with R330 the evening prior and was again assigned to her care for the current shift. NA-G stated R330 was ambulatory but only walking "mostly with therapy" and rarely, if ever, found to be self-transferring. NA-G stated they were "not really sure" if R330 used or wanderguard-type device or if she'd been wandering since admission adding, "I worked with her only once." R330's care plan, dated 8/2/24, identified R330 was at low risk for elopement/wandering and	F 689	monitored to ensure deficient practice will not recur, i.e., what quality assurance program will be put into practice. Audits related to resident falls 1x per week for 1 month and 2x per month for 2 months. Audit review and analysis will be brought to QAPI to determine ongoing frequency and duration of audits. 5)Administrator or designee will ensure compliance. The date of compliance is September 5, 2024		

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F 689	Continued From page 60 listed a goal, "The resident's safety will be maintained through the review date," along with a single intervention which read, "Assess elopement status quarterly and as needed." The care plan lacked evidence or intervention after being found on another unit near the entrance (progress note, dated 8/3/24). Further, R330's medical record was reviewed and lacked evidence R330 had been comprehensively reassessed for wandering or a potential elopement risk despite being found on a different floor near the exit of the building. When interviewed on 8/6/24 at 10:13 a.m., licensed practical nurse (LPN)-B explained they were currently assigned care for R330 but had also worked with her prior since she admitted a week or so prior. LPN-B verified R330 had cognitive impairment and stated she needed help with transfers and could move with some assistance needed. LPN-B stated they were unaware of any wandering episodes for R330, and explained any re-evaluation of their wandering risk would be "according to how alert and oriented they [resident] are." LPN-B stated they felt R330, if found to be wandering at some point, would likely need a wanderguard adding, "I would think she would need one." LPN-B stated this was due to R330 not always knowing where she was and being 'forgetful.' Further, LPN-B stated any re-assessment of the need for a wanderguard or similar intervention would be done by the nurse manager or director of nursing (DON) adding, "[They] can do their little assessment and say yay or nay." On 8/6/24 at 11:27 a.m., registered nurse manager (RN)-E was interviewed, and verified they had reviewed R330's medical record. RN-E	F 689			

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F 689	Continued From page 61 stated the IDT was aware of R330's episode of being found on the first floor and had verbally discussed it, however, felt since it was not actually 'exit-seeking' that a wanderguard wasn't needed. However, RN-E stated the floor staff were going to repeat the elopement screening tool as R330 was now more ambulatory, and they verified the record lacked any re-evaluation despite R330 being found by an entrance on another floor days prior. RN-E stated if staff see behaviors of exit-seeking or wandering, then it should be reported and it was important to do an evaluation "so staff is aware and it's communicated and her [R330] safety is maintained." A provided Resident Elopement policy, dated 6/2022, identified staff should report any resident who attempts to leave the premises or is missing. The policy outlined procedures to follow when a resident including upon a resident return (if discovered as missing) which included, "Apply a wander guard bracelet with MD order as needed," and, "Document relevant information in the resident's medical record." However, the policy lacked information on how wandering, including with potential to elope, would be evaluated or assessed and care-planned (i.e., frequency, person responsible). R64 R64's significant change MDS dated 5/12/24, indicated R64 had severely impaired cognition and had no rejection of care behaviors. The MDS indicated R64 was diagnosed with dementia,			F 689			

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F 689	Continued From page 62 kidney disease, and diabetes. The MDS indicated R64 used a walker as a mobility device and was independent with transferring and walking. R64's care plan dated 5/3/24, indicated R64 was a "high risk" for falls related to impulsivity and a history of falls. The care plan indicated staff were to anticipate and meet R64's needs and R64 needed prompt responses to all requests for assistance. The care plan indicated R64 required the assistance of one staff member with ambulation and used a walker. The care plan did not include R64's need for reminders to use his walker. R64's incident report dated 7/19/24 at 11:57 p.m., indicated R64 had an unwitnessed fall and R64 reported that he was unable to grab his walker because it was too far from him. The report included a "predisposing situation factors" section with using a walker selected. The report indicated immediate action taken was assessing R64's vital signs and assisting R64 back to bed. The report did not include what fall interventions were newly attempted to prevent further falls based on a root cause analysis of the fall. R64's medical record was reviewed and did not include what if any, new fall interventions were attempted after the fall on 7/19/24 based on a root cause analysis. During an observation on 8/6/24 at 9:13 a.m., R64 was observed walking in his room, barefoot, with no walker. NA-B was observed in the room, facing R64 but assisting his roommate. R64 was observed to bend over and attempt to pick something up off the floor. R64 was observed to walk out of his room with no walker and barefoot	F 689			

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F 689	Continued From page 63 while occasionally using the wall for assistance when he stumbled, and NA-B was not observed reminding him to use his walker. R64 was observed to turn around and walk back into the room. R64 was observed to sit down in a chair and put socks on. R64's walker was not within reach from this R64's chair but was on the far side of the room. NA-B was then observed to leave the room and was not observed to move the walker closer to R64 or remind him to use it if he got up. At 9:24 a.m., R64 was observed stumbling towards the walker that was on the far side of the room and caught himself on the double closet doors. R64 was then observed to walk back to his chair without his walker and sit back down. On observation, signs, or visual reminders for R64 to use his walker were not noted. During an interview and observation on 8/6/24 at 9:32 a.m., NA-B stated she worked with R64 multiple days a week. NA-B stated R64 was independent with ambulation but was supposed to use his walker but commonly forgot it. NA-B acknowledged she had noticed R64 walking without his walker but had not attempted to redirect or remind R64 to use his walker before leaving the room. NA-B stated she thought he might have fallen in the past previously but was unsure. NA-B was observed reviewing R64's Kardex and stated it indicated R64 was supposed to have assistance while walking but "no one [facility staff]" provided assistance to R64 during ambulation. During an interview on 8/7/24 at 12:36 p.m., the assistant director of nursing (ADON) stated R64 had fallen on 7/19/24 and after reviewing the medical record and the incident report with	F 689			

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F 689	Continued From page 64 related notes dated 7/19/24, a fall analysis that had related interventions had not yet been implemented. The ADON stated R64 was impulsive, and they had talked about possible fall interventions this week, and they were going to implement a reminder such as signs in R64's room to remember his walker but had not gotten to it yet. The ADON stated R64 was independent with ambulation but needed frequent reminders to use his walker. The ADON stated R64's care plan and Kardex had not been updated to demonstrate this and continued to show he needed assistance with ambulation. The ADON stated she would now update the care plan and Kardex to demonstrate R64's current independence with ambulation with reminders to use a walker. During an interview on 8/7/24 at 1:28 p.m., the director of nursing (DON) stated they reviewed falls every morning and discussed possible root causes and ideally, this would be documented with appropriate care plan interventions but that might not always have been occurring. The facility Falls and Fall Risk Managing policy dated 10/4/21 indicated facility staff would identify fall interventions based on the resident's specific risk factors and potential fall causes to prevent further falls.	F 689			
F 699 SS=D	Trauma Informed Care CFR(s): 483.25(m) §483.25(m) Trauma-informed care The facility must ensure that residents who are trauma survivors receive culturally competent, trauma-informed care in accordance with professional standards of practice and accounting for residents' experiences and preferences in	F 699			9/5/24

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F 699	Continued From page 65 order to eliminate or mitigate triggers that may cause re-traumatization of the resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to comprehensively assess past trauma and develop a comprehensive person-centered care plan with goals and interventions utilizing a trauma-informed approach including monitoring of PTSD (post-traumatic stress disorder) for 1 of 1 (R76) residents reviewed for trauma-informed care. Findings include: R76's admission Minimum Data Set (MDS), dated 6/24/24, identified R76 with moderately impaired cognition and diagnoses included: PTSD, bipolar disease (a disorder associated with episodes of mood swings ranging from depressive lows to manic highs), anxiety disorder, and fibromyalgia (medical syndrome which caused chronic widespread pain). R76's Trauma Informed Care History Assessment, dated 6/27/24, identified R76 as alert, orientated and cognitively intact. The document identified through a question with a radio-button answered "yes" that R76 experienced any life traumatic events. The assessment form disclosed a traumatic event that happened to R76 related to her time in military service. Furthermore, assessment indicated "are you aware of any particular triggers that may make this worse for you," the box below had a typed response of "N/A". R76's care plan, printed 8/6/24, indicated "a	F 699	1)What corrective actions(s) will be accomplished for those residents found to have been affected by the deficient practice. R76 plan of care reviewed and triggers for resident was updated on care plan 2)How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. All residents with PTSD have the potential to be affected by the deficient practice and plan of care will be reviewed and updated as needed. 3)What measures will be put in place or what systemic changes will you make to ensure that the deficient practice does not recur. Education to be provided to all staff related to Trama Informed Care policy and IDT will get additional training on completion of trauma questionnaire on admission. Social Services to assess on admission and with quarterly review. 4)How the corrective actions(s) will be monitored to ensure deficient practice will not recur, i.e., what quality assurance program will be put into practice. Audits completed on trauma informed care history 1x per week for 1 month and 2x per month for 1 month. Audit review		

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F 699	Continued From page 66 PASARR [preadmission screening and resident review] screening has determined that a serious mental disorder, intellectual disability or related disorder exists (Bipolar, PTSD)" with an intervention of "coordinate PASARR Level II recommendations. Psychiatry referral as ordered." The care plan lacked evidence of any other mention of R76 suffering from PTSD, discussing possible triggers, interventions to determine triggers, measurable objectives, interventions, and timeframes for how staff are expected to meet R76's desired goals and outcomes concerning her PTSD. Furthermore, the document identified R76 was "dependent on staff etc. for meeting emotional, intellectual, physical, and social needs r/t [related to] cognitive deficits, physical limitation. During an interview on 8/07/24 at 10:05 a.m., R76 was observed lying in bed. R76 stated, "No one from here has ever talked to me about any of my past traumaI have sexual trauma from the militaryI would like it if someone would talk to meI do have triggers that make it worseSometimes when the men lean over me to provide cares, it triggers me, I know they have to do that when they provide cares but it does trigger me at times." R76 stated she would like to work with the social worker to identify triggers as "no one has ever asked me about what triggers me." On 8/07/24 at 11:09 a.m., nursing assistant (NA)-D verified they are familiar with R76. NA-D stated they are not sure if R76 has PTSD or any triggers. On 8/06/24 at 3:36 p.m., NA-C verified they are familiar with R76 and work with her often. NA-C	F 699	and analysis will be brought to QAPI to determine ongoing frequency and duration of audits. 5)Social Services and/ or designee will ensure compliance. The date of compliance is September 5, 2024		

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F 699	Continued From page 67 stated they are not aware if R76 has PTSD or any triggers that make it worse. NA-C stated they received training on trauma informed care. On 8/07/24 at 11:18 a.m., registered nurse (RN)-C verified they are responsible for R76's care and familiar with her care. RN-C stated they are unsure if R76 has PTSD or any known triggers. After review of care plan, RN-C verified there was no documentation on the care plan relating PTSD except for reference to diagnosis with the PASARR. RN-C verified there were no interventions to determine any triggers, known triggers, or for staff to assess for triggers in R76's care plan. On 8/07/24 at 1:21 p.m., social worker (SW) verified that she is familiar with R76. SW stated that she has visited with R76 about her time in the military. SW verified she has not talked with R76 about any triggers. SW verified R76 did not identify any triggers for R76. SW stated a trauma informed assessment was completed upon assessment and verified that "N/A" stands for "not applicable." On 8/07/2024 at 1:38 p.m., assistant director of nursing (ADON) stated that she believes staff get trained on trauma informed care annually and during orientation. ADON stated, "I do not know if it [PTSD] is on the care plan" when asked about R76 diagnosis and triggers. A facility policy titled Trauma-Informed and Culturally Competent Care, dated 10/18/22, was provided. The document purpose is "to address the needs of trauma survivors by minimizing triggers and/or re-traumatization." In the section "Resident Care Planning" it identified to "develop	F 699			

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F 699	Continued From page 68	F 699			
F 756 SS=D	individualized care plans that address past trauma in collaboration with the resident and family, as appropriate." 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 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	F 756			9/5/24

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F 756	Continued From page 69 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 facility failed to act upon the consultant pharmacist's recommendation for 1 of 1 resident (R13) reviewed for unnecessary medications. Findings include: R13's quarterly Minimum Data Set (MDS) dated 5/31/24, indicated R13 was cognitively intact, did not experience hallucinations or delusions and did not refuse cares. MDS indicated R13 needed extensive assistance with transfers, hygiene, bathing, and dressing. R13 needed set up with oral hygiene and eating. R13's Clinical Diagnosis report printed 8/7/24, indicated Parkinson's disease with dyskinesia (disorder of the central nervous system that affects movement, often including tremors), dementia with other behavioral disturbances, neurocognitive disorder with Lewy Bodies (type of dementia characterized by build up of protein deposits in regions of the brain memory, thinking and movement) , essential hypertension(abnormally high blood pressure that's not the result of a medical condition) , and vitamin d deficiency. R13's Clinical orders report printed 8/7/24, included an order dated 9/11/23 for quetiapine (an antipsychotic medication) 25 milligrams (mg) at bedtime for hallucinations.			F 756	1. How corrective action will be accomplished for those residents found to have been affected by the deficient practice. R13 was reviewed by health care provider and GDR implemented. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice. All GDR pharmacy recommendations for the month of July have been reviewed and followed up on. 3. What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur. Any outstanding pharmacy recommendations that have not been addressed by the health care provider will be reviewed the following month at QAPI. 4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. Audit of pharmacy recommendations 1x per week for 1 month and 2x per month for 1 month. Audit review and analysis will be brought to QAPI to determine ongoing frequency and duration of audits.		

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F 756	Continued From page 70 R13's Consultant Pharmacist Recommendation to Physician dated 4/16/24 and 7/20/24 indicated the quetiapine 25 mg dose was active since 3/7/22. Recommendation read "Within the first year in which a resident is admitted on a psychotropic medication or after the prescribing practitioner has initiated a psychotropic medication, the facility must attempt a GDR [gradual dose reduction] in two separate quarters (with at least one month between the attempts), unless clinically contraindicated. After the first year, A GDR must be attempted annually, unless clinically contraindicated". The recommendation included a message directed to the provider, as follow: "Resident is due for a dose reduction assessment. During your next visit could you please review whether resident continues on the lowest doses of his/her regimen. If a dose is contraindicated, please document clinical rationale below." Both recommendations did not contain documentation showing and answer to the recommendations. During interview on 8/6/24 at 3:26 p.m., assistant director of nursing (ADON) stated the facility switched providers in April. In July, in order to make changes to the residents' psychotropic medications the new nurse practitioner requested a detailed psychosocial review and when the last GDRs were done for each resident. ADON stated the psychosocial reviews were on her "to do list". During interview on 8/7/24 at 2:02 p.m., director of nursing (DON) stated the previous nurse practitioner left on April 10th. DON stated when the new nurse practitioner started, she didn't want to make any changes without knowing the	F 756	5. Director of Nursing and/or designee will ensure compliance. The date of compliance is September 5, 2024.		

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F 756	Continued From page 71 residents. DON stated in July she asked for the psychosocial reviews and our ADON will be working on them. DON verified the pharmacist recommendations for the month of April and July were not done. The facility title Medication Monitoring and Management, Antipsychotics dated 5/2022, indicated "If a resident is admitted on an antipsychotic medication or the facility initiates antipsychotic therapy, the facility must attempt a GDR in two separate quarters (with at least one month between the attempts) within the first year, unless clinically contraindicated. After the first year, a GDR must be attempted annually, unless clinically contraindicated.	F 756			
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or	F 757			9/5/24

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F 757	Continued From page 72 §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure non-pharmacological interventions were attempted and recorded prior to administration of as-needed (PRN) narcotic medication to reduce the risk of potential complications for 1 of 5 residents (R4) reviewed for unnecessary medication use. Findings include: R4's admission Minimum Data Set (MDS), dated 7/15/24, identified R4 had intact cognition and consumed opioid (i.e., narcotic) medication during the review period. R4's care plan, dated 8/5/24, identified R4 had potential for pain due to recent hip surgery. A goal was listed which read, " ... will not have an interruption in normal activities due to pain through the review date," along with several interventions to help R4 meet this goal including, "The resident's pain is alleviated/relieved by: Ice, rest, pain medications." The intervention start date was recorded as, "08/05/2024." R4's Order Summary Report, signed 7/29/24, identified R4's physician orders while at the care center. This included an order which read, "HYDROMorphone HCL [Dilaudid, a narcotic] Oral Tablet 2 MG [milligrams] ... by mouth every 6 hours as needed ... ," with a start date recorded, "07/22/2024." R4's corresponding SKILLED note, dated 7/29/24, identified R4 was seen by the	F 757	1. How corrective action will be accomplished for those residents found to have been affected by the deficient practice. R4 discharged on August 21, 2024. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice. All residents who are receiving PRN pain medications have the potential to be affected by the deficient practice. Plan of care will be reviewed and updated as necessary. 3. What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur. Nursing staff will be educated on using and documenting non-pharmacological interventions prior to giving PRN pain medications. 4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. Audit of documentation of PRN pain management 1x per week for 1 month and 2x per month for 1 month. Audit		

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F 757	Continued From page 73 nurse practitioner (NP) for a follow-up visit with notation of R4 having been hospitalized until 7/9/24 for a femur fracture and post-surgical infection. The note outlined R4's pain regimen with dictation, " ... Reports pain increased overnight last night and some difficulty sleeping but overall well controlled. Seen working with PT [therapy] prior to visit and no observed significant pain. PT reports [R4] is able to perform all exercises with some pain but overall she does not feel it is interfering with [R4] progress." The NP identified R4 was consuming the narcotic 2-3 times per day and listed several orders including, "DECREASE dilaudid frequency to BID PRN [twice daily, as needed] - separate doses by at least 4 hours." On 8/7/24 at 8:52 a.m., R4 was observed in the dining room on her unit. R4 finished eating and stood up next to the table with nursing assistant (NA)-I immediately beside her. R4 took several steps using a front-wheeled walker and ambulated down the hallway to her room without any obvious physical signs of pain (i.e., grimace, moaning) present. Following, at 9:01 a.m., R4 was interviewed and stated she felt her pain was being well-managed at the care center. R4 stated she was taking the hydromorphone "since I've been here" and expressed the NP was "trying to take me off it before I go home." R4 stated the staff had not offered or asked about ice packs or heat packs before giving the narcotic before but expressed she was open to trying such interventions, if offered. R4's Medication Administration Record (MAR), dated August 2024, identified R4's consumed medications for the month-period. This included R4's hydromorphone with directions, " ... 2 mg by	F 757	review and analysis will be brought to QAPI to determine ongoing frequency and duration of audits. 5. Director of Nursing and/or designee will ensure compliance. The date that each deficiency will be corrected on September 5, 2024.		

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F 757	Continued From page 74 mouth every 12 hours as needed ...," with a corresponding pain level being written with each recorded administration. A total of six administrations for the month, so far, had been recorded as follows: On 8/1/24 at 3:30 a.m., for pain rated nine out of 10 with the dose being effective. A corresponding progress note, dated 8/1/24, identified the medication was given with dictation, " ... Resident requested and given for right hip pain. Rated pain as 9/10 on the pain scale." However, the note lacked further information on what, if any, physical symptoms were demonstrated (i.e., grimace, crying) or what, if any, non-pharmacological interventions were offered or refused prior to the narcotic being given. On 8/2/24 at 12:17 a.m., for pain rated 10 out of 10 with the dose being effective. A corresponding progress note, dated 8/2/24, identified the medication was given with dictation, " ... Resident requested and given for right hip pain. Rated pain as 10/10 on the pain scale at this time." However, the note lacked further information on what, if any, physical symptoms were demonstrated (i.e., grimace, crying) or what, if any, non-pharmacological interventions were offered or refused prior to the narcotic being given. On 8/2/24 at 11:17 p.m., for pain rated nine out of 10 with the dose being effective. A corresponding progress note, dated 8/2/24, identified the medication was given, however, lacked any further dictation or rationale for the medication; nor information on what, if any, physical symptoms were demonstrated (i.e., grimace, crying) or what, if any, non-pharmacological interventions were offered or refused prior to the	F 757			

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F 757	Continued From page 75 narcotic being given. On 8/4/24 at 1:28 a.m., for pain rated nine our of 10 with the dose being effective. A corresponding progress note, dated 8/4/24, identified the medication was given, however, lacked any further dictation or rationale for the medication; nor information on what, if any, physical symptoms were demonstrated (i.e., grimace, crying) or what, if any, non-pharmacological interventions were offered or refused prior to the narcotic being given. On 8/4/24 at 7:05 p.m., for pain rated 10 out of 10 with the dose being effective. A corresponding progress note, dated 8/4/24, identified the medication was given with dictation, " ... Res c/o [complain] pain 10/10 on right hip." However, the note lacked further information on what, if any, physical symptoms were demonstrated (i.e., grimace, crying) or what, if any, non-pharmacological interventions were offered or refused prior to the narcotic being given. On 8/5/24 at 7:41 a.m., for pain rated eight out of 10 with the dose being effective. A corresponding progress note, dated 8/5/24, identified the medication was given, however, lacked any further dictation or rationale for the medication; nor information on what, if any, physical symptoms were demonstrated (i.e., grimace, crying) or what, if any, non-pharmacological interventions were offered or refused prior to the narcotic being given. R4's medical record was reviewed and lacked evidence non-pharmacological interventions had been attempted prior to the administration of the PRN narcotic medication despite newly			F 757			

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F 757	Continued From page 76 care-planned, effective non-pharmacological interventions for her pain being listed and the medical provider actively trying to decrease the frequency of the narcotic use. When interviewed on 8/7/24 at 9:48 a.m., NA-F stated they had worked with R4 prior but had not, at least to their recall, ever heard R4 complain about pain adding, "I've never heard her." NA-F stated they had not offered or given R4 ice packs or anything; nor had they ever been told to by the nurses adding, "Not that I know of." NA-F verified R4 was working with therapy and reiterated R4 had not complained about pain to their recall adding, "I never see her do that [pain symptoms]." On 8/7/24 at 9:51 a.m., registered nurse (RN)-A was interviewed. RN-A verified they had worked with R4 prior and explained she (R4) had hydromorphone ordered "two times max a day" for pain. RN-A stated R4 would most often have pain in the early morning but added the pain, overall, seemed to be "going down a little bit." RN-A stated with use of as-needed pain medications, including narcotics, the staff should be trying ice or "topicals" prior to giving it. RN-A reviewed R4's medical record and stated R4 used to have an order for ice to be applied but added, "We might have taken it out." RN-A verified non-pharmacological interventions should be attempted prior to a as-needed narcotic being given and recorded in the progress notes adding, "Technically, that's what were supposed to do." RN-A stated it was important to attempt non-pharmacological interventions and chart them to help ensure "the least dose" of medication is used adding, "If it's not charted, it's not done."			F 757			

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F 757	Continued From page 77	F 757			
F 758 SS=D	When interviewed on 8/7/24 at 11:25 a.m., registered nurse manager (RN)-E verified they had reviewed R4's medical record, and they "could not find anything non-pharmacological [recorded]," adding further, "The expectation is they're offered prior." RN-E stated the care center was looking into building non-pharmacological use into the order set and verified they should be offered, attempted and recorded with as-needed narcotic use adding such was important due to "medications can have side effects, so if they can be avoided [better]." A facility' policy on as-needed narcotic management was not provided. 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 unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record;	F 758		9/5/24	

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F 758	Continued From page 78 §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 observation, interview, and document review, the facility failed to ensure an appropriate indication was given for continued antipsychotic medication use for 1 of 5 residents (R68) reviewed for unnecessary medications. Findings include: R68's quarterly Minimum Data Set (MDS) dated 7/15/24, indicated R68 had severely impaired			F 758	1.What corrective actions(s) will be accomplished for those residents found to have been affected by the deficient practice. R68 -Seroquel was discontinued on 8/8/24 per pharmacy recommendation. Care plan was updated 2.How you will identify other residents		

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F 758	Continued From page 79 cognition and was diagnosed with dementia, anxiety, depression, and a stroke. The MDS indicated R68 had no signs of psychosis such as hallucinations or delusions and did not have behavioral symptoms during the look-back period (LBP). The MDS indicated R68 was dependent on staff for all activities of daily living and was receiving hospice services. R68's medical diagnoses report dated 1/16/24, indicated R68 had dementia "without behavioral disturbance". R68's Order Summary Report dated 1/16/24, included an order dated 1/16/24, for quetiapine (an antipsychotic medication) 12.5 milligrams (mg) every evening for "agitation". R68's care plan dated 1/29/24, indicated R68 had a "behavioral problem" related to dementia and would call out for family members as well as experience hallucinations and delusions. The care plan indicated facility staff were to document behaviors and the potential causes. The care plan indicated staff could intervene by giving reassurance, using distraction, "rest", or providing a less stimulating environment. The care plan dated 1/17/24, indicated R68 used psychotropic medications related to "dementia and end of life". The care plan indicated staff were to record occurrences of target behavior symptoms including agitation, restlessness, sadness, and isolation. R68 Medication Administration Record (MAR) dated 5/1/24 through 8/6/24, indicated nursing staff were to document if behaviors were observed related to quetiapine use and "no" was charted daily during the period.			F 758	having the potential to be affected by the same deficient practice and what corrective action will be taken. All residents who are prescribed Psychotropic Medications have the potential to be affected by the deficient practice and plan of care will be reviewed and updated as needed. Medications are reviewed on a monthly basis by the consultant pharmacist. 3.What measures will be put in place or what systemic changes will you make to ensure that the deficient practice does not recur. Education to be provided to nurses and providers on the importance of having the proper diagnosis for psychotropic medications. 4.How the corrective actions(s) will be monitored to ensure deficient practice will not recur, i.e., what quality assurance program will be put into practice. Audits related to the use of psychotropic medications and proper medical diagnosis 1x per week for 1 month and 2x per month for 1 months. Audit review and analysis will be brought to QAPI to determine ongoing frequency and duration of audits. 5.DON and/or designee will ensure compliance. The date of compliance is September 5, 2024		

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F 758	Continued From page 80 R68's Behavior Monitoring and Interventions report dated 5/21/24 through 8/8/24 indicated, facility staff documented whether R68 had behaviors, what these behaviors were, and what interventions were taken approximately every shift. All entries during this period were documented as "no behaviors observed" or "not applicable". R68's progress note dated 5/21/24 at 12:42 p.m., indicated R68 was sleeping and had no behaviors or hallucinations that morning. R68's provider note dated 5/21/24, indicated R68 was "declining" and was on hospice. The note indicated R68 was "mostly sleeping" and "mostly nonverbal". The note indicated R68 was confused but had no behaviors. R68's Consultant Pharmacist Recommendation to Physician dated 6/23/24, indicated R164 was receiving quetiapine for a diagnosis of agitation "which is not considered an appropriate indication for antipsychotic use." The report indicated if the antipsychotic use was to continue, to clarify the appropriate diagnosis. The provider responded on 7/15/24 by indicating the associated diagnosis was "behavioral or psychological symptoms of dementia (BPSD) that present a danger to the resident or others". R68's provider note dated 7/22/24, indicated R68 had severe dementia and was "nonverbal". The note indicated R68 appeared comfortable and was sleeping. The note did not indicate what behaviors or psychological symptoms of dementia that R68 had that would present a danger to R68 or others.	F 758			

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F 758	Continued From page 81 R68's progress note dated 8/3/24 at 8:33 a.m., indicated R68 had yelled out for family early in the morning but was now sleeping. R68's progress notes dated 5/21/24 through 8/5/24 were reviewed and did not indicate R68 had presented with behaviors that were a danger to the resident or others. During an interview and observation on 8/6/24 at 9:22 a.m., nursing assistant (NA)-A stated she worked with R68 frequently and had noticed that he got "confused". NA-A stated if R68 was left in his wheelchair for a while, R68 would become "very uncomfortable" and then somewhat restless but once they would move him out of his wheelchair into bed, they did not notice any restlessness. NA-A stated she had not noticed R68 having any other behaviors. R68 was observed sitting in his wheelchair in his room with his eyes closed and no signs of agitation. During an interview on 8/6/24 at 1:59 p.m., NA-B stated R68 was "always sleeping" and she had not noticed any behaviors or agitation. During an interview on 8/6/24 at 2:00 p.m., registered nurse (RN)-F stated she was the nurse in charge of R68's care. RN-F stated R68 was "usually just dosing off" and she had not noticed any behaviors or signs of agitation. During an interview on 8/7/24 at 11:17 a.m., nurse practitioner (NP)-A stated she had been working with R68 since April of this year. NP-A stated it looked like quetiapine had been started in January for "behavioral issues". NP-A stated she had signed the pharmacist review dated 6/23/24.	F 758			

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F 758	Continued From page 82 NP-A stated the resident was "so new" to her so she was unsure if R68 was currently or previously had behavioral symptoms that were a danger to himself or others. NP-A stated she now reviewed the medical record and did not see any behaviors documented since April of this year. NP-A stated she was not sure why "behavioral or psychological symptoms of dementia (BPSD) that present a danger to the resident or others" was the diagnosis chosen as she did not see documentation that this was correct. NP-A stated if R68 was having behavioral symptoms warranting antipsychotic use, she would have expected nursing staff to document these symptoms. NP-A stated she would defer to the assistant director of nursing (ADON) as she knew the resident and what behaviors he might be presenting with, better than she would. During an interview on 8/7/24 at 12: 42 p.m., the ADON stated she had reviewed the medical record and did not see any evidence of active behaviors or signs of agitation for R68. The ADON stated she knew he had a history of hallucinations but did not see evidence in the medical record that those were still present. The ADON stated she had reviewed R68's pharmacist review dated 6/23/24 and acknowledged that R68 did not have any behaviors that made him a danger to himself or others and was unsure why the provider had selected that as the diagnosis. The facility policy dated Medication Monitoring and Management dated 5/22, was received but did not address indications for antipsychotic use.	F 758			
F 791 SS=D	Routine/Emergency Dental Srvcs in NFs CFR(s): 483.55(b)(1)-(5)	F 791			9/5/24

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F 791	Continued From page 83 §483.55 Dental Services The facility must assist residents in obtaining routine and 24-hour emergency dental care. §483.55(b) Nursing Facilities. The facility- §483.55(b)(1) Must provide or obtain from an outside resource, in accordance with §483.70(g) of this part, the following dental services to meet the needs of each resident: (i) Routine dental services (to the extent covered under the State plan); and (ii) Emergency dental services; §483.55(b)(2) Must, if necessary or if requested, assist the resident- (i) In making appointments; and (ii) By arranging for transportation to and from the dental services locations; §483.55(b)(3) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay; §483.55(b)(4) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; and §483.55(b)(5) Must assist residents who are	F 791			

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F 791	Continued From page 84 eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State plan. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the need for routine dental care (i.e., dental appointment) was assessed and, if needed or wanted, offered to promote oral hygiene and reduce the risk of complication for 1 of 1 resident (R4) reviewed who reported losing their dentures just prior to admission. Findings include: R4's admission Minimum Data Set (MDS), dated 7/15/24, identified R4 admitted to the care center on 7/9/24 from the acute care hospital. The MDS outlined R4 had intact cognition and demonstrated no delusional thinking. Further, The MDS recorded under, "Section L - Oral/Dental Status," R4 had no broken or loosely fitting dentures, abnormal mouth tissue, or obvious cavities with a check placed next to the option reading, "Z. None of the above were present." R4's Clinical Census listing, printed 8/6/24, identified R4's current payer source was listed as, "MSHO Medicaid." On 8/5/24 at 1:15 p.m., R4 was interviewed and stated she admitted to the care center about a month prior. R4 was asked if she had any issues with her teeth or dental care while at the care center, and R4 responded she had "no teeth" on the top palate and only a few remaining on the bottom palate. R4 stated she had "lost my dentures" at the hospital prior to admitting to the	F 791	1.What corrective actions(s) will be accomplished for those residents found to have been affected by the deficient practice. R4 discharged on 8/21/2024 2.How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. All residents have the potential to be affected by the deficient practice and plan of care of all residents requesting dental follow up. All residents have the right to request a dental appointment. Residents will be reviewed on admission and at quarterly care conferences for dental needs. 3.What measures will be put in place or what systemic changes will you make to ensure that the deficient practice does not recur. Residents will be reviewed on admission and at quarterly care conferences for dental needs. The facility will ensure all requested dental needs will be followed up on and coordinated with the resident' s dental provider. 4.How the corrective actions(s) will be monitored to ensure deficient practice will not recur, i.e., what quality assurance program will be put into practice.		

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F 791	Continued From page 85 care center and, so far, nobody from the care center had discussed or asked about getting a dental appointment made to possibly get new ones. R4 reiterated she'd like to pursue getting new dentures, if able, adding not having them was frustrating as it was "hard to chew without [them]." R4's Nurse Admission/Readmission 05212021 - V15, dated 7/10/24, identified R4 admitted from the hospital and listed a primary rationale for admission, "TCU- [transitional care unit]." The evaluation contained a section labeled, "Oral Status," which had a checkmark placed next to the option reading, "Broken or loose fitting full or partial denture ...," and a location of broken, carious or missing teeth listed, "Upper gum." The evaluation outlined R4 used an upper denture and a partial lower denture; however, the evaluation lacked any information or evidence of when R4's last dental visit had been or if was was currently wanted/needed. R4's Social Service Care Conference - IDT 03302021 - V3, dated 7/26/24, identified R4's care conference was held with R4 present. The form outlined spaces for respective disciplines to record information including, "Section E: Social Services," which contained a subsection asking, "Any referrals needed (podiatry, optometry ...);," however, this section was left blank. The completed summary lacked evidence what, if any, appointments were asked or offered to R4. R4's care plan, dated 8/5/24, identified a section for oral health which was initiated on 8/5/24 and outlined, "The resident has potential oral/dental health problems r/t [related to] denture fit." The care plan listed interventions to help R4 remain	F 791	Audit all residents who require dental access 1x per week for 1 month and 2x per month for 1 month. Audit review and analysis will be brought to QAPI to determine ongoing frequency and duration of audits. 5. DON and/or designee will ensure compliance. The date of compliance is September 5, 2024		

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F 791	Continued From page 86 free of oral infection or pain which included, "Coordinate arrangements for dental care, transportation as needed/as ordered." When interviewed on 8/6/24 at 10:08 a.m., nursing assistant (NA)-F stated they had worked with R4 prior. NA-F explained R4 did not, at least to their knowledge, have their own teeth and used dentures but often didn't wear them adding, "I've never seen her put it on [in] before." NA-F stated they were unsure if R4's dentures were even at the care center or not and expressed R4 had never made any comments about them. NA-F stated any dental appointments, if needed or wanted, would be made by the nurses. At 10:11 a.m., NA-F and the surveyor checked R4's room for what, if any, dentures were present. R4 was present laying in her bed and stated aloud, "I don't have none." NA-F verified no dentures were present. R4's medical record was reviewed and lacked evidence R4 had been asked, offered or referred to a dental provider despite admitting to the care center nearly a month prior and being assessed upon admission as having potential broken or loose-fitting dentures. When interviewed on 8/6/24 at 10:23 a.m., licensed practical nurse (LPN)-B stated dental care, including the need or desire for an appointment, was done upon admission and recorded "in the admission assessment [i.e., Nurse Admission/Readmission]." LPN-B stated if there was concerns or complaints about dentition then, it would be referred to the dental provider and, if not, then re-evaluated in three months during the next routine review (i.e., MDS cycle). At 10:25 a.m., the medical records coordinator	F 791			

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F 791	Continued From page 87 (MRC) joined the interview and verified they scheduled appointments for the campus. MRC stated R4 had not yet been scheduled for any dental appointments and nobody had referred any concerns about it to them. MRC stated they would go follow-up with R4 about it. On 8/6/24 at 1:44 p.m., the assistant director of nursing (ADON) was interviewed, and verified they had followed up on R4's dental appointment adding MRC was "working on" getting R4 scheduled for one now. ADON stated the nurses complete the admission assessments and, from that, information gets pulled to the care plan adding the care conference is also an opportunity to record what, if any, appointments are needed or offered but R4's section "was blank." ADON stated residents' on the TCU are usually "more therapy focused" but verified dental appointments and the need for such "should be looked at." ADON verified the medical record lacked evidence R4 had been offered or evaluated for what, if any, dental appointments were needed or wanted; and expressed the care center was looking at their assessments to see if they could add more to them to ensure it was addressed. ADON stated it was important to ensure dental needs were offered or provided to ensure "we're getting their needs [met] and continuity of care." A provided Dental Services policy, dated 2/2022, identified routine and emergency dental services were available to meet resident' oral health needs in accordance with the assessment and plan of care. The policy outlined the social services team would assist with appointments, transportation arrangements and reimbursement, if needed. The policy concluded, "All dental services provided are recorded in the resident's medical	F 791			

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F 791	Continued From page 88 record."	F 791			
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility 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 take appropriate steps to ensure the proper sanitization of dishware used for meal preparation and resident service when 1 of 1 high-temperature commercial dishwashers was identified as not reaching adequate final rinse temperature (i.e., 180 F). This had potential to affect all 80 residents within the nursing home, staff, and visitors who consumed food from the main production kitchen. Findings include:	F 812	1. Dishwasher temperatures were reviewed upon notification. 2. This citation has the potential to affect all residents. Dishwasher was serviced and repaired on August 6, 2024. 3. The Dietary Manager and/ or designee will conduct re-education for all staff responsible for dishwashing on proper use of the dishwashing machines and logging temperatures appropriately.	8/30/24	

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F 812	Continued From page 89 On 8/5/24 at 7:06 p.m., a kitchen tour was completed with dietary staff (DS)-A and DS-B present. A single Hobart Tempstar commercial dishwasher was present along the wall with several hard plastic racks placed in front of the machine on the floor. DS-B loaded several metallic cookware pans onto other hard plastic racks and placed them into the dishwasher. A single, white-colored gauge present on top of the machine which did not move for the entirety of the wash or rinse cycle. A silver-colored plate was mounted to the side of the machine, under the counter area, which identified the make and model of the dishwasher along with, "Minimum Rinse Temperature ... 180 F [Fahrenheit]." DS-B moved the stacked hard-plastic racks from in front of the machine which exposed two, white-colored analog gauges labeled, "R" and "W," respectively. Both gauges were covered with a hard white film. DS-B stated these gauges were for the dishwasher temperatures. DS-B stated she is not able to read the gauges and requested DS-A assistance. DS-A verified that she cannot read the gauges on the dishwasher. DS-A verified that she does write on the dishwasher temperature log and verified again that she is unable to read the gauges due to the gauges being full of a hard white film. Surveyor was unable to read the temperature on the gauges. On 8/06/24 at 8:13 a.m., an additional follow-up kitchen tour was completed with dietary manager (DM). DM verified the dishwasher is a high temperature dishwasher and needs to 180 F. DM rinsed a few dishes, set them in onto other hard plastic racks and placed them into the dishwasher. The dishwasher was run at least four times with the highest temperature of 172 F. DM stated the dishwasher was serviced last week.	F 812	4. Audits of dishwasher temperatures daily x2 weeks, then weekly x2, then monthly x2 to ensure temperatures are recorded accurately. Audit results will be taken to the QAPI committee for further recommendations. 5. Administrator and/or designee will ensure compliance. Date Compliant 8/30/24		

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F 812	Continued From page 90 DM stated it is important the dishwasher is reaching 180 F "so the dishes are getting sanitized or there is risk for food borne illnesses." On 8/6/24 at 8:37 a.m., DS-A verified that when they checked the temperature on the dishwasher this morning it was "121 and 127 degrees," and verified the log sheet was not recorded correctly. DS-A verified, "the dishwasher did not reach 184 this morning even though the log sheet says it does." On 8/06/24 at 2:22 p.m., administrator verified that he was notified this morning of the dishwasher not reaching temperature and was going to follow up now to see if the service company had been out today to fix the issue. Administrator stated that if the issue has not been addressed then the facility would be using paper and plastic products until the dishwasher is fixed to ensure resident safety. On 8/06/24 at 2:35 p.m. DM and administrator met with surveyor. DM informed surveyor that the dishwasher was reaching temperature and dishwasher cycle and was observed to have reached 184 F. DM stated, "we ran a lot of cycles to get it to hit temp," and verified the cycles ran this morning with temperatures not meeting the required 180 F. Administrator stated the facility will use paper and plastic until the dishwasher can be serviced due to the inconsistency of the temperatures. On 8/07/24 at 11:45 a.m., administrator updated surveyor that the dishwasher was just fixed. Administrator stated they fixed a pressure valve that was malfunctioning causing the dishwasher to not reach temperature consistently.	F 812			

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F 812	Continued From page 91 During observation on 8/07/24 at 12:06 p.m., temperature on dishwasher was observed and reached 186 F. A provided Cleaning Dishes/Dish Machine policy, dated 2017, identified all flatware, serving dishes, and cookware will be cleaned, rinsed and sanitized after each use. The policy outlined, "Staff should check the dish machine gauges throughout the cycle to assure proper temperatures for sanitation [sic]," along with a corresponding table which outlined the type(s) of dish machines and their corresponding final rinse temperatures. This included, "High Temperature Dishwasher ... 180 F."	F 812			
F 883 SS=D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative	F 883			9/5/24

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F 883	Continued From page 92 was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure recommended pneumococcal immunizations, as outlined by the Centers for Disease Control (CDC), were offered	F 883	1.What corrective actions(s) will be accomplished for those residents found to have been affected by the deficient practice.		

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F 883	Continued From page 93 and/or provided in a timely manner to reduce the risk of severe disease for 1 of 5 residents (R18) reviewed for immunizations. This had the ability to affect all 80 residents residing the in the facility Findings include: A CDC Pneumococcal Vaccine Timing for Adults feature, dated 3/2023, identified several tables with corresponding recommendations when to receive various versions (i.e., PPSV23, PCV13, PCV20) of the pneumococcal vaccine. The graph labeled, "Adults 19-64 years old with chronic health conditions ...," identified persons who received only a PPSV23 had an option to either get a PCV15 or PCV20 a year after the last PPSV23 dose. The conditions listed including alcoholism and cigarette smoking. Further, The graph labeled, "Adults [at or older than] 65 years old," outlined persons with a complete series of pneumococcal vaccination (i.e., PCV13 at any age, PPSV23 at or above 65 years old) should have shared clinical decision-making between the resident and healthcare provider to determine if PCV20 was appropriate. R18's quarterly Minimum Data Set (MDS) dated 7/3/24, indicated R18 admitted to the facility in March of 2024, was 82 years old and had intact cognition. R18 had diagnoses of Alzheimer's disease (a type of dementia that affects memory, thinking, and behavior), anemia, high blood pressure, kidney failure, anxiety, and depression. R18's Minnesota Immunization Information Connection form dated 3/22/24 indicated R18 received the PPSV23 most recently on 10/4/07, and received the PCV-13 on 1/26/15, prior to her admission.			F 883	R18 received her pneumococcal vaccination on 8/8/24 2.How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. All residents have the potential to be affected by the deficient practice. consent forms for all residents reviewed to ensure no outstanding pneumococcal immunization needed. Pneumococcal immunization given to any resident that is eligible and consented to the vaccine. 3.What measures will be put in place or what systemic changes will you make to ensure that the deficient practice does not recur. Education will be provided to IP regarding the regulations for pneumococcal immunizations. IP or designee will offer recommended vaccines at admission and ensure consent forms are completed. IP or designee will circle back routinely to residents that have refused for reeducation or change of mind and will offer recommended immunizations if resident consents. 4.How the corrective actions(s) will be monitored to ensure deficient practice will not recur, i.e., what quality assurance program will be put into practice. Audit□s all residents to identify outstanding Pneumococcal Vaccine orders 1x per week for 1 month and 2x per month for 1 months. Audit review and		

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F 883	Continued From page 94 R18's PointClickCare (electronic medical record) Clinical Immunization form, printed 8/7/24, did not include further record of a pneumococcal vaccine. A review of R18's medical record did not include, based on shared clinical decision making, R18 had been offered and/or provided the PCV-20 per CDC guidelines. A facility form titled Revolving Immunization Consent or Declination, dated, 3/12/24 and signed by R18 indicated R18 consented to receive the influenza vaccination, the pneumococcal vaccination, and the COVID vaccination per CDC guidelines. During interview on 8/6/24 at 2:25 p.m., the assistant director of nursing (ADON) verified responsibility as the facility's infection preventionist (IP). The ADON explained when a resident admitted to the facility, the admission nurse was responsible for consenting the resident for vaccines and providing the Vaccine information Sheet (VIS). The ADON stated the consent forms were reviewed and entered into the vaccine spreadsheet tracking log to maintain which residents consented to receive or declined the vaccines. The ADON stated a resident's immunization records were reviewed and the CDC's mobile app, PneumoRecs VaxAdvisor, was utilized to determine a resident's pneumococcal vaccination eligibility. The ADON stated it was important to assess a resident's vaccination status and offer eligible vaccinations because residents living in closer quarters, and it placed them at a higher risk for "getting things". The ADON reviewed the spreadsheet tracking log for R18 and stated it appeared R18 had refused the pneumococcal vaccinations. The ADON			F 883	analysis will be brought to QAPI to determine ongoing frequency and duration of audits. 5. Director of Nursing and/or designation will ensure compliance. The date of compliance is September 5, 2024		

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F 883	Continued From page 95 reviewed R18's electronic health record (EHR) and verified her consent to receive the pneumococcal vaccination dated 3/12/24 and verbalized being unsure of what happened, but "maybe it fell through the cracks." The ADON stated R18 initially refused the vaccinations but later changed her mind and the spreadsheet was not updated. During interview on 8/7/24 at p.m., the director of nursing (DON), stated there was a formal audit system in place to ensure vaccinations statuses are checked and updated and stated the vaccination would of been found on the next audit. A facility policy titled Pneumococcal Vaccine last reviewed 7/24, indicated all residents would be offered pneumococcal vaccines to aid in preventing pneumonia/pneumococcal infections. The policy indicated prior to admission, residents would be assessed for eligibility to receive the pneumococcal vaccine series, and when indicated, will be offered the vaccine series within thirty (30) days of admission to the facility unless medically contraindicated or the resident has already been vaccinated. Furthermore, the policy indicated assessments of pneumococcal vaccination status would be conducted within five (5) working days of the resident's admission if not conducted prior to admission, and administration of the pneumococcal vaccines or revaccinations would be made in accordance with current CDC recommendations at the time of the vaccination.	F 883			



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
August 19, 2024

Administrator
St Anthony Park Home Inc
2237 Commonwealth Avenue
Saint Paul, MN 55108

Re: State Nursing Home Licensing Orders
Event ID: 9TEN11

Dear Administrator:

The above facility was surveyed on August 5, 2024 through August 7, 2024 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

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

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

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

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

Pete Cole, RN Regional Operations Supervisor
Metro Team C District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
625 Robert Street N
P.O. Box 64975
Saint Paul, Minnesota 55164-0975
Email: peter.cole@state.mn.us
Office/Mobile: (651) 249-1724

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

Please feel free to call me with any questions.



Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

Minnesota Department of Health

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NAME OF PROVIDER OR SUPPLIER ST ANTHONY PARK HOME INC			STREET ADDRESS, CITY, STATE, ZIP CODE 2237 COMMONWEALTH AVENUE SAINT PAUL, MN 55108		
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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 8/5/24 to 8/7/24, a licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). In addition, a complaint investigation was completed. Your facility was found not in compliance with the MN State Licensure and the following correction orders are issued. Please	2 000			

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Electronically Signed

TITLE

(X6) DATE

08/29/24

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00997	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 08/07/2024
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2 000	Continued From page 1 indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed. In addition to the recertification survey, the following complaints were reviewed with no deficiency issued. H50636482C (MN00105311) H50636224C (MN00105091) H50636503C (MN00105012) H50636504C (MN00104098) H50636502C (MN00103235) H50636501C (MN00103146) H50636506C (MN00103134) H50636500C (MN00098733) H50636507C (MN00098507) H50636721C (MN00105515) The following complaints were reviewed with deficient practices identified related to survey findings. H50636568C (MN00105432) - Licensing order issued at 0900 H50636505C (MN00105028) - Licensing order issued at 0900 MDH 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 asevidence by." Following	2 000			

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2 000	Continued From page 2 the surveyors findings are the Suggested Method of Correction and Time period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "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			
2 830	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	2 830			9/5/24

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2 830	Continued From page 3 of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure behaviors of potential wandering were comprehensively assessed and, if needed, interventions placed to ensure safety and prevent elopement for 1 of 1 residents (R330); and failed to ensure fall interventions were implemented to prevent fall and injury for 1 of 3 residents (R64) reviewed for falls and accidents. Findings include: R330 R330's Nurse Admission/Readmission 05212021 - V15, dated 7/31/24, identified R330 admitted to the care center from the hospital. R330 was recorded as being alert to person and time, however, not to place or aware of her clinical situation with an option being checked, "Short term memory loss." The evaluation concluded with a section labeled, "Admission Summary," which outlined, " ... alert and oriented X2 with forgetfulness ... assist of one with cares ... ". On 8/5/24 at 2:35 p.m., R330 was observed lying on her bed while in her room which was at the end of a hallway next to a stairwell. R330 smiled at the surveyor upon entrance to the room and expressed aloud, "You remember me?!" R330	2 830	"Corrected"		

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2 830	Continued From page 4 added, "I'm your first cousin!" R330 stated she had been at the care center "just a few days." R330 had flip-flop style shoes in place on her feet, however, did not have any visible wanderguard devices (alerts when attempting to leave an area or building) on her person. Immediately following, at 2:39 p.m., registered nurse (RN)-B was interviewed and stated R6 was "very confused." RN-B stated R6 could "fool you" for awhile but had impaired cognition adding it had been like that since she admitted. R330's initial Elopement Risk Evaluation - V2, dated 8/2/24, identified R330 was non-ambulatory or able to self propel her wheelchair, did not have a history of exit-seeking, and had not eloped or attempted to elope from the facility since the previous observation. The option to select which read, "3. Resident is a new admit," was left unchecked. The evaluation determined R330 was at low-risk for elopement and listed spacing to record what, if any, interventions were implemented including a personal safety alarm, exit alarm, or visual barriers. However, these were all left unchecked. The evaluated concluded, "Was the care plan: Initiated [marked]." However, R330's progress note, dated 8/3/24 at 2:03 p.m., identified R330 was seen wandering on another floor looking for the bathroom. The note outlined, "During breakfast, Staff was unable to locate resident on her floor and found resident on the first floor, towards the front entrance, sitting on the couch [sic]. It appears as if resident did not remember how to get back to her floor. Resident was redirected." The note lacked what, if any, interventions to reduce the risk of wandering and/or subsequent potential elopement were placed or offered.	2 830			

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2 830	Continued From page 5 When interviewed on 8/6/24 at 9:52 a.m., nursing assistant (NA)-G stated they had worked with R330 the evening prior and was again assigned to her care for the current shift. NA-G stated R330 was ambulatory but only walking "mostly with therapy" and rarely, if ever, found to be self-transferring. NA-G stated they were "not really sure" if R330 used or wanderguard-type device or if she'd been wandering since admission adding, "I worked with her only once." R330's care plan, dated 8/2/24, identified R330 was at low risk for elopement/wandering and listed a goal, "The resident's safety will be maintained through the review date," along with a single intervention which read, "Assess elopement status quarterly and as needed." The care plan lacked evidence or intervention after being found on another unit near the entrance (progress note, dated 8/3/24). Further, R330's medical record was reviewed and lacked evidence R330 had been comprehensively reassessed for wandering or a potential elopement risk despite being found on a different floor near the exit of the building. When interviewed on 8/6/24 at 10:13 a.m., licensed practical nurse (LPN)-B explained they were currently assigned care for R330 but had also worked with her prior since she admitted a week or so prior. LPN-B verified R330 had cognitive impairment and stated she needed help with transfers and could move with some assistance needed. LPN-B stated they were unaware of any wandering episodes for R330, and explained any re-evaluation of their wandering risk would be "according to how alert and oriented they [resident] are." LPN-B stated they felt R330, if found to be wandering at some	2 830			

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2 830	Continued From page 6 point, would likely need a wanderguard adding, "I would think she would need one." LPN-B stated this was due to R330 not always knowing where she was and being 'forgetful.' Further, LPN-B stated any re-assessment of the need for a wanderguard or similar intervention would be done by the nurse manager or director of nursing (DON) adding, "[They] can do their little assessment and say yay or nay." On 8/6/24 at 11:27 a.m., registered nurse manager (RN)-E was interviewed, and verified they had reviewed R330's medical record. RN-E stated the IDT was aware of R330's episode of being found on the first floor and had verbally discussed it, however, felt since it was not actually 'exit-seeking' that a wanderguard wasn't needed. However, RN-E stated the floor staff were going to repeat the elopement screening tool as R330 was now more ambulatory, and they verified the record lacked any re-evaluation despite R330 being found by an entrance on another floor days prior. RN-E stated if staff see behaviors of exit-seeking or wandering, then it should be reported and it was important to do an evaluation "so staff is aware and it's communicated and her [R330] safety is maintained." A provided Resident Elopement policy, dated 6/2022, identified staff should report any resident who attempts to leave the premises or is missing. The policy outlined procedures to follow when a resident including upon a resident return (if discovered as missing) which included, "Apply a wander guard bracelet with MD order as needed," and, "Document relevant information in the resident's medical record." However, the policy lacked information on how wandering, including with potential to elope, would be evaluated or	2 830			

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2 830	Continued From page 7 assessed and care-planned (i.e., frequency, person responsible). R64 R64's significant change MDS dated 5/12/24, indicated R64 had severely impaired cognition and had no rejection of care behaviors. The MDS indicated R64 was diagnosed with dementia, kidney disease, and diabetes. The MDS indicated R64 used a walker as a mobility device and was independent with transferring and walking. R64's care plan dated 5/3/24, indicated R64 was a "high risk" for falls related to impulsivity and a history of falls. The care plan indicated staff were to anticipate and meet R64's needs and R64 needed prompt responses to all requests for assistance. The care plan indicated R64 required the assistance of one staff member with ambulation and used a walker. The care plan did not include R64's need for reminders to use his walker. R64's incident report dated 7/19/24 at 11:57 p.m., indicated R64 had an unwitnessed fall and R64 reported that he was unable to grab his walker because it was too far from him. The report included a "predisposing situation factors" section with using a walker selected. The report indicated immediate action taken was assessing R64's vital signs and assisting R64 back to bed. The report did not include what fall interventions were newly attempted to prevent further falls based on a root cause analysis of the fall. R64's medical record was reviewed and did not include what if any, new fall interventions were attempted after the fall on 7/19/24 based on a root cause analysis.	2 830			

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2 830	Continued From page 8 During an observation on 8/6/24 at 9:13 a.m., R64 was observed walking in his room, barefoot, with no walker. NA-B was observed in the room, facing R64 but assisting his roommate. R64 was observed to bend over and attempt to pick something up off the floor. R64 was observed to walk out of his room with no walker and barefoot while occasionally using the wall for assistance when he stumbled, and NA-B was not observed reminding him to use his walker. R64 was observed to turn around and walk back into the room. R64 was observed to sit down in a chair and put socks on. R64's walker was not within reach from this R64's chair but was on the far side of the room. NA-B was then observed to leave the room and was not observed to move the walker closer to R64 or remind him to use it if he got up. At 9:24 a.m., R64 was observed stumbling towards the walker that was on the far side of the room and caught himself on the double closet doors. R64 was then observed to walk back to his chair without his walker and sit back down. On observation, signs, or visual reminders for R64 to use his walker were not noted. During an interview and observation on 8/6/24 at 9:32 a.m., NA-B stated she worked with R64 multiple days a week. NA-B stated R64 was independent with ambulation but was supposed to use his walker but commonly forgot it. NA-B acknowledged she had noticed R64 walking without his walker but had not attempted to redirect or remind R64 to use his walker before leaving the room. NA-B stated she thought he might have fallen in the past previously but was unsure. NA-B was observed reviewing R64's Kardex and stated it indicated R64 was supposed to have assistance while walking but "no one	2 830			

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2 830	Continued From page 9 [facility staff]" provided assistance to R64 during ambulation. During an interview on 8/7/24 at 12:36 p.m., the assistant director of nursing (ADON) stated R64 had fallen on 7/19/24 and after reviewing the medical record and the incident report with related notes dated 7/19/24, a fall analysis that had related interventions had not yet been implemented. The ADON stated R64 was impulsive, and they had talked about possible fall interventions this week, and they were going to implement a reminder such as signs in R64's room to remember his walker but had not gotten to it yet. The ADON stated R64 was independent with ambulation but needed frequent reminders to use his walker. The ADON stated R64's care plan and Kardex had not been updated to demonstrate this and continued to show he needed assistance with ambulation. The ADON stated she would now update the care plan and Kardex to demonstrate R64's current independence with ambulation with reminders to use a walker. During an interview on 8/7/24 at 1:28 p.m., the director of nursing (DON) stated they reviewed falls every morning and discussed possible root causes and ideally, this would be documented with appropriate care plan interventions but that might not always have been occurring. The facility Falls and Fall Risk Managing policy dated 10/4/21 indicated facility staff would identify fall interventions based on the resident's specific risk factors and potential fall causes to prevent further falls. SUGGESTED METHOD OF CORRECTION: The	2 830			

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2 830	Continued From page 10 director of nursing (DON), or designee, could review applicable policies on the evaluation of wandering, elopement and/or falls; then educate staff and audit to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one days	2 830			
2 900	MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure assessed and care-planned interventions for preventative skin care were consistently implemented for 1 of 1 residents (R31) reviewed for pressure ulcers. Findings include:	2 900	"Corrected"	9/5/24	

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2 900	Continued From page 11 R31's quarterly Minimum Data Set (MDS) dated 7/23/24, indicated R31 had severely impaired cognition with no hallucinations or delusions. Diagnoses included: dementia (loss of memory, language, problem,-solving and other thinking abilities that are severe enough to interfere with daily life), anxiety, depression, other frontotemporal neurocognitive disorder (progressive disease of the brain involving frontal and temporal lobes of the brain; can also be referred to as frontotemporal dementia), and polyosteoarthritis (type of arthritis that involves five or more joints at the same time). In addition, R31 was dependent on staff for all ADLs including bed mobility and all hygiene needs. In section H: Bladder and Bowel: section H0300 Urinary Continence: R31 was coded as "Always incontinent (no episodes of continent voiding)," and in section H0400: Bowel Continence: R31 was coded as "Always incontinent (no episodes of continent bowel movements)." In Section M: Skin Condition: M0150 risk of pressure ulcers: R31 was identified at risk for developing pressure ulcers. R31's care plan, printed 8/6/24, indicated R31 "has potential impairment to skin integrity r/t [related to] incontinence, immobility, impaired cognition, and history of pressure ulcer right heal," with the following interventions: -"reposition q[every] 2-3 hrs [hours] R31's care plan further indicated R21 has "functional bladder and blower incontinent r/t [related to] severe cognitive impairment d/t [due to] dx [diagnosis] of Frontotemporal Dementia" with the following interventions: - "BRIEF USE: The resident uses disposable XL yellow briefs, Change per schedule and prn [as needed]."	2 900			

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2 900	Continued From page 12 - "INCONTINENT: Check/change 2-3 hours and as required for incontinent. Wash, rinse and dry perineum. Change clothing PRN after incontinent episodes." Care plan further indicated, "ADL self-care needs total assist of one secondary to advanced dementia" with the following interventions: - "PERSONAL HYGIENE/ORAL CARE: The resident is totally dependent on (1) staff for personal hygiene and oral care." - "TOILET USE: The resident is not toileted. Dignity protocol every 2-3 hours." R31's progress notes, dated 7/9/24 to 8/7/24, were reviewed. Progress notes lacked evidence of R31 refusing staff assistance or documentation of any behaviors. R31's Kardex, printed 8/7/24, indicated R31 required assistance of 1-2 [staff] for bed mobility and to be repositioned every 2-3 hours. Furthermore, document identified R31 as "Incontinent: Check/change 2-3 hours and as required for incontinence. Wash, rinse and dry perineum. Change clothing PRN after incontinence episodes." During continual observation on 8/06/24: -8:42 a.m., R31 was observed to be seated at the dining room table in her wheelchair, facing the television with two other residents at the table with her breakfast tray in front of her. -8:56 a.m., R31 was assisted with her breakfast -9:34 a.m., R31 continues to sit in the dining room in the same position and a group activity was starting. -10:23 a.m., R31 continues to sit in her wheelchair in the same spot she had breakfast in. R31 has not moved from the location. -11:15 a.m., R31 continues to be seated in her	2 900			

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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
2 900	Continued From page 13 wheelchair in the dining room, in the same position and location. -11:39 a.m., R31 continues to be seated in her wheelchair in the dining room, in the same position and location. -12:15 p.m., R31 continues to be seated in her wheelchair in the same position, in the same location she has been in since observation began. -12:22 p.m., R31's meal is placed in front of her on the table. -12:30 p.m., staff sit next to R31 to assist with her meal. -1:54 p.m., R31 remains seated in the dining room, has not been repositioned or brought back to her room. -2:14 p.m., R31 remains in the dining room. R31 has been in the same location, in the same position (5 hours 32 minutes after observation began). -3:06 p.m., R31 was observed lying in bed. During interview on 8/06/24 at 2:04 p.m., nursing assistant (NA)-C stated the expectation is to check and change a resident that is incontinent is every 2 hours along with reposition them. NA-C verified they have not repositioned or changed R31 "since this morning before breakfast." NA-C verified this over two hours. NA-C stated, "I haven't had a chance because I have a lot of work to do. We are short staffed." NA-C stated they were going to work on it now and verified they are working with R31 today. During interview on 8/06/24 at 2:14 p.m., NA-B stated it is expected to reposition, and "check and change" any resident that is incontinent every 2 hours. NA-B stated they helped transfer R31 this morning prior to breakfast. NA-B stated they have not assisted R31 with any cares, repositioning, or	2 900			

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2 900	Continued From page 14 transfers since before breakfast. During interview on 8/06/24 at 3:36 p.m., NA-C stated that after talking with surveyor they brought R31 to their room, transferred her to bed and provided incontinent cares. NA-C verified that R31 had been incontinent of urine and a small amount of bowel movement. During interview on 8/07/2024 at 1:38 p.m., assistant director of nursing (ADON) stated the expectation is residents who are incontinent of bowel and bladder need to be checked and changed every 2-3 hours along with repositioned. ADON stated, "it would be based on the residents care plan." During interview on 8/07/2024 at 2:11 p.m., director of nursing (DON) stated the expectation for residents who need to be repositioned and are incontinent is "they are checked and changed every 2-3 hours or what the care plan says." DON stated it is important to do to offload residents to reduce pressure and to ensure they are clean and dry. A policy titled Prevention of Pressure Injuries, dated 9/29/21, indicated "reposition all residents with or at risk of pressure injuries on an individualized schedule, as determined by the interdisciplinary care team." SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, should review all residents at risk for pressure ulcers to assure they are receiving the necessary treatment/services to prevent pressure ulcers from developing and to promote healing of pressure ulcers. The director of nursing or	2 900			

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2 900	Continued From page 15 designee should conduct measurable audits for a specific amount of time of the delivery of care to residents affected and those who have the potential to be affected to ensure appropriate care and services are implemented and reduce the risk for pressure ulcer development. The DON or designee should bring all audit information to the Quality Assurance Performance Improvement (QAPI) committee to determine compliance or the need for further monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 900			
2 920	MN Rule 4658.0525 Subp. 6 B Rehab - ADLs Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that: B. a resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the facility failed to ensure routine personal care (i.e., incontinent cares, nail care) were provided for 2 of 3 residents (R6, R31) reviewed for dependent activities of daily living (ADL's). Findings include: R6	2 920	"Corrected"		9/5/24

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2 920	Continued From page 16 R6's significant change Minimum Data Set (MDS), dated 6/14/24, identified R6 had moderate cognitive impairment but demonstrated no delusional thinking. Further, the MDS outlined R6 was dependent on staff for most personal hygiene needs and was not diabetic. On 8/5/24 at 1:47 p.m., R6 was observed seated in a recliner chair while in his room. R6 had long fingernails present on both hands, with the nail edge both having a dark-colored debris present and being several millimeters (mm) long on multiple nails. R6 was questioned on his nail care and who, if anyone, helps him with it. R6 looked at his nails and expressed aloud, "My nails need to be clipped." R6 stated he used to clip them himself, however, had lost the clippers awhile back. R6 stated the staff helped him with showers on a weekly basis but nobody from the care center, to his recall, had asked him about clipping his nails in the past few weeks. R6's care plan, dated 7/2024, identified R6 had an ADL self-care deficit due to post-polio syndrome and impaired mentation. The care plan directed, "PERSONAL HYGIENE/ORAL CARE: Requires assistance of 1." The care plan lacked any information on nail care (i.e., preferred length, clipping frequency). On 8/6/24 at 9:40 a.m., R6 was observed again seated in his recliner chair. R6's fingernails remained long and soiled as had been observed the day prior. R6's Weekly Skin Review Assessment, dated 8/3/24, identified R6 had no skin issues along with dictation, "[R6] had shower. skin check completed with no new skin issue noted." The completed evaluation lacked evidence if nail care	2 920			

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2 920	Continued From page 17 had been offered, provided or refused. Further, R6's medical record, including progress notes, lacked evidence nail care had been done, offered or refused within the last week despite R6 having long, potentially soiled nails present. When interviewed on 8/6/24 at 10:02 a.m., nursing assistant (NA)-F stated they had worked with R6 multiple times prior and described him as needing "total help" with cares and hygiene. NA-F stated R6 rarely, if ever, refused care and the NA's would be responsible to help him complete nail care with his showers. NA-F stated if nail care was refused, then the nurse should be told and they likely charted it but the NA charting didn't have spacing to record such. At 10:06 a.m., NA-F observed R6's nails while licensed practical nurse (LPN)-B was present in the room helping R6's roommate. NA-F verified R6's nails were long adding, "They need to be trimmed and cleaned." NA-F stated it looked as it had "been awhile" since nail care was last done and verified R6 was unable to clip his own adding, "He's total [care] and we have to do everything for him." NA-F stated they had never seen or heard of R6 having his own clippers before. On 8/6/24 at 10:20 a.m., LPN-B was interviewed. LPN-B was questioned on R6's fingernails adding aloud, "I noticed that [just prior]." LPN-B stated the nails appeared like they'd been cut and expressed, "I will cut them." LPN-B stated nail care, including cleaning and clipping, should be done on scheduled bath days adding the care center had recently switched to a new form (i.e., Weekly Skin Review) which not longer asked about nail care so it was maybe being missed by staff. LPN-B verified R6's nail length and condition adding, "That is the longest I've seen them." LPN-B stated R6's nails "grow fast" and	2 920			

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2 920	Continued From page 18 the length of them appeared it had been "well over a week" since they were last clipped. LPN-B stated R6 was not a diabetic and the NA could help him with clipping, too, if needed. Further, LPN-B stated there was no current place to record nail care being done or offered, but they verified nail care should be completed regularly as long nails could break off, create injury, or "promote infection." When interviewed on 8/6/24 at 11:32 a.m., registered nurse (RN)-E stated the care center had recently changed with "UDAs [assessments]" and no longer had nail care recorded on the weekly skin review. However, RN-E stated nail care should be completed with bathing adding, "That's always been the expectation." RN-E stated if nail care was refused, then the nurse should record such in the progress notes after re-approaching the resident; however, RN-E verified the medical record lacked evidence of such. RN-E stated nails should be clipped and kept clean so R6 didn't hurt himself or others with them. A provided Fingernails/Toenails, Care Of policy, dated 2022, identified nail care included daily cleaning and regular trimming adding, "Proper nail care can aid in the prevention of skin problems around the nail bed." The policy directed nail care should be recorded in the medical record, including if offered and refused. R31 R31's quarterly Minimum Data Set (MDS), dated 7/23/24, indicated R31 had severely impaired cognition with no hallucinations or delusions. Diagnoses included: dementia (loss of memory, language, problem,-solving and other thinking	2 920			

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2 920	Continued From page 19 abilities that are severe enough to interfere with daily life), anxiety, depression, other frontotemporal neurocognitive disorder (progressive disease of the brain involving frontal and temporal lobes of the brain; can also be referred to as frontotemporal dementia), and polyosteoarthritis (type of arthritis that involves five or more joints at the same time). In addition, R31 was dependent on staff for all ADLs including bed mobility and all hygiene needs. In section H: Bladder and Bowel: section H0300 Urinary Continence: R31 was coded as "Always incontinent (no episodes of continent voiding)," and in section H0400: Bowel Continence: R31 was coded as "Always incontinent (no episodes of continent bowel movements)." R31's care plan, printed 8/6/24, indicated R31 has "functional bladder and blower incontinent r/t [related to] severe cognitive impairment d/t [due to] dx [diagnosis] of Frontotemporal Dementia" with the following interventions: - "BRIEF USE: The resident uses disposable XL yellow briefs, Change per schedule and prn [as needed]." - "INCONTINENT: Check/change 2-3 hours and as required for incontinent. Wash, rinse and dry perineum. Change clothing PRN after incontinent episodes." Care plan further indicated, "ADL self-care needs total assist of one secondary to advanced dementia" with the following interventions: - "PERSONAL HYGIENE/ORAL CARE: The resident is totally dependent on (1) staff for personal hygiene and oral care." - TOILET USE: The resident is not toileted. Dignity protocol every 2-3 hours." R31's progress notes, dated 7/9/24 to 8/7/24, were reviewed. Progress notes lacked evidence	2 920			

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2 920	Continued From page 20 of R31 refusing staff assistance or documentation of any behaviors. R31's Kardex, printed 8/7/24, indicated R31 required assistance of 1-2 [staff] for bed mobility and to be repositioned every 2-3 hours. Furthermore, the document identified R31 as "Incontinent: Check/change 2-3 hours and as required for incontinence. Wash, rinse and dry perineum. Change clothing PRN after incontinence episodes." During continual observation on 8/06/24: -8:42 a.m., R31 was observed to be seated at the dining room table in her wheelchair, facing the television with two other residents at the table with her breakfast tray in front of her. -8:56 a.m., R31 was assisted with her breakfast -9:34 a.m., R31 continues to sit in the dining room in the same position and a group activity was starting. -10:23 a.m., R31 continues to sit in her wheelchair in the same spot she had breakfast in. R31 has not moved from the location. -11:15 a.m., R31 continues to be seated in her wheelchair in the dining room, in the same position and location. -11:39 a.m., R31 continues to be seated in her wheelchair in the dining room, in the same position and location. -12:15 p.m., R31 continues to be seated in her wheelchair in the same position, in the same location she has been in since observation began. -12:22 p.m., R31's meal is placed in front of her on the table. -12:30 p.m., staff sit next to R31 to assist with her meal. -1:54 p.m., R31 remains seated in the dining room, has not been repositioned or brought back	2 920			

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2 920	Continued From page 21 to her room. -2:14 p.m., R31 remains in the dining room. R31 has been in the same location, in the same position (5 hours 32 minutes after observation began). -3:06 p.m., R31 was observed lying in bed. During interview on 8/06/24 at 2:04 p.m., nursing assistant (NA)-C stated the expectation is to check and change a resident that is incontinent is every 2 hours along with repositioning them. NA-C verified they have not repositioned or changed R31 "since this morning before breakfast." NA-C verified this was over two hours. NA-C stated, "I haven't had a chance because I have a lot of work to do. We are short staffed." NA-C stated they were going to work on it now and verified they are working with R31 today. During interview on 8/06/24 at 2:14 p.m., NA-B stated it is expected to reposition, "check and change" any resident that is incontinent every 2 hours. NA-B stated they helped transfer R31 this morning prior to breakfast. NA-B stated they have not assisted R31 with any cares, repositioning, or transfers since before breakfast. During interview on 8/06/24 at 3:36 p.m., NA-C stated that after talking with surveyor they brought R31 to their room, transferred her to bed and provided incontinent cares. NA-C verified that R31 had been incontinent of urine and a small amount of bowel movement. During interview on 8/07/2024 at 1:38 p.m., assistant director of nursing (ADON) stated the expectation is residents who are incontinent of bowel and bladder need to be checked and changed every 2-3 hours along with repositioned. ADON stated, "it would be based on the residents	2 920			

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2 920	Continued From page 22 care plan." During interview on 8/07/2024 at 2:11 p.m., director of nursing (DON) stated the expectation for residents who are incontinent is "they are checked and changed every 2-3 hours or what the care plan says." DON stated it is important to do to offload residents to reduce pressure and to ensure they are clean and dry. A policy titled Activities of Daily Living (ADLs), Supporting, dated 12/7/21, indicated, "residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene." SUGGESTED METHOD OF CORRECTION: The director of nursing and/or designee could educate responsible staff to provide care to residents' dependant on facility staff, based on residents' comprehensively assessed needs. The DON or designee could conduct audits of dependent resident cares to ensure their personal hygiene needs are met consistently. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 920			
21132	MN RULE 4658.0670 Subp. 1 Dishwashing; Requirements Requirements. The dishwashing operation must provide separation in the handling of soiled and	21132			8/30/24

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21132	Continued From page 23 clean dishes and utensils, and must conform with either part 4658.0675 <http://www.revisor.leg.state.mn.us/arule/4658/0675.html> or 4658.0680 <http://www.revisor.leg.state.mn.us/arule/4658/0680.html> for washing, rinsing, sanitizing, and drying. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to take appropriate steps to ensure the proper sanitization of dishware used for meal preparation and resident service when 1 of 1 high-temperature commercial dishwashers was identified as not reaching adequate final rinse temperature (i.e., 180 F). This had potential to affect all 80 residents within the nursing home, staff, and visitors who consumed food from the main production kitchen. Findings include: On 8/5/24 at 7:06 p.m., a kitchen tour was completed with dietary staff (DS)-A and DS-B present. A single Hobart Tempstar commercial dishwasher was present along the wall with several hard plastic racks placed in front of the machine on the floor. DS-B loaded several metallic cookware pans onto other hard plastic racks and placed them into the dishwasher. A single, white-colored gauge present on top of the machine which did not move for the entirety of the wash or rinse cycle. A silver-colored plate was mounted to the side of the machine, under the counter area, which identified the make and model of the dishwasher along with, "Minimum Rinse Temperature ... 180 F [Fahrenheit]." DS-B	21132	"Corrected"		

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21132	Continued From page 24 moved the stacked hard-plastic racks from in front of the machine which exposed two, white-colored analog gauges labeled, "R" and "W," respectively. Both gauges were covered with a hard white film. DS-B stated these gauges were for the dishwasher temperatures. DS-B stated she is not able to read the gauges and requested DS-A assistance. DS-A verified that she cannot read the gauges on the dishwasher. DS-A verified that she does write on the dishwasher temperature log and verified again that she is unable to read the gauges due to the gauges being full of a hard white film. Surveyor was unable to read the temperature on the gauges. On 8/06/24 at 8:13 a.m., an additional follow-up kitchen tour was completed with dietary manager (DM). DM verified the dishwasher is a high temperature dishwasher and needs to 180 F. DM rinsed a few dishes, set them in onto other hard plastic racks and placed them into the dishwasher. The dishwasher was run at least four times with the highest temperature of 172 F. DM stated the dishwasher was serviced last week. DM stated it is important the dishwasher is reaching 180 F "so the dishes are getting sanitized or there is risk for food borne illnesses." On 8/6/24 at 8:37 a.m., DS-A verified that when they checked the temperature on the dishwasher this morning it was "121 and 127 degrees," and verified the log sheet was not recorded correctly. DS-A verified, "the dishwasher did not reach 184 this morning even though the log sheet says it does." On 8/06/24 at 2:22 p.m., administrator verified that he was notified this morning of the dishwasher not reaching temperature and was going to follow up now to see if the service	21132			

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21132	Continued From page 25 company had been out today to fix the issue. Administrator stated that if the issue has not been addressed then the facility would be using paper and plastic products until the dishwasher is fixed to ensure resident safety. On 8/06/24 at 2:35 p.m. DM and administrator met with surveyor. DM informed surveyor that the dishwasher was reaching temperature and dishwasher cycle and was observed to have reached 184 F. DM stated, "we ran a lot of cycles to get it to hit temp," and verified the cycles ran this morning with temperatures not meeting the required 180 F. Administrator stated the facility will use paper and plastic until the dishwasher can be serviced due to the inconsistency of the temperatures. On 8/07/24 at 11:45 a.m., administrator updated surveyor that the dishwasher was just fixed. Administrator stated they fixed a pressure valve that was malfunctioning causing the dishwasher to not reach temperature consistently. During observation on 8/07/24 at 12:06 p.m., temperature on dishwasher was observed and reached 186 F. A provided Cleaning Dishes/Dish Machine policy, dated 2017, identified all flatware, serving dishes, and cookware will be cleaned, rinsed and sanitized after each use. The policy outlined, "Staff should check the dish machine gauges throughout the cycle to assure proper temperatures for sanitation [sic]," along with a corresponding table which outlined the type(s) of dish machines and their corresponding final rinse temperatures. This included, "High Temperature Dishwasher ... 180 F."	21132			

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21132	Continued From page 26 SUGGESTED METHOD OF CORRECTION: The dietary manager, registered dietitian, or administrator, could ensure appropriate security and sanitation of food items and or equipment in the kitchen and dining areas. The facility should also ensure appropriate sanitation of kitchen equipment and food items occurs. The facility could update or create policies and procedures and educate staff on these changes and perform competencies. The dietary manager, registered dietitian, or administrator could perform audits and report audit findings to the Quality Assurance Performance Improvement (QAPI) for further recommendations or to determine compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21132			
21325	MN Rule 4658.0725 Subp. 1 Providing Routine & Emergency Oral Health Ser Subpart 1. Routine dental services. A nursing home must provide, or obtain from an outside resource, routine dental services to meet the needs of each resident. Routine dental services include dental examinations and cleanings, fillings and crowns, root canals, periodontal care, oral surgery, bridges and removable dentures, orthodontic procedures, and adjunctive services that are provided for similar dental patients in the community at large, as limited by third party reimbursement policies. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure the need for routine dental care (i.e., dental appointment) was assessed and,	21325	"Corrected"		9/5/24

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21325	Continued From page 27 if needed or wanted, offered to promote oral hygiene and reduce the risk of complication for 1 of 1 resident (R4) reviewed who reported losing their dentures just prior to admission. Findings include: R4's admission Minimum Data Set (MDS), dated 7/15/24, identified R4 admitted to the care center on 7/9/24 from the acute care hospital. The MDS outlined R4 had intact cognition and demonstrated no delusional thinking. Further, The MDS recorded under, "Section L - Oral/Dental Status," R4 had no broken or loosely fitting dentures, abnormal mouth tissue, or obvious cavities with a check placed next to the option reading, "Z. None of the above were present." R4's Clinical Census listing, printed 8/6/24, identified R4's current payer source was listed as, "MSHO Medicaid." On 8/5/24 at 1:15 p.m., R4 was interviewed and stated she admitted to the care center about a month prior. R4 was asked if she had any issues with her teeth or dental care while at the care center, and R4 responded she had "no teeth" on the top palate and only a few remaining on the bottom palate. R4 stated she had "lost my dentures" at the hospital prior to admitting to the care center and, so far, nobody from the care center had discussed or asked about getting a dental appointment made to possibly get new ones. R4 reiterated she'd like to pursue getting new dentures, if able, adding not having them was frustrating as it was "hard to chew without [them]." R4's Nurse Admission/Readmission 05212021 -	21325			

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21325	Continued From page 28 V15, dated 7/10/24, identified R4 admitted from the hospital and listed a primary rationale for admission, "TCU- [transitional care unit]." The evaluation contained a section labeled, "Oral Status," which had a checkmark placed next to the option reading, "Broken or loose fitting full or partial denture ...," and a location of broken, carious or missing teeth listed, "Upper gum." The evaluation outlined R4 used an upper denture and a partial lower denture; however, the evaluation lacked any information or evidence of when R4's last dental visit had been or if was currently wanted/needed. R4's Social Service Care Conference - IDT 03302021 - V3, dated 7/26/24, identified R4's care conference was held with R4 present. The form outlined spaces for respective disciplines to record information including, "Section E: Social Services," which contained a subsection asking, "Any referrals needed (podiatry, optometry ...);," however, this section was left blank. The completed summary lacked evidence what, if any, appointments were asked or offered to R4. R4's care plan, dated 8/5/24, identified a section for oral health which was initiated on 8/5/24 and outlined, "The resident has potential oral/dental health problems r/t [related to] denture fit." The care plan listed interventions to help R4 remain free of oral infection or pain which included, "Coordinate arrangements for dental care, transportation as needed/as ordered." When interviewed on 8/6/24 at 10:08 a.m., nursing assistant (NA)-F stated they had worked with R4 prior. NA-F explained R4 did not, at least to their knowledge, have their own teeth and used dentures but often didn't wear them adding, "I've never seen her put it on [in] before." NA-F stated	21325			

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21325	Continued From page 29 they were unsure if R4's dentures were even at the care center or not and expressed R4 had never made any comments about them. NA-F stated any dental appointments, if needed or wanted, would be made by the nurses. At 10:11 a.m., NA-F and the surveyor checked R4's room for what, if any, dentures were present. R4 was present laying in her bed and stated aloud, "I don't have none." NA-F verified no dentures were present. R4's medical record was reviewed and lacked evidence R4 had been asked, offered or referred to a dental provider despite admitting to the care center nearly a month prior and being assessed upon admission as having potential broken or loose-fitting dentures. When interviewed on 8/6/24 at 10:23 a.m., licensed practical nurse (LPN)-B stated dental care, including the need or desire for an appointment, was done upon admission and recorded "in the admission assessment [i.e., Nurse Admission/Readmission]." LPN-B stated if there was concerns or complaints about dentition then, it would be referred to the dental provider and, if not, then re-evaluated in three months during the next routine review (i.e., MDS cycle). At 10:25 a.m., the medical records coordinator (MRC) joined the interview and verified they scheduled appointments for the campus. MRC stated R4 had not yet been scheduled for any dental appointments and nobody had referred any concerns about it to them. MRC stated they would go follow-up with R4 about it. On 8/6/24 at 1:44 p.m., the assistant director of nursing (ADON) was interviewed, and verified they had followed up on R4's dental appointment adding MRC was "working on" getting R4	21325			

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21325	Continued From page 30 scheduled for one now. ADON stated the nurses complete the admission assessments and, from that, information gets pulled to the care plan adding the care conference is also an opportunity to record what, if any, appointments are needed or offered but R4's section "was blank." ADON stated residents' on the TCU are usually "more therapy focused" but verified dental appointments and the need for such "should be looked at." ADON verified the medical record lacked evidence R4 had been offered or evaluated for what, if any, dental appointments were needed or wanted; and expressed the care center was looking at their assessments to see if they could add more to them to ensure it was addressed. ADON stated it was important to ensure dental needs were offered or provided to ensure "we're getting their needs [met] and continuity of care." A provided Dental Services policy, dated 2/2022, identified routine and emergency dental services were available to meet resident' oral health needs in accordance with the assessment and plan of care. The policy outlined the social services team would assist with appointments, transportation arrangements and reimbursement, if needed. The policy concluded, "All dental services provided are recorded in the resident's medical record." SUGGESTED METHOD OF CORRECTION: The director of nursing (DON), or designee, could review applicable policies and procedures regarding dental evaluation and assessment; then educate staff and audit to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one days	21325			

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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 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.	21530			9/5/24

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21530	Continued From page 32 This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to act upon the consultant pharmacist's recommendation for 1 of 1 resident (R13) reviewed for unnecessary medications. Findings include: R13's quarterly Minimum Data Set (MDS) dated 5/31/24, indicated R13 was cognitively intact, did not experience hallucinations or delusions and did not refuse cares. MDS indicated R13 needed extensive assistance with transfers, hygiene, bathing, and dressing. R13 needed set up with oral hygiene and eating. R13's Clinical Diagnosis report printed 8/7/24, indicated Parkinson's disease with dyskinesia (disorder of the central nervous system that affects movement, often including tremors), dementia with other behavioral disturbances, neurocognitive disorder with Lewy Bodies (type of dementia characterized by build up of protein deposits in regions of the brain memory, thinking and movement) , essential hypertension(abnormally high blood pressure that's not the result of a medical condition) , and vitamin d deficiency. R13's Clinical orders report printed 8/7/24, included an order dated 9/11/23 for quetiapine (an antipsychotic medication) 25 milligrams (mg) at bedtime for hallucinations. R13's Consultant Pharmacist Recommendation to Physician dated 4/16/24 and 7/20/24 indicated the quetiapine 25 mg dose was active since	21530	"Corrected"		

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21530	Continued From page 33 3/7/22. Recommendation read "Within the first year in which a resident is admitted on a psychotropic medication or after the prescribing practitioner has initiated a psychotropic medication, the facility must attempt a GDR [gradual dose reduction] in two separate quarters (with at least one month between the attempts), unless clinically contraindicated. After the first year, A GDR must be attempted annually, unless clinically contraindicated". The recommendation included a message directed to the provider, as follow: "Resident is due for a dose reduction assessment. During your next visit could you please review whether resident continues on the lowest doses of his/her regimen. If a dose is contraindicated, please document clinical rationale below." Both recommendations did not contain documentation showing and answer to the recommendations. During interview on 8/6/24 at 3:26 p.m., assistant director of nursing (ADON) stated the facility switched providers in April. In July, in order to make changes to the residents' psychotropic medications the new nurse practitioner requested a detailed psychosocial review and when the last GDRs were done for each resident. ADON stated the psychosocial reviews were on her "to do list". During interview on 8/7/24 at 2:02 p.m., director of nursing (DON) stated the previous nurse practitioner left on April 10th. DON stated when the new nurse practitioner started, she didn't want to make any changes without knowing the residents. DON stated in July she asked for the psychosocial reviews and our ADON will be working on them. DON verified the pharmacist recommendations for the month of April and July were not done.	21530			

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21530	Continued From page 34 The facility title Medication Monitoring and Management, Antipsychotics dated 5/2022, indicated "If a resident is admitted on an antipsychotic medication or the facility initiates antipsychotic therapy, the facility must attempt a GDR in two separate quarters (with at least one month between the attempts) within the first year, unless clinically contraindicated. After the first year, a GDR must be attempted annually, unless clinically contraindicated. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) 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, irregularities are being acted upon, and when required the provider documents a clear clinical rationale for actions taken or not taken; including but not limited to risks and benefits to justify the continued use. 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	21535			9/5/24

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21535	Continued From page 35 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 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 observation, interview and document review, the facility failed to ensure non-pharmacological interventions were attempted and recorded prior to administration of as-needed (PRN) narcotic medication to reduce the risk of potential complications for 1 of 5 residents (R4) reviewed for unnecessary medication use. Findings include: R4's admission Minimum Data Set (MDS), dated 7/15/24, identified R4 had intact cognition and consumed opioid (i.e., narcotic) medication during the review period. R4's care plan, dated 8/5/24, identified R4 had	21535	"Corrected"		

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21535	Continued From page 36 potential for pain due to recent hip surgery. A goal was listed which read, " ... will not have an interruption in normal activities due to pain through the review date," along with several interventions to help R4 meet this goal including, "The resident's pain is alleviated/relieved by: Ice, rest, pain medications." The intervention start date was recorded as, "08/05/2024." R4's Order Summary Report, signed 7/29/24, identified R4's physician orders while at the care center. This included an order which read, "HYDROmorphone HCL [Dilaudid, a narcotic] Oral Tablet 2 MG [milligrams] ... by mouth every 6 hours as needed ... ," with a start date recorded, "07/22/2024." R4's corresponding SKILLED note, dated 7/29/24, identified R4 was seen by the nurse practitioner (NP) for a follow-up visit with notation of R4 having been hospitalized until 7/9/24 for a femur fracture and post-surgical infection. The note outlined R4's pain regimen with dictation, " ... Reports pain increased overnight last night and some difficulty sleeping but overall well controlled. Seen working with PT [therapy] prior to visit and no observed significant pain. PT reports [R4] is able to perform all exercises with some pain but overall she does not feel it is interfering with [R4] progress." The NP identified R4 was consuming the narcotic 2-3 times per day and listed several orders including, "DECREASE dilaudid frequency to BID PRN [twice daily, as needed] - separate doses by at least 4 hours." On 8/7/24 at 8:52 a.m., R4 was observed in the dining room on her unit. R4 finished eating and stood up next to the table with nursing assistant (NA)-I immediately beside her. R4 took several steps using a front-wheeled walker and ambulated down the hallway to her room without	21535			

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21535	Continued From page 37 any obvious physical signs of pain (i.e., grimace, moaning) present. Following, at 9:01 a.m., R4 was interviewed and stated she felt her pain was being well-managed at the care center. R4 stated she was taking the hydromorphone "since I've been here" and expressed the NP was "trying to take me off it before I go home." R4 stated the staff had not offered or asked about ice packs or heat packs before giving the narcotic before but expressed she was open to trying such interventions, if offered. R4's Medication Administration Record (MAR), dated August 2024, identified R4's consumed medications for the month-period. This included R4's hydromorphone with directions, " ... 2 mg by mouth every 12 hours as needed ...," with a corresponding pain level being written with each recorded administration. A total of six administrations for the month, so far, had been recorded as follows: On 8/1/24 at 3:30 a.m., for pain rated nine out of 10 with the dose being effective. A corresponding progress note, dated 8/1/24, identified the medication was given with dictation, " ... Resident requested and given for right hip pain. Rated pain as 9/10 on the pain scale." However, the note lacked further information on what, if any, physical symptoms were demonstrated (i.e., grimace, crying) or what, if any, non-pharmacological interventions were offered or refused prior to the narcotic being given. On 8/2/24 at 12:17 a.m., for pain rated 10 out of 10 with the dose being effective. A corresponding progress note, dated 8/2/24, identified the medication was given with dictation, " ... Resident requested and given for right hip pain. Rated pain as 10/10 on the pain scale at this time." However,	21535			

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21535	Continued From page 38 the note lacked further information on what, if any, physical symptoms were demonstrated (i.e., grimace, crying) or what, if any, non-pharmacological interventions were offered or refused prior to the narcotic being given. On 8/2/24 at 11:17 p.m., for pain rated nine out of 10 with the dose being effective. A corresponding progress note, dated 8/2/24, identified the medication was given, however, lacked any further dictation or rationale for the medication; nor information on what, if any, physical symptoms were demonstrated (i.e., grimace, crying) or what, if any, non-pharmacological interventions were offered or refused prior to the narcotic being given. On 8/4/24 at 1:28 a.m., for pain rated nine our of 10 with the dose being effective. A corresponding progress note, dated 8/4/24, identified the medication was given, however, lacked any further dictation or rationale for the medication; nor information on what, if any, physical symptoms were demonstrated (i.e., grimace, crying) or what, if any, non-pharmacological interventions were offered or refused prior to the narcotic being given. On 8/4/24 at 7:05 p.m., for pain rated 10 out of 10 with the dose being effective. A corresponding progress note, dated 8/4/24, identified the medication was given with dictation, " ... Res c/o [complain] pain 10/10 on right hip." However, the note lacked further information on what, if any, physical symptoms were demonstrated (i.e., grimace, crying) or what, if any, non-pharmacological interventions were offered or refused prior to the narcotic being given. On 8/5/24 at 7:41 a.m., for pain rated eight out of	21535			

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21535	Continued From page 39 10 with the dose being effective. A corresponding progress note, dated 8/5/24, identified the medication was given, however, lacked any further dictation or rationale for the medication; nor information on what, if any, physical symptoms were demonstrated (i.e., grimace, crying) or what, if any, non-pharmacological interventions were offered or refused prior to the narcotic being given. R4's medical record was reviewed and lacked evidence non-pharmacological interventions had been attempted prior to the administration of the PRN narcotic medication despite newly care-planned, effective non-pharmacological interventions for her pain being listed and the medical provider actively trying to decrease the frequency of the narcotic use. When interviewed on 8/7/24 at 9:48 a.m., NA-F stated they had worked with R4 prior but had not, at least to their recall, ever heard R4 complain about pain adding, "I've never heard her." NA-F stated they had not offered or given R4 ice packs or anything; nor had they ever been told to by the nurses adding, "Not that I know of." NA-F verified R4 was working with therapy and reiterated R4 had not complained about pain to their recall adding, "I never see her do that [pain symptoms]." On 8/7/24 at 9:51 a.m., registered nurse (RN)-A was interviewed. RN-A verified they had worked with R4 prior and explained she (R4) had hydromorphone ordered "two times max a day" for pain. RN-A stated R4 would most often have pain in the early morning but added the pain, overall, seemed to be "going down a little bit." RN-A stated with use of as-needed pain medications, including narcotics, the staff should	21535			

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21535	Continued From page 40 be trying ice or "topicals" prior to giving it. RN-A reviewed R4's medical record and stated R4 used to have an order for ice to be applied but added, "We might have taken it out." RN-A verified non-pharmacological interventions should be attempted prior to a as-needed narcotic being given and recorded in the progress notes adding, "Technically, that's what were supposed to do." RN-A stated it was important to attempt non-pharmacological interventions and chart them to help ensure "the least dose" of medication is used adding, "If it's not charted, it's not done." When interviewed on 8/7/24 at 11:25 a.m., registered nurse manager (RN)-E verified they had reviewed R4's medical record, and they "could not find anything non-pharmacological [recorded]," adding further, "The expectation is they're offered prior." RN-E stated the care center was looking into building non-pharmacological use into the order set and verified they should be offered, attempted and recorded with as-needed narcotic use adding such was important due to "medications can have side effects, so if they can be avoided [better]." A facility' policy on as-needed narcotic management was not provided. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON), or designee, could review applicable policies on medication management, non-pharmacological interventions, and psychotropic medications to ensure accuracy; then educate staff and audit to ensure ongoing compliance.	21535			

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21535	Continued From page 41	21535			
	TIME PERIOD FOR CORRECTION: Twenty-one days				
21805	MN St. Statute 144.651 Subd. 5 Patients & Residents of HC Fac.Bill of Rights Subd. 5. Courteous treatment. Patients and residents have the right to be treated with courtesy and respect for their individuality by employees of or persons providing service in a health care facility. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure resident's needs were addressed in a respectful and dignified manner when a resident (R34) used a call light for help. Additionally, the facility failed to ensure all staff knock on individual resident bedroom doors and introduce themselves prior to entry for 3 residents (R68, R76, R74). Furthermore, the facility failed to provide a dignified dining experience for 3 residents (R21, R31, R68). Findings include: Call Lights R34's quarterly Minimum Data Set (MDS) dated 6/3/24, indicated intact cognition and diagnoses of hemiplegia (one-side paralysis) and hemiparesis (weakness or the inability to move on one side of the body) after a stroke and high blood pressure. R34's care plan dated 8/30/23, indicated he was	21805	"Corrected"		9/5/24

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21805	Continued From page 42 dependent on staff/volunteers/family for meeting his emotional, intellectual, physical, and social needs related to his tendency to not seek out activities. The care plan also identified R34's activities of daily living (ADL) self-care needs related to his left-sided weakness, including an assist of one staff person to transfer with an "EZ stand medium harness". During continuous observation on 8/6/24 between 12:51 p.m. and 1:24 p.m., two call lights were on in the same hallway with an alarm sounding. - At 12:55 p.m., R34's call light was noted to be on as indicated by the light on above his door, however the alarm was not sounding. - At 12:58 p.m., registered nurses (RN)-D and RN-F were standing in front of the medication carts in the dining area when R34 was heard calling, "hello" from his room. - At 12:59 p.m., nursing assistant (NA)-C exited a room in the same hallway as R34's room with meal trays in hand and walked towards the dining area. RN-F walked towards R34's room but turned and knocked to go into a different room to assist another resident. - At 1:00 p.m., RN-D approached the room where the first call light was observed to be on, knocked and entered the room and turned the call light off. - At 1:01 p.m., RN-D exited the room with a meal tray. R34's call light remained unchanged. - At 1:02 p.m., the assistant director of nursing (ADON) walked out from behind the nurse's station, into the dining area and down the hallway where R34's room was. The ADON turned into the tub/shower room. R34's call light remained unchanged. - At 1:03 p.m., RN-D was standing at the medication cart in the dining room. - At 1:05 p.m., NA-B walked down the hallway and into the room RN-F was in.	21805			

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21805	Continued From page 43 - At 1:07 p.m., the call light alarm box at the nurse's station displayed the text, "W226 NORMAL" and was alarming with sound. It did not display a duration the call light had been on for. - At 1:08 p.m., RN-F exited the room and walked away from R34's and into the dining area. - At 1:11 p.m., RN-F walked down the hallway towards R34's room and entered another resident's room without a call light on. - At 1:12 p.m., RN-F exited the room and performed hand hygiene. RN-F walked down the hallway towards R34's room and entered a different resident's room without a call light on. RN-D was standing at the medication cart in the dining area. - At 1:13 p.m., RN-F exited the room with the resident and walked to the dining area. RN-F performed hand hygiene at the medication cart. R34's call light remained unchanged. - At 1:14 p.m., R34 stated in an interview he turned his call light on at 12:51 p.m. because he wanted to transfer into his recliner. He stated he needed staff assistance and the "EZ Stand" to transfer. R34 stated he experienced long call light wait times "most of the time" and stated, "it's getting old." - At 1:18 p.m., RN-F walked down the hallway with a medication cup in hand towards R34's room. RN-F entered another resident's room that had a call light on. - At 1:19 p.m., RN-F exited the room and walked down the hallway towards the dining area. R34's call light remained unchanged. - At 1:21 p.m., NA-C walked down the hallway with another unidentified resident and entered a different room. - At 1:22 p.m., NA-C stopped into a room with a call light on near R34's room. - At 1:23 p.m., NA-C answered R34's call light	21805			

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21805	Continued From page 44 request. - At 1:28 p.m., NA-C pushed R34 down the hallway in his wheelchair and into the tub/shower room. During interview on 8/6/24 at 1:37 p.m., RN-D stated the goal is to keep the call light wait time under 20 minutes but understood that "a lot of residents" required two staff for assistance. RN-D verified waiting 30 minutes was "pushing it" and stated the floor was "pretty full census wise" so it could be a strain. During interview on 8/6/24 at 3:04 p.m., the ADON stated, "I do expect there would be someone to answer the call light, even if you can't help them, to acknowledge them and see what they need." The ADON confirmed 30 minutes was "too extended" and expected the call light to be answered sooner. The ADON expected any staff, from activities to housekeeping to "all my nursing staff", to address a call light if passing by. The ADON stated the risks of not answering a call light in a timely manner included the risk of incontinence, bowel incontinence, and a potential for unsafe self-transfers, although the ADON didn't believe R34 would attempt to self-transfer. During interview on 8/7/24 at 11:52 a.m., the director of nursing (DON) stated it was "disappointing" to hear about a call light being on for 30 minutes and stated the expectation was for it to be answered in a "reasonable" time and suggested 10 minutes as a reasonable time. The DON stated the facility attempts to staff up during the day shift to accommodate resident needs. The DON verified concern for dignity with the extended call light wait time and expected all staff, including nurses, to answer call lights.	21805			

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21805	Continued From page 45 A facility policy titled Answer the Call Light dated 10/18/22, indicated its purpose was to ensure timely responses to the resident's requests and needs. The policy guided staff to answer the resident call system immediately. A facility policy titled Dignity dated 12/8/21, indicated each resident should be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, and feels of self-worth and self-esteem. The policy indicated residents were treated with dignity and respect at all times and the facility culture supported dignity and respect for residents by honoring resident goals, choices, preferences, values and beliefs. Dignified Dining R31's significant change Minimum Data Set (MDS) assessment, dated 4/23/24, indicated R31 had severely impaired cognition with no hallucinations, or delusions. Further indicated R31 was dependent on staff for all activities of daily living (ADLs) including eating. R21's quarterly MDS assessment, dated 6/11/24, indicated R21 had severely impaired cognition with no hallucinations, or delusions. Further indicated R21 was dependent on staff for all activities of daily living (ADLs) including eating. R68's quarterly MDS assessment, dated 7/15/24, indicated R68 had severely impaired cognition with no hallucinations or delusions. Further indicated R68 was dependent on staff for all activities of daily living (ADLs) including eating. On 8/06/24 at 8:42 a.m., a table of three residents	21805			

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21805	Continued From page 46 were seated in wheelchairs at a table. One resident was sitting with her eyes closed with an almost empty plate of food in front of her. The second resident was being assisted by a staff member to eat. R31 was the third resident at the table. Directly in front of R31, on the table, sat a hard plastic tray that contained on it, a warming plate with a cover, bowl with a plastic cover along with covered drinks. R31 was intermittently yelling out which caused other residents to look over at her. R31 continued to sit at the table with a clothes protector on with the covered food tray in front of her. No staff were interacting with R31. At 8:56 a.m., staff sat next to R31, uncovered the food in front of her and started to feed her (14 minutes after observation started). R31's food was left on the hard plastic tray during the meal. R31 stopped yelling out when staff started to assist her with her breakfast. During observation on 8/6/24 at 12:18 p.m., two lunch carts were brought to 2nd floor and delivered to the 2nd floor dining room by unknown dietary staff. Each lunch cart was an enclosed metal cart on wheels with slots, that held hard plastic trays that contained resident meals. Each slot could hold two hard plastic trays which could be slid from the front or back of the approximately 6-foot metal cart. The hard plastic trays each contained a paper slip that identified who the meal was intended for, a plate of food that was sitting on a plate warmer and was covered with a hard plastic dome shaped lid. The tray contained a set of silverware along with a napkin. Staff would grab the trays from the lunch cart, add the drinks that were requested from a different cart and deliver the entire tray to residents sitting at the table. Staff would leave the food and drinks on the hard plastic tray that contained the entire meal including the drinks and silverware.	21805			

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21805	Continued From page 47 At 12:22 p.m., R31, R21 and R68 were observed to be seated at the same table. R31 and R21's lunch trays were set in front of them (just the way trays sent up from the kitchen). At 12:23 p.m., R68's tray was set in front of him. Staff proceed to get drinks for all the trays and set them in front of R31, R21 and R68 on the hard plastic trays. At 12:30 p.m., staff sat next to R31 to assist her to eat. At 12:35 p.m., a second staff sat next to R68 to assist him to eat (13 minutes after the food had been placed in front of him). At 12:38 p.m. a third staff sat next to R21 to assist her to eat (16 minutes after her food had been sitting in front her). R21, R31 and R68 were non-interviewable as unable to answer questions. During an interview on 8/06/24 at 2:04 p.m., nursing assistant (NA)-C stated meal trays are not handed out in a certain order, and "we just make sure residents get the right tray." NA-C verified they do not take food off the hard plastic trays to serve the residents. NA-C verified that some residents must wait to be assisted with their meals. During an interview on 8/06/24 at 2:14 p.m., NA-B stated that each staff passes out their own resident trays. NA-B stated that after all the trays are handed out to residents then they assist residents who need help. NA-B verified that residents may have to wait a little while for assistance with their meals as they have other to help and must pass out other trays. NA-B verified the plates and drinks are not removed from the plastic trays when they are served to residents as	21805			

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21805	Continued From page 48 it makes serving easier. During an interview on 8/07/24 at 11:09 a.m., NA-D stated that residents in the dining room are served first, then room trays are delivered and then residents who need assistance are assisted. NA-D stated all meals are served on the hard plastic trays to residents and "have always done that," adding it makes it easier to clean up. During an interview on 8/07/24 at 11:18 a.m., registered nurse (RN)-C stated that meal trays are not served in any order but "we try to serve independent people first, then those who need supervision and then those who we assist last." RN-C stated there is no assigned seating in the dining room but try to have resident who need supervision or assistance sit together. RN-C stated, "trays are left underneath the meals." On 8/07/2024 at 1:38 p.m., assistant director of nursing (ADON) stated meal trays are not served in a certain order and there is no assigned seating. ADON verified that meals are served to residents on the hard plastic trays (food items are not removed and placed directly on the table) stating, "there is not a reason why we do that It is easier to carry." On 8/07/2024 at 2:11 p.m., director of nursing (DON) verified there is no specific reason that meals are served on hard plastic trays to residents. DON stated residents should be served meals at the same time and staff should be able to assist when meals are served. NOT KNOCKING ON RESIDENTS' DOOR PRIOR TO ENTERING	21805			

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21805	Continued From page 49 R68's quarterly MDS assessment, dated 7/15/24, indicated R68 had severely impaired cognition with no hallucinations or delusions with an admission date of 1/16/24. R76's admission MDS assessment, dated 6/24/24, indicated R76 has moderately impaired cognition with no hallucinations or delusions with an admission date of 6/18/24. R74's admission MDS assessment, dated 6/7/24, indicated R74 had severely impaired cognition with no hallucinations or delusions with an admission date of 6/3/24. During observation on 8/06/24 between 10:30 a.m. and 10:55 a.m., nursing assistant (NA)-B entering R68's room numerous times without knocking or announcing self. NA-B was also observed entering R76's room, during that time, without knocking, announcing self, or talking with R76 prior to entering room. During interview at 8/6/24 at 11:01 a.m., NA-B verified that they entered R68's numerous times within the last 30 minutes without knocking or announcing self. R68 stated, "I am very busy but should've knocked." NA-B couldn't count how many times she had been in and out of R68's room without knocking but stating, "a lot." NA-B verified they entered R76 room without knocking as "she could see me in the hallway, and I was talking to her." NA-B verified they should always knock before entering a resident's room as "it is a privacy and dignity thing to knock on a door prior to entering rooms. " On 8/07/24 at 10:10 a.m., housekeeper (HSK)-A was observed opening R74's room door and entering R74's room without knocking or	21805			

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21805	Continued From page 50 announcing self. On 8/7/24 at 10:12 a.m., HSK-A verified they had delivered soap to R74's room. HSK-A verified they had not knocked or announce themselves prior to opening R74's door and entering room. HSK-A stated, "I thought they were sleeping.". HSK-A further indicated, "you should always knock because you are entering their room." On 8/07/24 at 10:14 a.m., R74 was observed to be lying in bed. R74 answered questions mumbled and non-sensical. On 8/07/24 at 10:16 a.m., R68 did not respond when asked questions. During interview on 8/07/2024 at 1:38 p.m., assistant director of nursing (ADON) stated it is expected to knock prior to entering a resident's room and should be done all the time. ADON stated, "we should treat everyone like humans ...we a lot of people have dementia, and we don't want to scare them ...it's just the right thing to do." During interview on 8/07/2024 at 2:11 p.m., with director of nursing (DON) stated it is expected that staff either knock or announce themselves by saying hello announce. DON stated this is "for dignity and alert them so don't startle them." A facility policy titled Dignity, dated 12/8/21, indicated "residents are treated with dignity and respect at all times." Further indicated, "residents are provided with a dignified dining experience." SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON), or designee could develop and implement a plan of	21805			

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21805	Continued From page 51 care by the interdisciplinary team to ensure residents dignity is being maintained at all times. The facility could update policies and procedures, educate staff on these changes, and audit to ensure resident(s) dignity are maintained. The results of these audits will be reviewed by the quality assurance committee to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21805			
21880	MN St. Statute 144.651 Subd. 20 Patients & Residents of HC Fac.Bill of Rights Subd. 20. Grievances. Patients and residents shall be encouraged and assisted, throughout their stay in a facility or their course of treatment, to understand and exercise their rights as patients, residents, and citizens. Patients and residents may voice grievances and recommend changes in policies and services to facility staff and others of their choice, free from restraint, interference, coercion, discrimination, or reprisal, including threat of discharge. Notice of the grievance procedure of the facility or program, as well as addresses and telephone numbers for the Office of Health Facility Complaints and the area nursing home ombudsman pursuant to the Older Americans Act, section 307(a)(12) shall be posted in a conspicuous place. Every acute care inpatient facility, every residential program as defined in section 253C.01, every nonacute care facility, and every facility employing more than two people that provides outpatient mental health services shall have a written internal grievance procedure that, at a minimum, sets forth the process to be	21880			9/5/24

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21880	Continued From page 52 followed; specifies time limits, including time limits for facility response; provides for the patient or resident to have the assistance of an advocate; requires a written response to written grievances; and provides for a timely decision by an impartial decision maker if the grievance is not otherwise resolved. Compliance by hospitals, residential programs as defined in section 253C.01 which are hospital-based primary treatment programs, and outpatient surgery centers with section 144.691 and compliance by health maintenance organizations with section 62D.11 is deemed to be compliance with the requirement for a written internal grievance procedure. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to respond to and resolve a report of missing clothing for 1 of 1 residents (R182) reviewed for grievances. Findings include: R182's quarterly minimum assessment data (MDS) indicated, R182 had severe cognitive impairment, no behaviors, hallucinations, or delusions. R182 had limited range of motion in one side of her body, was dependent with grooming, toileting, dressing, and transfers. R182 was unable to ambulate, needed help to set up her meals, and was able to propel her wheelchair. R182's Clinical Diagnosis record printed 8/7/24, indicated diagnosis of hemiplegia and hemiparesis (paralysis and weakness of one side	21880	"Corrected"		

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21880	Continued From page 53 of the body) following cerebral infarction (stroke) affecting left non-dominant side (area of damaged tissue on the brain), lymphedema (swelling due to build-up of lymph fluid in the body), vascular dementia (problems with reasoning, planning, judgement, memory, and other thought processes caused by brain damage from impaired blood flow to the brain), essential hypertension (an abnormally high blood pressure that's not the result of a medical condition) , neuralgia (pain caused by damaged or irritated nerves) , chronic pulmonary embolism (condition caused by a blood clot blocking the pulmonary artery, reduces blood flow and increases pressure in the lungs), chronic pain syndrome, and major depressive disorder. R182's progress note dated 11/21/23 at 2:32 p.m., by a licensed practical nurse (LPN)-C indicated "the resident is complaining of her missing dresses." Facility's grievance log for 2023 lacked documentation of a grievance filed on behalf of R182 regarding the missing clothing. During interview on 8/7/24 at 1:46 p.m., social worker (SW) stated when a resident reports a missing item, staff look in the residents' room and call the laundry. SW stated, sometimes they will call me or the administrator. The family will file a grievance form. SW stated we usually find the clothes and if we can't find the items, we call the family and let them know. SW stated, the administrator is in charge and directs the director of nursing (DON) and SW if any further action is necessary. During interview on 8/7/24 at 1:24 p.m., administrator stated, typically missing items are	21880			

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21880	Continued From page 54 brought up to the nurse's attention. The nurses search the resident's room and call the laundry. This information would be discussed during the daily IDT meeting [Monday-Friday]. Depending on the item it will be assigned to the appropriate department and be followed up. During the weekend, concerns are brought up to the nurse in charge, and depending on the seriousness of the concern they will contact the DON or the administrator. Administrator was not aware a progress note was made indicating R182 reported missing dresses. Administrator stated grievance forms sometimes are part of the process to report missing personal items. Administrator stated grievance forms were available to staff, residents, and families. The facility's policy titled Filing Grievances/Complaints dated 12/14/21, indicated "Any resident, family member, or appointed resident representative may file a grievance or complaint concerning care, treatment, behavior of residents, staff members, theft of property, or any other concerns regarding his or her stay at the facility. The facility's policy titled Staff Responsibility Grievances/Complaints dated 10/28/21, indicated "staff members are encouraged to guide residents about where and how to file a grievance and/or complaint when the resident believes his/her rights have been violated." Additionally, policy indicated: Any allege abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, must be reported to the administrator immediately, but no later than 2 hours after the allegation is made if the events that cause the allegations involve abuse or result in serious bodily injury, or no later than 24 hours if the	21880			

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21880	Continued From page 55 events that cause the allegations do not involve abuse and do not result in serious bodily injury. SUGGESTED METHOD OF CORRECTION: The administrator or designee could review applicable policies and procedures related to grievances and handling of such; then inservice staff and audit to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21880			

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted on August 6, 2024, by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, St. Anthony Park Home, was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.	K 000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Electronically Signed

TITLE

(X6) DATE

09/01/2024

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. ST ANTHONY PARK HOME is a three-story building with basement The St Anthony Park Home was constructed at three different times. The original building was built in the 1900's, is 3 stories, with a basement and was determined to be of a Type II (111) construction with a wood frame roof system that meets the exception to "The Life Safety Code"	K 000			

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K 000	Continued From page 2 NFPA 101 (2000 edition) Section 16.1.6.2. In 1960 an addition was constructed to the west of original building, which was 1-story, with a basement, and was determined to be Type II (111) construction. In 1999 a 2nd and 3rd floor were constructed over the 1960 addition that are separated with a 2 hour fire barrier from the 1900 original building and are Type II (111) construction. The building is divided into 11 smoke zones (3 each level except the basement) by at least 1 hour fire barriers. Because the original building and the addition are compatible construction types allowed for existing buildings of this height, 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 84 beds and had a census of 76 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by: Stairways and Smokeproof Enclosures CFR(s): NFPA 101	K 000			
K 225 SS=F	Stairways and Smokeproof Enclosures Stairways and Smokeproof enclosures used as exits are in accordance with 7.2. 18.2.2.3, 18.2.2.4, 19.2.2.3, 19.2.2.4, 7.2	K 225		8/29/24	

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K 225	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility did not properly maintain enclose stairways used for exits and smoke proof enclosures in accordance with NFPA 101 (2012), Life Safety Code, section 7.1.3.2.1. This deficient finding could a widespread impact on the residents within the facility. Findings include: On 08/06/2024, between 10:00 AM and 12:00 PM, it was revealed by observation that storage materials had been placed in the South Stairwell. An interview with the Administrator verified this deficient finding at the time of discovery.	K 225	It is the policy of St Anthony Park Home to follow all Federal, State, and local guidelines, laws, regulations and statutes. This plan of correction is not to be construed as an admission of deficient practice by the facility administrator, employees, agents, or other individuals. The response to the alleged deficient practice cited in this statement of deficiencies does not constitute agreement with citations. The preparation, submission and implementation of this plan of correction will serve as our credible allegation of compliance. 1)What corrective actions(s) will be accomplished to correct deficiency. The scale and storage materials in the south stairwell have been removed. 2)Address measures put into place to ensure deficiency does not reoccur. All stairwells within the building are clear and have free egress. 3)How will facility plan to monitor future performance to ensure solutions are maintained. Maintenance Director and Environmental Director been educated on the NFPA 101 (2012), Life safety code, section7.1.3.2.1. Keeping all areas of stairwell free of any facility equipment.		

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K 293	Continued From page 5 An interview with the Administrator verified this deficient finding at the time of discovery.	K 293	3)How will facility plan to monitor future performance to ensure solutions are maintained. The administrator and Director of Maintenance will ensure exits continue to be clearly marked and illuminated. 4)Identify who is responsible for the corrective actions and monitoring of compliance. Inspections will be conducted 1x month 2 months. Audit review and analysis will be brought to QAPI to determine ongoing frequency and duration of audits. 5)Administrator and/or designee will ensure compliance. The actual date of completion was August 27, 2024.		
K 712 SS=F	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	K 712	1)What corrective actions(s) will be accomplished to correct deficiency. Fire drills will be conducted in	8/29/24	

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K 712	Continued From page 6 101 (2012 edition), Life Safety Code, sections 19.7.1.6, 4.7.4, and 4.6.1.1. These deficient findings could have a widespread impact on the residents within the facility. Findings include: On 08/06/2024, between 10:00 AM and 12:00 PM, it was revealed by a review of available documentation that the fire drills that were conducted were not conducted during varied times. Drill need to be at least 90 minutes apart from each other. An interview with the Administrator verified these deficient findings at the time of discovery.	K 712	accordance with NFPA requirements at an interval of one per shift per quarter and no closer than 90 minutes apart from the last recorded drill. 2)Address measures put into place to ensure deficiency does not reoccur. The facilities fire alarm tracking system will be updated to reflect the timing of drills to ensure 90 minute frequency compliance. 3)How will facility plan to monitor future performance to ensure solutions are maintained. The Maintenance Director will be educated on executing fire drills noting the varied times that are at least 90 minutes before or after the previous drill time. 4)Identify who is responsible for the corrective actions and monitoring of compliance. Audits will be 1x month for 2 months. Fire drill reports will be brought to QAPI to determine ongoing compliance. 5) Maintenance Director and/or designee will ensure compliance. The actual or proposed date for completion of the remedy is August 29, 2024		
K 761 SS=F	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested	K 761		8/27/24	

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K 761	Continued From page 7 annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to inspect fire doors per NFPA 101 (2012 edition), Life Safety Code section 8.3.3.1, and NFPA 80 (2010 edition), Standard for Fire Doors and Other Opening Protectives, section 5.2.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 08/06/2024, between 10:00 AM and 12:00 PM, it was revealed by a review of available documentation at the time of the survey the facility could not provide an annual fire door inspection report. An interview with the Administrator verified this deficient finding at the time of discovery.	K 761	1)What corrective actions(s) will be accomplished to correct deficiency. The annual 13 point fire door inspection was completed by 8/27/2024. 2)Address measures put into place to ensure deficiency does not reoccur. During drills fire doors were visibly inspected to ensure proper function however, it was not documented in writing. Documentation was obtained and used to correct this deficient finding. 3)How will facility plan to monitor future performance to ensure solutions are maintained. The facility obtained the proper documentation from the fire marshal and entered it into the facilities task list under annual life safety check within TELS. 4)Identify who is responsible for the corrective actions and monitoring of		

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NAME OF PROVIDER OR SUPPLIER ST ANTHONY PARK HOME INC			STREET ADDRESS, CITY, STATE, ZIP CODE 2237 COMMONWEALTH AVENUE SAINT PAUL, MN 55108		
(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 920	Continued From page 9 facility failed to maintain the usage of electrical adaptive devices NFPA 99 (2012 edition), Health Care Facilities Code, sections 10.5.2.3.1 and 10.2.4.2.1, NFPA 101 (2012 edition), Life Safety Code, section 9.1.2, NFPA 70, (2011 edition), National Electrical Code, sections 400.8, and UL 1363. These deficient findings could have a patterned impact on the residents within the facility. Findings include: On 08/06/2024, between 10:00 AM and 12:00 PM, it was revealed by observation that in the Business Office, there was a microwave plugged into a power strip and an addition extension cord was being used to supply power to the computer equipment. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 920	accomplished to correct deficiency. On August 6, 2024, Administrator and Office Manager corrected the deficient practice by plugging microwave directly into the wall, eliminating the extension cord. 2)Address measures put into place to ensure deficiency does not reoccur. All appliance power cords within the facility were checked to ensure they were plugged directly into the wall. 3)How will facility plan to monitor future performance to ensure solutions are maintained. All staff will be educated on extension cord usage within the facility and ensure no extension cords are used to power appliances. 4)Identify who is responsible for the corrective actions and monitoring of compliance. Inspections will be conducted 1x week for 4 weeks, 1x month for a month, then annually thereafter. Audit review and analysis will be brought to QAPI to determine ongoing frequency and duration of audits. 5) The Environmental Director and/or designee will ensure compliance. The actual date of completion is September 5, 2024.		