Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Submitted
September 29, 2023

Administrator
Bay View Nursing & Rehabilitation Center
1412 West Fourth Street
Red Wing, MN 55066

RE: CCN: 245223
Cycle Start Date: September 14, 2023

Dear Administrator:

On September 14, 2023, survey was completed at your facility by the Minnesota Department 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.

Your facility was not in substantial compliance with the participation requirements and the conditions in your facility constituted an immediate jeopardy to resident health or safety. This survey found the most serious deficiencies in your facility to be a pattern of deficiencies that constituted immediate jeopardy (Level K) whereby corrections were required. The Statement of Deficiencies (CMS-2567) is being electronically delivered.

REMOVAL OF IMMEDIATE JEOPARDY

On September 13, 2023, the situation of immediate jeopardy to potential health and safety cited at F812 was removed. However, continued non-compliance remains at the lower scope and severity of F.

REMEDIES

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

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective October 14, 2023.

This Department is also recommending that CMS impose a civil money penalty (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective October 14, 2023, (42 CFR 488.417 (b)), (42 CFR 488.417 (b)). They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective October 14, 2023, (42 CFR 488.417 (b)).

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

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $11,995; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by October 14, 2023, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Bay View Nursing & Rehabilitation Center will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from October 14, 2023. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions.

However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

ELECTRONIC PLAN OF CORRECTION (ePOC)

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

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

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

DEPARTMENT CONTACT

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by March 14, 2024, (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at 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.

APPEAL RIGHTS DENIAL OF PAYMENT

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

Steven.Delich@cms.hhs.gov

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

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
202-795-7490

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

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

APPEAL RIGHTS NURSE AIDE TRAINING PROHIBITION

Pursuant to the Federal regulations at 42 CFR Sections 498.3(b)(13)(2) and 498.3(b)(15), a finding of substandard quality of care that leads to the loss of approval by a Skilled Nursing Facility (SNF) of its NATCEP is an initial determination. In accordance with 42 CFR part 489 a provider dissatisfied with an initial determination is entitled to an appeal. If you disagree with the findings of substandard quality of care which resulted in the conduct of an extended survey and the subsequent loss of approval to conduct or be a site for a NATCEP, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40, et. Seq.

A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to the Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration) at the following address:

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

A request for a hearing should identify the specific issues and the findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. You do not need to submit records or other documents with your hearing request. The Departmental Appeals Board (DAB) will issue instructions regarding the proper submittal of documents for the hearing. The DAB will also set the location for the hearing, which is likely to be in Minnesota or in Chicago, Illinois. You may be represented by counsel at a hearing at your own expense.

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

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

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900

St. Paul, Minnesota 55164-0900

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

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

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

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

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

Please contact me with any questions regarding this letter.

Sincerely,

Lori Hagen, Compliance Analyst
Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Telephone: 651-201-4306
E-Mail: Lori.Hagen@state.mn.us

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
September 29, 2023

Administrator
Bay View Nursing & Rehabilitation Center
1412 West Fourth Street
Red Wing, MN 55066

Re: State Nursing Home Licensing Orders
Event ID: B5SX11

Dear Administrator:

The above facility was surveyed on September 11, 2023, through September 14, 2023, for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

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

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

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

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

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

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

Please contact me with any questions regarding this letter.

Sincerely,

Lori Hagen, Compliance Analyst
Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Telephone: 651-201-4306
E-Mail: Lori.Hagen@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245223	A. BUILDING _____ B. WING _____	C 09/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAY VIEW NURSING & REHABILITATION CENTER	1412 WEST FOURTH STREET RED WING, MN 55066

(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 9/11/23 to 9/14/23, a survey for compliance with Appendix Z, the Emergency Preparedness Requirements for Long Term Care facilities, was conducted during a standard recertification survey. Bay View Nursing & Rehabilitation Center was found 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 037 SS=C	EP Training Program CFR(s): 483.73(d)(1) §403.748(d)(1), §416.54(d)(1), §418.113(d)(1), §441.184(d)(1), §460.84(d)(1), §482.15(d)(1), §483.73(d)(1), §483.475(d)(1), §484.102(d)(1), §485.68(d)(1), §485.542(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	E 037		10/16/23

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

Electronically Signed | 10/06/2023

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

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E 037	Continued From page 1 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 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:	E 037		

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E 037	Continued From page 2 (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 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:	E 037		

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E 037	Continued From page 3 (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 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	E 037		

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E 037	Continued From page 4 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 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 record review the facility failed to ensure all staff completed emergency preparedness training annually. This had the potential to affect all 72 residents, staff and visitors at the facility. Findings include:	E 037	E037 Emergency Preparedness Training Program CFR(s): 483.73(d)(1) "Educare training modules were reviewed for completion of EP training by current staff. All staff that have not completed the training have been notified that this mandatory training must be completed by	

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E 037	Continued From page 5 Review of the facility emergency preparedness training log indicated 26 staff members had not completed online emergency preparedness training annually. During an interview on 9/15/23 at 1:00 p.m., the administrator verified not all staff had completed annual training on the facility's emergency preparedness policies and procedures to ensure they knew what to do during an emergency in the facility.	E 037	October 16th, 2023. Any staff member that does not have this training completed by this date will be removed from the schedule until they complete the required training. "Initial training in emergency preparedness policies and procedures will be required of all new staff upon hire prior to beginning any on-the-floor training or orientation. Training is assigned to all staff annually. "Policy for Staff Development training revised to include Emergency preparedness training. "Infection Preventionist/Staff Development nurse will audit randomly to determine compliance of all staff completion of mandatory modules and maintain documentation of all training. "Date of completion 10/16/2023	
E 041 SS=C	Hospital CAH and LTC Emergency Power CFR(s): 483.73(e) §482.15(e) Condition for Participation: (e) Emergency and standby power systems. The hospital must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section and in the policies and procedures plan set forth in paragraphs (b)(1)(i) and (ii) of this section. §483.73(e), §485.625(e), §485.542(e) (e) Emergency and standby power systems. The [LTC facility CAH and REH] must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section.	E 041		10/16/23

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

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E 041	Continued From page 7 552(a) and 1 CFR part 51. You may obtain the material from the sources listed below. You may inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the Federal Register to announce the changes. (1) National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169, www.nfpa.org, 1.617.770.3000. (i) NFPA 99, Health Care Facilities Code, 2012 edition, issued August 11, 2011. (ii) Technical interim amendment (TIA) 12-2 to NFPA 99, issued August 11, 2011. (iii) TIA 12-3 to NFPA 99, issued August 9, 2012. (iv) TIA 12-4 to NFPA 99, issued March 7, 2013. (v) TIA 12-5 to NFPA 99, issued August 1, 2013. (vi) TIA 12-6 to NFPA 99, issued March 3, 2014. (vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011. (viii) TIA 12-1 to NFPA 101, issued August 11, 2011. (ix) TIA 12-2 to NFPA 101, issued October 30, 2012. (x) TIA 12-3 to NFPA 101, issued October 22, 2013. (xi) TIA 12-4 to NFPA 101, issued October 22, 2013. (xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including	E 041		

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E 041	Continued From page 8 TIAs to chapter 7, issued August 6, 2009.. This REQUIREMENT is not met as evidenced by: Based on observation, review of available documentation and staff interview, the facility failed to test the on-site emergency generator system per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.4.4.1.1.3, 6.4.4.2 and NFPA 110 (2010 edition), Standard for Emergency and Standby Power Systems, 8.3.4, 8.3.4.1, 8.4.9, 8.4.9.2. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 9/13/2023, between 10:00 AM and 5:00 PM, it was revealed by a review of available documentation that no documentation was presented for review to confirm that 36-month - 4-hour load bank testing was occurring. An interview with the Maintenance Director verified this deficient finding at the time of discovery. See K-918 for additional information.	E 041	E041 Hospital CAH and LTC Emergency Power CFR(s): 483.73(e) "On 9/21/2023 the Generator 4-hour load bank test was completed by Hunt Electric Corporation from 8:30am to 12:30pm. The generator passed the test. The results are attached. To maintain compliance, this test will be completed every 36 months per regulation. "Policy updated to reflect maintenance required for generator. "All maintenance personnel who handle or potentially handle serving the generator are educated on updated policy. "Date of completion 10/16/2023	
F 000	INITIAL COMMENTS On 9/11/23 to 9/14/23, a standard abbreviated survey was completed at your facility by surveyors from the Minnesota Department of Health (MDH). The facility was not found not to be in compliance with the requirements of 42 CFR Part 483, Subpart B, requirements for Long Term Care Facilities. The survey resulted in an immediate jeopardy (IJ)	F 000		

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F 000	Continued From page 9 at F812 which began on 9/11/23, when when the facility began receiving and serving unpasteurized, undercooked eggs. The administrator and director of nursing (DON) were notified of the IJ on 9/12/23 at 1:04 PM and the immediacy was removed on 9/13/23 at 9:59 a.m.. The following complaints were reviewed: H52235265C (MN85709) with a deficiency cited at F921 H52235267C (MN85709) with a deficiency cited at F921 The following complaints were reviewed: H52235326C (MN96661) H52235263C (MN84449) H52235264C (MN89608) H52235243C (MN83818) H52235246C (MN90408) H52235361C (MN96787) H52235562C (MN96031) 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 that substantial compliance with the regulations has been attained.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights.	F 550		10/16/23

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F 550	Continued From page 10 The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart.	F 550		

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F 550	Continued From page 11 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure served meals were provided in a dignified, homelike manner for 1 of 1 resident (R5) reviewed who had cognitive impairment and an altered texture diet (i.e., pureed). Findings include: R5's quarterly Minimum Data Set (MDS), dated 8/25/23, identified R5 had severe cognitive impairment and required set-up with supervision for eating. On 9/13/23 at 7:17 a.m., R5 was observed seated in a high-back wheelchair in the commons area of the locked unit and a metallic, mobile cart was in the hallway outside the dining room which contained the unit resident' meal trays. At 7:30 a.m., licensed practical nurse (LPN)-B removed a meal tray from the cart and brought it over to R5. LPN-B placed the tray on a bedside table, and positioned the table over R5's lap saying aloud, "That's your breakfast." LPN-B placed a cloth protector on R5 and removed the dome on the scoop plate which had visible pureed items including sausage, biscuit(s), and scrambled egg present and separated. LPN-B then expressed aloud they were going to "mix it up a little bit for you" as they stirred all the items on the plate together; however, LPN-B did not ask R5 if they wanted the items mixed together prior to doing such. LPN-B mixed the entire plate contents together using a spoon and then expressed aloud it would "make it easier for you [R5]." LPN-B then placed the spoon in the mixed-together blend of pureed food and walked away. R5 then picked up	F 550	F550 Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) "Coaching provided to the nursing staff involved in unacceptable procedure of mixing R5 food together. "Education provided to all nursing staff to ensure served meals will be provided in a dignified, homelike manner for all residents; for residents with cognitive impairment and an altered texture diet, staff have been educated that mixing food together without resident expressing this as a preference is not an acceptable practice. "Random audits to be completed by Clinical Coordinators during mealtimes to assure compliance is maintained, audits to continue until determined by QAPI. "Plan of care and preferences reviewed for R5. "Policy updated to include for residents with cognitive impairments requiring altered diets, staff will not mix food together when serving unless the resident specifically requests this to be done. "Date of completion 10/16/2023	

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F 550	Continued From page 12 the spoon using his left hand and started to eat the meal. R5's care plan, dated 9/11/23, identified R5 had dysphagia (i.e., swallowing difficulties), consumed a pureed food diet with nectar thick liquids, and was independent with eating after set-up. However, the care plan lacked any intervention or evidence R5 was to have his meal items mixed together for service or consumption. Further, R5's medical record was reviewed and lacked evidence such action had been assessed or evaluated to ensure R5's acceptance and/or preference of having his meal items all blended together when served as LPN-B had done. When interviewed on 9/13/23 at 8:02 a.m., LPN-B verified they had mixed all of R5's meal items together when serving the breakfast meal. LPN-B expressed they did such as they had "seen others [staff] do that" with R5 and other residents on the unit adding the meal items were somewhat dry and "crumbly," so they felt mixing them together would make them easier to eat. When asked if R5 was acceptable to having such completed, LPN-B expressed they "think so" as R5 consumed the meal. LPN-B stated they were unsure if doing such action (i.e., mixing the items together) was care planned for R5 or not, however, reiterated they had seen other staff members do it. LPN-B verified they had not asked R5 if he wanted the meal items mixed together or not prior to doing so, and LPN-B acknowledged doing such action was a potential dignity issue for him adding, "I get it." On 9/13/23 at 11:56 a.m., licensed practical nurse care coordinator (LPN)-C was interviewed. LPN-C explained R5 was "totally dependent" for	F 550		

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F 550	Continued From page 13 cares and was "not with it" cognitively. LPN-C stated R5 had been on a pureed diet for, at least, nearly a year now and he should not have his food mixed together when served adding, "We don't mix his food." LPN-C stated such action was not on R5's care plan and expressed the nurse may have been confused since they don't routinely work on the unit. LPN-C stated they were going to complete some education with the nurse and reiterated the meal items should not have been mixed up adding staff should "just do [serve] what's normal for everyone [else]." LPN-C added, "I wouldn't want mine all mixed up." A facility provided Assistance with Meals policy, dated 1/2022, identified residents' would receive assistance with meals in a manner which met their individual needs. The policy outlined a section labeled, "Dining Room Residents," which outlined residents' unable to feed themselves would be fed with attention to safety, comfort and dignity with several examples listed including, "Not standing over residents while assistance them with meals," and, "Avoiding the use of labels when referring to residents." However, the policy lacked information on when, or if, mixing food items together for cognitively impaired residents with altered texture diets would be allowed and/or acceptable.	F 550		
F 551 SS=D	Rights Exercised by Representative CFR(s): 483.10(b)(3)-(7)(i)-(iii) §483.10(b)(3) In the case of a resident who has not been adjudged incompetent by the state court, the resident has the right to designate a representative, in accordance with State law and any legal surrogate so designated may exercise the resident's rights to the extent provided by	F 551		10/16/23

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F 551	Continued From page 14 state law. The same-sex spouse of a resident must be afforded treatment equal to that afforded to an opposite-sex spouse if the marriage was valid in the jurisdiction in which it was celebrated. (i) The resident representative has the right to exercise the resident's rights to the extent those rights are delegated to the representative. (ii) The resident retains the right to exercise those rights not delegated to a resident representative, including the right to revoke a delegation of rights, except as limited by State law. §483.10(b)(4) The facility must treat the decisions of a resident representative as the decisions of the resident to the extent required by the court or delegated by the resident, in accordance with applicable law. §483.10(b)(5) The facility shall not extend the resident representative the right to make decisions on behalf of the resident beyond the extent required by the court or delegated by the resident, in accordance with applicable law. §483.10(b)(6) If the facility has reason to believe that a resident representative is making decisions or taking actions that are not in the best interests of a resident, the facility shall report such concerns when and in the manner required under State law. §483.10(b)(7) In the case of a resident adjudged incompetent under the laws of a State by a court of competent jurisdiction, the rights of the resident devolve to and are exercised by the resident representative appointed under State law to act on the resident's behalf. The court-appointed resident representative exercises the resident's	F 551		

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F 551	Continued From page 15 rights to the extent judged necessary by a court of competent jurisdiction, in accordance with State law. (i) In the case of a resident representative whose decision-making authority is limited by State law or court appointment, the resident retains the right to make those decisions outside the representative's authority. (ii) The resident's wishes and preferences must be considered in the exercise of rights by the representative. (iii) To the extent practicable, the resident must be provided with opportunities to participate in the care planning process. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to assist R5 to pursue a guardian, following a neuropsychological evaluation which indicated R5 had significant cognitive impairment. Findings include: R5's Clinical Profile form dated 9/14/23, identified R5 as the "Responsible Party", no family or friends were listed under contact information. R5's quarterly Minimum Data Set (MDS), dated 8/25/23 indicated R5 had severe cognitive impairment, demonstrated occasional physical behaviors, did not refuse personal cares, and had several diagnoses including non-traumatic chronic subdural hemorrhage (brain bleed without trauma), hemiplegia (paralysis of one side of the body), depression, bipolar disorder (a mental condition that causes mood swings), traumatic disorder with anxiety and personal history of traumatic brain injury.	F 551	F551 Rights Exercised by Resident CFR(s): 483.10(b)(3)-(7)(i)(iii) "R5 is a South Dakota resident residing temporarily in Minnesota. On 10/31/2019, an application was submitted to South Dakota requesting guardianship for resident. Their response was they cannot assist because he resides in Minnesota. "In other cases, for residents at the facility, social services has reached out to their county of residence to request assistance with pursuing guardianship. Social worker was told by the Adult Protection department intake worker that unless there is an open Adult Protection Case, the county will not step in to assist. "R5 s care plans states: he cannot reliably recognize a dangerous situation due to dx TBI. He cannot remove himself to safety in a dangerous situation due to use of wheelchair for mobility. Date Initiated: 03/29/2016; staff are aware to anticipate his needs due to his cognition	

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F 551	Continued From page 16 R5's Diagnosis Report dated 9/14/23, indicated, R5 was admitted to the facility on 3/3/16. R5's communication care plan indicated, R5 had an alteration in communication related to his diagnosis of non-traumatic subdural hemorrhage. R5's care plan goal indicated, R5 will have adequate ability to communicate basic needs. R5's care plan did not addressed his cognitive impairment. During observation on 9/11/23 at 12:54 p.m., R5 was seated in a high-back wheelchair by the window, when asked how long he had lived at facility, R5 answered "yesterday". R5 offered non-sensical responses to questions about his personal cares. During interview on 9/13/23 at 2:29 p.m., licensed practical nurse (LPN)-B stated R5 was able to understand simple commands and was able to respond to questions about basic needs i.e., hunger, cold, thirst, going to bed or staying up in his wheelchair. LPN-B stated R5 couldn't make complex decisions i.e., understanding the cons of cancer treatment or surgical procedures. During interview on 9/13/23 at 2:35 p.m., LPN-C stated R5 was his own person, and made his own decisions. LPN-C verified R5's BIMS score of 7. A letter form the Associated Clinic of Psychology dated 10/18/19, indicated R5 had a neuropsychological evaluation done on 6/27/19. The results were included, and the treatment plan indicated "I recommend that he [R5] have a Court ordered Guardian to assist him in making healthcare and financial decisions due to his	F 551	and inability to make informed decisions. "During referral review, if it is documented anywhere that the hospital believes a guardian is recommended, needed, or there is concern for cognition, this process will be either be started or completed prior to admission to facility. Facility to obtain copies of confirmation of the petition prior to admission to facility . "Social services will ensure documentation to be included in the resident s chart related to all inquiries for pursuance of Guardianship. "Audit of care plans is being completed by Social Services for accuracy and edits as needed for residents needing a cognition focus and interventions. "Audits to continue until determination made by QAPI Team "Date of completion 10/16/2023	

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F 551	Continued From page 17 significant cognitive impairment". An application for guardianship dated 10/8/19 was completed by the social worker (SS)-A. The application indicated, the neuropsychologist recommended a guardian for R5, and under a section titled "Type of protection you think this person requires", two options were marked: both guardianship and conservatorship and emergency appointment." During interview on 9/14/23 at 1:36 p.m., SS-A verified R5's BIMS score was 7, and verified R5 was listed on the clinical profile as "responsible party". SS-A stated a review of R5's admission documentation did not provide information about family or friends. SS-A stated the application for guardianship was sent to South Dakota and the facility never received a letter about the guardianship application. SS-A contacted a person in South Dakota who said, South Dakota wouldn't pay for a guardian because R5 was living in Minnesota. SS-A stated other inquires were made in Minnesota without results. SS-A verified there was no documentation of the conversation with the person contacted in South Dakota, or the other contacts made with agencies in Minnesota. The policy titled Appointing a Resident Representative dated 12/16, does not address residents with severe cognitive impairment.	F 551		
F 645 SS=D	PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3) §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability.	F 645		10/16/23

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F 645	Continued From page 18 §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services; or (ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission- (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability. §483.20(k)(2) Exceptions. For purposes of this section- (i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital. (ii) The State may choose not to apply the preadmission screening program under	F 645		

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F 645	Continued From page 19 paragraph (k)(1) of this section to the admission to a nursing facility of an individual- (A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital, (B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and (C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services. §483.20(k)(3) Definition. For purposes of this section- (i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1). (ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure a Level I Pre-Admission Screening (PAS) and, if needed, a Level II Pre-Admission Screening and Resident Review (PASARR) were completed, retained in the medical record, and readily available to ensure continuity of care with mental health needs for two of two residents (R5, R38) reviewed for PASARR. Findings include: R5's quarterly Minimum Data Set (MDS), dated 8/25/23 indicated R5 had severe cognitive	F 645	F645 PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3) "As part of the admission s process, all PASARR screenings are received prior to admission to facility to ensure a level II PAS is not needed or is completed prior to admission. If a PAS advises criteria is not met for a level II, no further action is required, and the resident meets level of care. The original PASARR serves as the final documentation as labeled Preadmissions Screening Results. If a PAS advises the lead agency to send documents to the nursing facility, the lead	

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F 645	Continued From page 20 impairment, demonstrated occasional physical behaviors, did not refuse personal cares, and had several diagnoses including non-traumatic chronic subdural hemorrhage (brain bleed without trauma), hemiplegia (paralysis of one side of the body), depression, bipolar disorder (a mental condition that causes mood swings), traumatic disorder with anxiety and personal history of traumatic brain injury. R5's Diagnosis Report dated 9/14/23 indicated, R5 was admitted to facility on 3/3/16. An attached Fax from Senior LinkAge Line, dated 3/7/16, included R5's Preadmission Screening (PAS) which stated "Based on the information provided for this nursing home admission, it appears this consumer MEETS Level of Care for purposes of MA payment of long-term care, Final determination will be made once the form is received by Senior LinkAge". R5's entire medical record was reviewed and there was no follow up documentation from the Senior LinkAge Line. During interview on 9/13/23 at 11:14 p.m., social worker (SS)-A, stated "the referral was received by Senior LinkAge and no follow up was needed, [R5] did not meet criteria for level II." SS-A reviewed R5's medical record and verified R5's medical record lacked documentation of any further assessment done by the Senior LinkAge Line or a letter to confirm R5 did not meet the requirements to be evaluated for a level II screening. The facility Admissions Criteria policy dated 3/23, indicated the facility would conduct a level I	F 645	agency will only send additional information if warranted. "See attached lead agency responsibilities: Program status If a person is on the programs above at the time the PAS is submitted, the Senior LinkAge Line will triage the PAS to the lead agency for processing. It is recommended that the lead agency complete needed activity as soon as possible from the date of receiving the referral from the Senior LinkAge Line to ensure timely completion of any needed face-to-face assessment to avoid delays in nursing facility MA billing and payment. Essential Community Supports the Essential Community Supports (ECS) program serves people who do not meet NF LOC. When a PAS is submitted for an ECS participant, Senior LinkAge Line forwards the information to the lead agency to exit the person from the ECS program. -PASARR Booklet attached, page 8 references the lead agency. The final processing does not affect the result of the PAS but ensures the lead agency has processed them out of the current program they are in (such as waiver services), if necessary to ensure the SNF can bill. "In the case of R38, her PAS was processed by Blue Plus as she admitted to her previous facility, The Terrace at Cannon Falls from the community. Her PAS had to be processed to remove her from her current waiver to allow the SNF to bill for services. The PAS that was received from Rice County is identical to the PAS received from Senior Linkage.	

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F 645	Continued From page 21 PASARR screen for all potential admissions. The PASARR results would then be used by the interdisciplinary team to determine appropriateness of resident admission. R38's significant change Minimum Data Set (MDS) dated 6/24/23, indicated R38 had intact cognition with diagnoses including anxiety, major depressive disorder with psychotic symptoms, neurocognitive disorder with Lewy Bodies (causing changes in behavior and cognition), and psychotic disorder with hallucinations. R38's PASARR dated 8/19/22 indicated "the PAS [PASARR] is not final until the lead agency sends the documentation to the nursing facility." During an interview on 9/13/23 at 10:38 a.m., licensed practical nurse (LPN)-E stated she was responsible for managing the resident PASARRs. LPN-E stated because R38 had transferred from another facility she assumed R38's PASARR was completed. LPN-E verified she had not received any other PASARR paperwork from the previous facility. LPN-E stated if it had been greater than a year since completion of the PASARR, she would request a new one, adding "obviously, I don't know that much about it." During an interview on 9/14/23 at 3:50 p.m., the director of nursing (DON), stated she was unaware of the PASARR process and LPN-E was responsible for PASARR completion and maintenance. The facility Admissions Criteria policy dated 3/23, indicated the facility would conduct a level I PASARR screen for all potential admissions. The PASARR results would then be used by the	F 645	"In the case of R5, his PAS was processed in 2016. The facility will ensure a process is in place to confirm all paperwork is received from Senior Linkage Line. During survey, a note was added by Social Worker advising Senior Linkage did process the PAS but due to their new system, a paper copy can no longer be pulled. "So, no further residents will be affected, the facility will ensure that upon admission, initial PASARR is received and no level II is triggered. If transferring from another facility, this facility will contact Senior Linkage and request copy of most current PASARR. If more than one year old, a new PAS will be completed. If further action is required, the facility will contact lead agency listed and confirm no action is required by facility. A progress note will be made in resident s chart. "Admission s Director and Social Services educated on new process for all incoming admissions. "Date of completion 10/16/2023	

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F 645	Continued From page 22 interdisciplinary team to determine appropriateness of resident admission.	F 645		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure nails were trimmed and clean for 2 of 2 residents (R5, R10) and oral cares were offered and performed for 1 of 2 residents (R10) who were dependent on staff for activities of daily living (ADLs). Findings include: R5's quarterly Minimum Data Set (MDS), dated 8/25/23, indicated R5 had severe cognitive impairment, demonstrated occasional physical behaviors, did not refuse personal cares, was dependent with transfers, needed extensive assistance with bed mobility, locomotion on/off the unit, dressing, toileting, and personal hygiene. R5's diagnoses included non-traumatic chronic subdural hemorrhage (brain bleed without trauma), hemiplegia (paralysis of one side of the body), depression, bipolar disorder (a mental condition that causes mood swings), traumatic disorder with anxiety and personal history of traumatic brain injury. R5's care plan dated 9/11/23, indicated R5 required staff assist with dressing, grooming, and bathing related to impaired mobility and impaired	F 677	F677 ADL Care Provided to Residents CFR(s) 483.24(a)(2) "Education provided to direct care staff that fingernails need to be trimmed and clean. If resident preference to keep nails longer, they will be filed and clean. Oral cares are to be completed twice daily for all residents. Any refusal of cares must be reported to the nurse and must be documented in resident s chart. Care Plan is to be updated with resident s preferences and history of refusals if pertinent. "Nail care completed for residents R5 and R10 "Audits of nail care, oral care, and skin checks to be completed weekly by Clinical Coordinator of each unit for all residents until compliance is determined by QAPI team discussion. "Date of completion 10/16/2023	10/16/23

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F 677	Continued From page 23 cognition. R5's care plan directed staff to provide nail care on shower days as needed. R5's clinical orders dated 9/14/23 included an order for nurses to complete weekly skin assessment after shower/bath and to cut fingernails and toenails as needed. During observation on 9/11/23 at 12:54 p.m., R5 was seated in high-back wheelchair, R5's fingernails on both hands were long and had substantial black colored debris underneath some of his nails. During observation on 9/13/23 at 12:15 p.m., R5 was observed eating lunch, his fingernails were about 1/4 to ½ inch long and had debris underneath every fingernail. The debris' color ranged between light yellow and black. During interview on 9/13/23 at 12:41 a.m., nursing assistant (NA)-B stated R5 sometimes refused nail cares. NA-B stated residents' nails were supposed to be cut after weekly showers or baths. During interview on 9/13/23 at 12:48 p.m., licensed practical nurse (LPN)-C stated she could try to cut R5's fingernails but sometimes R5 refused nail care. LPN-C stated usually the staff can cut one or two nails at the time. LPN-C verified R5's fingernails were long and had debris underneath every fingernail. LPN-C stated R5's could scratch himself with his long and dirty fingernails and get a skin infection. During observation on 9/14/23 at 11:20 a.m., R5's fingernails were long and had debris underneath.	F 677		

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F 677	Continued From page 24 R5's progress notes between 5/19/23 and 9/11/23 lacked documentation of refusal of nail care or education related to having dirty long nails. During interview on 9/15/23 at 10:04 a.m., director of nursing (DON) stated fingernails and toenails were supposed to be done on shower days. The DON stated refusal to get nail trimmed needed to be documented on the weekly skin assessment and progress notes. DON stated dirty fingernails were an infection control issue, as we don't know what is underneath. R10's quarterly Minimum Data Set (MDS) identified severely impaired cognition and required extensive to total staff assistance with personal hygiene and grooming. R10's care plan updated on 7/14/23, indicated maximum assist from another person to complete personal hygiene. R10's face sheet printed 9/15/23, included personal history of traumatic brain injury, diabetes mellitus type 2 (DM2) and alcohol dependence with alcohol-induced persisting dementia. On 9/13/23 at 8:37 a.m., R10 was observed to have ½ inch long fingernails, with a dark brown, unknown substance caked under each nail on both hands. Certified nursing assistant (CNA)-B assisted R10 with morning cares and directed him to go to breakfast. CNA-B did not offer R10 oral cares. During interview on 9/13/23 at 12:55 p.m., CNA-B confirmed she had not offered oral cares for R10.	F 677		

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F 677	Continued From page 25 She stated R10 was resistive to cares at times. Previously, he had thrown the tooth brush and called her names. CNA-B stated "I have tried a second time since then with the same results. So now, I no longer ask or try to do R10's oral cares because he will just refuse." On 9/14/23 at 8:59 a.m., R10 was observed with ½ inch long fingernails, and a dark brown, unknown substance caked under each nail on both hands. On 9/14/23 at 9:22 a.m., certified nursing assistant (CNA)-C confirmed R10's fingernails were long, dirty, and needed to be clipped. She stated R10 had a history of removing his brief and playing in the fecal matter, masturbating and picking at an open wound on his abdomen. Nails were addressed on bath day or as needed unless the resident refused. R10 nails were to be kept short and clean because he picked at an open wound. On 9/14/23 at 9:30a.m., registered nurse (RN)-D confirmed R10's fingernails on both hands, were approximately ½ inch long with a dark brown, unknown substance under each nail. RN-D stated R10 had behaviors of playing in his feces and his nails can got dirty quickly. However, it was important we keep his nails short and clean due to getting a possible infection in his open abdominal wound. On 9/14/23 at 10:14 a.m., director of nursing (DON) stated her expectation was when residents, refused activities of daily living, staff reapproached or another staff tried. She expected staff charted when cares were refused and was not okay to not offer cares due to previous	F 677		

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F 677	Continued From page 26 refusals. When staff saw long or dirty nails, she expected nail care was completed. DON stated residents were vulnerable and don't have the mental or physical capacity to do it themselves. DON stated residents can't make their needs known and staff need to anticipate their needs. Facility policy: Activities of Daily Living (ADLs) Supporting, stated 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. The policy titled Care of Fingernails/Toenails Care dated 2/2018, indicated the purpose of this procedure was to clean the anil bed, to keep nails trimmed, and to prevent infections.	F 677		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide an ordered abdominal binder for a parastomal hernia and bilateral ankle foot orthosis (AFOs) needed for resident ambulation due to foot drop for 1 of 1 resident (R58) reviewed for quality of care.	F 684	F684 Quality of Care CFR(s): 483.25 "Education provided to therapy and nursing management that based on Comprehensive assessment all residents will receive treatment and care in accordance with professional standards,	10/16/23

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F 684	Continued From page 27 Findings include: R58's quarterly Minimum Data Set (MDS), dated 5/31/23 indicated R58 was cognitively intact and required supervision with most activities of daily living. R58's Medical Diagnoses List, printed on 9/15/23, indicated R58 was admitted to the facility on 3/15/23 with diagnoses of chronic kidney disease and type II diabetes. R58 was additionally diagnosed with parastomal hernia (a type of incisional hernia occurring in abdominal wall in the vicinity of a stoma) on 6/14/23. R58's Physician orders included an order, dated 8/8/23, to evaluate and treat for an abdominal binder for parastomal hernia and an order dated 7/1/22 to fit for bilateral ankle foot orthosis (a brace used to improve walking patterns by reducing, preventing, or limiting movement of the lower leg and foot and by supporting weak muscles. They are also used to maintain joint alignment, accommodate deformity and to help reduce spasticity), recommended for life. R58's care plan and treatment record in the electronic medical record (EMR) lacked evidence R58 ever received or was utilizing an abdominal binder or bilateral AFOs. During an interview on 9/11/23 at 4:10 p.m., R58 stated she had been talked to by staff about getting an abdominal binder for her hernia and bilateral braces for her feet but does not currently have them and has not had any follow up with staff since. R58's further stated she was having occasional pain in her abdomen due to her hernia	F 684	the comprehensive person-centered care plan, and the resident s choices. This includes all braces, binders or orthotics recommended by the physicians will be obtained, maintained, and repaired in a timely manner. "R58 has discharged from the facility. "Audits are to be completed monthly by Therapy Director to assure all residents with orders for braces, orthotics or binders have them, they are in working order and are providing the support intended for them. Audits to be completed until QAPI team reviews for compliance. "Date of completion 10/16/2023	

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F 684	Continued From page 28 and believed an abdominal binder would help. During an interview on 9/13/23 at 11:40 a.m., occupational therapist (OT)-A stated she was aware of the order for bilateral AFOs about a year ago but was under the impression physical therapy (PT) was taking care of it. Occupational therapy assistant (OTA)-A stated therapy had found a left an AFO for R58 that she wears when she is walking but had never obtained AFOs for both feet. OTA-A stated she had asked many times for R58 to get her own, bilateral AFOs but was unsure why she never did. OT-A stated she was also unsure why R58 did not have an abdominal binder stating, "We probably didn't even see the order." During an interview on 9/13/23 at 11:57 a.m., the restorative aide (RA)-A confirmed that R58 did not have an abdominal binder and only wore an AFO on her left foot when ambulating. During an interview on 9/13/23 at 12:31 p.m., OT-A clarified R58's face sheet was sent to Tillges, the company used for braces, and a technician came out to the facility to measure and fit R58 for bilateral AFOs. The company was waiting for the physician order to send out the braces and never received it from the facility and on 9/15/22 the order was voided. OT-A stated the order was never initiated again and it "fell through." OT-A further clarified the order for the abdominal binder was a nursing order and the facility had abdominal binders in their central supply and was unsure why that order was not followed up on. During an interview on 9/14/23 at 2:00 p.m., nurse manager and licensed practical nurse	F 684		

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F 684	Continued From page 29 (LPN)-J stated she was aware of the order for R58's abdominal binder confirming if she had an abdominal binder it would be the treatment record, stating if R58 said she did not have one then she most likely did not receive an abdominal binder. LPN-J confirmed, "I should have followed up on that but did not." LPN-J was unsure why R58 only had a left AFO and was unaware of an order for bilateral AFOs. During an interview on 9/15/23 at 10:24 a.m., the director of nursing stated physical therapy would be expected to follow up with the orders for R58's bilateral AFOs and abdominal binder. A facility policy titled Assistive Devices and Equipment, revised 1/2020, indicated the facility would provide or obtain certain devices and equipment that assist with resident mobility, safety and independence are provided for residents, including those needed for resident safety and mobility.	F 684		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an	F 690		10/16/23

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F 690	Continued From page 30 indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record document review, the facility failed to ensure appropriate management of an indwelling catheter was provided for 1 of 1 residents (R72) reviewed for indwelling catheter. Findings include: R72's 5 Day Minimum Data Set (MDS) dated 8/7/23, indicated R72 was cognitively intact and had a diagnoses of obstructive and reflux uropathy (condition that affects the urinary tract due to blockage or backward flow of urine). In addition, R72 identified as having an indwelling catheter.	F 690	F690 Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) "Education provided to all nursing staff on caring for residents with indwelling catheter, to assure all bags are covered whether in or out of resident s room and not to allow them to be on the floor. "Education provided to Clinical Coordinators that residents personalized plan of care must match their physician orders. "Policy reviewed and updated to include bag should not be allowed to lay on the floor at any time. "R72 care plan reviewed and updated. "R72 was provided with a catheter bag	

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F 690	Continued From page 31 R72's care plan dated 6/27/23, indicated R72 had an indwelling catheter and required staff to provide catheter cares twice per day. R72's physician orders (PO) dated 7/18/23, instructed staff to provide R72 catheter cares twice a day and as needed. During observation and interview with R72 on 9/12/23 at 8:21 a.m., R72 foley drainage bag was laying flat on the floor with no privacy cover on it. R72 stated the facility staff, "leave it on the floor and sometimes they hook it to the bed". R72 stated the staff, "never put it in a bag to cover it". During interview with nursing assistant (NA)-A on 9/13/23 at 7:46 a.m., stated foley catheter bags, "must be covered because of infection control and dignity". NA-A stated a foley drainage bag should be covered. During interview with licensed practical nurse (LPN)-A stated, "a privacy bag should cover the drainage bag, even if the resident is in their room." During interview with director of nursing (DON) on 9/15/23 at 8:52 a.m., DON stated the expectation of staff to provide privacy bags to cover all catheter drainage bags. Facility policy titled Quality of Life-Dignity revised February 2020 , direct staff to, "keep urinary catheter bags covered".	F 690	privacy cover. "Coaching form completed with staff working on R72 unit immediately when noted by surveyor. "Audits to be completed 3 times weekly by HUC to assure all catheter bags are covered and kept off the floor, to be continued until discussed with QAPI team to determine compliance continues to be met. "Date of completion 10/16/2023	
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration.	F 692		10/16/23

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F 692	Continued From page 32 (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to monitor weight gain in a dialysis dependent resident whose goal was to lose weight for 1 of 1 resident (R58) reviewed for nutrition. Findings include: R58's quarterly Minimum Data Set (MDS), dated 5/3/23 indicated R58 was cognitively intact and required supervision with most activities of daily living. R58's Medical Diagnoses list, printed 9/12/23 indicated R58 was admitted to the facility on 3/15/23 with diagnoses of dialysis dependent chronic kidney disease and type II diabetes. R58	F 692	F692 Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) "Education provided to Dietician and Nursing Management to review and document on all weight gains or losses, to document desired weight of resident, offer therapeutic diet if necessary and to educate residents on diet restrictions. "Nursing Management to notify Dietician when resident is gaining or losing weight that is not planned. "Dietician to meet with resident to provide guidance and education on dietary choices within a week of notification. "All residents weights to be reviewed. Dietician to document any concerns and update nursing management.	

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F 692	Continued From page 33 was additionally diagnosed with parastomal hernia (a type of incisional hernia occurring in abdominal wall in the vicinity of a stoma) on 6/14/23. R58's electronic medical record (EMR) indicated R58's weight was 219 pounds on 5/1/23 and 230 pounds on 9/1/23, a 5% weight gain in 4 months. R58's physician orders, dated 4/12/22, indicated an order for facility staff to weigh R58 before and after dialysis. R58 also had an order, dated 6/16/23 for a 48 ounce fluid restriction daily. R58's Care Plan, dated 10/26/22, indicated R58 had altered cardiovascular status related to hypertension (high blood pressure), coronary artery diseases (damage or disease in the heart's major blood vessels, usually caused by the buildup of plaque, causing coronary arteries to narrow, limiting blood flow to the heart), hypertensive heart disease with chronic kidney disease and atrial fibrillation (an irregular, often rapid heart rate that commonly causes poor blood flow). The care plan further indicated for staff to "encourage low fat, low salt intake" and for "diet consult as necessary." During an interview on 9/11/23 at 1:46 p.m., R58 stated her goal while at the facility was to lose weight however, she had gained "11 or 12 pounds." R58 stated staff had not talked with her about her weight goals and she had "cut back" on her eating on her own after recognizing her weight gain. During an interview and document review on 9/13/23 at 1:05 p.m., registered dietician (RD) stated he spoke with R58's dialysis dietician	F 692	"R58 has discharged from facility. "Director of Nursing or Designee to audit weights monthly for concerns and follow up with Dietician to assure compliance. Audits to be discussed monthly at QAPI meetings. "Date of completion 10/16/2023	

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F 692	Continued From page 34 frequently but had not spoken to R58 since July despite having R58 coded as "high risk" due to her dependance on dialysis. The RD acknowledged R58's weight gain, stating R58 had told him in the past about her goal to lose weight. The RD stated when a resident had a significant weight gain he would speak with the resident about there goals and offer education and talk with the resident about portion sizes and exercise, however he stated he had not spoken to R58 about this. The RD stated R58's current body mass index (BMI) was 44.9 which was "concerning" given her dependence on dialysis and diagnosis of heart disease. The RD stated if a concern was noted, he would meet with the resident and document his recommednations in a progress note. The RD's documentation in R36's progress notes did not indicate there was a noted concern about R36's weight gain and BMI. During an interview on 9/14/23 at 10:05 a.m., nursing assistant (CNA)-D stated that the expectation was to notify the nurse if a resident was gaining or losing weight and confirmed R58 had been gaining weight. During an interview on 9/14/23 at 2:00 p.m., nurse manager and licensed practical nurse (LPN)-J stated R58's dialysis staff had been concerned about her weight gain for the past month, stating it was discussed to have R58 add a fourth dialysis run during the week and restricting R58's water intake further. LPN-J stated this had made R58 upset but she had not notified the RD regarding R58's weight gain concerns. During an interview on 9/15/23 at 10:24 a.m., the director of nursing stated the expectation was for	F 692		

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F 692	Continued From page 35 the RD to monitor resident weights monthly and for the nurse managers to notify the RD if a weight gain or lose was noted. A facility policy tilted Weight Assessment and Intervention, revised 9/2003, indicated "any weight change of 5% or more since the last weight assessment will be retaken the next day for confirmation. If the weight is verified, nursing will immediately notify the Dietitian via email. Verbal notification must be confirmed in writing." The policy further indicated "the Dietitian will respond within 24 hours of receipt of written notification."	F 692		
F 693 SS=D	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic	F 693		10/16/23

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F 693	Continued From page 36 abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure tube feeding formula was labeled according to professional standards to avoid the possibility of feeding tube complications and or related infections for 1 of 1 resident (R70). Findings include: R70's quarterly Minimum Assessment Data (MDS) dated 8/28/23, indicated R70 was severely impaired, was unable to communicate needs, received enteral feeding via a gastric (stomach) tube, needed extensive assist with bed mobility and toileting, was dependent with transfers, dressing, bathing, feeding and personal hygiene. R70's diagnoses included acute respiratory failure, unspecified hypoxia (low level of oxygen in the blood), hypercapnia (when carbon dioxide is built up in the blood stream), neurogenic bladder (lack of bladder control due to spine or nerve injuries), viral hepatitis (is an infection that causes liver inflammation and damage) , cerebral vascular accident (damage to the brain from interruption of its blood supply), quadriplegia (paralysis of all four limbs), malnutrition, disorder of the autonomic nervous system, dysphagia post cerebral vascular accident (difficulty swallowing after cerebral vascular accident), tachycardia (heart rate over 100 beats a minute) , gastrostomy tube (GT- a medical device used to provide liquid nourishment, fluids, and medications by bypassing the oral intake), and tracheostomy (a surgically created hole in your windpipe that provides an alternative airway for breathing).	F 693	F693 Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)-(5) "All nurses have been educated to ensure proper feeding in use per MD order, label date, time and initial all tube feeding formula when initiated to avoid the possibility of feeding tube complications and or related infections. "R70 tube feeding formula removed from use and new properly labeled feeding was started. "Audits being completed 3 times weekly by Clinical Coordinator until determined by QAPI team. "Completion date 10/16/2023	

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F 693	Continued From page 37 R70's Orders report indicated "Enteral nutrition: Administer Nutren 2.0 via G-tube [gastric tube] and feeding pump at a rate of 44 ml [milliliters] per hour continuous every shift for life sustaining." R70's care plan dated 5/5/23, indicated R70 had a nutritional problem or potential for nutritional problem related to dysphagia and cerebral vascular accident. R70's care plan goal indicated R70 will maintain adequate nutritional status. During observation on 9/11/23 at 1:30 p.m., R70 was receiving enteral nutrition via a feeding pump, the pump indicated a flow rate of 44 ml per hour. A sealed bag of Nutren 2.0 hung from a feeding pole and the label was blank. The label included "patient name, patient ID, date/time started and tube feeding order." During interview on 9/11/23 at 5:19 p.m., the licensed practical nurse (LPN)-F verified the Nutren formula bag's label was blank. LPN-F stated the bag needed to be labeled, and stated nursing staff needed to know how long the bag had been hanging to prevent complications. LPN-F verified the medication administration record (MAR) did not indicate when a new bag was hung, the MAR included the tube feeding order and this was documented every shift. During interview on 9/13/23 at 10:52 a.m., registered nurse (RN)-B stated the nurses needed to write the time, date, and nurse initials. RN-B stated the formula might be too old and unsafe to infuse. During interview and observation on 9/15/23 at 9:21 a.m., R70's was receiving enteral nutrition	F 693		

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F 693	Continued From page 38 via a feeding pump, the pump indicated a flow rate of 44 ml per hour. The Nutren formula bag's label was blank. The LPN-G stated the label was not dated, initialed and didn't indicate when the formula was started. LPN-G stated the feeding had to be stopped and a properly labeled feeding bag needed to be started to prevent potential negative consequences to the patient. During interview on 9/15/23 at 9:59 a.m., the director of nursing (DON) stated the tube feeding formulas needed to be dated, timed, and initialed. DON stated the tube feeding formula was good for 24 hours and was not safe to use a feeding formula bag without knowing when the formula bag was started. DON stated residents might experience gastrointestinal upset if the formula is older than 24 hours. The policy title Enteral Nutrition dated 11/18 indicated adequate nutritional support through enteral nutrition is provided to residents as ordered.	F 693		
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon.	F 756		10/16/23

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F 756	Continued From page 39 (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 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 observation, interview and document review, the facility failed to implement appropriate monitoring for a resident receiving antipsychotic medications for 1 of 5 resident (R36) reviewed for unnecessary medications. Findings include: R36's quarterly Minimum Data Set, dated 8/25/23, indicated R36 was admitted to the facility on 3/3/23, had short term andlong term memory problems and required extensive assistance with	F 756	F756 Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) "Education provided to Clinical Coordinators that all Psychotropic medications must have Side effect monitoring, Target Behaviors and Non-pharmacological interventions. AIMS and orthostatic blood pressures must be completed for all residents receiving Antipsychotic medications. This must be entered into the resident s orders and	

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F 756	Continued From page 40 most activities of daily living (ADLs). R36's Diagnoses List, printed on 9/15/23, indicated R36 had several medical diagnoses including anxiety, major depressive disorder, bi-polar (a disorder associated with episodes of mood swings ranging from depressive lows to manic highs) and Friedreich Ataxia (a rare inherited disease that causes progressive damage to your nervous system and movement problems as nerve fibers in your spinal cord and peripheral nerves degenerate). R36's Physician Orders, printed on 9/15/23, indicated R36 had the following orders: Venlafaxine extended release, 75 milligrams (mg) in the morning and 37.5mg every morning for bipolar, dated 8/11/23; Depakene oral solution, 7.5 milliliters (mL) three times a day for bipolar, dated 8/11/23; and risperidone, 1 mg in the afternoon for bipolar, dated 8/11/23. R36's Physician Orders also indicated an order to monitor for side effects related to antipsychotic medication use but lacked non-pharmacological behavior interventions or to monitor orthostatic blood pressures. R36's electronic medical record (EMR), including her treatment record and care plan, lacked non-pharmacological behavior interventions and orthostatic blood pressure monitoring related to antipsychotic medication use. R36's EMR indicated a pharmacy recommendation, dated 3/6/23, to monitor R36's orthostatic blood pressures related to antipsychotic use and a pharmacy recommendation, dated 4/14/23 to add non-pharmacological behavior interventions to	F 756	care plan on admission. "Task added to Admission guide sheet for Clinical Coordinators to complete with each new admission. "Reviews of current residents on psychotropic medications are completed during monthly behavior meetings with Consultant pharmacist to ensure compliance is maintained. "Audits of each new admission to be completed by DON or Designee "R36 orders and Care plan updated with appropriate monitoring. "Completed 10/16/2023	

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F 756	Continued From page 41 behavior monitoring related to antipsychotic use. During an interview on 9/14/23 at 1:40 p.m., licensed practical nurse (LPN)-I stated residents who are on antipsychotic medications have behavioral monitoring and non-pharmacological behavior interventions listed on the treatment record and orthostatic blood pressures were also documented in the treatment record. LPN-I confirmed this was not present for R36 stating, "I am not sure why" because R36 was on multiple antipsychotic medications. During an interview on 9/15/23 at 9:50 a.m., the consulting pharmacist (CP) stated with all antipsychotics she would expect non-pharmacological behavior interventions to be in place that are specific to each resident. The CP also stated the importance of monitoring R36's orthostatic blood pressure due to her risperidone use to monitor for orthostasis (a form of low blood pressure that happens with position changes). During an interview on 9/14/23 at 2:00 p.m., nurse manager and licensed practical nurse LPN-J stated the expectation was for any resident on an antipsychotic medication to have monitoring in place for medication side effects, behaviors, and non-pharmacological behavior interventions. LPN-J stated the interventions are expected to be resident specific and would be in the treatment record. LPN-J also stated ortho static blood pressure monitoring would also be in the treatment record and confirmed that neither were in R36's treatment record but, "should be." During an interview on 9/15/23 at 10:24 a.m., the director of nursing (DON) stated R36 was hospitalized in August and antipsychotic	F 756		

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F 756	Continued From page 42 monitoring fell off her treatment record at that time, however she would have expected appropriate monitoring to be put back on her treatment record. The DON stated the expectation was that non-pharmacological behavior interventions were documented for all residents on an antipsychotic medication. A facility policy titled Antipsychotic Use, revised on 3/2016, indicated the policy was to assure all non-medication interventions have been attempted to assist with residents displaying mood, behaviors or sleep concerns and further indicated nursing staff should monitor and report side effects to the physician, including orthostatic hypotension.	F 756		
F 791 SS=D	Routine/Emergency Dental Srvcs in NFs CFR(s): 483.55(b)(1)-(5) §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	F 791		10/16/23

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F 791	Continued From page 43 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 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 dental needs were appropriately acted upon for 1 of 1 residents (R38) reviewed for dental. Findings include: R38's significant change Minimum Data Set (MDS) dated 6/24/23, indicated R38 had intact cognition with diagnoses including Parkinson's disease and dementia. R38 required extensive assistance for personal hygiene and did not reject cares. R38's care plan dated 3/18/23, identified R38 was	F 791	F791 Routine Emergency Dental Services CFR(s):483.55(b)(1)-(5) "Education provided to HUC to assure a list is made of any resident that is not seen for Health Drive appointments including, audiology, vision or dental due to not enough time and to assure those residents are seen first on the provider s next visit. "R38 was placed on list for missed at last visit and was seen on 9/21/2023 by dental to address her concerns. "Audit will be completed by DON monthly to assure residents missed on any health drive provider visits are on list to be seen	

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F 791	Continued From page 44 at risk for alteration in dental care related to Parkinson's disease. Interventions included setting up dental appointments as needed. R38's nurse practitioner (NP) note dated 7/18/23, indicated R38 wanted her partial denture fixed. The facility dental Visit Summary dated 7/27/23, indicated R38 was not treated during the visit due to the dentist's time restraint. The facility dental Visit Summary dated 8/15/23, did not include R38 as a treated or non-treated patient. When interviewed on 9/11/23 at 3:35 p.m., R38 stated her dentures were uncomfortable and needed to be adjusted. When interviewed on 9/13/23 at 7:38 a.m., R38 stated she had not seen a dentist since she admitted 3/3/23. R38 stated the ridges of her dentures were too high and would become painful after wearing them for a while. R38 stated they were adjusted a few months ago but continued to feel uncomfortable. When interviewed on 9/13/23 at 11:17 a.m., nursing assistant (NA)-E stated on 9/11/23, he informed an unknown nurse that R38 was unable to chew with her dentures in because they were uncomfortable and therefore, she removed them. When interviewed on 9/13/23 at 11:41 a.m., health unit coordinator (HUC)-A stated the facility dentist ran out of time to see R38 on 6/27/23, and should have been added to the list for 8/15/23, but had not. HUC-A stated there was not a process to ensure unseen residents were carried	F 791	at next visit. "Policy titled Routine Dental Care Services updated to include guidance to ensure missed appointments are rescheduled. "Completed 10/16/2023	

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F 791	Continued From page 45 over to the next appointment. When interviewed on 9/14/23 at 3:55 p.m., the director of nursing (DON) stated HUC-A was responsible for communicating resident's needs with the dental group. The DON stated she would have expected HUC-A to add R38 to the next dental appointment list after the dentist was not able to see her on 6/27/23. The DON stated she would expect a resident to receive the soonest available appointment especially if they were having pain or discomfort. A Routine Dental Care Services policy, undated, indicated each resident would be offered dental services as needed, including fitting dentures. However, the policy contained no guidance to ensure a missed appointment was rescheduled.	F 791		
F 809 SS=D	Frequency of Meals/Snacks at Bedtime CFR(s): 483.60(f)(1)-(3) §483.60(f) Frequency of Meals §483.60(f)(1) Each resident must receive and the facility must provide at least three meals daily, at regular times comparable to normal mealtimes in the community or in accordance with resident needs, preferences, requests, and plan of care. §483.60(f)(2)There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except when a nourishing snack is served at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span. §483.60(f)(3) Suitable, nourishing alternative meals and snacks must be provided to residents	F 809		10/16/23

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F 809	Continued From page 46 who want to eat at non-traditional times or outside of scheduled meal service times, consistent with the resident plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure that breakfast was provided to R14 outside traditional meals times prior to her regular morning appointment for hemodialysis. Findings include: R14's quarterly Minimum Data Set (MDS) dated 8/12/23, indicated R14 had intact cognition and required set up help for eating. R14's provider note dated 9/11/23 indicated R14 had a diagnosis of "Type 2 diabetes mellitus with diabetic nephropathy". R14's physician order (PO) summary dated 9/15/23 indicated diagnoses of end stage renal disease, dependence on renal dialysis, anxiety and dependence on supplemental oxygen. The PO did not indicate a diagnosis of diabetes mellitus. PO indicated R14 with, "Modified Renal diet Regular texture, Regular (Thin) consistency, 1.5L fluid restriction for Dialysis diet; low phosphorus, low sodium, low potassium". R14's care plan (CP) dated 9/12/23 indicated R14, "has Diabetes Mellitus" and, "offer substitutes for foods not eaten". In addition the CP indicated R14 "will go to outpatient dialysis 3x week". During interview with R14 on 9/11/23 at 6:31 p.m., R14 stated she did not receive breakfast that	F 809	F809 Frequency of meals/Snacks at Bedtime CFR(s): 483.60(f)(1)-(3) *Nursing staff education completed that residents must not go more than 14 hours between a substantial evening meal and breakfast the following day. A suitable nourishing alternative meal/snack must be provided to the residents that choose to eat during non-traditional times or outside of scheduled mealtimes. *Meal alternatives such as a sandwich, cold cereal, cottage cheese, yogurt, cheese sticks and various fruits are available on each nursing unit if a resident needs to eat outside of traditional mealtimes. If alternative meals are refused by the resident, this must be documented in the resident s clinical progress notes. Documentation must include what was offered, the time it was offered and residents reason for refusal. *Alternative meals will be sent with resident on appointments to assure food is available if they choose not to eat meal alternative offered before leaving. Documentation will be placed in resident s clinical chart if resident refuses to accept meal. *Batch monitoring order has been completed for Residents receiving meals outside of traditional mealtimes requiring	

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F 809	Continued From page 47 morning prior to leaving for scheduled hemodialysis. R14 stated, "I did not eat until I came back from dialysis' and indicated she was not offered a snack. During interview with the certified dietary manager (CDM) on 9/13/23 10:07 a.m., CDM stated, "the early morning cook is responsible for ensuring residents on dialysis get their breakfast before the go off to dialysis". The CDM stated R14 did not receive her breakfast on 9/11/23 prior to dialysis appointment and it, "did not happen". CDM stated concern for dialysis residents to miss a meal prior to dialysis and, "it is mean to leave someone without a meal". During interview with dietary cook (C)-A on 9/13/23 at 10:39 a.m., CA indicated early breakfast trays are the responsibility of the early morning cook. CA stated she was scheduled to work on the early morning shift on 9/11/23 and "was running late". CA stated R14 did not receive her early morning breakfast tray prior to leaving for hemodialysis on 9/11/23 and, "it was my mess up and will take blame on it." During interview with registered dietician, (RD)-A on 9/13/23 at 1:05 p.m., RD-A stated concern for dialysis residents missing a morning meal and, "I would be concerned if they didn't get anything." RD-A stated general nutrition, hydration or dehydration would be a reason for concern regarding missed meals. "If they have diabetes, which is not uncommon for dialysis residents it would be even more concerning" indicating a concern for the potential for a low blood sugar. During interview with nurse practitioner (NP)-A on 9/15/23 at 8:40 a.m., NP-A stated missed	F 809	nurse to document resident received a meal or suitable meal alternative. *ETAR audit will be completed by D.O.N. or Designee three times weekly until QAPI team determines sustained compliance. "Completed 10/16/2023	

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F 809	Continued From page 48 breakfast for R14 is a concern because R14's, "blood sugar could tank". During interview with director of nursing (DON) on 9/15/23 at 8:49 a.m., indicated R14 should not miss a meal and, "we need to have a backup plan" for when a meal is not provided prior to sending a resident to dialysis. "it did not happen". Facility policy titled Frequency of Meals revised January 2022 indicate, "Alternative meals will be offered to residents who choose to eat at non-traditional or outside of scheduled mealtimes, consistent with the plan of care".	F 809		
F 812 SS=K	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:	F 812		10/16/23

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F 812	Continued From page 49 Based on observation, interview and document review, the facility failed to ensure unpasteurized eggs were fully cooked and prepared in manner to prevent foodborne illness. This resulted in an immediate jeopardy (IJ) situation for 6 of 6 residents (R4, R9, R14, R38, R56, R59) identified to routinely consume unpasteurized, undercooked eggs and had an increased risk of contracting a potentially life-threatening foodborne illness. In addition, the facility failed to ensure dishwasher and cooking utensils were properly sanitized to reduce risk of cross contamination. In addition, the facility failed to ensure accurate monitoring and timely removal of facility food stored in refrigerators, freezers, and dry storage. In addition, the facility also failed to ensure kitchen refrigerator temperatures were properly monitored and maintained in a manner to reduce risk of foodborne illness. These facility failures had the potential to affect all 72 residents who consumed food from the facility kitchen. Further, the facility failed to ensure staff were trained in maintaining and properly harvesting a fruit and vegetable garden according to food procurement standards. This had the potential to affect all staff, residents and visitors who ate food from the facility garden. The IJ began on 9/11/23, when the facility was observed to be serving unpasteurized, undercooked eggs (runny yolks). The director of nursing (DON) and administrator were notified of the IJ at 1:04 p.m. on 9/12/23. The IJ was removed on 9/13/23, at 9:59 a.m., however non-compliance remained at the lower scope and severity of no actual harm with potential for more than minimal harm that is not immediate jeopardy (level F).	F 812	F812 Food Procurement, Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) "Serving of any type of undercooked eggs were stopped immediately on 9/11/2023 from being served as soon as the issue was identified. The partial case of eggs in the kitchen cooler and the full case in the downstairs cooler will be removed from the facility today to remove any potential of an undercooked egg being served. Residents have been notified of this change and pasteurized eggs are expected on the next delivery later this week. In the meantime, hard boiled and scrambled eggs are still available, and alternatives will be offered to the best of our ability. Two local grocery stores were checked today as an alternative and did not have pasteurized eggs available. Dietary staff will attempt again later this week to see if they are available prior to the next anticipated truck delivery. "The six residents identified (R4, R9, R14, R38, R56, and R59) have assessments and monitoring entered for 48 hours for signs and symptoms of GI upset such as fever, diarrhea, vomiting, abdominal pain, muscle aches, and poor appetite related to their consumption of unpasteurized eggs. All residents in the facility were then interviewed for how they prefer their eggs; anyone receiving undercooked eggs also had monitoring entered into their charts to ensure no symptoms. "Food distribution representative has been contacted and will remove unpasteurized eggs from our food formulary for ordering. She has also flagged our account to not	

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F 812	Continued From page 50 Findings include: The United States (US) Food and Drug Administration (FDA) article, "Egg Safety: What You Need to Know" dated March 2021, indicated fresh, shelled eggs may contain a bacteria called Salmonella that could cause food borne illness (food poisoning). People infected with Salmonella may experience diarrhea, fever, abdominal cramps, and vomiting 12 to 72 hours after exposure. Symptoms usually last four to seven days and may be severe enough to require hospitalization. A Salmonella infection could also move from the intestines to the bloodstream and spread throughout the body causing death. Older adults, and people with weakened immune systems (transplant patients, individuals with diabetes, cancer, or human immunodeficiency virus [HIV] or acquired immunodeficiency syndrome [AIDS]). The article also indicated when preparing raw or undercooked eggs "use either shell eggs that have been treated to destroy Salmonella, by pasteurization or another approved method, or pasteurized egg products". The article further indicated using a food thermometer was "the only way to ensure the safety of egg products for all cooking methods. These foods must be cooked to a safe minimum internal temperature to destroy any harmful bacteria." In addition, a Centers for Disease Control and Prevention (CDC) article, "Salmonella and Eggs" dated 2/16/21, indicated Salmonella from the inside of an egg that was "raw or lightly cooked" could cause illness such as diarrhea, vomiting, fever, and abdominal cramps. The article indicated to use only pasteurized eggs when consuming raw or lightly cooked eggs with an	F 812	send a substitute if pasteurized eggs are not available. "Immediate QAPI held to identify potential outcomes and concerns related to serving undercooked non-pasteurized eggs as well as discuss plan of correction. Our Medical Director was included in our findings and in agreement with POC. "All dietary staff have been educated regarding the difference between the two types of eggs as well as safe food handling. The policy surrounding safe food handling was reviewed during this education and found to be appropriate related to recognition of inadequate cooking and improper holding temperatures. The handouts attached were read in completion to the staff not available in person today. They received a hard copy as well. Additionally, the facility has developed a policy specifically related to eggs and their storage, handling, and preparation. "Dietary staff are also aware they need to notify management should any case of unpasteurized eggs be received during truckload delivery if assisting with putting delivery away. "Notification has been sent out to all facility staff regarding why current supplies of eggs have been removed and not replenished until the end of the week. They have also received a copy of the education presented and why undercooked eggs are not currently available. "Further, policy and procedure were developed for checking and monitoring of dishwasher temperatures to ensure	

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F 812	Continued From page 51 internal cooking temperature of 160 degrees Fahrenheit (F). The article further indicated people who are over the age of 65, or have weakened immune systems (HIV/AIDS, diabetes, or an organ transplant) may have more serious symptoms that could be life threatening. A facility egg invoice for the period of 1/01/23 through 09/19/2023 indicated the facility did not receive pasteurized eggs between 2/22/23 and 9/14/23, the last order being on 2/21/23. The facility then received their first sole order of unpasteurized eggs on 2/28/23. They then received 795 dozen unpasteurized eggs between 2/28/23 an 9/14/23. R4's quarterly Minimum Data Set (MDS) dated 8/3/23, indicated R4 had intact cognition with diagnoses including morbid obesity and diabetes. R9's quarterly MDS dated 8/8/23, indicated R9 had intact cognition with diagnoses including kidney disease and diabetes. R14's quarterly MDS dated 8/12/23, indicated R14 had intact cognition with diagnoses including renal disease with dialysis, respiratory failure, a cardiac pacemaker, and morbid obesity. R38's significant change MDS dated 6/24/23, indicated R38 had intact cognition with diagnoses including Parkinson's disease and a neurocognitive disorder with Lewy Bodies (causing changes in behavior and cognition). R56's significant change MDS dated 6/29/23, indicated R56 had intact cognition with a diagnosis of multiple sclerosis (MS, which caused damage to the brain and spinal cord) and liver	F 812	maintaining appropriate temperature during cycles. The policy states the correct temperatures to be met during cycles, keeping a log of these temps, who to notify if not reaching appropriate temperature, and the procedure for sanitizing dishes until the machine can be serviced by the manufacturer. "Contractor was in house on 9/20/2023 when they received the microchips to be replaced in the booster heater for the dishwashing machine. "Education was developed and completed with all dietary staff to include reviewing the policy, understanding the correct temperatures, and awareness of procedure should dishes have to be washed manually. "CDM has been randomly auditing completion of checking of temperatures and providing correction and coaching as needed. "Further, maintenance is no longer in charge of checking the refrigerator temperatures in the kitchen. The CDM was provided with a procedure for the kitchen staff to take over checking the temperatures immediately on 9/15/23. See attached procedure. Administrator and Maintenance Director (MTD) both to be notified immediately if fridge temp did not return to normal range with recheck to ensure proper follow up action is taken timely. "All refrigerators in the kitchen area were marked with corresponding numbers to the temperature log for ease of identification. Staff were educated on the new procedure for checking temps and	

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F 812	Continued From page 52 disease. R59's quarterly MDS dated 6/29/23, indicated R59 had intact cognition with diagnoses including hemiplegia/hemiparesis (partial to complete paralysis of one side of the body), anemia (insufficient number of oxygen carrying cells), and hypertension (high blood pressure). During observation on 9/11/23 at 12:46 p.m., an open, 15 dozen box of eggs was noted in the first floor, double door refrigerator with approximately 60 eggs missing. There was no stamp or markings on the box or eggs to indicate they had been pasteurized (a process used to eliminate bacteria and disease-producing microorganisms in foods, such as dairy; often denoted by a "P" stamped on eggs). At 1:38 p.m., an unopened box of 15 dozen eggs was noted in basement cooler, also with no stamp or marking on box or eggs. During an interview on 9/11/23 at 3:10 p.m., R59 stated she had over easy eggs (method for preparing eggs involving a cooked egg white and a not fully cooked runny yolk) for breakfast and did not like them scrambled. During an interview on 9/11/23 at 3:11 p.m., R56 stated she ate eggs with runny yolks for breakfast every morning. During an interview on 9/11/23 at 3:37 p.m., R38 stated she ate a fried egg with a runny yolk for breakfast that day. During an interview on 9/12/23 at 8:30 a.m., R4 stated he frequently ordered over easy eggs with runny yolks and could soak up his yolk with his	F 812	who was responsible on each duty shift to ensure this has been getting completed daily. CDM to review and ensure it is being completed. "On 9/14/23 Fridge #2 was cleared of all food items due to recurrent high temperatures. On 9/15/23, refrigeration contract service was here to evaluate fridge and confirmed parts needed and they were ordered. On 9/22/23, refrigeration contract service was back in the building to replace the faulty parts and the refrigerator was brought back into service. "Further, refrigerated, and frozen foods are dated upon delivery. Foods with expiration dates are used prior to the date on the package. All canned goods will be dated, and staff will use the FIFO (first in/first out) method to rotate foods. Canned and dry foods without expiration dates are used within six months of delivery or according to the manufacturer s guidelines. "Kitchen staff have been re-educated on the importance of labeling of food items upon delivery and during storage and use, per MN Dept of Health Food Guidelines, attached. "Further, the policy regarding the facility garden was updated to reflect coverage of use of fertilizers. A log was created for tracking dates, times, and specific fertilizers used on the garden and to ensure staff are following manufacturer instructions. "All life enrichment staff were educated on the policy update for resident-maintained gardens as well as safe food handling	

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F 812	Continued From page 53 toast at breakfast yesterday. During interview and record review on 9/11/23 at 5:16 p.m., the certified dietary manager (CDM) stated her food distributor informed her that if the eggs were pasteurized, the egg box would have "pasteurized" written on the side, which she stated it did not. The CDM concluded they had started to receive unpasteurized eggs starting in February of this year and presented the food invoices from 8/29/23 - 9/8/23. The invoice indicated 15 dozen large grade AA white eggs and no pasteurized eggs had been ordered three times in that period. The CDM indicated these eggs were not pasteurized. During an interview on 9/12/23 at 8:35 a.m., nursing assistant (NA)-A stated R4, R38, R56 received eggs with runny yolks on a regular basis. During an interview on 9/12/23 at 11:46 a.m., trained medication aide (TMA)-B stated R9 ate her eggs fried with a runny yolk on a regular basis. TMA-B presented R9's filled out menu for 9/13/23 with writing that indicated, "over easy eggs," indicating menu choice. R59's Submitted food menu dated 9/13/23 was also reviewed. It indicated R56 ordered a piece of dry toast with a soft fried egg on top. Soft fried egg was circled and over easy was written in large letters to the right of the text. During an interview on 9/12/23 at 12:00 p.m., TMA-A stated R14 ate over-easy eggs every day. During an interview on 9/12/23 at 8:41 a.m., C-A stated she often worked the 6 a.m. to 2:30 p.m. shift. C-A stated they normally used those (pointed to the unpasteurized eggs) eggs to cook	F 812	procedures. "All produce from the facility garden to be washed and stored per safe food handling guidelines and labeled as such. "Date completed 10/16/2023	

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F 812	Continued From page 54 residents over easy eggs. She stated herself and other staff had cooked over easy eggs, with these eggs, since she started a year and half ago. C-A stated they would take temperatures of the fully cooked egg white, but not the yolk because they didn't want to break it. C-A stated she was unaware of the difference between pasteurized and unpasteurized eggs. During an interview on 9/12/23 at 10:28 a.m., C-B stated she had been cooking for "a long time" and did not have a certification. C-B was unsure how many residents received runny eggs in the morning but knew it was at least nine. C-B stated she would take the temperature of the egg white instead of the egg yolk because she did not want it to run. During interview and record review on 9/11/23 at 5:41 p.m., cook (C)-C stated if temperatures of fried eggs were taken, they would add a line to the food temperature log, hand write fried eggs, and record temperature there. C-C presented the food logs for 8/27, 8/31, 9/3, and 9/4. She was unable to locate temperature logs for the past month or week. The temperature logs presented did not document fried egg temperatures. During an interview on 9/11/23 at 5:54 p.m., the CDM stated staff knew their fried eggs are cooked to temperature by putting the egg in the pan and then they "flip it and flip it again." The CDM stated temperatures were not taken of fried eggs because the egg would "run all over." The CDM stated the residents should not receive unpasteurized, not fully cooked eggs because this population was more susceptible to acquiring a salmonella infection.	F 812		

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F 812	Continued From page 55 The IJ which began 9/11/23, and was removed on 9/13/23, after it was verified through observation, interview, and record review the facility stopped serving undercooked, unpasteurized eggs to residents and when the facility implemented a removal plan which included: - Removed the unpasteurized eggs from made-to-order service and ordering new, pasteurized eggs to use when preparing undercooked, fried eggs; - Provided education to the dietary and nursing staff regarding State and Federal requirements for safe egg handling and preparation and; - Implemented audits to ensure the correct eggs are being ordered, delivered and prepared. On 9/13/23 from 8:48 p.m. to 9:04 p.m. direct dietary and nursing staff were interviewed and verified they had received education regarding the safe preparation of made-to-order, undercooked eggs; and the kitchen was toured to ensure no unpasteurized eggs were available to use for made-to-order cooking. Dishwasher Temperature: During an interview on 9/11/23 at 6:36 p.m., the CDM stated the facility did not monitor the dishwasher temperature. During an interview and observation on 9/13/23 at 12:59 p.m., the CDM stated dishwasher temperatures were not recorded and an accompanying policy did not exist. The CDM stated they use a high temperature dishwasher by Ecolab (EC-44). Dietary aide (DA)-A filled the	F 812		

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F 812	Continued From page 56 dishwasher rack with various dishware and advanced the rack into the machine. The dishwasher wash temperature read at 150 F with a rinse of 172 F. DA-A retrieved the dishwasher rack from the exit and loaded the rack again, reaching a rinse temperature of 178 F. At 1:07 p.m., another dish rack was loaded into the machine with a final rinse temperature of 168 F. At 1:08 p.m., DA-A stated he ran the dishes through the washer twice because they it does not reach 180 degrees. During an interview and observation on 9/14/23 at 1:41 p.m., DA-B put a large strainer through the dishwasher and the final rinse cycle reached 176 F. DA-B picked up the strainer and ran it through again, this time reaching a temperature of 178 F. He picked up the strainer and stated he would run the dishes through the washer twice if the temperature was low but did not use any additional sanitizing methods. During an interview on 9/14/23 at 9:40 a.m., the Maintenance Director (MTD) stated the dishwasher booster needed replacing. The MTD stated he recommended staff run dishes through the machine twice until it was fixed and that would kill the germs and bacteria. The MTD stated the rinse cycle should have reached 180 F but was reaching 130-140 F. During an interview on 9/14/23 at 3:01 p.m., the administrator stated the dishwasher should have reached 180 F and until it did, staff would not use the machine and instead, use sanitizing liquid. Refrigerator temperature: During an interview on 9/14/23 at 9:03 a.m., the	F 812		

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F 812	Continued From page 57 MTD stated the refrigerator temperatures were taken daily by one of his staff members. The MTD stated if maintenance staff (M)-A checked the temperature and if it was elevated, the elevated temperature would be recorded, but a recording of the rechecked temperature would not be expected. During an interview and observation on 9/14/23 at 10:47 a.m., M-A stated during the few years he worked for the facility, he solely, monitored the refrigerator temperatures. M-A stated because of this, they were not taken on the weekends or when he was on vacation. M-A stated he was unsure what refrigerators matched the numbers on the temperature log. M-A stated he recorded the temperatures between 8:00 a.m. - 9:00 a.m., and the goal temperature was between 30-40 F. M-A stated if the temperature was high, he assumed it was related to an open refrigerator door. M-A would try to recheck it but often would not have time. M-A stated a few weeks ago (pointing to the temperature log for 8/15/23 through 9/13/23) he noticed rising temperature in the double door cooler used to store eggs and other perishable foods. M-A stated he notified the CMD on 8/18/23, after temperatures stayed between 45-48 F for three days. During an interview on 9/14/23 at 11:03 a.m., the CDM stated she expected the refrigerators to be kept at a temperature below 40 degrees and staff had not informed her of elevation. The CDM was also unsure what refrigerators matched the numbering system used in the temperature log. A facility invoice from a refrigerator repair company dated 8/28/23, indicated the two-door cooler was warm so it was recharged but a new	F 812		

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F 812	Continued From page 58 evaporator was needed. During an interview on 9/14/23 at 12:53 p.m., the MTD stated he was unaware of the faulty evaporator, which would cause the refrigerator temperature to rise. The MTD stated the refrigerator company managed this, not him. During an interview on 9/14/23 at 3:01 p.m., the administrator stated the refrigerator temperature should not be higher than 40 degrees Fahrenheit, and until the issue was resolved the refrigerator should not be used. Facility refrigerator temperature logs for 6/20/23 through 9/14/23 were reviewed. The temperature of refrigerator two was greater than 41 F, 37 days during the period. The temperature of refrigerator three was greater than 41 F, 17 days during the period. The temperature was not taken 29 days in the 86-day period. This temperature log did not include action taken when a temperature was above 41 F. Unlabeled food: During the initial kitchen observation and interview on 9/11/23 at 12:43 p.m.,the following foods were found in the double door freezer on the first floor: -Opened, undated sausage in clear plastic bag. -Undated pancakes in an opened clear plastic bag. -Undated carrots in opened clear plastic bag. The following foods were observed in the double door cooler on the first floor:	F 812		

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F 812	Continued From page 59 -Opened, undated coleslaw in plastic bag; undated, half empty -One-gallon jug of thousand island dressing -Opened undated onions in clear plastic basket. The following foods were found in the dry storage room on the first floor: -undated, loose wafer bars in clear basket; -undated opened package of gluten-free brownies in a clear basket; The following foods were observed in the secondary refrigerator in the first-floor kitchen: -Opened, undated, one gallon jug of pasta salad with cheddar cheese. -Undated, 18-quart container filled to four-quart mark with breadcrumbs. -Three, undated, half-empty bags of spaghetti noodles. - An opened, undated container of croutons. The following foods were observed in basement walk-in freezer: - undated opened bag of hashbrowns; - undated bag opened bag of hamburger buns; -Two undated lemon meringue pies; - Four, undated banana cream pies. - Unopened, undated waffles in clear plastic bag. During a tour of the walk-in basement cooler, an unopened five pound bag of shredded cheddar cheese dated 7/24/23 was observed. The CDM stated they normally keep items one month past the listed date and the CDM took the bag of cheese and disposed it. During interview on 9/11/23 at 5:48 p.m., the	F 812		

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F 812	Continued From page 60 CDM stated the gluten free brownies were safe for consumption up to three months when frozen. The CDM stated they were purchased on 4/17/23. The CDM stated she educated staff on the importance of labeling food. The CDM stated she because of this she would worried about a food-borne illness related to expired food. The facility Refrigerators and Freezers policy dated 12/08, indicated acceptable temperatures for a refrigerator were 35-40 F. These temperatures should be tracked on monthly sheets that include an action taken column for unacceptable temperatures. The designated employee should check the refrigerator and freezer with the first opening and at closing in the evening and immediate action should be taken for temperature out of range. This policy indicated all food should be properly dated including dating individual items removed from the box or case. Facility garden During an observation and interview on 9/15/23 at 10:14 a.m., a bowl of cherry tomatoes and a container of peppers was stored in the second-floor life enrichment (LE) refrigerator. The LE director (LED) stated the vegetables were grown in the facility garden and were for the residents to eat. During an observation and interview on 9/15/23 at 10:28 a.m., behind the facility near the smoking area accessible to all residents, one large planter box contained raspberry plants and another large planter box contained various peppers, cucumbers, and cherry tomatoes. The LED stated the raspberries had been growing since	F 812		

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F 812	Continued From page 61 before he started working there a few years prior. The LED stated he did not water, fertilize or care for the raspberry plants in any way, allowing them to grow naturally. The LED stated he had planted the peppers, cucumber, and tomatoes by seed, that spring and had added a standard plant soil to the planter box. A bottle of Miracle Grow "Pour and Feed" fertilizer and spray bottle were sitting on top of the vegetable planter box. The LED stated he would pour the fertilizer into the spray bottle, add water, and spray the plants. The LED stated he had sprayed the plants approximately three times since he planted them, however, he was unable to provide the dates they were fertilized. The LED also stated he was unaware of a recommended time to wait before picking and/or eating the vegetables after they were sprayed with the fertilizer. The LED further stated he had not received any training regarding safe food handling or procurement during his employment at the facility. During an interview on 9/15/23 at 9:16 a.m., the IP stated she was not involved in the care of the facility garden and was unaware it existed until that week. The IP stated she was unsure if she should be involved in the project but would expect the staff avoid using fertilizer on the plants and to wash the fruits and vegetables appropriately to avoid contamination or resident illness. The IP further stated she had not educated the LE staff on proper food handling or procurement. During an interview on 9/15/23 at 12:19 p.m., the administrator stated she did not have any involvement in the facility garden; however, she would expect the LED to follow the facility policies and procedures regarding the safe growing and handling of the food grown in the garden for	F 812		

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F 812	Continued From page 62 resident consumption to avoid contamination and/or food born illnesses. The facility Resident-Maintained Gardens policy dated January 2022, indicated the facility was to follow safe food handling practices at all times when handling produce harvested from the facility garden. The facility was also to follow all State and local requirements related to food grown on site for resident consumption. The policy also indicated preventing contamination was more effective in preventing foodborne illness than relying on washing or cooking the produce. The policy also indicated the use of green manure or heat-treated manure for fertilizer and to maximize the time between manure application and harvest. Further, staff were to follow hand hygiene practices before and after gardening and before and after handling the produce. The facility Dishwasher Machine Use policy dated 11/10, indicated the hot water sanitation rinse temperature should reach 180 F. It also indicated the operator should check the temperatures with each cycle and record the results in a log. The policy indicated if the temperature was inadequate, it should be reported to the supervisor and machine should not be used until corrected. The facility policy titled Preventing Foodborne Illness, dated 1/22, indicated potentially hazardous foods kept between 41 F to 135 F for more than four hours will be discarded. The policy indicated all food service equipment and utensils will be sanitized according to current guidelines. The policy indicated that all potentially hazardous food will be cooked to appropriate temperature and will not be held between 41 F to 135 F for more than 4 hours.	F 812		

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F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to:	F 880		10/16/23

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F 880	Continued From page 64 (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to implement COVID outbreak status at the facility after three staff members tested positive for COVID and had been at work within 24 hours of testing positive exposing vulnerable, ventilator dependent residents to COVID. In addition the facility also failed to implement symptom tracking and surveillance for residents with infection symptoms who were not on antibiotics. This had the ability to affect all 72 residents in the facility.	F 880	F880 Infection Prevention & Control *COVID outbreak status was implemented immediately when IP nurse was notified of 3 staff members testing positive for COVID within 24 hours of working at facility. *COVID policies and procedures reviewed for accuracy of information using CMS and MDH guidelines.	

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F 880	Continued From page 65 Findings include: According to the most current Center for Disease Control (CDC) recommendations, revised 5/2023, a long-term care facility should deem the facility in COVID outbreak status after recognition of three staff or residents with COVID symptoms or one staff or resident with a positive COVID test. During observation at entrance to the facility on 9/11/23, staff were not wearing masks except for the activities director (AD) who was observed wearing a surgical mask. During an interview on 9/13/23 at 1:49 p.m., activity aide (AA)-A stated she had tested positive for COVID on 9/9/23 after her roommate, who was also an activity aide (AA-B) developed COVID symptoms that morning. AA-A stated she was at work when she tested positive and had worked as a nursing assistant on second and third floor before hosting a coffee and trivia activity with 8 residents that morning. AA-A stated AA-B had also tested positive for COVID on 9/9/23 and the AD was notified. During an interview on 9/13/23 at 2:30 p.m., the AD stated he was made aware of AA-A testing positive for COVID on 9/9/23 when AA-A called the AD immediately to report her positive COVID test. The AD stated he notified the IP and the administrator that same day by email. Later that afternoon the AD was notified that AA-B had also tested positive for COVID. The AD received a list of residents AA-A was in contact with the morning of 9/9/23 but confirmed they did not have a list of any residents AA-A or AA-B were in contact with the day prior (9/8/23).	F 880	*For any staff or resident testing positive for COVID, IP nurse will notify D.O.N. and Administrator, current situation will be reviewed/discussed to assure all correct measures are initiated. *IP nurse has been educated on current COVID policy/procedures and CMS guidelines. *Symptom tracking implemented to provide surveillance for residents with infection symptoms who are not on antibiotics. *Administrator/D.O.N. to audit outbreak status and all new COVID positive cases daily to ensure compliance. Audits to continue until substantial compliance determined by QAPI. *Date completed 10/16/2023	

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F 880	Continued From page 66 During an interview on 9/13/23 at 2:20 p.m., the infection preventionist (IP) stated she was made aware on 9/9/23 that AA-A and AA-B testing positive for COVID that day and was given a list of the residents who attended the morning activity but was unaware AA-A had also helped as a nursing assistant on second and third floor that morning. The IP stated a staff member from the kitchen had also tested positive on Saturday but did not have any direct exposure to residents. The IP stated she waited until Monday to test the known residents who had exposure despite their policy being to test 24 hours after exposure and again 48 hours after the first test and again 48 hours after the second test. The IP further stated she had not considered the facility in outbreak status and had only instructed the activities department to wear masks. In an outbreak status, the IP stated she should have tested the whole facility for COVID 24 hours after exposure and instructed all staff members working with the ventilator patients to wear masks, stating all staff members would only be required to wear masks if a resident tested positive for COVID. During observation on 9/14/23 at 7:00 a.m., a sign posted at the front door to the facility, and at the reception desk, stated the facility was in COVID outbreak status. All facility staff were observed to be wearing surgical masks. During a subsequent interview on 9/14/23 at 8:06 a.m., the IP stated she implemented all staff were required to wear masks and test for COVID twice a week. The IP stated all residents were tested for COVID that morning (9/14/23) and were all COVID negative, but two additional staff members tested positive for COVID. The IP	F 880		

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F 880	Continued From page 67 stated the facility would continue to test 14 days past the last positive COVID test. During an interview on 9/14/23 at 10:53 a.m., the IP stated she tracked all residents on antibiotics using a excel spreadsheet but was not formally tracking symptoms of infection that did require antibiotic use. The IP stated resident infection symptoms were discussed in an interdisciplinary team meeting every morning but for best practice every symptom should be tracked, further stating going forward that would be her practice. During an interview on 9/15/23 at 10:24 a.m., the director of nursing stated she was aware of the concerns with the COVID tracking and testing and did not have any more information to add that was not discussed with the IP. A facility policy on COVID was requested but not received. A facility policy titled Surveillance for Infections, revised 9/2017, indicated, "the Infection Preventionist will conduct ongoing surveillance for Healthcare-Associated Infections (HAIs) and other epidemiologically significant infections that have substantial impact on potential resident outcome and that may require transmission-based precautions and other preventative interventions."	F 880		
F 921 SS=E	Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i) §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.	F 921		10/16/23

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F 921	Continued From page 68 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure structural issues and items in disrepair were addressed and fixed in 1 of 1 locked unit area(s) to help promote a homelike, sanitary environment. This had potential to affect 15 of 15 residents identified to reside on the unit during the survey. Findings include: A provided 3E Report Sheet, dated 8/10/23, identified a total of 15 residents resided on the locked unit at the time of survey. On 9/11/23 at 5:51 p.m., a tour of the "3E [East]" locked unit was completed which identified the unit consisted of three separate wings (i.e., East, middle, West) with a central commons area and main dining room. However, the following items in obvious disrepair were observed: 1) The East hallway (Rms. 3001 - 3008) had a tan-colored panel present in the mid-wall slightly above waist level. This had wall paper surrounding it, however, the paper was torn down from the panel to the floor exposing an unpainted wall underneath of it. The tear was over 12" in width and extended several feet down the wall. In addition, multiple door frames present into each resident' room had obvious chipped white-colored paint exposing a metallic color underneath. Further, several rooms, including Rm. 3001, Rm. 3003, Rm. 3004, Rm. 3008, and the dining room entrances(s) all had plastic door frame guard(s) installed; however, these guards were cracked and chipped away in several spots exposing sharp corners on the plastic, and a yellow-colored glue-type substance underneath which, in areas,	F 921	F921 Safe/Functional/Sanitary/Comfortable Environment CFR(s): 483.90(i) "Repairs were made to the 3E unit: torn wallpaper was removed and replaced with fresh wallpaper; all broken door guards were removed, glue was sanded, and doors were repainted; all chipped paint surrounding resident doors and entry ways was repainted; exposed sheet rock was sanded, filled, and repainted; all outlet covered were evaluated and tightened, no painters tape covering outlet covers. "Audit created to choose a unit each month, identify areas of concern that need repairs, input to TELS for tracking, and make repairs as facility resources allow. "Completion date 10/16/2023	

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F 921	Continued From page 69 was over 24" in length and went from the floor to waist-level. 2) The far East hallway had another small, green-colored hallway which lead to a stairwell. The entire one side of the hallway had visible scrapes present at waist level going along the wall with visible, white-colored sheet rock underneath being exposed. The wall had multiple areas of exposed sheet rock which were several inches in width and a tan-colored electrical outlet was attached to the wall with visible blue-colored painters' tape on the top. The outlet cover was loose to touch. 3) The central hallway had resident' rooms (Rms. 3018 - 3024) present with nearly all for the doorframes having the white-colored paint chipped away in various places. This exposed a metallic color underneath. 4) The West hallway had the main entrance to the unit along with resident' rooms (Rms. 3042 - 3047) present. However, again, nearly all of the resident' room doorframes had the white-colored paint chipped away in various places which exposed a metallic color underneath. In addition, several rooms, including Rm. 3024, Rm. 3044, Rm. 3047, had plastic door frame guard(s) installed; however, these guards were cracked and chipped away in several spots exposing sharp corners on the plastic, and a yellow-colored glue-type substance underneath which, in areas, was over 12" in length and went from the floor to waist-level. On 9/13/23 at 9:08 a.m., nursing assistant (NA)-B was interviewed and toured the unit with the surveyor. NA-B verified these areas in disrepair	F 921		

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F 921	Continued From page 70 and expressed they all had been like such since for, at least, several months. NA-B stated they were unaware if the maintenance department was aware of the issues or not but added, "I think they [maintenance] should be checking." At 9:17 a.m., NA-C joined the interview and reiterated the items in disrepair. NA-C stated they doorframes, wallpaper, and damaged plastic door guards had been in such condition for "quite awhile" and had likely been caused by a previous resident who used to damage them. However, the resident was no longer present and had expired nearly a year prior. NA-C stated the items in disrepair needed to be addressed and fixed adding, "It looks bad." On 9/13/23 at 2:37 p.m., the maintenance director (MTD)-A was interviewed and toured the unit with the surveyor. MTD-A observed the green-colored wall on the East hallway and verified it's condition stating it had been like such for "three months" or so. MTD-A explained they were "all alone" until just recently when another maintenance person was finally hired and, as a result, they could not address items as timely as needed adding, "I know things need to be done." MTD-A observed the plastic door frame protectors and verified they were in disrepair and had sharp edges present. MTD-A stated they would speak with the contractor to get those repaired. MTD-A observed the paint chipped door frames and expressed when they were the only person working, as had been for several months until recently, there was "no way I'm getting to that." MTD-A explained the nursing home used a "TELS" system to report and tracked work-items, however, none had been submitted to maintenance for these items in disrepair adding the surveyor was "the first one" to report all of these. MTD-A stated staff should be reporting	F 921		

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F 921	Continued From page 71 issues when observed so they can be addressed. During the recertification survey, from 9/11/23 to 9/15/23, no evidence was provided demonstrating these items had been reported to the maintenance department for action. A provided Maintenance Service policy, dated 12/2009, identified maintenance would be provided to all areas of the building, ground, and equipment. The policy outlined maintenance personnel were responsible to maintain the building in compliance with current federal regulations and, "Maintaining the building in good repair and free from hazards."	F 921		
F 925 SS=F	Maintains Effective Pest Control Program CFR(s): 483.90(i)(4) §483.90(i)(4) Maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to implement an effective pest control program to eliminate flies from the building for 4 of 4 residents (R5, R30, R56, R59). This deficient practice had the potential to affect all 72 residents who resided in the facility. Findings include: R30's significant change Minimum Data Set (MDS) dated 7/27/23, indicated R30 had intact cognition with diagnoses including arthritis, a stroke and hemiplegia/hemiparesis (paralysis of one side of the body). R38 required extensive assistance with bed mobility, transferring,	F 925	F925 Maintains Effective Pest Control Program CFR(s): 483.90(i)(4) "Pest Control contracted service comes to the facility quarterly for routine maintenance of pests and insects. Pest control contract service has advised that for additional services needed, such as excessive flies, they will come to the facility more frequently and service the facility specifically for this insect. "Facility policy regarding pest control has been updated to reflect this advisement. Staff are to report to the Environmental Services Director any pest control issues, such as excessive flies, to be reported to	10/16/23

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F 925	Continued From page 72 dressing, and eating. During observation and interview on 9/11/23 at 2:32 p.m., R30, who resided in the locked unit on the third floor, was lying in bed in her room with multiple flies flying around her face and body. R30 stated the flies were bothersome and they had been present "since it got warm" outside. R30 stated staff were aware of the flies as it "bothers them too." R30 stated she was unsure if actions had been taken to control them but,"what can you do[?]" At 2:34 p.m., nursing assistant (NA)-B entered R30's room and saw the flies present. NA-B then picked up a white-colored fly swatter from R30's bedside dresser and tried to kill the flies in the room. NA-B stated the flies had been present since "the summer" and, as a result, staff go to resident rooms and try to kill them every so often during the shifts. NA-B stated they use a fly swatter because maintenance did not want to use spray to kill them. R5's quarterly MDS dated 8/25/23, identified R5 had severe cognitive impairment with diagnoses including hemiplegia/hemiparesis, depression, and bipolar disease. R5 required extensive assistance with bed mobility, transferring, and personal hygiene. During observation on 9/13/23 at 7:30 a.m., R5 was served his meal tray while sitting in the common area of the locked unit on the third floor in his wheelchair. R5 had multiple flies present around his head and, at times, landing on his pillow and blanket while R5 ate his breakfast. R56's significant change MDS dated 6/29/23, indicated R56 required setup for eating and dressing but was independent with bed mobility	F 925	Pest Control contracted service for immediate service. The policy also notes that use of fly tape is not permitted. "Education to be provided to all staff regarding this policy change so they are aware of who to notify of noted situations. "Periodic audits of resident areas will be completed by ESD or designee to ensure pests/pest debris is controlled. "Completion date 10/16/2023	

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F 925	Continued From page 73 and walking. R56 had intact cognition with a diagnosis of multiple sclerosis (A disease that affects central nervous system that makes it difficult for the brain to send signals to rest of the body). R59's quarterly MDS dated 6/29/23, indicated R59 was independent with bed mobility, eating, and walking in room but required assistance with dressing. R59 had intact cognition with diagnoses including hemiplegia/hemiparesis, anemia (insufficient number of oxygen-carrying cells), and hypertension (high blood pressure). During an observation and interview on 9/11/23 at 2:34 p.m., upon entry to R56 and R59's room on the first floor, a fly strip approximately two and a half feet long by one and a half inches wide hung from the ceiling to the right of the door. The fly strip hung near the edge of R59's bed. R56 stated she and her roommate (R59) always had fly swatters with them because the flies were bothersome. The fly strip near R59's bed was approximately 90% covered with flies, and four flies were flying around the room. R56 stated the fly strip had been hung by staff a while ago. Trained medication aide (TMA)-C entered the room and although he stated he was aware fly strips were not allowed to be used in the facility, he had not removed the fly strip from R56 and R59's room. During an interview on 9/13/23 at 11:23 a.m., R56 stated staff removed the fly strip the day before and had discussed putting up a new one. R59 stated the fly strip was "grossing us out" because the flies would sometimes fall off the strip and land on the bedside table she ate on.	F 925		

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F 925	Continued From page 74 During an interview on 9/13/23 at 11:27 a.m., registered nurse (RN)-A stated she was unaware of the fly strip in R56 and R59's room, but she thought they were "kind of nasty." RN-A further verified R56 and R59's room had many flies and RN-A was unsure of pest control methods being used to control the flies. During an interview on 9/13/23 at 12:04 p.m., NA-A stated the fly strip had been present in R56 and R59's room since the beginning of summer and had been "covered" in flies. NA-A stated although the fly strip was not allowed, because R56 complained about the flies, staff left it hanging in their room. NA-A stated she had noticed the overabundance of flies but was unsure of pest control methods used. During an interview on 9/14/23 at 1:00 p.m., TMA-C stated the overabundance of flies began at the onset of summer when the air conditioners were placed in the windows. He informed maintenance in June, but TMA-C was unaware of any pest control methods used. TMA-C stated the fly strip was placed in R56 and R59's room sometime between 6/7/23 and 6/16/23 and had not been replaced. During an interview on 9/14/23 at 1:14 p.m., RN-A stated they had discussed the overabundance of flies at an unknown morning meeting with maintenance staff. She thought maintenance had sprayed for insects but was unsure of any other interventions regarding the flies. During an interview on 9/14/23 at 9:14 a.m., maintenance director (MTD) stated he would call pest control when he received a complaint regarding pests either verbally or electronically.	F 925		

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F 925	Continued From page 75 MTD stated he was aware fly strips were not allowed as a pest control method and was unaware who would have hung one in R56 and R59's room. Although MTD knew fly strips were not allowed, MTD further stated if a resident family brought in a fly strip and hung it in a resident room, he would not remove it. During an interview on 9/14/23 at 4:14 p.m., the director of nursing (DON) stated she frequently observed flies in patient care areas. The DON expected staff to attempt to kill them with a fly swatter and was unaware of anyone spraying for them. The DON thought R56 may have bought the fly strip but was unsure who would have hung it in the room. The DON stated fly strips were an infection risk and not allowed to be used. Review of the facility pest control invoices dated 6/16/23, 7/12/23, and 8/9/23, lacked indication fly extermination treatment was completed. The facility Pest Control policy dated 2/14/2022, indicated pest control problems would be promptly reported to the contractor. Monitoring of the environment was to be done by facility staff and additional visits would be warranted when problems were detected.	F 925		

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	00149	A. BUILDING: _____ B. WING _____	C 09/14/2023

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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 9/11/23 to 9/14/23, a licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was not in compliance with the MN State Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you have reviewed these orders and	2 000		

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

Electronically Signed | 10/06/23

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2 000	Continued From page 1 identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE	2 000		

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2 000	Continued From page 2 IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 302	MN State Statute 144.6503 Alzheimer's disease or related disorder train ALZHEIMER'S DISEASE OR RELATED DISORDER TRAINING: MN St. Statute 144.6503 (a) If a nursing facility serves persons with Alzheimer's disease or related disorders, whether in a segregated or general unit, the facility's direct care staff and their supervisors must be trained in dementia care. (b) Areas of required training include: (1) an explanation of Alzheimer's disease and related disorders; (2) assistance with activities of daily living; (3) problem solving with challenging behaviors; and (4) communication skills. (c) The facility shall provide to consumers in written or electronic form a description of the training program, the categories of employees trained, the frequency of training, and the basic topics covered. (d) The facility shall document compliance with this section. This MN Requirement is not met as evidenced by: Based on interview and document review, the	2 302	Corrected	10/16/23

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2 302	Continued From page 3 facility failed to ensure the facility's direct care staff and their supervisors received training that included all required components of Alzheimer's/dementia care. This had the potential to affect all 13 residents currently residing in the facility with a diagnosis of Alzheimer's or Dementia. Findings include: During record review it was noted that the syllabuses for the Alzheimer's and Dementia training did not include training for assistance with activities of daily living. Certified Nursing Assistant (CNA)-F education records lacked evidence the required dementia care training was received. Licensed practical nurse (LPN)-H education records lacked evidence the required dementia care training was received. Trained medication aide (TMA)-C education records lacked evidence the required dementia care training was received. Registered nurse (RN)-C education record lacked evidence the required dementia care training was received. Infection control preventionist (IP) education records lacked evidence the required dementia care training was received. Licensed practical nurse (LPN)-C, education record lacked evidence the required dementia care training was received. Director of Nursing (DON) education record laced	2 302		

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2 302	Continued From page 4 evidence the required dementia care training was received. During interview on 09/14/23 10:09 a.m., Director of Nursing (DON) confirmed the staff had not completed the required Alzheimer's and Dementia training. The DON stated "the expectation is we will follow the state regulations regarding Alzheimer's and dementia education. We switched who oversaw education and the Educare system [electronic learning managment system]. The education regarding assistance with activities of daily living with residents with Alzheimer's and Dementia was missed and not assigned to staff. We have corrected it and have now assigned it to everyone and going forward will be in back in our Educare for new hires." Although requested, no policy related to Alzheimer's training was provided. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) could develop and implement policies and procedures related to the required Alzheimer's training program requirements. The quality assessment and assurance committee could perform random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty (21) days	2 302		
2 840	MN Rule 4658.0520 Subp. 2 B Adequate and Proper Nursing Care; Clean skin Subp. 2. Criteria for determining adequate and proper care. The criteria for determining adequate and proper care include:	2 840		10/16/23

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2 840	Continued From page 5 B. Clean skin and freedom from offensive odors. A bathing plan must be part of each resident's plan of care. A resident whose condition requires that the resident remain in bed must be given a complete bath at least every other day and more often as indicated. An incontinent resident must be checked at least every two hours, and must receive perineal care following each episode of incontinence. [144A.04 Subd. 11. Incontinent residents. Notwithstanding Minnesota Rules, part 4658.0520, an incontinent resident must be checked according to a specific time interval written in the resident's care plan. The resident's attending physician must authorize in writing any interval longer than two hours unless the resident, if competent, or a family member or legally appointed conservator, guardian, or health care agent of a resident who is not competent, agrees in writing to waive physician involvement in determining this interval, and this waiver is documented in the resident's care plan.] Clean linens or clothing must be provided promptly each time the bed or clothing is soiled. Perineal care includes the washing and drying of the perineal area. Pads or diapers must be used to keep the bed dry and for the resident's comfort. Special attention must be given to the skin to prevent irritation. Rubber, plastic, or other types of protectors must be kept clean, be completely covered, and not come in direct contact with the resident. Soiled linen and clothing must be removed immediately from resident areas to prevent odors.	2 840		

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2 840	Continued From page 6 This MN Requirement is not met as evidenced by: Based on observation, interview, and record document review, the facility failed to ensure appropriate management of an indwelling catheter was provided for 1 of 1 residents (R72) reviewed for indwelling catheter. Findings include: R72's 5 Day Minimum Data Set (MDS) dated 8/7/23, indicated R72 was cognitively intact and had a diagnoses of obstructive and reflux uropathy (condition that affects the urinary tract due to blockage or backward flow of urine). In addition, R72 identified as having an indwelling catheter. R72's care plan dated 6/27/23, indicated R72 had an indwelling catheter and required staff to provide catheter cares twice per day. R72's physician orders (PO) dated 7/18/23, instructed staff to provide R72 catheter cares twice a day and as needed. During observation and interview with R72 on 9/12/23 at 8:21 a.m., R72 foley drainage bag was laying flat on the floor with no privacy cover on it. R72 stated the facility staff, "leave it on the floor and sometimes they hook it to the bed". R72 stated the staff, "never put it in a bag to cover it". During interview with nursing assistant (NA)-A on 9/13/23 at 7:46 a.m., stated foley catheter bags, "must be covered because of infection control and dignity". NA-A stated a foley drainage bag should be covered. During interview with licensed practical nurse	2 840	Corrected	

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2 840	Continued From page 7 (LPN)-A stated, "a privacy bag should cover the drainage bag, even if the resident is in their room." During interview with director of nursing (DON) on 9/15/23 at 8:52 a.m., DON stated the expectation of staff to provide privacy bags to cover all catheter drainage bags. Facility policy titled Quality of Life-Dignity revised February 2020 , direct staff to, "keep urinary catheter bags covered". SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review all physician orders for residents with catheters to ensure cares are performed as ordered. The director of nursing or designee, could conduct routine audits to ensure appropriate care and services were implemented as ordered. The results of those audits should be taken to the QAPI committee for a determined amount of time to ensure compliance or the need for further monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	2 840		
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.	2 920		10/16/23

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2 920	Continued From page 8 This MN Requirement is not met as evidenced by: Based on observation, interview, and record document review, the facility failed to ensure appropriate management of an indwelling catheter was provided for 1 of 1 residents (R72) reviewed for indwelling catheter. Findings include: R72's 5 Day Minimum Data Set (MDS) dated 8/7/23, indicated R72 was cognitively intact and had a diagnoses of obstructive and reflux uropathy (condition that affects the urinary tract due to blockage or backward flow of urine). In addition, R72 identified as having an indwelling catheter. R72's care plan dated 6/27/23, indicated R72 had an indwelling catheter and required staff to provide catheter cares twice per day. R72's physician orders (PO) dated 7/18/23, instructed staff to provide R72 catheter cares twice a day and as needed. During observation and interview with R72 on 9/12/23 at 8:21 a.m., R72 foley drainage bag was laying flat on the floor with no privacy cover on it. R72 stated the facility staff, "leave it on the floor and sometimes they hook it to the bed". R72 stated the staff, "never put it in a bag to cover it". During interview with nursing assistant (NA)-A on 9/13/23 at 7:46 a.m., stated foley catheter bags, "must be covered because of infection control and dignity". NA-A stated a foley drainage bag should be covered.	2 920	Corrected	

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2 920	Continued From page 9 During interview with licensed practical nurse (LPN)-A stated, "a privacy bag should cover the drainage bag, even if the resident is in their room." During interview with director of nursing (DON) on 9/15/23 at 8:52 a.m., DON stated the expectation of staff to provide privacy bags to cover all catheter drainage bags. R10's quarterly Minimum Data Set (MDS) identified severely impaired cognition and required extensive to total staff assistance with personal hygiene and grooming. R10's care plan updated on 7/14/23, indicated maximum assist from another person to complete personal hygiene. R10's face sheet printed 9/15/23, included personal history of traumatic brain injury, diabetes mellitus type 2 (DM2) and alcohol dependence with alcohol-induced persisting dementia. On 9/13/23 at 8:37 a.m., R10 was observed to have ½ inch long fingernails, with a dark brown, unknown substance caked under each nail on both hands. Certified nursing assistant (CNA)-B assisted R10 with morning cares and directed him to go to breakfast. CNA-B did not offer R10 oral cares. During interview on 9/13/23 at 12:55 p.m., CNA-B confirmed she had not offered oral cares for R10. She stated R10 was resistive to cares at times. Previously, he had thrown the tooth brush and called her names. CNA-B stated "I have tried a second time since then with the same results. So now, I no longer ask or try to do R10's oral cares because he will just refuse."	2 920		

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2 920	Continued From page 10 On 9/14/23 at 8:59 a.m., R10 was observed with ½ inch long fingernails, and a dark brown, unknown substance caked under each nail on both hands. On 9/14/23 at 9:22 a.m., certified nursing assistant (CNA)-C confirmed R10's fingernails were long, dirty, and needed to be clipped. She stated R10 had a history of removing his brief and playing in the fecal matter, masturbating and picking at an open wound on his abdomen. Nails were addressed on bath day or as needed unless the resident refused. R10 nails were to be kept short and clean because he picked at an open wound. On 9/14/23 at 9:30a.m., registered nurse (RN)-D confirmed R10's fingernails on both hands, were approximately ½ inch long with a dark brown, unknown substance under each nail. RN-D stated R10 had behaviors of playing in his feces and his nails can got dirty quickly. However, it was important we keep his nails short and clean due to getting a possible infection in his open abdominal wound. On 9/14/23 at 10:14 a.m., director of nursing (DON) stated her expectation was when residents, refused activities of daily living, staff reapproached or another staff tried. She expected staff charted when cares were refused and was not okay to not offer cares due to previous refusals. When staff saw long or dirty nails, she expected nail care was completed. DON stated residents were vulnerable and don't have the mental or physical capacity to do it themselves. DON stated residents can't make their needs known and staff need to anticipate their needs.	2 920		

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2 920	Continued From page 11 Facility policy: Activities of Daily Living (ADLs) Supporting, stated 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. Facility policy titled Quality of Life-Dignity revised February 2020 , direct staff to, "keep urinary catheter bags covered". SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review all physician orders and care plans for residents who are depedent with personal cares to ensure cares are performed as ordered. The director of nursing or designee, could conduct routine audits to ensure appropriate care and services were implemented as ordered. The results of those audits should be taken to the QAPI committee for a determined amount of time to ensure compliance or the need for further monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	2 920		
2 930	MN Rule 4658.0525 Subp. 7 B. Rehab - Nasogastric, Gastrostomy tubes Subp. 7. Nasogastric tubes, gastrostomy tubes, and feeding syringes. Based on the comprehensive resident assessment, a nursing home must ensure that: B. a resident who is fed by a nasogastric or gastrostomy tube or feeding syringe receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting,	2 930		10/16/23

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2 930	Continued From page 12 dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal feeding function. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure tube feeding formula was labeled according to professional standards to avoid the possibility of feeding tube complications and or related infections for 1 of 1 resident (R70). Findings include: R70's quarterly Minimum Assessment Data (MDS) dated 8/28/23, indicated R70 was severely impaired, was unable to communicate needs, received enteral feeding via a gastric (stomach) tube, needed extensive assist with bed mobility and toileting, was dependent with transfers, dressing, bathing, feeding and personal hygiene. R70's diagnoses included acute respiratory failure, unspecified hypoxia (low level of oxygen in the blood), hypercapnia (when carbon dioxide is built up in the blood stream), neurogenic bladder (lack of bladder control due to spine or nerve injuries), viral hepatitis (is an infection that causes liver inflammation and damage) , cerebral vascular accident (damage to the brain from interruption of its blood supply), quadriplegia (paralysis of all four limbs), malnutrition, disorder of the autonomic nervous system, dysphagia post cerebral vascular accident (difficulty swallowing after cerebral vascular accident), tachycardia (heart rate over 100 beats a minute) , gastrostomy tube (GT- a medical device used to	2 930	Corrected	

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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
2 930	Continued From page 13 provide liquid nourishment, fluids, and medications by bypassing the oral intake), and tracheostomy (a surgically created hole in your windpipe that provides an alternative airway for breathing). R70's Orders report indicated "Enteral nutrition: Administer Nutren 2.0 via G-tube [gastric tube] and feeding pump at a rate of 44 ml [milliliters] per hour continuous every shift for life sustaining." R70's care plan dated 5/5/23, indicated R70 had a nutritional problem or potential for nutritional problem related to dysphagia and cerebral vascular accident. R70's care plan goal indicated R70 will maintain adequate nutritional status. During observation on 9/11/23 at 1:30 p.m., R70 was receiving enteral nutrition via a feeding pump, the pump indicated a flow rate of 44 ml per hour. A sealed bag of Nutren 2.0 hung from a feeding pole and the label was blank. The label included "patient name, patient ID, date/time started and tube feeding order." During interview on 9/11/23 at 5:19 p.m., the licensed practical nurse (LPN)-F verified the Nutren formula bag's label was blank. LPN-F stated the bag needed to be labeled, and stated nursing staff needed to know how long the bag had been hanging to prevent complications. LPN-F verified the medication administration record (MAR) did not indicate when a new bag was hung, the MAR included the tube feeding order and this was documented every shift. During interview on 9/13/23 at 10:52 a.m., registered nurse (RN)-B stated the nurses needed to write the time, date, and nurse initials. RN-B stated the formula might be too old and	2 930		

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2 930	Continued From page 14 unsafe to infuse. During interview and observation on 9/15/23 at 9:21 a.m., R70's was receiving enteral nutrition via a feeding pump, the pump indicated a flow rate of 44 ml per hour. The Nutren formula bag's label was blank. The LPN-G stated the label was not dated, initialed and didn't indicate when the formula was started. LPN-G stated the feeding had to be stopped and a properly labeled feeding bag needed to be started to prevent potential negative consequences to the patient. During interview on 9/15/23 at 9:59 a.m., the director of nursing (DON) stated the tube feeding formulas needed to be dated, timed, and initialed. DON stated the tube feeding formula was good for 24 hours and was not safe to use a feeding formula bag without knowing when the formula bag was started. DON stated residents might experience gastrointestinal upset if the formula is older than 24 hours. The policy title Enteral Nutrition dated 11/18 indicated adequate nutritional support through enteral nutrition is provided to residents as ordered. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON) or designee could review and revise policies for the proper care and use of tube feeding supplies according to professional standards of practice. Nursing staff could be educated as necessary to the importance of changing and cleaning tube feeding supplies according to physician orders to avoid complications and/or infections. The DON or designee, should audit nursing staff assigned to residents effected and take that information to	2 930		

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2 930	Continued From page 15 QAPI to ensure compliance and determine the need for further education/monitoring/compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 930		
21030	MN Rule 4658.0620 Subp. 1 Frequency of Meals; Time of meals Subpart 1. Time of meals. The nursing home must provide at least three meals daily at regular times. There must be no more than 14 hours between a substantial evening meal and breakfast the following day. A "substantial evening meal" means an offering of three or more menu items at one time, one of which is a high-quality protein such as meat, fish, eggs, or cheese. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure that breakfast was provided to R14 outside traditional meals times prior to her regular morning appointment for hemodialysis. Findings include: R14's quarterly Minimum Data Set (MDS) dated 8/12/23, indicated R14 had intact cognition and required set up help for eating. R14's provider note dated 9/11/23 indicated R14 had a diagnosis of "Type 2 diabetes mellitus with diabetic nephropathy". R14's physician order (PO) summary dated 9/15/23 indicated diagnoses of end stage renal	21030	Corrected	10/16/23

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21030	Continued From page 16 disease, dependence on renal dialysis, anxiety and dependence on supplemental oxygen. The PO did not indicate a diagnosis of diabetes mellitus. PO indicated R14 with, "Modified Renal diet Regular texture, Regular (Thin) consistency, 1.5L fluid restriction for Dialysis diet; low phosphorus, low sodium, low potassium". R14's care plan (CP) dated 9/12/23 indicated R14, "has Diabetes Mellitus" and, "offer substitutes for foods not eaten". In addition the CP indicated R14 "will go to outpatient dialysis 3x week". During interview with R14 on 9/11/23 at 6:31 p.m., R14 stated she did not receive breakfast that morning prior to leaving for scheduled hemodialysis. R14 stated, "I did not eat until I came back from dialysis' and indicated she was not offered a snack. During interview with the certified dietary manager (CDM) on 9/13/23 10:07 a.m., CDM stated, "the early morning cook is responsible for ensuring residents on dialysis get their breakfast before the go off to dialysis". The CDM stated R14 did not receive her breakfast on 9/11/23 prior to dialysis appointment and it, "did not happen". CDM stated concern for dialysis residents to miss a meal prior to dialysis and, "it is mean to leave someone without a meal". During interview with dietary cook (C)-A on 9/13/23 at 10:39 a.m., CA indicated early breakfast trays are the responsibility of the early morning cook. CA stated she was scheduled to work on the early morning shift on 9/11/23 and "was running late". CA stated R14 did not receive her early morning breakfast tray prior to leaving for hemodialysis on 9/11/23 and, "it was my mess	21030		

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21030	Continued From page 17 up and will take blame on it." During interview with registered dietician, (RD)-A on 9/13/23 at 1:05 p.m., RD-A stated concern for dialysis residents missing a morning meal and, "I would be concerned if they didn't get anything." RD-A stated general nutrition, hydration or dehydration would be a reason for concern regarding missed meals. "If they have diabetes, which is not uncommon for dialysis residents it would be even more concerning" indicating a concern for the potential for a low blood sugar. During interview with nurse practitioner (NP)-A on 9/15/23 at 8:40 a.m., NP-A stated missed breakfast for R14 is a concern because R14's, "blood sugar could tank". During interview with director of nursing (DON) on 9/15/23 at 8:49 a.m., indicated R14 should not miss a meal and, "we need to have a backup plan" for when a meal is not provided prior to sending a resident to dialysis. "it did not happen". Facility policy titled Frequency of Meals revised January 2022 indicate, "Alternative meals will be offered to residents who choose to eat at non-traditional or outside of scheduled mealtimes, consistent with the plan of care". SUGGESTED METHOD OF CORRECTION: The administrator, registered dietician, or designee should ensure dietary interventions are implemented in a timely manner. The facility should review and/or update or create policies and procedures, and educate staff on specific requirements or interventions related to weight and nutrition. The administrator, registered dietician, or designee should perform audits for a	21030		

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21030	Continued From page 18 measurable amount of time as determined by the Quality Assurance Performance Improvement (QAPI) committee to ensure food items given, offered, or consumed by residents are implemented as identified or ordered. The facility should report those findings to QAPI for further recommendations and determine the need for further monitoring or compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21030		
21080	MN Rule 4658.0650 Subp. 1 Food Supplies; Clean,free from spoilage Subpart 1. Food. All food must be clean, wholesome, free from spoilage, free from adulteration and misbranding, and safe for human consumption. Canned or preserved food which has been processed in a place other than a commercial food-processing establishment is prohibited for use by nursing homes. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure unpasteurized eggs were fully cooked and prepared in manner to prevent foodborne illness. This resulted in an immediate jeopardy (IJ) situation for 6 of 6 residents (R4, R9, R14, R38, R56, R59) identified to routinely consume unpasteurized, undercooked eggs and had an increased risk of contracting a potentially life-threatening foodborne illness. In addition, the facility failed to ensure dishwasher and cooking utensils were properly sanitized to reduce risk of cross contamination. In addition, the facility failed to	21080	Corrected	10/16/23

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21080	Continued From page 19 ensure accurate monitoring and timely removal of facility food stored in refrigerators, freezers, and dry storage. In addition, the facility also failed to ensure kitchen refrigerator temperatures were properly monitored and maintained in a manner to reduce risk of foodborne illness. These facility failures had the potential to affect all 72 residents who consumed food from the facility kitchen. Further, the facility failed to ensure staff were trained in maintaining and properly harvesting a fruit and vegetable garden according to food procurement standards. This had the potential to affect all staff, residents and visitors who ate food from the facility garden. The IJ began on 9/11/23, when the facility was observed to be serving unpasteurized, undercooked eggs (runny yolks). The director of nursing (DON) and administrator were notified of the IJ at 1:04 p.m. on 9/12/23. The IJ was removed on 9/13/23, at 9:59 a.m., however non-compliance remained at the lower scope and severity of no actual harm with potential for more than minimal harm that is not immediate jeopardy (level F). Findings include: The United States (US) Food and Drug Administration (FDA) article, "Egg Safety: What You Need to Know" dated March 2021, indicated fresh, shelled eggs may contain a bacteria called Salmonella that could cause food borne illness (food poisoning). People infected with Salmonella may experience diarrhea, fever, abdominal cramps, and vomiting 12 to 72 hours after exposure. Symptoms usually last four to seven days and may be severe enough to require hospitalization. A Salmonella infection could also move from the intestines to the bloodstream and	21080		

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21080	Continued From page 20 spread throughout the body causing death. Older adults, and people with weakened immune systems (transplant patients, individuals with diabetes, cancer, or human immunodeficiency virus [HIV] or acquired immunodeficiency syndrome [AIDS]). The article also indicated when preparing raw or undercooked eggs "use either shell eggs that have been treated to destroy Salmonella, by pasteurization or another approved method, or pasteurized egg products". The article further indicated using a food thermometer was "the only way to ensure the safety of egg products for all cooking methods. These foods must be cooked to a safe minimum internal temperature to destroy any harmful bacteria." In addition, a Centers for Disease Control and Prevention (CDC) article, "Salmonella and Eggs" dated 2/16/21, indicated Salmonella from the inside of an egg that was "raw or lightly cooked" could cause illness such as diarrhea, vomiting, fever, and abdominal cramps. The article indicated to use only pasteurized eggs when consuming raw or lightly cooked eggs with an internal cooking temperature of 160 degrees Fahrenheit (F). The article further indicated people who are over the age of 65, or have weakened immune systems (HIV/AIDS, diabetes, or an organ transplant) may have more serious symptoms that could be life threatening. A facility egg invoice for the period of 1/01/23 through 09/19/2023 indicated the facility did not receive pasteurized eggs between 2/22/23 and 9/14/23, the last order being on 2/21/23. The facility then received their first sole order of unpasteurized eggs on 2/28/23. They then received 795 dozen unpasteurized eggs between 2/28/23 an 9/14/23.	21080		

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21080	Continued From page 21 R4's quarterly Minimum Data Set (MDS) dated 8/3/23, indicated R4 had intact cognition with diagnoses including morbid obesity and diabetes. R9's quarterly MDS dated 8/8/23, indicated R9 had intact cognition with diagnoses including kidney disease and diabetes. R14's quarterly MDS dated 8/12/23, indicated R14 had intact cognition with diagnoses including renal disease with dialysis, respiratory failure, a cardiac pacemaker, and morbid obesity. R38's significant change MDS dated 6/24/23, indicated R38 had intact cognition with diagnoses including Parkinson's disease and a neurocognitive disorder with Lewy Bodies (causing changes in behavior and cognition). R56's significant change MDS dated 6/29/23, indicated R56 had intact cognition with a diagnosis of multiple sclerosis (MS, which caused damage to the brain and spinal cord) and liver disease. R59's quarterly MDS dated 6/29/23, indicated R59 had intact cognition with diagnoses including hemiplegia/hemiparesis (partial to complete paralysis of one side of the body), anemia (insufficient number of oxygen carrying cells), and hypertension (high blood pressure). During observation on 9/11/23 at 12:46 p.m., an open, 15 dozen box of eggs was noted in the first floor, double door refrigerator with approximately 60 eggs missing. There was no stamp or markings on the box or eggs to indicate they had been pasteurized (a process used to eliminate bacteria and disease-producing microorganisms	21080		

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21080	Continued From page 22 in foods, such as dairy; often denoted by a "P" stamped on eggs). At 1:38 p.m., an unopened box of 15 dozen eggs was noted in basement cooler, also with no stamp or marking on box or eggs. During an interview on 9/11/23 at 3:10 p.m., R59 stated she had over easy eggs (method for preparing eggs involving a cooked egg white and a not fully cooked runny yolk) for breakfast and did not like them scrambled. During an interview on 9/11/23 at 3:11 p.m., R56 stated she ate eggs with runny yolks for breakfast every morning. During an interview on 9/11/23 at 3:37 p.m., R38 stated she ate a fried egg with a runny yolk for breakfast that day. During an interview on 9/12/23 at 8:30 a.m., R4 stated he frequently ordered over easy eggs with runny yolks and could soak up his yolk with his toast at breakfast yesterday. During interview and record review on 9/11/23 at 5:16 p.m., the certified dietary manager (CDM) stated her food distributor informed her that if the eggs were pasteurized, the egg box would have "pasteurized" written on the side, which she stated it did not. The CDM concluded they had started to receive unpasteurized eggs starting in February of this year and presented the food invoices from 8/29/23 - 9/8/23. The invoice indicated 15 dozen large grade AA white eggs and no pasteurized eggs had been ordered three times in that period. The CDM indicated these eggs were not pasteurized. During an interview on 9/12/23 at 8:35 a.m.,	21080		

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21080	Continued From page 23 nursing assistant (NA)-A stated R4, R38, R56 received eggs with runny yolks on a regular basis. During an interview on 9/12/23 at 11:46 a.m., trained medication aide (TMA)-B stated R9 ate her eggs fried with a runny yolk on a regular basis. TMA-B presented R9's filled out menu for 9/13/23 with writing that indicated, "over easy eggs," indicating menu choice. R59's Submitted food menu dated 9/13/23 was also reviewed. It indicated R56 ordered a piece of dry toast with a soft fried egg on top. Soft fried egg was circled and over easy was written in large letters to the right of the text. During an interview on 9/12/23 at 12:00 p.m., TMA-A stated R14 ate over-easy eggs every day. During an interview on 9/12/23 at 8:41 a.m., C-A stated she often worked the 6 a.m. to 2:30 p.m. shift. C-A stated they normally used those (pointed to the unpasteurized eggs) eggs to cook residents over easy eggs. She stated herself and other staff had cooked over easy eggs, with these eggs, since she started a year and half ago. C-A stated they would take temperatures of the fully cooked egg white, but not the yolk because they didn't want to break it. C-A stated she was unaware of the difference between pasteurized and unpasteurized eggs. During an interview on 9/12/23 at 10:28 a.m., C-B stated she had been cooking for "a long time" and did not have a certification. C-B was unsure how many residents received runny eggs in the morning but knew it was at least nine. C-B stated she would take the temperature of the egg white instead of the egg yolk because she did not want it to run.	21080		

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21080	Continued From page 24 During interview and record review on 9/11/23 at 5:41 p.m., cook (C)-C stated if temperatures of fried eggs were taken, they would add a line to the food temperature log, hand write fried eggs, and record temperature there. C-C presented the food logs for 8/27, 8/31, 9/3, and 9/4. She was unable to locate temperature logs for the past month or week. The temperature logs presented did not document fried egg temperatures. During an interview on 9/11/23 at 5:54 p.m., the CDM stated staff knew their fried eggs are cooked to temperature by putting the egg in the pan and then they "flip it and flip it again." The CDM stated temperatures were not taken of fried eggs because the egg would "run all over." The CDM stated the residents should not receive unpasteurized, not fully cooked eggs because this population was more susceptible to acquiring a salmonella infection. The IJ which began 2/28/23, and was removed on 9/13/23, after it was verified through observation, interview, and record review the facility stopped serving undercooked, unpasteurized eggs to residents and when the facility implemented a removal plan which included: - Removed the unpasteurized eggs from made-to-order service and ordering new, pasteurized eggs to use when preparing undercooked, fried eggs; - Provided education to the dietary and nursing staff regarding State and Federal requirements for safe egg handling and preparation and; - Implemented audits to ensure the correct eggs are being ordered, delivered and prepared.	21080		

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21080	Continued From page 25 On 9/13/23 from 8:48 p.m. to 9:04 p.m. direct dietary and nursing staff were interviewed and verified they had received education regarding the safe preparation of made-to-order, undercooked eggs; and the kitchen was toured to ensure no unpasteurized eggs were available to use for made-to-order cooking. Dishwasher Temperature: During an interview on 9/11/23 at 6:36 p.m., the CDM stated the facility did not monitor the dishwasher temperature. During an interview and observation on 9/13/23 at 12:59 p.m., the CDM stated dishwasher temperatures were not recorded and an accompanying policy did not exist. The CDM stated they use a high temperature dishwasher by Ecolab (EC-44). Dietary aide (DA)-A filled the dishwasher rack with various dishware and advanced the rack into the machine. The dishwasher wash temperature read at 150 F with a rinse of 172 F. DA-A retrieved the dishwasher rack from the exit and loaded the rack again, reaching a rinse temperature of 178 F. At 1:07 p.m., another dish rack was loaded into the machine with a final rinse temperature of 168 F. At 1:08 p.m., DA-A stated he ran the dishes through the washer twice because they it does not reach 180 degrees. During an interview and observation on 9/14/23 at 1:41 p.m., DA-B put a large strainer through the dishwasher and the final rinse cycle reached 176 F. DA-B picked up the strainer and ran it through again, this time reaching a temperature of 178 F. He picked up the strainer and stated he would run the dishes through the washer twice if the	21080		

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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
21080	Continued From page 26 temperature was low but did not use any additional sanitizing methods. During an interview on 9/14/23 at 9:40 a.m., the Maintenance Director (MTD) stated the dishwasher booster needed replacing. The MTD stated he recommended staff run dishes through the machine twice until it was fixed and that would kill the germs and bacteria. The MTD stated the rinse cycle should have reached 180 F but was reaching 130-140 F. During an interview on 9/14/23 at 3:01 p.m., the administrator stated the dishwasher should have reached 180 F and until it did, staff would not use the machine and instead, use sanitizing liquid. Refrigerator temperature: During an interview on 9/14/23 at 9:03 a.m., the MTD stated the refrigerator temperatures were taken daily by one of his staff members. The MTD stated if maintenance staff (M)-A checked the temperature and if it was elevated, the elevated temperature would be recorded, but a recording of the rechecked temperature would not be expected. During an interview and observation on 9/14/23 at 10:47 a.m., M-A stated during the few years he worked for the facility, he solely, monitored the refrigerator temperatures. M-A stated because of this, they were not taken on the weekends or when he was on vacation. M-A stated he was unsure what refrigerators matched the numbers on the temperature log. M-A stated he recorded the temperatures between 8:00 a.m. - 9:00 a.m., and the goal temperature was between 30-40 F. M-A stated if the temperature was high, he assumed it was related to an open refrigerator	21080		

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21080	Continued From page 27 door. M-A would try to recheck it but often would not have time. M-A stated a few weeks ago (pointing to the temperature log for 8/15/23 through 9/13/23) he noticed rising temperature in the double door cooler used to store eggs and other perishable foods. M-A stated he notified the CMD on 8/18/23, after temperatures stayed between 45-48 F for three days. During an interview on 9/14/23 at 11:03 a.m., the CDM stated she expected the refrigerators to be kept at a temperature below 40 degrees and staff had not informed her of elevation. The CDM was also unsure what refrigerators matched the numbering system used in the temperature log. A facility invoice from a refrigerator repair company dated 8/28/23, indicated the two-door cooler was warm so it was recharged but a new evaporator was needed. During an interview on 9/14/23 at 12:53 p.m., the MTD stated he was unaware of the faulty evaporator, which would cause the refrigerator temperature to rise. The MTD stated the refrigerator company managed this, not him. During an interview on 9/14/23 at 3:01 p.m., the administrator stated the refrigerator temperature should not be higher than 40 degrees Fahrenheit, and until the issue was resolved the refrigerator should not be used. Facility refrigerator temperature logs for 6/20/23 through 9/14/23 were reviewed. The temperature of refrigerator two was greater than 41 F, 37 days during the period. The temperature of refrigerator three was greater than 41 F, 17 days during the period. The temperature was not taken 29 days in the 86-day period. This temperature log did not	21080		

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21080	Continued From page 28 include action taken when a temperature was above 41 F. Unlabeled food: During the initial kitchen observation and interview on 9/11/23 at 12:43 p.m.,the following foods were found in the double door freezer on the first floor: -Opened, undated sausage in clear plastic bag. -Undated pancakes in an opened clear plastic bag. -Undated carrots in opened clear plastic bag. The following foods were observed in the double door cooler on the first floor: -Opened, undated coleslaw in plastic bag; undated, half empty -One-gallon jug of thousand island dressing -Opened undated onions in clear plastic basket. The following foods were found in the dry storage room on the first floor: -undated, loose wafer bars in clear basket; -undated opened package of gluten-free brownies in a clear basket; The following foods were observed in the secondary refrigerator in the first-floor kitchen: -Opened, undated, one gallon jug of pasta salad with cheddar cheese. -Undated, 18-quart container filled to four-quart mark with breadcrumbs. -Three, undated, half-empty bags of spaghetti noodles. - An opened, undated container of croutons.	21080		

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21080	Continued From page 29 The following foods were observed in basement walk-in freezer: - undated opened bag of hashbrowns; - undated bag opened bag of hamburger buns; -Two undated lemon meringue pies; - Four, undated banana cream pies. - Unopened, undated waffles in clear plastic bag. During a tour of the walk-in basement cooler, an unopened five pound bag of shredded cheddar cheese dated 7/24/23 was observed. The CDM stated they normally keep items one month past the listed date and the CDM took the bag of cheese and disposed it. During interview on 9/11/23 at 5:48 p.m., the CDM stated the gluten free brownies were safe for consumption up to three months when frozen. The CDM stated they were purchased on 4/17/23. The CDM stated she educated staff on the importance of labeling food. The CDM stated she because of this she would worried about a food-borne illness related to expired food. The facility Refrigerators and Freezers policy dated 12/08, indicated acceptable temperatures for a refrigerator were 35-40 F. These temperatures should be tracked on monthly sheets that include an action taken column for unacceptable temperatures. The designated employee should check the refrigerator and freezer with the first opening and at closing in the evening and immediate action should be taken for temperature out of range. This policy indicated all food should be properly dated including dating individual items removed from the box or case. Facility garden	21080		

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21080	Continued From page 30 During an observation and interview on 9/15/23 at 10:14 a.m., a bowl of cherry tomatoes and a container of peppers was stored in the second-floor life enrichment (LE) refrigerator. The LE director (LED) stated the vegetables were grown in the facility garden and were for the residents to eat. During an observation and interview on 9/15/23 at 10:28 a.m., behind the facility near the smoking area accessible to all residents, one large planter box contained raspberry plants and another large planter box contained various peppers, cucumbers, and cherry tomatoes. The LED stated the raspberries had been growing since before he started working there a few years prior. The LED stated he did not water, fertilize or care for the raspberry plants in any way, allowing them to grow naturally. The LED stated he had planted the peppers, cucumber, and tomatoes by seed, that spring and had added a standard plant soil to the planter box. A bottle of Miracle Grow "Pour and Feed" fertilizer and spray bottle were sitting on top of the vegetable planter box. The LED stated he would pour the fertilizer into the spray bottle, add water, and spray the plants. The LED stated he had sprayed the plants approximately three times since he planted them, however, he was unable to provide the dates they were fertilized. The LED also stated he was unaware of a recommended time to wait before picking and/or eating the vegetables after they were sprayed with the fertilizer. The LED further stated he had not received any training regarding safe food handling or procurement during his employment at the facility. During an interview on 9/15/23 at 9:16 a.m., the IP stated she was not involved in the care of the	21080		

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21080	Continued From page 31 facility garden and was unaware it existed until that week. The IP stated she was unsure if she should be involved in the project but would expect the staff avoid using fertilizer on the plants and to wash the fruits and vegetables appropriately to avoid contamination or resident illness. The IP further stated she had not educated the LE staff on proper food handling or procurement. During an interview on 9/15/23 at 12:19 p.m., the administrator stated she did not have any involvement in the facility garden; however, she would expect the LED to follow the facility policies and procedures regarding the safe growing and handling of the food grown in the garden for resident consumption to avoid contamination and/or food born illnesses. The facility Resident-Maintained Gardens policy dated January 2022, indicated the facility was to follow safe food handling practices at all times when handling produce harvested from the facility garden. The facility was also to follow all State and local requirements related to food grown on site for resident consumption. The policy also indicated preventing contamination was more effective in preventing foodborne illness than relying on washing or cooking the produce. The policy also indicated the use of green manure or heat-treated manure for fertilizer and to maximize the time between manure application and harvest. Further, staff were to follow hand hygiene practices before and after gardening and before and after handling the produce. The facility Dishwasher Machine Use policy dated 11/10, indicated the hot water sanitation rinse temperature should reach 180 F. It also indicated the operator should check the temperatures with each cycle and record the results in a log. The	21080		

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21080	Continued From page 32 policy indicated if the temperature was inadequate, it should be reported to the supervisor and machine should not be used until corrected. The facility policy titled Preventing Foodborne Illness, dated 1/22, indicated potentially hazardous foods kept between 41 F to 135 F for more than four hours will be discarded. The policy indicated all food service equipment and utensils will be sanitized according to current guidelines. The policy indicated that all potentially hazardous food will be cooked to appropriate temperature and will not be held between 41 F to 135 F for more than 4 hours. SUGGESTED METHOD OF CORRECTION: The certified dietary manager (CDM) or registered dietician (RD) could review and revise policies regarding safe use of egg products and safe storage of perishable food items and then inservice staff to ensure products are consumed or used by state and federal food safety standards; then audit to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21080		
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	21325		10/16/23

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21325	Continued From page 33 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 dental needs were appropriately acted upon for 1 of 1 residents (R38) reviewed for dental. Findings include: R38's significant change Minimum Data Set (MDS) dated 6/24/23, indicated R38 had intact cognition with diagnoses including Parkinson's disease and dementia. R38 required extensive assistance for personal hygiene and did not reject cares. R38's care plan dated 3/18/23, identified R38 was at risk for alteration in dental care related to Parkinson's disease. Interventions included setting up dental appointments as needed. R38's nurse practitioner (NP) note dated 7/18/23, indicated R38 wanted her partial denture fixed. The facility dental Visit Summary dated 7/27/23, indicated R38 was not treated during the visit due to the dentist's time restraint. The facility dental Visit Summary dated 8/15/23, did not include R38 as a treated or non-treated patient. When interviewed on 9/11/23 at 3:35 p.m., R38 stated her dentures were uncomfortable and needed to be adjusted.	21325	Corrected	

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21325	Continued From page 34 When interviewed on 9/13/23 at 7:38 a.m., R38 stated she had not seen a dentist since she admitted 3/3/23. R38 stated the ridges of her dentures were too high and would become painful after wearing them for a while. R38 stated they were adjusted a few months ago but continued to feel uncomfortable. When interviewed on 9/13/23 at 11:17 a.m., nursing assistant (NA)-E stated on 9/11/23, he informed an unknown nurse that R38 was unable to chew with her dentures in because they were uncomfortable and therefore, she removed them. When interviewed on 9/13/23 at 11:41 a.m., health unit coordinator (HUC)-A stated the facility dentist ran out of time to see R38 on 6/27/23, and should have been added to the list for 8/15/23, but had not. HUC-A stated there was not a process to ensure unseen residents were carried over to the next appointment. When interviewed on 9/14/23 at 3:55 p.m., the director of nursing (DON) stated HUC-A was responsible for communicating resident's needs with the dental group. The DON stated she would have expected HUC-A to add R38 to the next dental appointment list after the dentist was not able to see her on 6/27/23. The DON stated she would expect a resident to receive the soonest available appointment especially if they were having pain or discomfort. A Routine Dental Care Services policy, undated, indicated each resident would be offered dental services as needed, including fitting dentures. However, the policy contained no guidance to ensure a missed appointment was rescheduled.	21325		

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21325	Continued From page 35 SUGGESTED METHOD OF CORRECTION: The DON or designee could develop, review, and/or revise policies and procedures to ensure dental services are provided. The DON or designee could educate all appropriate staff on the policies and procedures. The DON or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21325		
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	21530		10/16/23

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21530	Continued From page 36 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. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to implement appropriate monitoring for a resident receiving antipsychotic medications for 1 of 5 resident (R36) reviewed for unnecessary medications. Findings include: R36's quarterly Minimum Data Set, dated 8/25/23, indicated R36 was admitted to the facility on 3/3/23, had short term andlong term memory problems and required extensive assistance with most activities of daily living (ADLs). R36's Diagnoses List, printed on 9/15/23, indicated R36 had several medical diagnoses including anxiety, major depressive disorder, bi-polar (a disorder associated with episodes of mood swings ranging from depressive lows to manic highs) and Friedreich Ataxia (a rare inherited disease that causes progressive damage to your nervous system and movement	21530	Corrected	

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21530	Continued From page 37 problems as nerve fibers in your spinal cord and peripheral nerves degenerate). R36's Physician Orders, printed on 9/15/23, indicated R36 had the following orders: Venlafaxine extended release, 75 milligrams (mg) in the morning and 37.5mg every morning for bipolar, dated 8/11/23; Depakene oral solution, 7.5 milliliters (mL) three times a day for bipolar, dated 8/11/23; and risperidone, 1 mg in the afternoon for bipolar, dated 8/11/23. R36's Physician Orders also indicated an order to monitor for side effects related to antipsychotic medication use but lacked non-pharmacological behavior interventions or to monitor orthostatic blood pressures. R36's electronic medical record (EMR), including her treatment record and care plan, lacked non-pharmacological behavior interventions and orthostatic blood pressure monitoring related to antipsychotic medication use. R36's EMR indicated a pharmacy recommendation, dated 3/6/23, to monitor R36's orthostatic blood pressures related to antipsychotic use and a pharmacy recommendation, dated 4/14/23 to add non-pharmacological behavior interventions to behavior monitoring related to antipsychotic use. During an interview on 9/14/23 at 1:40 p.m., licensed practical nurse (LPN)-I stated residents who are on antipsychotic medications have behavioral monitoring and non-pharmacological behavior interventions listed on the treatment record and orthostatic blood pressures were also documented in the treatment record. LPN-I confirmed this was not present for R36 stating, "I am not sure why" because R36 was on multiple	21530		

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21530	Continued From page 38 antipsychotic medications. During an interview on 9/15/23 at 9:50 a.m., the consulting pharmacist (CP) stated with all antipsychotics she would expect non-pharmacological behavior interventions to be in place that are specific to each resident. The CP also stated the importance of monitoring R36's orthostatic blood pressure due to her risperidone use to monitor for orthostasis (a form of low blood pressure that happens with position changes). During an interview on 9/14/23 at 2:00 p.m., nurse manager and licensed practical nurse LPN-J stated the expectation was for any resident on an antipsychotic medication to have monitoring in place for medication side effects, behaviors, and non-pharmacological behavior interventions. LPN-J stated the interventions are expected to be resident specific and would be in the treatment record. LPN-J also stated ortho static blood pressure monitoring would also be in the treatment record and confirmed that neither were in R36's treatment record but, "should be." During an interview on 9/15/23 at 10:24 a.m., the director of nursing (DON) stated R36 was hospitalized in August and antipsychotic monitoring fell off her treatment record at that time, however she would have expected appropriate monitoring to be put back on her treatment record. The DON stated the expectation was that non-pharmacological behavior interventions were documented for all residents on an antipsychotic medication. A facility policy titled Antipsychotic Use, revised on 3/2016, indicated the policy was to assure all non-medication interventions have been attempted to assist with residents displaying	21530		

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21530	Continued From page 39 mood, behaviors or sleep concerns and further indicated nursing staff should monitor and report side effects to the physician, including orthostatic hypotension. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON), or designee, could review applicable policies and procedures with staff to ensure knowledge, then audit to ensure ongoing compliance. TIME FRAME FOR CORRECTION: Twenty one (21) days.	21530		
21665	MN Rule 4658.1400 Physical Environment A nursing home must provide a safe, clean, functional, comfortable, and homelike physical environment, allowing the resident to use personal belongings to the extent possible. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure structural issues and items in disrepair were addressed and fixed in 1 of 1 locked unit area(s) to help promote a homelike, sanitary environment. This had potential to affect 15 of 15 residents identified to reside on the unit during the survey. Findings include: A provided 3E Report Sheet, dated 8/10/23, identified a total of 15 residents resided on the locked unit at the time of survey. On 9/11/23 at	21665	Corrected	10/16/23

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BAY VIEW NURSING & REHABILITATION CENT	1412 WEST FOURTH STREET RED WING, MN 55066

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21665	Continued From page 40 5:51 p.m., a tour of the "3E [East]" locked unit was completed which identified the unit consisted of three separate wings (i.e., East, middle, West) with a central commons area and main dining room. However, the following items in obvious disrepair were observed: 1) The East hallway (Rms. 3001 - 3008) had a tan-colored panel present in the mid-wall slightly above waist level. This had wall paper surrounding it, however, the paper was torn down from the panel to the floor exposing an unpainted wall underneath of it. The tear was over 12" in width and extended several feet down the wall. In addition, multiple door frames present into each resident' room had obvious chipped white-colored paint exposing a metallic color underneath. Further, several rooms, including Rm. 3001, Rm. 3003, Rm. 3004, Rm. 3008, and the dining room entrances(s) all had plastic door frame guard(s) installed; however, these guards were cracked and chipped away in several spots exposing sharp corners on the plastic, and a yellow-colored glue-type substance underneath which, in areas, was over 24" in length and went from the floor to waist-level. 2) The far East hallway had another small, green-colored hallway which lead to a stairwell. The entire one side of the hallway had visible scrapes present at waist level going along the wall with visible, white-colored sheet rock underneath being exposed. The wall had multiple areas of exposed sheet rock which were several inches in width and a tan-colored electrical outlet was attached to the wall with visible blue-colored painters' tape on the top. The outlet cover was loose to touch. 3) The central hallway had resident' rooms (Rms.	21665		

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21665	Continued From page 41 3018 - 3024) present with nearly all for the doorframes having the white-colored paint chipped away in various places. This exposed a metallic color underneath. 4) The West hallway had the main entrance to the unit along with resident' rooms (Rms. 3042 - 3047) present. However, again, nearly all of the resident' room doorframes had the white-colored paint chipped away in various places which exposed a metallic color underneath. In addition, several rooms, including Rm. 3024, Rm. 3044, Rm. 3047, had plastic door frame guard(s) installed; however, these guards were cracked and chipped away in several spots exposing sharp corners on the plastic, and a yellow-colored glue-type substance underneath which, in areas, was over 12" in length and went from the floor to waist-level. On 9/13/23 at 9:08 a.m., nursing assistant (NA)-B was interviewed and toured the unit with the surveyor. NA-B verified these areas in disrepair and expressed they all had been like such since for, at least, several months. NA-B stated they were unaware if the maintenance department was aware of the issues or not but added, "I think they [maintenance] should be checking." At 9:17 a.m., NA-C joined the interview and reiterated the items in disrepair. NA-C stated they doorframes, wallpaper, and damaged plastic door guards had been in such condition for "quite awhile" and had likely been caused by a previous resident who used to damage them. However, the resident was no longer present and had expired nearly a year prior. NA-C stated the items in disrepair needed to be addressed and fixed adding, "It looks bad." On 9/13/23 at 2:37 p.m., the maintenance director (MTD)-A was interviewed and toured the	21665		

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21665	Continued From page 42 unit with the surveyor. MTD-A observed the green-colored wall on the East hallway and verified it's condition stating it had been like such for "three months" or so. MTD-A explained they were "all alone" until just recently when another maintenance person was finally hired and, as a result, they could not address items as timely as needed adding, "I know things need to be done." MTD-A observed the plastic door frame protectors and verified they were in disrepair and had sharp edges present. MTD-A stated they would speak with the contractor to get those repaired. MTD-A observed the paint chipped door frames and expressed when they were the only person working, as had been for several months until recently, there was "no way I'm getting to that." MTD-A explained the nursing home used a "TELS" system to report and tracked work-items, however, none had been submitted to maintenance for these items in disrepair adding the surveyor was "the first one" to report all of these. MTD-A stated staff should be reporting issues when observed so they can be addressed. During the recertification survey, from 9/11/23 to 9/15/23, no evidence was provided demonstrating these items had been reported to the maintenance department for action. A provided Maintenance Service policy, dated 12/2009, identified maintenance would be provided to all areas of the building, ground, and equipment. The policy outlined maintenance personnel were responsible to maintain the building in compliance with current federal regulations and, "Maintaining the building in good repair and free from hazards." SUGGESTED METHOD OF CORRECTION: The	21665		

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21665	Continued From page 43 administrator, or designee, could ensure any identified structural issues or items in disrepair were addressed and fixed, then audit to ensure ongoing compliance. TIME FRAME FOR CORRECTION: Twenty one (21) days	21665		
21730	MN Rule 4658.1415 Subp. 11 Plant Housekeeping, Operation, & Maintenance Subp. 11. Insect and rodent control. Any condition on the site or in the nursing home conducive to the harborage or breeding of insects, rodents, or other vermin must be eliminated immediately. A continuous pest control program must be maintained by qualified personnel. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to implement an effective pest control program to eliminate flies from the building for 4 of 4 residents (R5, R30, R56, R59). This deficient practice had the potential to affect all 72 residents who resided in the facility. Findings include: R30's significant change Minimum Data Set (MDS) dated 7/27/23, indicated R30 had intact cognition with diagnoses including arthritis, a stroke and hemiplegia/hemiparesis (paralysis of one side of the body). R38 required extensive assistance with bed mobility, transferring, dressing, and eating. During observation and interview on 9/11/23 at	21730	Corrected	10/16/23

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21730	Continued From page 44 2:32 p.m., R30, who resided in the locked unit on the third floor, was lying in bed in her room with multiple flies flying around her face and body. R30 stated the flies were bothersome and they had been present "since it got warm" outside. R30 stated staff were aware of the flies as it "bothers them too." R30 stated she was unsure if actions had been taken to control them but,"what can you do[?]" At 2:34 p.m., nursing assistant (NA)-B entered R30's room and saw the flies present. NA-B then picked up a white-colored fly swatter from R30's bedside dresser and tried to kill the flies in the room. NA-B stated the flies had been present since "the summer" and, as a result, staff go to resident rooms and try to kill them every so often during the shifts. NA-B stated they use a fly swatter because maintenance did not want to use spray to kill them. R5's quarterly MDS dated 8/25/23, identified R5 had severe cognitive impairment with diagnoses including hemiplegia/hemiparesis, depression, and bipolar disease. R5 required extensive assistance with bed mobility, transferring, and personal hygiene. During observation on 9/13/23 at 7:30 a.m., R5 was served his meal tray while sitting in the common area of the locked unit on the third floor in his wheelchair. R5 had multiple flies present around his head and, at times, landing on his pillow and blanket while R5 ate his breakfast. R56's significant change MDS dated 6/29/23, indicated R56 required setup for eating and dressing but was independent with bed mobility and walking. R56 had intact cognition with a diagnosis of multiple sclerosis (A disease that affects central nervous system that makes it difficult for the brain to send signals to rest of the	21730		

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21730	Continued From page 45 body). R59's quarterly MDS dated 6/29/23, indicated R59 was independent with bed mobility, eating, and walking in room but required assistance with dressing. R59 had intact cognition with diagnoses including hemiplegia/hemiparesis, anemia (insufficient number of oxygen-carrying cells), and hypertension (high blood pressure). During an observation and interview on 9/11/23 at 2:34 p.m., upon entry to R56 and R59's room on the first floor, a fly strip approximately two and a half feet long by one and a half inches wide hung from the ceiling to the right of the door. The fly strip hung near the edge of R59's bed. R56 stated she and her roommate (R59) always had fly swatters with them because the flies were bothersome. The fly strip near R59's bed was approximately 90% covered with flies, and four flies were flying around the room. R56 stated the fly strip had been hung by staff a while ago. Trained medication aide (TMA)-C entered the room and although he stated he was aware fly strips were not allowed to be used in the facility, he had not removed the fly strip from R56 and R59's room. During an interview on 9/13/23 at 11:23 a.m., R56 stated staff removed the fly strip the day before and had discussed putting up a new one. R59 stated the fly strip was "grossing us out" because the flies would sometimes fall off the strip and land on the bedside table she ate on. During an interview on 9/13/23 at 11:27 a.m., registered nurse (RN)-A stated she was unaware of the fly strip in R56 and R59's room, but she thought they were "kind of nasty." RN-A further verified R56 and R59's room had many flies and	21730		

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21730	Continued From page 46 RN-A was unsure of pest control methods being used to control the flies. During an interview on 9/13/23 at 12:04 p.m., NA-A stated the fly strip had been present in R56 and R59's room since the beginning of summer and had been "covered" in flies. NA-A stated although the fly strip was not allowed, because R56 complained about the flies, staff left it hanging in their room. NA-A stated she had noticed the overabundance of flies but was unsure of pest control methods used. During an interview on 9/14/23 at 1:00 p.m., TMA-C stated the overabundance of flies began at the onset of summer when the air conditioners were placed in the windows. He informed maintenance in June, but TMA-C was unaware of any pest control methods used. TMA-C stated the fly strip was placed in R56 and R59's room sometime between 6/7/23 and 6/16/23 and had not been replaced. During an interview on 9/14/23 at 1:14 p.m., RN-A stated they had discussed the overabundance of flies at an unknown morning meeting with maintenance staff. She thought maintenance had sprayed for insects but was unsure of any other interventions regarding the flies. During an interview on 9/14/23 at 9:14 a.m., maintenance director (MTD) stated he would call pest control when he received a complaint regarding pests either verbally or electronically. MTD stated he was aware fly strips were not allowed as a pest control method and was unaware who would have hung one in R56 and R59's room. Although MTD knew fly strips were not allowed, MTD further stated if a resident family brought in a fly strip and hung it in a	21730		

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21730	Continued From page 47 resident room, he would not remove it. During an interview on 9/14/23 at 4:14 p.m., the director of nursing (DON) stated she frequently observed flies in patient care areas. The DON expected staff to attempt to kill them with a fly swatter and was unaware of anyone spraying for them. The DON thought R56 may have bought the fly strip but was unsure who would have hung it in the room. The DON stated fly strips were an infection risk and not allowed to be used. Review of the facility pest control invoices dated 6/16/23, 7/12/23, and 8/9/23, lacked indication fly extermination treatment was completed. The facility Pest Control policy dated 2/14/2022, indicated pest control problems would be promptly reported to the contractor. Monitoring of the environment was to be done by facility staff and additional visits would be warranted when problems were detected. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could educate staff regarding the importance of maitaining an effective pest control program. The DON or designee, could coordinate with maintenance and housekeeping staff to conduct periodic audits of areas residents frequent to ensure pests and pest debris is controlled to ensure a clean, functional and homelike environment is maintained to the extent possible. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21730		

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21805	Continued From page 48	21805		
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 served meals were provided in a dignified, homelike manner for 1 of 1 resident (R5) reviewed who had cognitive impairment and an altered texture diet (i.e., pureed). Findings include: R5's quarterly Minimum Data Set (MDS), dated 8/25/23, identified R5 had severe cognitive impairment and required set-up with supervision for eating. On 9/13/23 at 7:17 a.m., R5 was observed seated in a high-back wheelchair in the commons area of the locked unit and a metallic, mobile cart was in the hallway outside the dining room which contained the unit resident' meal trays. At 7:30 a.m., licensed practical nurse (LPN)-B removed a meal tray from the cart and brought it over to R5. LPN-B placed the tray on a bedside table, and positioned the table over R5's lap saying aloud, "That's your breakfast." LPN-B placed a cloth protector on R5 and removed the dome on the scoop plate which had visible pureed items including sausage, biscuit(s), and scrambled egg present and separated. LPN-B then expressed	21805	Corrected	10/16/23

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21805	Continued From page 49 aloud they were going to "mix it up a little bit for you" as they stirred all the items on the plate together; however, LPN-B did not ask R5 if they wanted the items mixed together prior to doing such. LPN-B mixed the entire plate contents together using a spoon and then expressed aloud it would "make it easier for you [R5]." LPN-B then placed the spoon in the mixed-together blend of pureed food and walked away. R5 then picked up the spoon using his left hand and started to eat the meal. R5's care plan, dated 9/11/23, identified R5 had dysphagia (i.e., swallowing difficulties), consumed a pureed food diet with nectar thick liquids, and was independent with eating after set-up. However, the care plan lacked any intervention or evidence R5 was to have his meal items mixed together for service or consumption. Further, R5's medical record was reviewed and lacked evidence such action had been assessed or evaluated to ensure R5's acceptance and/or preference of having his meal items all blended together when served as LPN-B had done. When interviewed on 9/13/23 at 8:02 a.m., LPN-B verified they had mixed all of R5's meal items together when serving the breakfast meal. LPN-B expressed they did such as they had "seen others [staff] do that" with R5 and other residents on the unit adding the meal items were somewhat dry and "crumbly," so they felt mixing them together would make them easier to eat. When asked if R5 was acceptable to having such completed, LPN-B expressed they "think so" as R5 consumed the meal. LPN-B stated they were unsure if doing such action (i.e., mixing the items together) was care planned for R5 or not, however, reiterated they had seen other staff members do it. LPN-B verified they had not asked	21805		

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21805	Continued From page 50 R5 if he wanted the meal items mixed together or not prior to doing so, and LPN-B acknowledged doing such action was a potential dignity issue for him adding, "I get it." On 9/13/23 at 11:56 a.m., licensed practical nurse care coordinator (LPN)-C was interviewed. LPN-C explained R5 was "totally dependent" for cares and was "not with it" cognitively. LPN-C stated R5 had been on a pureed diet for, at least, nearly a year now and he should not have his food mixed together when served adding, "We don't mix his food." LPN-C stated such action was not on R5's care plan and expressed the nurse may have been confused since they don't routinely work on the unit. LPN-C stated they were going to complete some education with the nurse and reiterated the meal items should not have been mixed up adding staff should "just do [serve] what's normal for everyone [else]." LPN-C added, "I wouldn't want mine all mixed up." A facility provided Assistance with Meals policy, dated 1/2022, identified residents' would receive assistance with meals in a manner which met their individual needs. The policy outlined a section labeled, "Dining Room Residents," which outlined residents' unable to feed themselves would be fed with attention to safety, comfort and dignity with several examples listed including, "Not standing over residents while assistance them with meals," and, "Avoiding the use of labels when referring to residents." However, the policy lacked information on when, or if, mixing food items together for cognitively impaired residents with altered texture diets would be allowed and/or acceptable.	21805		

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21805	Continued From page 51 SUGGESTED METHOD OF CORRECTION: The director of nursing (DON), or designee, could review applicable policies and procedures with staff to ensure knowledge, then audit to ensure ongoing compliance. TIME FRAME FOR CORRECTION: Twenty one (21) days.	21805		

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	245223	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**09/13/2023**

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BAY VIEW NURSING & REHABILITATION CENTER	**1412 WEST FOURTH STREET** **RED WING, MN 55066**

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 09/13/2023. At the time of this survey, BAY VIEW NURSING HOME AND REHABILITATION CENTER was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		10/06/2023

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245223	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**09/13/2023**

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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. BAY VIEW NURSING HOME AND REHABILITATION CENTER is a three-story building with a partial basement The building was constructed at (3) different times. The original building was constructed in 1965 and was determined to be of Type II (222) construction. In 1972, an addition was constructed to the West Wing that was	K 000		

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K 000	Continued From page 2 determined to be of Type II (222) construction. In 1999 a small addition was constructed to the West Wing. Because the original building and the (2) additions meet the construction types allowed for existing buildings, those portions of the facility were surveyed as one building. A full fire sprinkler system protects the building. In addition, 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 120 beds and had a census of 77 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 291 SS=F	Emergency Lighting CFR(s): NFPA 101 Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 This REQUIREMENT is not met as evidenced by: Based on observation, a review of available documentation and staff interview, the facility failed to maintain, test and inspect the emergency lighting fixtures per NFPA 101 (2012 edition) Life Safety Code, sections 19.2.9.1, 7.9, 7.9.3. These deficient findings could have a widespread impact on the residents within the facility. Findings include:	K 291	K291 Emergency Lighting: The emergency lighting has been inspected and will be inspected monthly. The inspection will be recorded on a log placed in the life safety book. Environmental Services Director to audit periodically to ensure documentation is complete and accurate. ESD is responsible for ensuring completion and	10/16/23

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K 291	Continued From page 3 1. On 09/13/2023 between 10:00 AM and 5:00 PM, it was revealed during documentation review that the documentation presented for review that last monthly tested occurred in May of 2023. 2. On 09/13/2023 between 10:00 AM and 5:00 PM, it was revealed during observation that the emergency light located in the Basement Generator Room did not illuminate upon testing. An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K 291	accuracy of information. Will be completed 10/10/23 initially and moving forward.	
K 324 SS=F	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through	K 324		10/16/23

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K 324	Continued From page 4 19.3.2.5.5, 9.2.3, TIA 12-2 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain proper safety and security measures related to a cooking device in a resident accessible corridor in accordance with NFPA 101 (2012 edition), Life Safety Code section 19.3.2.5, 19.3.2.5.3(9). These deficient findings could have an isolated impact on the residents within the facility. Findings Include: On 09/13/2023 between 10:00 AM and 5:00 PM, it was revealed by observation that in the following locations cooking device did not have the proper lock-out, timeout, and disconnect hardware connected to the device: 3rd Floor - 3W Dining Area; and Physical Therapy / Occupational Therapy Area. An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K 324	K324 Cooking Facilities: The oven in the therapy gym area will be equipped with a lock out/tag out device. Parts were ordered on 9/21/23 by Electrician who will install the equipment once the parts are delivered. This will stop the incident from happening again as the device will have an automatic lock out after a certain period of time of nonuse if not manually locked. Until the devices are installed, the door to therapy gym to remain locked when unattended, and the other oven that has a padlock currently will remained locked when not in use.	
K 345 SS=E	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system	K 345		10/16/23

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K 345	Continued From page 5 acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to conduct visual inspection of manual fire alarm boxes (pull-stations) per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.4.1, 9.6.1.3, and NFPA 72 (2010 edition), National Fire Alarm and Signaling Code, section 14.3.1, 14.3.1.9(e), 10.14.3.2, 14.5.1, 17.14, 3.3.140 These deficient findings could have a patterned impact on the residents within the facility. Findings include: On 09/13/2023 between 10:00 AM and 5:00 PM, it was revealed by observation that manual fire alarm pull-stations in the following locations were found to be missing the protective tamper rods: 2nd Floor - 2E stairwell and 2nd Floor Exit area. An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K 345	K345 Fire Alarm System: Contractor contacted on 10/4/23 to request a quote for replacement of both fire alarms due to difficulty with replacing tamper rods, due to age of pull systems. New pull systems do not require the tamper rods. Contractor to respond with pricing and availability of equipment. The issue will not be a reoccurrence as new devices do not require replacement of tamper rods when alarm is pulled. The timeline for compliance of fixing these two pull systems determined on the delivery date for new devices.	
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily	K 353		10/16/23

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K 353	Continued From page 6 available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to maintain the sprinkler system in accordance with NFPA 101 (2012 edition), Life Safety Code, sections 4.6.12, 9.7.5, 9.7.6, NFPA 25 (2011 edition) Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, section(s), 4.3, 5.1.1.1, 5.2.1.1.1, 5.2.1.1.2(5)(6), 5.2.1.2, NFPA 13 (2010 edition) Standard for the Installation of Sprinkler Systems, section 8.5.6. This deficient finding could have an widespread impact on the residents within the facility. Findings include: 1. On 09/13/2023 between 10:00 AM and 5:00 PM, it was revealed during documentation review that no documentation was presented to confirm that quarterly inspection for Q1 of 2023 had occurred. 2. On 09/13/2023 between 10:00 AM and 5:00 PM, it was revealed by observation that sprinkler heads in the 2E corridor exhibited signs of paint splatter.	K 353	K353 Sprinkler System: Contractor services the facility quarterly for sprinkler testing. Administrator to ensure all invoices paid up for inspection to happen as scheduled. Documentation to be kept by ESD. Sprinklers noted in 2567 to be replaced by Contractor. Quote called for on 9/15/23 for replacement sprinkler heads, awaiting confirmation of parts ordered for date of compliance. To ensure this issue with paint spray and grease does not happen again, sprinkler heads will be covered during any future renovations and inspected during Contractor□s quarterly or semi-annual visits.	

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K 353	Continued From page 7 3. On 09/13/2023 between 10:00 AM and 5:00 PM, it was revealed by observation that in the Kitchen of the facility that sprinkler heads in the vicinity exhibited signs of debris loading 4. On 09/13/2023 between 10:00 AM and 5:00 PM, it was revealed by observation that in the Annex Basement there was high storage of items and supplies closer to a vertical interspace distance of less-than 18 inches from sprinkler head(s). An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K 353		
K 355 SS=D	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by: Based on observation, review of available documentation and staff interview, the facility failed to properly inspect, and maintain documentation of portable fire extinguishers in accordance with NFPA 101 (2012 edition), Life Safety Code, sections 19.3.5.12, 9.7.4.1, and NFPA 10 (2010 edition), Standard for Portable Fire Extinguishers, section 6.1.3.3.1. This deficient finding could have an isolated impact on the residents within the facility. Findings include:	K 355	K355 Portable Fire Extinguishers: Kitchen staff have been educated on the importance of access to fire extinguishers immediately on 9/15/23. ESD to apply red reflective tape on areas surrounding fire extinguishers in the dishwashing areas to make it easier for staff to identify. ESD to implement by 10/11/23.	10/16/23

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K 355	Continued From page 8 On 09/13/2023 between 10:00 AM and 5:00 PM, it was revealed by observation, that the fire extinguisher located adjacent to the Dishwashing Room was access obstructed An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 355		
K 374 SS=F	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the smoke barrier doors per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.7.8 and 8.5.4.1. These deficient findings could have a widespread impact on the residents within the facility. Findings include:	K 374	K374 Smoke Barrier Doors: Doors were not self-sealing due to humidity in the building. As of 9/28/23 humidity levels were again lower in the building and all doors are self-sealing appropriately. Due to weather conditions, door inspections will be done more frequently than the required annual. They will be inspected during a fire drill each quarter to ensure	10/16/23

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K 374	Continued From page 9 1. On 09/13/2023 between 10:00 AM and 5:00 PM, it was revealed by observation that the following door assemblies did not self-close and seal the openings properly: 9/10; 17/18; 20/21; 35/36; 40/41; 42/43; 69/70; 71/72; 73/74 2. On 09/13/2023 between 10:00 AM and 5:00 PM, it was revealed by observation that the following door assemblies exhibited and air-gap greater that 1/8 inch, allowing the movement and passage of smoke: 3rd Floor - 3E door assembly; and 1st Floor - door assembly adjacent to RM 1046 An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K 374	doors are closing and self-sealing as required. If doors are noted not to be sealing, at that time facility to repair or replace parts as necessary. Date of compliance will be 10/25/23 on next scheduled fire drill. ESD to maintain documentation.	
K 511 SS=F	Utilities - Gas and Electric CFR(s): NFPA 101 Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to secure electrical panels in accordance with NFPA 101 (2012 edition), Life Safety Code, sections 19.5.1.1 and 9.1.2, NFPA	K 511	K511 Gas and Electric: Electrical panels on 2E that were found to be unlocked were locked immediately by maintenance staff on 9/13/23. All panels within the	10/16/23

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K 511	Continued From page 10 99 (2012 edition), section 6.3.2.2.1.3(A), NFPA 70 (2011 edition), National Electrical Code, section 110.26(F), 110.27(A)(1) This deficient finding could have a patterned impact on the residents within the facility. Findings include: On 09/13/2023 between 10:00 AM and 5:00 PM, it was revealed by observation that electrical panels #2120 and #2150, in the resident corridor, were found to be unsecured and readily accessible to unqualified individuals An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 511	facility were checked on 9/14/23 to ensure all covers were locked. Maintenance staff are the only personnel who hold keys to the electrical panels and signs are posted to call them for any concern with the electrical panels. Effective 10/1/23 maintenance staff to audit panel covers monthly as part of inspection to ensure all panel covers are locked and secured.	
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 per NFPA 101 (2012 edition), Life Safety Code, sections 19.7.1. These deficient findings	K 712	K712 Fire Drills: Review of records confirm no record of third and fourth quarter drills for 2022. The administrator and ESD reviewed process for fire drills if	10/16/23

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K 712	Continued From page 11 could have a widespread impact on the residents within the facility. Findings include: 1. On 09/13/2023 between 10:00 AM and 5:00 PM, it was revealed by review of available documentation that fire drill report forms were found to be missing content and information. 2. On 09/13/2023 between 10:00 AM and 5:00 PM, it was revealed by review of available documentation that no documentation was present to confirm that fire drills were conducted for 2nd shift - 3rd quarter, and 3rd shift - 4th quarter. An interview with Maintenance Director verified these deficient findings at the time of discovery.	K 712	ESD not the one hosting and confirmed third shift drill to be held as a silent drill with designated staff to time stamp response from alarm company as proof of drill. ESD and Administrator to audit quarterly to ensure drills are held as scheduled. Compliance to be met immediately as all drills held so far in 2023 per regulation and 4th quarter drill scheduled for 10/25/23.	
K 761 SS=F	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested 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	K 761		10/16/23

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	245223	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**09/13/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAY VIEW NURSING & REHABILITATION CENTER	**1412 WEST FOURTH STREET RED WING, MN 55066**

(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 761	Continued From page 12 by: Based on document review and staff interview the facility failed to inspect and test doors per NFPA 101 (2012 edition), Life Safety Code, sections 7.2.1.15, and NFPA 80 (2010 edition), sections 5.2.1, 6.1, 6.1.4.2, 6.1.4.3.1 This deficient finding could have a widespread impact on the residents within the facility. Findings include: 1. On 09/13/2023 between 10:00 AM and 5:00 PM, it was revealed by observation that the fire rated door of the 1st Floor - Dining Room - EXIT stairwell (# 68) did not self-close and latch, to seal the vertical stairwell. 2. On 09/13/2023 between 10:00 AM and 5:00 PM, it was revealed by observation that the fire rated door of the Basement - Generator Room did not self-close and latch. An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K 761	K761 Maintenance, Inspection, Testing of Doors: ESD to contact Door/Lock Repair service for repair of 1 Central Stairwell Door and Basement - Generator Room door due to delay in self-closure. ESD contacted Moseng on 10/4/23 to set up a date for quote and repair. As mentioned in K374, they will be inspected during a fire drill each quarter to ensure all doors are closing and self-sealing as required. If doors are noted not to be sealing, at that time facility to continue to repair or replace parts as necessary.	
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance	K 918		10/16/23

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	245223	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**09/13/2023**

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K 918	Continued From page 13 with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on observation, review of available documentation and staff interview, the facility failed to test the on-site emergency generator system per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.4.4.1.1.3, 6.4.4.2 and NFPA 110 (2010 edition), Standard for Emergency and Standby Power Systems, 8.3.4, 8.3.4.1, 8.4.9, 8.4.9.2. This deficient finding could have a widespread impact on the residents within the facility. Findings include:	K 918	K918 Essential Electric System: On 9/21/2023 the Generator 4-hour load bank test was completed by Contracted Electric Corporation from 8:30am to 12:30pm. The generator passed the test. The results are attached. To maintain compliance, this test will be completed every 36 months per regulation. ESD to keep records.	

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K 918	Continued From page 14 On 09/13/2023 between 10:00 AM and 5:00 PM, it was revealed by a review of available documentation that no documentation was presented for review to confirm that 36-month - 4-hour load bank testing is occurring An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 918		
K 920 SS=F	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by:	K 920		10/16/23

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	245223	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**09/13/2023**

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K 920	Continued From page 15 Based on observation and staff interview, the facility failed to manage usage of relocatable power taps in accordance with NFPA 99 (2012 edition), Health Care Facilities Code, section 10.2.3.6, and NFPA 70, (2011 edition), National Electrical Code, sections 110.3(B), 400.8 (1) and UL 1363. These deficient findings could have an widespread impact on the residents within the facility. Findings include: 1. On 09/13/2023 between 10:00 AM and 5:00 PM, it was revealed by observation that on 3rd Floor of the facility that: an extension cord was in use at the Nurses Station in the Dementia Care Unit; in the Clinical Coordinator Office an appliance was connected to relocatable power tap; in the Administrator Office an appliance connected to a relocatable power tap. 2. On 09/13/2023 between 10:00 AM and 5:00 PM, it was revealed by observation that on 2nd Floor of the facility that: in the 2E Office and appliance was connected to a relocatable power tap; in the Reception Office an extension cord was connected to a relocatable power tap. 3. On 09/13/2023 between 10:00 AM and 5:00 PM, it was revealed by observation that on 1st Floor of the facility that in the Activities Office an appliance was connected to a relocatable power tap An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K 920	K920 Power Cords and Extension Cords: On 9/13/23, all extension cords noted in patient care areas were removed by ESD. On 9/15/23 Electrician was in house and replaced the outlet at reception desk to accommodate necessary equipment, at this time the extension cord was also removed. The extension cord was removed from the activity□s office on 9/13/23 and staff notified of why it was not in compliance. On 9/15/23 2E office manager and Administrator were advised to plug appliances directly into outlets and not to be connected to power strips. Electrician received list of locations in facility to install additional outlets to decrease need for power strips and extension cords. This work began on 9/15/23 and will continue periodically as their schedule allows until the list is complete. ESD to audit during routine maintenance inspections.	
K 923 SS=F	Gas Equipment - Cylinder and Container Storag	K 923		10/16/23

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K 923	Continued From page 16 CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99)	K 923		

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K 923	Continued From page 17 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain proper medical gas storage and management per NFPA 99 (2012 edition), Health Care Facilities Code, sections 5.1.3.3.2(2), 11.6.5, 11.6.5.2, 11.6.5.3. These deficient findings could have a widespread impact on the residents within the facility. Findings include: 1. On 09/13/2023 between 10:00 AM and 5:00 PM, it was revealed by observation on the 2nd Floor, the Med Gas (O2) Storage Room was found unsecured. 2. On 09/13/2023 between 10:00 AM and 5:00 PM, it was revealed by observation on the 2nd Floor, the Med Gas (O2) Storage Room door hardware was not functioning properly. Upon finding the door unsecured, tested the door closing multiple times and observed the door would not self-close and latch. 3. On 09/13/2023 between 10:00 AM and 5:00 PM, it was revealed by observation that on 2nd Floor in the Med Gas (O2) Storage Rooms there was mixed storage of empty / full cylinders. An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K 923	K923 Gas Equipment Cylinder and Container Storage: Lock on Med Gas Storage Room to be replaced with a self-locking mechanism by 10/11/23. This will ensure compliance with keeping door locked as well as decrease the possibility of hardware not functioning properly due to being new. Lock/Door Repair contractor to install a door closure to ensure the door is self-latching. Contractor contacted on 10/4/23 for quote on service and date available to install. All supply bins were replaced with bins with locking lids. All cylinders will be labeled individually with tags identifying empty vs full. Tags to be oxygen safe and provided by contractor. Compliance to be met no later than 10/11/23.	

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
November 3, 2023

Administrator
Bay View Nursing & Rehabilitation Center
1412 West Fourth Street
Red Wing, MN 55066

RE: CCN: 245223
Cycle Start Date: September 14, 2023

Dear Administrator:

On September 29, 2023, we notified you a remedy was imposed. On October 23, 2023, the Minnesota Departments of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of October 16, 2023.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective October 14, 2023 be discontinued as of October 16, 2023. (42 CFR 488.417 (b))

As we notified you in our letter of September 29, 2023, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from October 14, 2023. This does not apply to or affect any previously imposed NATCEP loss.

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

Please contact me with any questions regarding this letter.

Sincerely,

Lori Hagen

Lori Hagen, Compliance Analyst
Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Telephone: 651-201-4306
E-Mail: Lori.Hagen@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

November 3, 2023

Administrator
Bay View Nursing & Rehabilitation Center
1412 West Fourth Street
Red Wing, MN 55066

Re: Reinspection Results
Event ID: B5SX12

Dear Administrator:

On October 23, 2023, survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on September 14, 2023. At this time these correction orders were found corrected.

Please contact me with any questions regarding this letter.

Sincerely,

Lori Hagen, Compliance Analyst
Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Telephone: 651-201-4306
E-Mail: Lori.Hagen@state.mn.us