Electronically delivered
October 11, 2023

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

RE: CCN: 245063
Cycle Start Date: September 28, 2023

Dear Administrator:

On September 28, 2023, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Pete Cole, RN 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 the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

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

If substantial compliance with the regulations is not verified by December 28, 2023, (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by March 28, 2024, (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

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

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

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

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

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

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

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

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

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
	245063	A. BUILDING ______ B. WING ______	C 09/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST ANTHONY PARK HOME	**2237 COMMONWEALTH AVENUE SAINT PAUL, MN 55108**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments On 9/25/23 to 9/28/23, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73 was conducted during a standard recertification survey. The facility was in compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On 9/25/23 to 9/28/23, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was not in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. In addition to the recertification survey, the following complaints were reviewed: The following complaints were reviewed with no deficiency issued. H50635681C (MN96522) H50635802C (MN96428) H50635803C (MN96427) H50635804C (MN93145) H50635822C (MN85480) H50635823C (MN85378) 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	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		10/20/2023

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

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F 000	Continued From page 1 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 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any,	F 580		10/24/23

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F 580	Continued From page 2 when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to ensure a provider and resident representative were notified in a timely manner of a change in status for 1 of 1 residents (R66) who had new onset of signs and symptoms of a possible infection and was tested for COVID-19. Findings include: R66's quarterly Minimum Data Set (MDS) dated 9/12/23, indicated R66 had severe cognitive deficits, required supervision for eating, limited assistance for transfers and was extensive assistance for all other activities of daily living (ADLs). R66's diagnoses included Parkinson's disease, neurocognitive disorder with Lewy Bodies (a brain disorder that can lead to	F 580	F 580 R 66 representative and provider were called and notified that they were omitted from notification in change in R 66s status and that he was not placed in the appropriate precautions per facility policy. All current residents from survey exit until present, their documentation was reviewed and any changes in condition not reported, the MD and resident representative will be notified. Future residents who experience a change in condition, the resident representative and MD will be notified per facility policy. Licensed nurses and nurse aides will be in-serviced on the change in condition policy with emphasis on reporting and	

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F 580	Continued From page 3 problems with thinking, movement, behavior, and mood.), falls, diabetes, end stage heart failure, liver cancer, and cirrhosis of the liver (impaired liver function caused by the formation of scar tissue). R66's Care Area Assessment (CAA) dated 6/20/23, indicated R66 triggered for delirium, cognitive loss/dementia, communication, ADL function, falls, nutrition, and pressure ulcers. R66's care plan dated 5/30/23, indicated R66 was dependent on staff/family/volunteers to meet emotional, intellectual, physical, and social needs. R66 also had ADL deficits and impaired communication and cognition. Interventions included anticipating R66's needs, to monitor/document physical/nonverbal indicators of discomfort or distress: follow up as needed and communicate with R66's family and caregivers regarding R66's capabilities and needs. The care plan also indicated R66 had potential for altered cardiovascular status. Interventions included observing vital signs and notifying the provider of any significant abnormalities. R66 also had diabetes. Interventions indicated if infection was present, to consult with a provider regarding necessary changes in diabetic medications. R66 also had liver disease and cancer. Intervention included monitoring/documenting/reporting lethargy, fatigue, anorexia, and altered level of consciousness to the provider. R66's orders dated 8/1/23, indicated when any standing orders were initiated, results were to be communicated to the provider the next working day. R66's progress note dated 9/13/23, indicated R66	F 580	notifying the MD/NP and resident representative with a resident change in status and licensed nurses will continue to monitor until the problem resolves or stabilizes. Director of Nursing and/or designee is responsible for compliance. Audits on resident change in status with MD/NP and responsible party notification will begin weekly x 2 weeks then monthly to ensure sustained compliance. All audits will be reviewed by the Administrator and the Administrator will take audit results to QAPI for review and further recommendation. Compliance: 10/24/2023	

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F 580	Continued From page 4	F 580		

was noted to be cold, had voice changes and a runny nose. R66 was tested for COVID-19 and was negative. Was then offered warm water, and a supplement shake. R66 ate only 50% of breakfast and lunch, took a nap after breakfast and had confusion during the shift. The progress note indicated the nurse would "push fluids," continue to monitor, and notify the provider if R66's condition worsens.

During an interview on 9/25/23 at 6:16 p.m., R66's family member (FM)-A stated she was unaware R66 had new onset of signs and symptoms that prompted him to be tested for COVID-19 and stated she would have wanted to be notified. FM-A further stated the family had been unable to determine if R66 should get the current COVID-19 booster vaccine and knowing he was showing possible signs or symptoms may have helped them make a decision.

During an interview on 9/26/23 at 1:34 p.m., licensed practical nurse (LPN)-C stated residents were given a rapid COVID-19 test as soon as they had signs or symptoms of a possible infection including a runny nose or cough. LPN-C stated she was unaware if the resident tested negative, the provider should have been notified, and the resident should have been retested after 48 hours. LPN-C further stated if the resident tested negative, they would not need to be isolated. LPN-C stated R66's voice had changed, and he had a runny nose, so she tested him for COVID-19 on 9/13/23; however, since he was negative, she did not notify the family, provider, or management. LPN-C stated she also did not place R66 on isolation or retest him after 48 hours according to the CDC guidelines.

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F 580	Continued From page 5 During an interview on 9/27/23 at 9:43 a.m., the assistant director of nursing (ADON) who was also the infection preventionist (IP) stated she was not aware R66 had new onset of symptoms of a possible infection including a runny nose and change of voice and would have expected to be, even though R66 tested negative for COVID-19. The ADON also would have expected the family and provider to be notified of the change in R66's condition and a second COVID-19 test should have been administered 48 hours after the first negative to ensure he was still negative. During an interview on 9/28/23 at 10:27 a.m., the director of nursing (DON) stated she was unaware R66 had new signs or symptoms of a possible infection or that he had been tested for COVID-19 on 9/13/23. The DON stated she and/or the ADON, the provider, and R66's family should have been notified even though he tested negative. During an interview on 9/28/23 at 1:44 p.m., nurse practitioner (NP)-A stated she was not notified R66 had been tested for COVID-19 or had developed a runny nose and changes in his voice and would have expected to have been, regardless of the results. The facility Standing Orders dated 3/9/23, indicated to complete COVID-19 antigen testing as indicated for outbreak and/or routine testing per facility policy. The facility Change in Resident's Condition or Status policy dated the facility notified the resident's provider and representative of changes in the resident's medical/mental condition and/or status including a need to alter the resident's	F 580		

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F 580	Continued From page 6 medical treatment significantly. A significant change was defined as having an impact on more than one area of the resident's health status, was not self-limiting, and required interdisciplinary review and/or revision to the care plan. The policy further indicated notifications were to be made within 24 hours of the change occurring.	F 580		
F 641 SS=B	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure the Minimum Data Set (MDS) was accurately coded to reflect restraint use for 3 of 3 residents (R7, R14, R45) reviewed for MDS accuracy. Failure to code the "MDS" correctly could potentially lead to inaccurate federal reimbursements and inaccurate assessment and care planning of the resident. Findings include: The Centers for Medicare and Medicaid Services (CMS) Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, dated 10/2018, identified the purpose of the RAI process was to help ensure holistic care was provided. A section labeled, "Section P: Restraints and Alarms," outlined directions for coding the subsequent sections including, "P0100: Physical Restraints." These directions outlined, "Code 2, used daily: if the item met the definition and was used on a daily basis during	F 641	F 641 R 7 had an MDS completed with accurate scoring of bed rail use completed 10/4/2023. R7 care plan was updated as needed. R 14 will have a new MDS completed 11/2023 and will have accurate scoring of bed rail use. R 14s care plan will be updated as needed. R 45 will have a MDS completed 10/11/2023 with accurate scoring of bed rail use. R 45s care plan will be updated as need. Current and future residents will have their bed rail assessment completed, care plan reviewed and their MDS scored correctly during their assessment period. The MDS coordinator was in-serviced on the RAI Manual Section P, Page 1 Definition of a Restraint with emphasis on any item that is attached to or adjacent to the resident body and restricts movement is considered a restraint. MDS coordinator is responsible for compliance.	10/24/23

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F 641	Continued From page 7 the look-back period." The Centers for Medicare and Medicaid Services (CMS) Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual dated 10/2018 identifies the step for assessing appropriate use of a restraint is to, "determine whether or not the device restricts freedom of movement or restrict the resident ' s access to their own body" and, "to determine the effect it has on the resident." R7 R7's quarterly Minimum Data Set (MDS) dated 9/1/23 indicate R7 with intact cognition and required assistance of staff for all activities of daily living (ADL's). R7 also with diagnoses of hemiplegia and hemiparesis (paralysis) following CVA (cerebral vascular accident)[impaired blood flow to a part of the brain] affecting left non dominant side, chronic pain, and delirium. In addition, R7's "P0100: Physical Restraints" section indicated restraints were bed rails used in bed and used daily. R7's physician orders (PO) dated 5/23/22 indicate, "Okay for grab bars to assist with bed repositioning". R7's care plan dated 3/2/23 indicate, "The resident uses bed assist bars r/t need for assistance with repositioning in bed". During observation on 9/25/23 at 3:27 p.m., R7 lying in bed with raised quarter side rails aligned with shoulder and neck of head of bed. During interview with nursing assistant (NA)-D on	F 641	Audits on coding of Section P bed rail accuracy will begin weekly x 2 weeks then monthly to ensure sustained compliance. All audits will be reviewed by the Administrator and the Administrator will take audit results to QAPI for review and further recommendation. Compliance: 10/24/2023	

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F 641	Continued From page 8	F 641		

9/28/23 at 8:28 a.m., NA-D stated R7's side rails do, "not stop her from getting in and out of bed".

R14

R14's quarterly MDS dated 8/10/23 indicate impaired cognition and required assistance from staff for all ADL's. R14 with diagnoses of Parkinson's, neurocognitive disorder (decrease in mental function), hallucinations, anxiety, and low vision. In addition, R14's "P0100: Physical Restraints" section indicated restraints were bed rails used in bed and used daily.

R14's PO dated 11/21/19 indicate, "Bilateral assist handles to increase participation and independence in bed mobility".

R14's care plan dated 5/22/23 indicate, "The resident uses assist handles to increase independence in bed mobility".

During observation on 9/28/23 at 8:35 a.m., R14's bed with raised quarter side rails aligned with shoulder and neck of head of bed.

R45

R45's quarterly MDS dated 8/10/23 indicate R45 with intact cognition and required assistance from staff for most ADL's. R45 with diagnoses of Parkinson's, spinal cord injury, paraplegia, and neurocognitive disorder. In addition, R45's "P0100: Physical Restraints" section indicated restraints were bed rails used in bed and used daily.

R45's PO dated 7/12/23 indicate, "ASSIST RAIL(S) ON BED TO PROMOTE MOBILITY AND

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F 641	Continued From page 9 INDEPENDENT FUNCTION".	F 641		

R45's care plan dated 3/21/23 indicate, "The resident uses bed rails r/t need for assistance with bed mobility."

During observation on 9/25/23 at 5:20p.m., R45 lying in bed with raised quarter side rails aligned with shoulder and neck of head of bed.

During interview with R45 on 9/28/23 at 8:31 a.m., R45 stated the quarter side rails on the top portion of his bed about twelve inches from the top of his mattress, "do not stop me from getting in and out of bed". R45 indicated the side rails do not limit his movement while in the bed and during transfers into and out of his bed.

During interview with registered nurse (RN)-B on 9/28/23 at 11:29 a.m., RN-B stated, "bed rails are a restraint. Anything that limits or restricts someone from getting into and out of a bed a restraint". RN-B stated R45's side rails "not a restraint".

During interview with MDS coordinator (MDS)-C on 9/28/23 at 11:25a.m., MDS-C stated she was responsible for coding every residents restraint section of the MDS for the facility. MDS-C stated, "bed rails don't always have to be considered a restraint" but was instructed to code, "any use of side rails as a restraint".

Undated facility policy titled Medicare Reimbursement Resource Manual Medicare, PPS and VBP state, "Each IDT member that completes an MDS section is responsible for the accuracy and completeness of the data".

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F 657	Continued From page 10	F 657		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure timeliness of person-centered care conferences for 2 of 2 (R45, R53) and to include review and revision by an interdisciplinary team and the resident in adjusting their care plan and making decisions about his or her care.	F 657	F 657 R 45 had a care conference on 10/16/2023. R 45□s care plan was reviewed and updated as needed. R 53 had a care conference on 10/17/2023. R 53□s care plan will be review and updated as needed. Current and future residents	10/24/23

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F 657	Continued From page 11 Findings include: R45's quarterly Minimum Data Set (MDS) dated 8/10/23, identified R45 with intact cognition, and required extensive assistance with all activities of daily living (ADL's). In addition, R45 had diagnosis of Parkinson's, delusions, spinal cord injury, anxiety, paraplegia (paralysis of all or part of your trunk, legs, and pelvic organs), and depression. R45's previous MDS assessments were 5/18/23, 2/15/23, and 11/17/22. R45's Care conference notes titled, "Social Service Care Conference-IDT" were dated 8/31/23, 4/25/23, and 8/25/22. R45's electronic medical record (EMR) failed to indicate a care conference was completed within the time frame for MDS assessments for 5/18/23, 2/15/23 and 11/17/22. R53's quarterly MDS dated 7/27/23, identified R53 with intact cognition, required assistance with transfers, and haD diagnoses of diabetes, stage three chronic kidney disease and chronic pain. R53's previous MDS assessments were 6/16/23, 5/3/23, 2/9/23 and 12/27/22. R53's Care conference notes titled, "Social Service Care Conference-IDT" were dated 6/8/23, 3/14/23, 9/11/22. R53's EMR failed to indicate a care conference was completed within the time frame for MDS assessments for 5/3/23, 2/9/23, and 12/27/22. During interview with R53 on 9/26/23 at 9:55 a.m., R53 stated indicated she could not recall if she was involved in any of her care conferences regarding care planning.	F 657	will have a care conference scheduled during the resident review period and as needed. The IDT team will be in-serviced on the Resident Care Conference Procedure with emphasis on opening the care conference assessment, the IDT team reviewing the care plan prior to the care conference and updating the care plan after the meeting as needed. Social Services and/or designee is responsible for compliance. Audits on timely care conferences and completion of the care conference assessment will begin weekly x 2 weeks then monthly to ensure sustained compliance. All audits will be reviewed by the Administrator and the Administrator will take audit results to QAPI for review and further recommendation. Compliance: 10/24/2023	

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During interview with director of nursing (DON) on 9/26/23 at 12:39 a.m., DON stated all care conference notes and documentation were in the EMR under "Social Service Care Conference-IDT" notes. Further, the DON stated care conferences, "should be done quarterly or with significant change". DON stated last care conference note for R53 was 6/8/23 and there should have been one around the 7/27/23 MDS. DON stated, "Looks like they are not being done reliably."

During interview with DON and assistant director of nursing (ADON) on 9/27/23 at 11:03 a.m., both reviewed R45's care conference notes from the EMR and DON indicated there were "missed" care conferences.

During interview with social worker (SS)-A on 9/28/23 at 10:30 a.m., SS-A stated all care conferences were her responsibility and she was to schedule them and, "should be done quarterly or with significant change" status. SS-A stated a "Big gap with scheduling the MDS and care conferences". SS-A stated the concern with missing care conferences would be a failure to review resident care plans and goals with caregivers, residents, and families.

Facility policy titled Resident Care Conference/Care Plan Review updated 03/30/2021 indicated the purpose of care conferences were to, "develop and plan care and to ensure that the resident goals and preferences be discussed and established."

F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3)	F 692		10/24/23

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F 692	Continued From page 13 §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to comprehensively assess significant weight changes for 1 of 1 residents (R51) reviewed for nutritional status. Findings include: R51's quarterly Minimum Data Set (MDS) dated 7/26/23, indicated R51 had intact cognition, was independent with eating and required extensive assistance for all other activities of daily living (ADLs). R51's diagnoses included atherosclerotic heart disease, depression, diabetes, high cholesterol, osteogenesis imperfecta (genetic disease resulting in brittle bones), and high blood	F 692	F 692 R 51 weekly weight order was obtained on 10/3/2023 and will be discontinued when baseline weight is achieved. R 51s nutritional care plan was reviewed and updated as needed. All current residents will be reviewed monthly for weight fluctuations and any significant weight discrepancies, a reweight will be obtained. Confirmed significant weight gains or losses, the MD, dietitian, and resident representative will be notified. Future residents will be weighed upon admission, the next day, weekly x 2 weeks then monthly thereafter.	

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F 692	Continued From page 14 pressure. R51's Care Area Assessment (CAA) dated 4/25/23, indicated R51 triggered for ADL function, psychosocial well-being, mood state, nutrition status, pressure ulcers, and psychotropic drug use. R51's care plan dated 12/10/22, indicated R51 had diabetes. Interventions included monitoring/documenting/reporting signs and/or symptoms of hyperglycemia (high blood sugar) including increased appetite, noncompliance with prescribed diet and malnutrition. Interventions also included weighing R51 according to provider orders. R51 also had the potential for nutritional risk. Interventions included a controlled (consistent) carbohydrate (CCHO) diet, encouraging greater than 75% intake of meals, offering a supplement if R51 refused meals. R51's dietary progress note dated 12/30/22, indicated the registered dietician (RD) recommended weekly weight monitoring due to R51's significant weight changes. R51's dietary progress note dated 2/24/23, indicated R54 had significant weight differences and "more frequent weight checks" were requested to "determine accurate baseline." R51's dietary progress note dated 3/6/23, indicated R51 had significant weight discrepancies and therefore, nursing was notified to complete weekly weight monitoring. R51's dietary progress note dated 4/23/23, indicated R54 continued to show significant weight discrepancies. The note indicated nursing	F 692	Director of Nursing will be in-serviced on the Weight Policy with emphasis on item #3 that any weight that is 5% or more since the last assessment will be retaken the next day and when confirmed, the dietitian will be notified in writing. Director of Nursing and/or designee is responsible for compliance. Audits on weekly weights and reweights for accuracy will begin weekly x 2 weeks then monthly to ensure sustained compliance. All audits will be reviewed by the Administrator and the Administrator will take audit results to QAPI for review and further recommendation. Compliance: 10/24/2023	

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was notified of recommendation to complete weekly weight monitoring due to the discrepancies.

R51's orders dated 6/12/23, indicated R51 was on a consistent carbohydrate (CCHO) diet. The orders lacked indication of an order to obtain weights for R51.

R51's weights (in pounds-lbs) were as follows:
-1/12/23 at 6:57 p.m., 203.3
-2/12/23 at 10.21 a.m., 201
-2/23/23 at 3:03 p.m., 245 (21.89 % gain)
-3/2/23 at 12:44 p.m., 243
-3/9/23 at 1:57 p.m., 243
-4/17/23 at 8:50 a.m., 202 (16.87% loss)
-4/19/23 at 1:27 p.m., 209
-5/7/23 at 7:42 a.m., 206
-5/23/23 at 8:22 a.m., 207
-6/7/23 at 3:16 p.m., 202.1
-7/9/23 at 2:25 p.m., 209
-8/7/23 at 7:31 a.m., 220 (5.26% gain)
-9/3/23 at 2:29 p.m., 213

R51's nutrition assessment dated 7/27/23, indicated R51 was to continue on a CCHO diet with no added salt. R54's Body Mass Index (BMI) was 34.8 (obese) and weighed 209 lbs. The assessment indicated diet education was provided and would be offered as needed.

R51's provider note dated 9/11/23, indicated R51 had worsening over-all control of his A1C levels (a blood test that averages blood glucose levels over a three-month period to determine effectiveness of diabetes management and confirming a diagnosis of diabetes if over 6.5%) as follows:

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-1/10/23, 6.7%
-4/25/23, 8.3%
-7/18/23, 8.6%

During an interview on 9/25/23 at 1:59 p.m., R51 stated he was concerned about his weight and wanted to know what his weight was. R51 stated he had not been weighed for a "couple of weeks" and did not know how often he was supposed to be weighed. R51 further stated he wondered if the scale was broken because his weight fluctuated "a lot."

During an interview on 9/28/23 at 11:03 a.m., the RD stated she met with R51 "pretty frequently" due to his excessive calorie intake and poor food choices, although he had been improving. The RD stated she received monthly weights for R51; however, after review of R51's dietary progress notes, the RD verified she had requested weekly weights due to significant discrepancies in December, February, March, and April, and they had not been done. The RD further stated R54 should have had weekly weights completed until she was able to determine a baseline weight and then she would discontinue the order. The RD verified she had suspected R54's weight of 220 lbs on 8/7/23, was an error; however, a re-weight had not been completed until 9/7/23, and should have been done immediately to determine accuracy. The RD stated an accurate weight was important to determine if R51 was reaching his goals or was having an acute medical concern such as fluid retention.

During an interview on 9/28/23 at 11:49a.m., the director of nursing (DON) verified a resident's weight log was expected to reflect the resident's most accurate weight. The DON verified R51's

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F 692	Continued From page 17 electronic medical record (EMR) lacked documentation explaining R51's significant weight discrepancies. The DON stated because the RD was in the facility only two days a week and did not attend the morning interdisciplinary team (IDT) meetings, she would have expected the RD to communicate recommendations for a change in resident care to the staff and management directly and for staff to follow her recommendations including weekly weights for R51. The facility Weight Assessment and Intervention policy dated 1/20/22, indicated the multidisciplinary team's (MDT) goal was to prevent, monitor, and intervene for undesirable weight loss. Any weight change of 5% or more since the previous weight assessment was to be retaken the following day. If the weight was verified, the dietician was to be immediately notified in writing and the dietician was to respond within 24 hours. The policy further indicated the dietician was to review resident weights on the 15th of the month to monitor for trends and report negative findings to the treatment team to determine if significant weight change criteria had been met. The MDT was to determine the resident's target weight range, current intake, relationship between the resident's medical condition and weight fluctuation and if weight stabilization or improvement could be anticipated. The policy indicated the dietician would discuss undesired weight gain with the resident and/or family and interventions should consider resident preferences and rights.	F 692		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i)	F 695		10/24/23

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F 695	Continued From page 18 § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure oxygen tubing was changed according to standards of care to prevent possible respiratory infections for 2 of 2 residents (R18, R54) who used oxygen. Findings include: R18 R18's quarterly Minimum Data Set (MDS) dated 9/6/23, indicated R18 was unable to complete the Brief Interview for Mental Status (BIMS) and had severe cognitive deficits, was totally dependent on staff for eating and required extensive assistance for all other activities of daily living (ADLs). R18's diagnoses included toxic encephalopathy (a brain disorder caused by exposure to a neurotoxic substance), acute respiratory failure with hypoxia (low oxygen), pneumonia due to COVID-19, cardiac arrhythmias, deep vein thrombosis and stroke. R18's orders dated 7/3/23, indicated R18's oxygen tubing was to be changed and dated every Monday, and received 2 liters per minute (lpm) of oxygen by nasal cannula to maintain an oxygen saturation level of greater than 90%.	F 695	F 695 Oxygen R18 oxygen tubing was changed on 9/26/23. R 54 oxygen tubing was changed on 9/26/23. R 18 and R 54s care plan for oxygen use was reviewed and updated as needed. All other existing residents who utilize oxygen will have their tubing orders and care plans reviewed and updated as needed. Future residents will have oxygen orders, tubing change orders and care plans initiated per facility policy. Licensed Nurses will be in-serviced on the Department of Respiratory policy with emphasis on the policy steps to change the oxygen tubing every 7 days and as needed and that oxygen tubing that is not in use must be stored in plastic bag. Director of Nursing and/or designee is responsible for compliance. Audits on oxygen tubing change dates and oxygen tubing storage will begin weekly x 2 weeks then monthly to ensure sustained compliance. All audits will be reviewed by the Administrator and the Administrator will take audit results to QAPI for review and further recommendation.	

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F 695	Continued From page 19	F 695	Compliance: 10/24/2023	

During an observation on 9/25/23 2:52 p.m., R18 was lying in bed, oxygen tubing was attached to a humidified bubbler with a piece of tape dated "9/12" indicating that was the last time the tubing had been changed.

During an interview on 9/26/23 at 1:45 p.m., nursing assistant (NA)-E stated nurses were responsible for changing resident oxygen tubing.

During an interview on 9/26/23 at 1:50 p.m., registered nurse (RN)-E stated she had never changed resident oxygen tubing and did not know how often it was supposed to be changed. RN-E verified R18's oxygen tubing indicated it was last changed on 9/12/23.

R54

R54's quarterly MDS dated 6/22/23, indicated R54 had severe cognitive deficits, required limited assistance for toileting, dressing and transfers, and supervision for bed mobility and personal hygiene. R54's diagnoses included Alzheimer's disease, dementia with behavioral disturbance, heart disease, obstructive sleep apnea (OSA), chronic obstructive pulmonary disease (COPD), morbid obesity, anxiety, congestive heart failure (CHF, resulting in fluid in the lungs), and nonspecific abnormal finding of the lung field.

R54's orders dated 7/13/23, indicated R54 was to use oxygen while in bed to keep oxygen saturation level above 90%. The orders also indicated R54's oxygen tubing was to be changed every evening shift on Tuesday.

During an observation on 9/25/23 at 3:37 p.m.,

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F 695	Continued From page 20 R54 was lying in bed. Nasal cannula oxygen tubing was connected to a concentrator and draped over the foot of his bed. The tubing had a label dated "9/12". R54 stated he used the oxygen when he needed it. During an observation on 9/26/23 at 2:27 p.m., R54 was in bed with oxygen tubing draped over his side table and dated "9/12". During an observation and interview on 9/26/23 at 2:38 p.m. RN-F stated she last changed R54's oxygen tubing on 9/12/23, but was unsure how often oxygen tubing was supposed to be changed and that the licensed nursing staff were responsible to ensure it was completed. During an interview on 9/27/23 at 10:00 a.m., the assistant director of nursing (ADON) who was also the infection preventionist (IP) stated oxygen tubing was to be changed weekly according to provider orders to avoid possible infection control concerns. The facility Departmental (Respiratory Therapy)-Prevention of Infection policy dated 1/10/23, indicated to mark the resident hydration bottle (bubbler) with date and initials upon opening and discard after 24 hours and also to change the oxygen cannula and tubing every seven days or as needed.	F 695		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include,	F 758		10/24/23

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F 758	Continued From page 21 but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic	F 758		

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F 758	Continued From page 22 drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to ensure psychotropic medications were reviewed for the appropriateness of a gradual dose reduction (GDR) for 1 of 1 residents (R54) reviewed for unnecessary medications. Findings include: R54's quarterly MDS dated 6/22/23, indicated R54 had severe cognitive deficits, required limited assistance for toileting, dressing and transfers, and supervision for bed mobility and personal hygiene. R54's diagnoses included dementia with behavioral disturbances, anxiety, and visual hallucinations. R54's care plan dated 8/10/22, indicated R54 received psychotropic medications. Interventions included consulting with the provider and pharmacy to consider dose reductions at least quarterly, and discuss the need for R54's ongoing use with the provider and family. R54's orders dated 9/13/23, indicated R54 had not had a GDR completed since his sertraline (an anti-depressant) was increased on 8/16/22, from 25 milligrams (mg) to 50 mg. The orders also indicated R54 had not had a GRD since his quetiapine (an anti-psychotic) was increased from 50 mg in the morning and 150 mg at bedtime to 100 mg in the morning and 200 mg at bedtime on 8/6/22.	F 758	F 758 GDR R 54 Gradual Dose Reduction (GDR) recommendation was completed on 9/28/2023. R 54 will be monitored for any adverse reactions from this reduction. All current resident pharmacy recommendations for August and September 2023 were reviewed and 3 GDRs were completed in August per recommendations and 4 were completed in September. Two recommendations remain outstanding and will be forward to the attending physician and/or Medical Director for review and response. Future residents will be reviewed for a GDR by the pharmacist and those recommended reductions will be forwarded to the MD for review and recommendation acceptance or refusal. Social Service and ADON will be in-serviced on the GDR Policy and Procedure with emphasis on ensuring that the resident has an attempt at a reduction within one year of admission and in 2 separate quarters and on the Pharmacy Drug Medication Review Policy with focus on item #7 that if recommendations are not completed by the attending physician, the recommendation will be forwarded to the Medical Director for review and recommendation. Social Services and/or designee is responsible for compliance.	

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F 758	Continued From page 23 During an interview on 9/28/23, at 12:16 p.m., consulting pharmacist (CP)-A stated he had consulted for the facility briefly while they transitioned to a new consulting pharmacy. CP-A stated the previous pharmacist scheduled a GDR for R54's sertraline on 9/4/23 and on 10/5/23 for his quetiapine; however, CP-A stated the GDRs should have been done by August 2023, within a year of them being increased. CP-A further verified there was no indication either medication had had a GDR attempted nor a reason why the GDRs would have been inappropriate. During an interview on 9/27/23 at 1:36 p.m., CP-B stated she began consulting for the facility when they switched pharmaceutical providers on 9/1/23, and therefore was unfamiliar with R54 or the status of his psychotropic medications. CP-B stated, however, that she would have expected the facility to attempt a GDR for his sertraline and/or quetiapine in the previous year according to the regulations or have a reason why it would have been inappropriate and verified she could not find evidence of either recommendation. The facility Gradual Dose Reduction Guideline dated 11/30/21, indicated a GDR should be attempted after a newly initiated psychotropic medication has been in use or the resident had been in the facility for one year. The GDR was to occur in two separate quarters unless the provider had documented a GDR was contraindicated.	F 758	Audits on GDR attempts and timely response to reduction request will begin weekly x 2 weeks then monthly to ensure sustained compliance. All audits will be reviewed by the Administrator and the Administrator will take audit results to QAPI for review and further recommendation. Compliance: 10/24/2023	
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be	F 761		10/24/23

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F 761	Continued From page 24 labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: During observation and interview the facility failed to ensure safe and secure storage of medications and to limit access to only authorized personnel for 2 of 3 medication storage rooms reviewed. Findings include: During observation on 9/26/23 at 9:47 a.m., the door to the third floor medication storage room was observed with door wedged open with no staff around the area. Six narrow and one small portable oxygen cylinders, a Pyxis (medication dispensing machine) with one means of securing	F 761	F 761 The facility medication storage rooms will have signage placed indicating that the room must be always locked. All door props were removed from the medication door storage areas. There was no ill effects experienced by residents or staff for this deficient practice. Licensed Nurses and any future TMA□s will be in-serviced on the Storage of Medication Policy and Procedure with focus on all medication cabinets, doors, cart must be locked when not in use and no door props will be allowed for	

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F 761	Continued From page 25 medications instead of two. Also, a small, unlocked refrigerator containing medication and a locked large tackle box (with one means of securing contents instead of two) were visible from the dining room and nursing station. During observation on 9/26/23 at 12:45 p.m., third floor medication storage room observed with door wedged open. Six narrow and one small portable oxygen cylinders, a Pyxis (with one means of securing medications instead of two). Also, a small, unlocked refrigerator containing medication and a locked large tackle box (with one means of securing contents instead of two) were visible from the dining room and nursing station. Lunch was being served in the dining room and several residents and facility staff were present in the dining room. No one was in or near the opened medication storage room. During interview with registered nurse (RN)-A on 9/26/23 at 12:45 p.m., RN-C stated the medication storage room door should be closed and locked. During interview with RN-B on 9/26/23 at 12:46 p.m., RN-B stated the medication storage room door should be closed and locked because the emergency kit and "other meds are in there too" including the Pyxis with narcotics. During observation on 9/27/23 at 7:47 a.m., the second floor medication storage room door was visibly open with no staff in the room. Twelve tall and 2 small portable oxygen cylinders were present in the medication storage room along with a Pyxis (with one means of securing medications instead of two). Also, a small unlocked refrigerator with medications inside.	F 761	medication storage areas and only personnel authorized to prepare and administer medications will be authorized in this area. Director of Nursing and/or designee is responsible for compliance. Audits on medication storage room doors and cart remaining locked when unoccupied will begin daily x5 days, weekly x 2 weeks then monthly to ensure sustained compliance. All audits will be reviewed by the Administrator and the Administrator will take audit results to QAPI for review and further recommendation. Compliance: 10/24/2023	

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F 761	Continued From page 26 During interview with RN-C on 9/27/23 at 7:47 a.m., RN-C stated the door is "not supposed to be open. The door should be closed and locked. I think someone forgot to close it." During interview with the director of nursing (DON) and assistant director of nursing (ADON) on 9/27/23 at 10:56 a.m., the DON stated, "medication storage rooms are supposed to be locked at all times." During observation and interview on 9/27/23 at 1:25 p.m., the third floor medication storage room was unlocked and door open. RN-D stated, "it should be closed". During observation and interview on 9/28/23 at 9:21 a.m., RN-A stated the medication storage room doors "is supposed to be locked at all times because only nurses are allowed to access the meds". RN-A stated the Pyxis machine contained prescribed narcotics. With the medication storage room door unlocked and open there would be one form of securing the narcotics instead of two. Facility policy titled Storage of Medications reviewed 12/03/2021 state purpose is to store, "all drugs and biologicals in a safe, secure, and orderly manner." Further, "Only persons authorized to prepare and administer medications have access to locked medications."	F 761		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must -	F 812		10/24/23

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F 812	Continued From page 27 §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to take appropriate steps to ensure the proper sanitization of dishware used for meal preparation and resident service when 1 of 1 high-temperature commercial dishwashers was identified as not reaching adequate final rinse temperature (i.e., 180 F). This had potential to affect all 67 residents within the nursing home, staff, and visitors who consumed food from the main production kitchen. Findings include: On 9/25/23 at 11:41 a.m., an initial kitchen tour was completed with cook (CK)-A and CK-B present. A single Hobart Tempstar commercial dishwasher was present along the wall with several hard plastic racks placed in front of the machine on the floor. CK-A loaded several metallic cookware pans onto other hard plastic racks and placed them into the dishwasher. A	F 812	F 812 Dish Sanitation The dishwasher was repaired on 9/27/2023. There were no ill effects experienced by residents or staff for this deficient practice. Future temperature wash and rinse cycles not meeting appropriate levels, the dietary department will utilize paper products and follow the manual cleaning of dishes facility policy. The entire dietary department will be in-serviced on the Cleaning Dish/Dish Machine Policy with emphasis on monitoring the dish cycle throughout the procedure to ensure proper temperatures are maintained and for dish machine malfunctions, the dietary staff will follow the policy on Manual Cleaning of Dishes with emphasis on wash rinse and sanitize procedures and utilizing test stripes to ensure sanitation solution levels are maintained.	

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F 812	Continued From page 28 series of wash chemicals, including rinse aide, were present on or around the machine with visible tubing connected to the dishwasher; along with a single, white-colored gauge present on top of the machine which did not move for the entirety of the wash or rinse cycle. A silver-colored plate was mounted to the side of the machine, under the counter area, which identified the make and model of the dishwasher along with, "Minimum Rinse Temperature ... 180 F [Fahrenheit]." There were no other visible gauges present on the machine to demonstrate what temperature the final rinse cycle was being completed at while dishes were loaded. Later, on 9/25/23 at 12:30 p.m., a return visit to the kitchen was made and the dishwasher inspected with CK-A present. CK-A stated the machine had been installed since "forever" and was a high-temperature sanitization machine. CK-A then moved the stacked hard-plastic racks from in front of the machine which exposed two additional, white-colored analog gauges labeled, "R" and "W," respectively. CK-A stated they "don't know" what each of the written letters meant. CK-A then placed a loaded rack of dishes into the machine to demonstrate the cleaning and sanitization process. The machine activated and completed the wash and rinse cycle, however, the only gauge which moved was the one labeled, "W," which attained only 163 F. A second load was then placed and ran through the machine and, again, the same gauge only attained a high temperature of 164 F on the final rinse cycle. These readings were verified by CK-A who then stated the machine had not been working for a few days adding the final rinse should be 180 F if we "went by the book [regulations]." CK-A explained the machine stopped reaching 180 F	F 812	Dietary Manager and/or designee is responsible for compliance. Audits on dish cycle monitoring and cycle temperatures will begin daily x 5 days, weekly x 2 weeks then monthly to ensure sustained compliance. All audits will be reviewed by the Administrator and the Administrator will take audit results to QAPI for review and further recommendation. Compliance: 10/24/2023	

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F 812	Continued From page 29	F 812		

the week prior and, as a result, they contacted an outside company to come out and inspect it which happened over the weekend. The inspection identified a new "pressure valve" was needed which had been ordered, however, not yet installed so the machine remained in disrepair. CK-A verified themselves and other kitchen staff were still doing dishes, including cookware and resident serviceware, in the machine despite it not hitting the 180 F expected to ensure proper sanitization. CK-A stated they had not been directed or asked to use disposable items (i.e., paper plates) or check surface temperatures of the washed items to ensure they were being sanitized properly. However, CK-A stated they had been trying to run loads of the dishes through the machine twice "for safety" since it wasn't hitting proper temperature. CK-A then presented a white-colored paper flow sheet which was attached to the walk-in cooler.

The provided High-Temperature Dish Machine Temperature Log, dated 9/14/23 to 9/25/23, identified multiple columns to record various information including the date, time, wash temperature, rinse temperature and staff initials. This outlined a hand-written, "180 [degrees]" was needed for the rinse temperature along with 17 recorded temperature checks. These included:

- 9/23/23 at 5 a.m., with 180 F rinse temperature recorded;

- 9/23/23 at 1:00 p.m., with 180 F rinse temperature recorded;

- 9/23/23 at 6:00 p.m., with 180 F rinse temperature recorded;

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- 9/24/23 at 6:00 (blank Latin identifiers for reference, i.e., a.m.), with 180 F rinse temperature recorded; and,

- 9/25/23 at 5:00 p.m. (in the future), with 180 F rinse temperature recorded. The final four entries were initialed by CK-A.

CK-A reviewed the provided flowsheet and stated the time for the 9/25/23 entry, timed 5:00 p.m., was in error and actually done in the morning (i.e., a.m.). When questioned on if the machine had hit 180 F and, if so, how such temperature was checked (since the gauge only read 164 F), CK-A stated they documented the temperature based on the same gauge and wrote 180 F as it "was around" the 180 F mark. CK-A stated they were unaware if the machine actually attained the 180 F or not, but they reiterated the administrator and the outside company were both aware of the machine not hitting 180 F and working to address the issue.

Following, on 9/25/23 at 12:48 p.m., the administrator was interviewed, and they verified the dishwasher was a high-temperature sanitization machine. They verified knowledge of the dishwasher not reaching temperature (i.e., 180 F) and, as a result, an outside company had been out over the weekend to inspect it which identified a new valve was needed. The administrator stated they had not directed staff to use disposable items for service or cooking while the machine was in disrepair, nor had they directed dietary staff to implement other measures to ensure proper sanitization (i.e., surface temp checking) but expressed they would do so immediately.

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The following day, on 9/26/23 at 9:33 a.m., a subsequent visit to the kitchen was made. The dishwasher had visible steam coming from it and was in a run cycle, with dietary aide (DA)-A loading various cookware and serviceware into the machine (i.e., plastic water pitchers, divided plates, dish domes). The same white-colored gauges were present and, again, the gauge labeled, "R," did not move during the various run cycles. The working gauge labeled, "W," only reached 158 F on the final rinse cycle. DA-A removed the items from the machine and verified they were items just used for the breakfast meal service. DA-A stated the dishwasher was "no good" and, as a result, they had been using disposable items for resident serviceware (i.e., plates, silverware), however, were still washing and cleaning the non-serviceware items in the dishwasher. Cook (CK)-C then presented to the dishwasher and verified the staff were still using it to wash, rinse and sanitize various items such as ice cups and plate domes. CK-C stated they had not been advised or directed to implement other washing or sanitizing methods for cookware items, such as manual washing and sanitization, but verified the administrator had discussed the dishwasher being in disrepair with them. Further, CK-C stated they were told the outside company would be onsite that day to repair the dishwasher.

The kitchen manager was offsite and unavailable for interview for the entirety of the survey.

During follow-up interview, on 9/26/23 at 2:26 p.m., the administrator stated they were helping as the "acting dietary manager" currently, and they explained the dishwasher was first noticed to be not hitting appropriate sanitization temperature during the previous week. As a result, they

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contacted the outside company to inspect it which happened over the previous weekend, and it was then determined a new "pressure cylinder" needed to be installed as the machine was losing part of the rinse pressure and, likely, 10-12 degrees of rinse temperature as a result. However, the outside company did not, to his knowledge, check the actual final rinse temperature of the machine at the time to determine what it was. The administrator stated disposable items should have been implemented when the machine was determined to be malfunctioning, however, it was not. When asked about the continued use of the machine, as was observed a few hours prior, they explained they had not directed staff to do manual washing and chemical sanitization of cookware items (i.e., pans, divided plates) but expressed, at the moment, was not "too worried about" it. The administrator stated the lack of instruction to staff to use a manual wash, rinse and sanitization method of cookware was possibly just due to "my [administrator] lack of full understanding [of what was needed]." Further, the administrator verified no gastrointestinal (GI) symptoms had presented in any residents since the dishwasher malfunctioned several days prior.

On 9/27/23 at 7:59 a.m., the registered dietitian (RD)-A was interviewed. RD-A explained they were onsite at the nursing home on a weekly basis and were aware the administrator was helping to oversee the kitchen in the absence of the dietary manager. RD-A stated they were not aware the dishwasher had malfunctioned the previous week, and verified the final rinse temperature on the nursing home' dishwasher should be 180 F to ensure proper sanitization. RD-A stated had they been updated, their

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F 812	Continued From page 33 direction would have been to use disposable items until the machine could be inspected and fixed. There was no provided evidence during the recertifcation survey, from 9/25/23 to 9/28/23, to demonstrate the outside company had checked or verified the actual final rinse temperature of the dishwasher while onsite the weekend prior (9/23/23 to 9/24/23). A provided Cleaning Dishes/Dish Machine policy, dated 2017, identified all flatware, serving dishes, and cookware will be cleaned, rinsed and sanitized after each use. The policy outlined, "Staff should check the dish machine gauges throughout the cycle to assure proper temperatures for sanitiation [sic]," along with a corresponding table which outlined the type(s) of dish machines and their corresponding final rinse temperatures. This included, "High Temperature Dishwasher ... 180 F."	F 812		
F 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:	F 880		10/24/23

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F 880	Continued From page 34 §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.	F 880		

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F 880	Continued From page 35 §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure a water management program was developed and maintained to help reduce the risk of Legionnaires' (Legionella) bacterial growth and subsequent contamination in the facility' water supply and/or storage. In addition, the facility failed to ensure potential signs and symptoms of COVID-19 were acted upon and evaluated (i.e., tested, transmission base precautions implemented) in accordance with current Centers for Disease Control (CDC) guidelines for 2 of 2 resident (R8, R66) reviewed who displayed potential symptoms of COVID-19; and failed to ensure transmission-based precautions (TBP) were implemented as posted for 1 of 2 residents (R38) reviewed in such precautions. These findings had potential to affect all 67 residents, staff, and visitors within the nursing home. Findings include: COVID-19 SYMPTOM TESTING: The CMS QSO-20-38-NH, dated 9/23/22,	F 880	F 880 PPE and COVID R 8 has since recovered from COVID. Isolation Precautions were discontinued for R 8 after hospital stay on 9/29/2023. R 38 has since recovered from Shingles and contact precautions were discontinued on 10/4/2023. There were no ill effects experienced by the resident from this deficient practice. All existing residents from survey exit until present, documentation was reviewed for sign and symptoms for COVID. Future residents who experience signs and symptoms related to COVID will be placed in transmission-based precautions (TBP) and tested for COVID and will have the appropriate PPE and hand hygiene performed per facility policy. The ADON/IP received 1:1 education by the regional nurse consultant on 10/4/2023 and the COVID Outbreak Testing Policy was updated on 10/17/2023 to include signs and symptoms of COVID. Licensed nurses and nurse aides will be	

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F 880	Continued From page 36 identified the most recent guidance for COVID-19 testing and management in the nursing home setting. The memo outlined nursing homes' were able to achieve prompt testing using either a rapid, point-of-care test or a laboratory test, and listed residents must be tested "as soon as possible" if having symptoms regardless of their vaccination status. While the results were pending, the resident should be placed on transmission based precautions (TBP) in accordance with CDC (Centers for Disease Control) guidelines. Further, the memo outlined nursing homes' were expected to document all administered tests to demonstrate compliance with applicable testing requirements. The corresponding CDC Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic, dated May 2023, identified anyone "with even mild symptoms of COVID-19" should be tested for the virus as soon as possible. The recommendations included, "Asymptomatic patients with close contact with someone with [COVID-19] should have a series of three viral tests ... recommended immediately ... and, if negative, again 48 hours after the first negative test and, if negative, again 48 hours after the second negative test. This will typically be at day 1 (where day of exposure is day 0), day 3, and day 5." Further, the recommendations outlined empiric TBP should be implemented and discontinued using clinical judgement and after any completed diagnostic testing. R8's quarterly Minimum Data Set (MDS), dated 6/15/23, identified R8 had severe cognitive impairment.	F 880	in-serviced on COVID Outbreak Testing Policy with emphasis on identifying signs and symptoms of COVID and timely implementation of TBP. In addition, nursing staff will be in-serviced on the Hand Hygiene and PPE donning and doffing policy with emphasis on the importance of using the proper PPE and hand hygiene to prevent the spread of infection. Assistant Director of Nursing and/or designee is responsible for compliance. Audits on will resident daily documentation for early s/s detection for COVID along with implementation of transmission-based precautions timely, hand hygiene and donning and doffing of PPE will begin daily x 5 days, weekly x 2 weeks then monthly to ensure sustained compliance. All audits will be reviewed by the Administrator and the Administrator will take audit results to QAPI for review and further recommendation. Compliance: 10/24/2023 Legionnaire Water Supply The facility water supply diagram template was developed on 10/20/2023 . Potential areas of risk were identified and marked on this diagram. There has been no ill effects experienced by residents or staff from this deficient practice. Future Legionnaire testing and water management updates will occur per facility policy. The Maintenance Director was in-serviced TELs Facility Electronic Management System Resource tab on how to obtain the Legionnaire CDC tool kit and TELs	

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F 880	Continued From page 37 On 9/25/23, upon entrance to the nursing home for the recertification survey, a single room was identified to have transmission based precaution (TBP) equipment posted outside with signage on the door outlining, "Droplet Precautions." During the entrance conference, on 9/25/23 at 11:56 a.m., it was verified R8 resided in the room with the posted information and was COVID-19 positive. When interviewed on 9/25/23 at 5:34 p.m., R8's family member (FM)-A stated R8 had COVID-19 and was in isolation as a result. FM-A stated the staff confirmed the infection on Sunday, 9/24/23, and moved R8 to a private room from his shared room. FM-A stated they felt R8 had a change and the COVID-19 symptoms prior to 9/24/23, however, with a "runny nose" and eye drainage starting "about a week ago." FM-A stated they were unaware if staff had tested R8 for COVID-19 upon the start of those symptoms. R8's progress note(s), dated 9/21/23 to 9/28/23, were reviewed and identified the following: On 9/21/23, R8 was recorded as having " ... an increase in temp 99.2 [F] ... cool cloth [applied] on forehead ... dropped down to [98.5 F] ..." There was no COVID-19 testing recorded as completed. On 9/21/23, R8 was recorded as " ... was tired and difficult to arouse," with stable vital signs. The nurse practitioner was updated and a urinalysis (UA) was ordered. There was no COVID-19 testing recorded as completed. On 9/22/23, R8 denied pain and had a recorded temperature of 98.9 F.	F 880	Water Management System plan. In-service education was provided with emphasis on creating and maintaining the facility water supply map and routine testing per facility policy. Maintenance Director and/or designee is responsible for compliance. Audits on legionnaire water testing and completion of the water management plan will begin weekly x 2 weeks then monthly to ensure sustained compliance. All audits will be reviewed by the Administrator and the Administrator will take audit results to QAPI for review and further recommendation. Compliance: 10/24/2023	

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On 9/23/23, R8 was recorded as having redness noted in both eyes along with ocular discharge adding, "[R8] states its itchy." A note was left for the nurse practitioner. However, again, there was no COVID-19 testing recorded as completed.

On 9/24/23, R8 was recorded as now having a hoarse voice but denied a sore throat. R8's temperature was 97.9 F and a rapid COVID-19 test was completed with dictation, " ... was positive." R8's family was updated along with the nurse practitioner, and medication was ordered.

When interviewed on 9/26/23 at 1:07 p.m., nursing assistant (NA)-C stated they had worked with R8 prior to him getting infected with COVID-19. NA-C stated R8 needed "total" care but was able to feed himself, nor did R8 have any history of having eye drainage prior to getting sick. NA-C stated R8 had not been placed in TBP, to their knowledge, prior to changing rooms (i.e., double room to private for isolation).

R8's medical record, including the progress notes and Treatment Administration Record (TAR), were reviewed and lacked any evidence R8 had been promptly tested for COVID-19 prior to 9/24/23, despite having objective symptoms of the illness (i.e., eye drainage, fatigue, elevated temperature). Further, there was no evidence TBP were implemented timely after these symptoms started until infection could be definitively verified or ruled out.

On 9/26/23 at 1:14 p.m., licensed practical nurse (LPN)-B was interviewed. LPN-B stated they had never cared for R8 prior to his isolation for COVID-19, however, expressed anyone having

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F 880	Continued From page 39 ocular drainage or a temperature should be tested for COVID-19 adding, "I think you might want to do COVID testing." LPN-B verified the nursing home had onsite, rapid COVID-19 tests available along with ongoing, standing orders to complete them if symptoms were observed or infection suspected. LPN-B stated any completed testing or implemented TBP should be recorded in the progress notes or TAR, and the director of nursing (DON) or assistant director of nursing (ADON) should be notified. On 9/27/23 at 9:42 a.m., the the assistant director of nursing (ADON) was interviewed and verified they were the infection preventionist (IP) for the nursing home. ADON verified they had reviewed R8's medical record and explained R8's temperature of 99 "point something" would not necessarily trigger enough concern on it's own to warrant COVID-19 testing given R8 displayed "no respiratory symptoms" with the elevated temperature. ADON stated they had heard the most recent variant of COVID-19 did display "more allergy signs and symptoms" than previous ones, however, even the combination of R8's symptoms, including fever and fatigue and eye drainage, still likely wouldn't warrant testing for COVID-19 given the lack of respiratory symptoms in their opinion. However, ADON explained the UA being ordered, on 9/21/23, should have triggered "an infection control case" to be opened to ensure appropriate UA-related monitoring, however, they had not been notified so it had not been done. ADON acknowledged appropriate infection monitoring should begin "the moment someone has a symptom" but reiterated the lack of respiratory symptoms on the initial progress notes did not warrant COVID-19 testing in their opinion, until R8 developed the hoarse voice and	F 880		

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F 880	Continued From page 40 was subsequently tested and placed in TBP. ADON verified any completed COVID-19 testing, and subsequent placement in TBP, should be documented in the medical record which R8's lacked. ADON acknowledged the CDC guidelines which outlined to test "as soon as possible" with symptom development and they stated COVID-19 could present itself "in so many ways," however, again voiced they were comfortable with how R8's symptoms and subsequent testing were handled. Further, ADON expressed testing residents or staff for single, potentially one-off symptoms could "overwhelm" the nursing home so they also relied on "nursing judgement" to help make these decisions. R66's quarterly MDS dated 9/12/23, indicated R66 had severe cognitive deficits, required supervision for eating, limited assistance for transfers and was extensive assistance for all other activities of daily living (ADLs). R66's diagnoses included Parkinson's disease, neurocognitive disorder with Lewy Bodies, hallucinations, falls, diabetes, end stage heart failure, liver cancer, and cirrhosis of the liver. R66's Care Area Assessment (CAA) dated 6/20/23, indicated R66 triggered for delirium, cognitive loss/dementia, communication, ADL function, falls, nutrition, and pressure ulcers. R66's care plan dated 9/26/23, indicated R66 had potential for altered cardiovascular status. Interventions included observing vital signs and notifying the provider of any significant abnormalities. R66 also had diabetes. Interventions indicated if infection was present, to	F 880		

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consult with a provider regarding necessary changes in diabetic medications. R66 also had liver disease/cancer. Intervention included monitoring/documenting/reporting lethargy, fatigue, anorexia, and altered level of consciousness to the provider.

R66's progress note dated 9/13/23, indicated R66 was noted to be cold, had voice changes and a runny nose. R66 was tested for COVID-19 and was negative. Offered warm water, and a supplement shake. R66 ate only 50% of breakfast and lunch, took a nap after breakfast and had confusion during the shift. The progress note indicated the nurse would "push fluids," continue to monitor, and notify the provider if R66's condition worsens.

R66's orders dated 8/1/23, indicated R66 may be placed on isolation precautions per facility infection control policy.

During an interview on 9/26/23 at 1:34 p.m., LPN-C stated residents were given a rapid COVID-19 test as soon as they had signs or symptoms of a possible infection including a runny nose or cough. LPN-C stated she was unaware if the resident tested negative, the resident should have been placed on transmission based precautions (TBP) and retested after 48 hours. LPN-C stated on 9/13/23, R66's voice had changed, and he had a runny nose, so she tested him for COVID-19; however, since his result was negative, she did not place R66 on TBP or retest him after 48 hours according to the CDC guidelines.

During an interview on 9/27/23 at 9:43 a.m., ADON who was also the IP, stated she was not

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F 880	Continued From page 42 aware R66 had new onset of symptoms of a possible infection including a runny nose and change of voice and would have expected to be, even though R66 tested negative for COVID-19. The ADON also would have expected a second COVID-19 test to have been administered 48 hours after the first negative test was completed. During an interview on 9/28/23 at 10:27 a.m., the director of nursing (DON) stated she was unaware R66 had new signs or symptoms of a possible infection or that he had been tested for COVID-19 on 9/13/23. The DON stated she and/or the ADON, the provider, and R66's family should have been notified even though he tested negative, and staff should have followed the facility policy regarding any further testing and/or TBP requirements. During an interview on 9/28/23 at 1:44 p.m., nurse practitioner (NP)-A stated she was not notified R66 had been tested for COVID-19 or had developed a runny nose and changes in his voice and would have expected to have been, regardless of the results. NP-A further stated she was unsure of the requirements regarding subsequent testing if a resident had a negative initial test; however, NP-A would have expected staff to follow the CDC guidelines. The facility Standing Orders, dated 3/9/23, indicated to complete COVID-19 antigen testing as indicated for outbreak and/or routine testing per facility policy. A provided COVID-19 Outbreak Testing policy, dated 5/16/23, identified facilities were required to test residents and staff based on parameters and frequency set forth by the CDC guidance and	F 880		

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local health department. The policy outlined, "Testing of residents who have signs or symptoms of COVID-19, regardless of their vaccination status, must be tested as soon as possible. While test results are pending, residents with signs or symptoms should be placed on [TBP] in accordance with CDC guidance." However, the policy lacked what, if any, specific symptoms which needed to be screened or present (i.e., respiratory versus other) before testing would begin in accordance with the policy.

Use of PPE

During observation on 9/27/23 at 9:07 a.m., a PPE cart was placed outside the door of R38 room. Signage on R38's door indicated Isolation room, special droplet/contact precautions and instructed all staff who enter the room to don PPE gown, N95 mask and gloves. Nursing assistant (NA)-A entered R38's room without sanitizing hands or putting on N95 or PPE gown and new gloves. NA-A assisted R38 to bathroom. Surveyor then asked registered nurse (RN)-B to R38 room and observed NA-A exiting R38's bathroom with R38. RN-A stated the PPE cart outside R38's room and the signage on R38's door, "is for guiding staff to wear PPE before entering the room". RN-A stated NA-A should know to wear PPE before entering R38 room. RN-A stated importance of wearing PPE is, "so we don't spread Covid virus". RN-A stated R38 was placed on isolation precautions because "his roommate tested positive this weekend" and was moved to first floor of facility leaving R38 alone.

During observation and interview with NA-A on 9/27/23 at 9:16 a.m., NA-A exited R38's room

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F 880	Continued From page 44 with breakfast tray. NA-A did not sanitize hands upon exiting R38 room. NA-A stated the PPE cart and signage on R38's door "means you have wear PPE before entering the room". NA-A stated he did not wear a PPE gown or N95 mask. NA-A stated importance of wearing PPE is "to limit transfer of virus". During interview on 9/27/23 at 9:22 a.m., NA-B indicated a PPE cart and signage on door guides staff as to what precautions to take before entering resident room. NA-B stated PPE use is "important to not spread the virus". During interview with R38 on 9/27/23 at 10:10 a.m., R38 stated he was informed about being placed in isolation the morning of 9/27/23 along with a PPE cart and signage was posted on his door. R38 stated no one from facility informed him that he should be on isolation at the same time his roommate was transferred out of their shared room following a positive covid test on 9/24/23. During interview with director of nursing on 9/27/23 at 11:07 a.m., DON stated R38 place on isolation due to precautions for malaise and that covid testing of R38 was negative. Facility policy titled Isolation-Categories of Transmission-Based Precautions revised October 2018 state, "When a resident is placed on transmission-based precautions, appropriate notification is placed on the room entrance door" and, "the signage informs the staff of the type of CDC precautions(s), instructions for use of PPE, and/or instructions to see nurse before entering the room."	F 880		

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Water Management

During interview on 9/27/23 at 10:03 a.m. Maintenance Supervisor (MS) stated that he does not have a current facility water supply flow diagram or a related water supply map to identify potential areas at risk for Legionella bacterial growth.

During interview on 9/27/23 at 1:17 p.m., administrator stated that the facility is required to develop and maintain a water management plan/program. Administrator provided a policy which outlined this directive but could not provide documentation of a current water management plan, facility water supply flow diagram, or water flow map that identified potential areas of risk for Legionella bacterial growth. Administrator further stated he could not find requested documents on the facility's/organization's shared computer drive or in the existing hard files still located on-site.

The facility's water management program policy, dated 10/18/22, indicted the facility would identify areas in the water system where Legionella bacteria can grow and spread, and to reduce the risk of Legionnaire's disease. The water management program includes the following elements: An interdisciplinary water management team, a detailed description and diagram of the water system in the facility. The identification of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245063	A. BUILDING ______ B. WING ______	C 09/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST ANTHONY PARK HOME	**2237 COMMONWEALTH AVENUE SAINT PAUL, MN 55108**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 46 areas in the water system that could encourage the growth and spread of Legionella or other waterborne bacteria.	F 880		

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	245063	A. BUILDING **01 - MAIN BUILDING 01** B. WING ______	**09/26/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST ANTHONY PARK HOME	**2237 COMMONWEALTH AVENUE** **SAINT PAUL, MN 55108**

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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 09/26/2023. At the time of this survey, ST ANTHONY PARK HOME was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		10/20/2023

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

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K 000	Continued From page 1 Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. ST ANTHONY PARK HOME is a three-story building with basement The St Anthony Park Home was constructed at three different times. The original building was built in the 1900's, is 3 stories, with a basement and was determined to be of a Type II (111) construction with a wood frame roof system that meets the exception to "The Life Safety Code" NFPA 101 (2000 edition) Section 16.1.6.2. In	K 000		

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ST ANTHONY PARK HOME	**2237 COMMONWEALTH AVENUE** **SAINT PAUL, MN 55108**

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K 000	Continued From page 2 1960 an addition was constructed to the west of original building, which was 1-story, with a basement, and was determined to be Type II (111) construction. In 1999 a 2nd and 3rd floor were constructed over the 1960 addition that are separated with a 2 hour fire barrier from the 1900 original building and are Type II (111) construction. The building is divided into 11 smoke zones (3 each level except the basement) by at least 1 hour fire barriers. Because the original building and the addition are compatible construction types allowed for existing buildings of this height, the facility was surveyed as one building. The building is protected by a full fire sprinkler system. The facility has a fire alarm system with full corridor smoke detection and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 84 beds and had a census of 76 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 211 SS=D	Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1	K 211		10/24/23

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K 211	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to maintain means of egress requirements per NFPA 101 (2012 edition), Life Safety Code sections 19.2.1, 7.1.10.1. These deficient findings could have a isolated impact on the residents within the facility. Findings include: On 09/26/2023 between 10:15 AM and 3:15 PM, it was revealed in the Basement Laundry Area that direct and immediate access to the exit was obstructed by racks and tables. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 211	K211 The basement laundry area table and racks have been rearranged to allow immediate access to the exit and proper avenue of egress. Education to the laundry and housekeeping staff completed. A sign will be posted on the door stating, DO NOT BLOCK EXIT. Maintenance Director or Designee will audit for compliance 3x weekly for 1 week, 1x weekly for 1 week. Area in compliance as of 10/16/23.	
K 221 SS=D	Patient Sleeping Room Doors CFR(s): NFPA 101 Patient Sleeping Room Doors Locks on patient sleeping room doors are not permitted unless the key-locking device that restricts access from the corridor does not restrict egress from the patient room, or the locking arrangement is permitted for patient clinical, security or safety needs in accordance with 18.2.2.2.5 or 19.2.2.2.5. 18.2.2.2, 19.2.2.2, TIA 12-4 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to maintain patient sleeping room doors per NFPA 101 (2012 edition), Life Safety Code sections 19.3.6.3, 19.3.6.3.5. This deficient finding could have a isolated impact on the	K 221	K221 Room 205 resident room door has been sanded, latches and hinges adjusted for proper closing and seal. All other doors have been checked for proper close and	10/24/23

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K 221	Continued From page 4 residents within the facility. Findings include: On 09/26/2023 between 10:15 AM and 3:15 PM, it was revealed by observation that on the 2nd Floor - RM 205 resident room door did not close and seal the opening upon testing. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 221	seal with no other issues. Audit of doors will be placed in the electronic maintenance system for monthly and as needed review and repair. Maintenance Director or Designee will confirm compliance. Door in compliance as of 10/16/23	
K 293 SS=D	Exit Signage CFR(s): NFPA 101 Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to properly configure illuminated exit signage per NFPA 101 (2012 edition), section(s) 19.2.10, 7.10, 7.10.2. This deficient finding could have a isolated impact on the residents within the facility. Findings include: On 09/26/2023 between 10:15 AM and 3:15 PM, it was revealed by observation that exit signage located in the Basement, adjacent to the stairwell	K 293	K293 The exit sign located in the basement adjacent to the stairwell has been replaced. The new sign includes proper marking to identify the path of travel to exit. All other exit signs have been checked for proper marking to identify the path of travel to exit. Maintenance Director or Designee will check TELS system for PMs due going forward to stay in compliance. In compliance as of 10/12/23	10/24/23

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K 293	Continued From page 5 did not have the proper marking to identify the path of travel to the exit. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 293		
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 19.3.2.5.5, 9.2.3, TIA 12-2 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation	K 324	K324	10/24/23

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K 324	Continued From page 6 and staff interview, the facility failed to maintain proper inspection schedule associated to range hood fire suppression system per NFPA 101 (2012 edition), Life Safety Code section 19.3.2.5, 9.2.3, and NFPA 96 (2014 edition), Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, section 11.2.1. This deficient finding could have an widespread impact on the residents within the facility. Findings Include: On 09/26/2023 between 10:15 AM and 3:15 PM, it was revealed by a review of available documentation that the facility was past-due on required 6-month inspections of range hood fire suppression system. The most recent inspection was completed on 03/21/2023. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 324	The required inspection of the range hood fire suppression system was completed on 10/20/2023. Inspection of the fire hood will be added to TELS PM system to have inspection completed every six months from date of last inspection. Maintenance Director or Designee will check TELS system for PMs due going forward to stay in compliance. In compliance as of: 10/20/2023	
K 345 SS=F	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 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 a review of available documentation and staff interview, the facility failed to conduct	K 345	K345 The required sensitivity testing of the fire	10/24/23

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K 345	Continued From page 7 sensitivity testing of the fire alarm system 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 14.4.5.3. This deficient finding could have a patterned impact on the residents within the facility. Findings include: On 09/26/2023 between 10:15 AM and 3:15 PM, it was revealed by a review of available documentation that the documentation presented for review identified that the most recent fire alarm sensitivity testing was completed in 2015. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 345	alarm system will be completed by LVC on 11/15/2023. The required fire sensitivity testing will be added to the TELS PM system for scheduled five-year reminder. Maintenance Director or Designee will check TELS system for monitoring sensitivity testing due dates going forward to stay in compliance. In compliance as of: 10/19/2023	
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 available. a) Date sprinkler system last checked ______ b) Who provided system test ______ c) Water system supply source ______ Provide in REMARKS information on coverage for	K 353		10/24/23

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K 353	Continued From page 8 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, a review of available documentation, 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, 4.4, 5.1.1.1, 5.2.1.1.1, 5.2.1.1.2, 5.2.2.2. These deficient findings could have a widespread impact on the residents within the facility. Findings include: 1. On 09/26/2023 between 10:15 AM and 3:15 PM, it was revealed by observation that sprinkler heads located in close proximity to HVAC ducting exhibited signs of debris loading 2. On 09/26/2023 between 10:15 AM and 3:15 PM, it was revealed by observation that in the following areas of the facility external load was bearing on sprinkler system piping: a. Basement - Kitchen, cabling on system b. Basement - Main Corridor, cabling on system c. Basement - Locker Room, cabling on system d. Basement - Med Storage Room, cabling on system e. Basement - Maintenance Storage Room, cabling attached to the system 3. On 09/26/2023 between 10:15 AM and 3:15 PM, it was revealed by a review of available	K 353	K353 1. All the sprinkler heads, near HVAC ducting, have been cleared of debris loading. All sprinkler heads throughout the entire building have been inspected and cleared of any debris loading. Quarterly inspection will be conducted semi-annually to ensure ongoing compliance. In compliance as of: 10/20/2023 2. External load has been removed from Basement □ Kitchen, Basement □ Main Corridor, Basement □ Locker room, Basement □ Med Storage Room, Basement □ Maintenance Storage Room. In compliance as of 10/24/23 3. 5-year maintenance and inspection are scheduled for December 6, 2023, by Lifesaver. In compliance as of: 10/17/2023 Maintenance staff education completed regarding hanging load on sprinkler pipes. Vendors will be educated and monitored for same at time of service. An audit will be completed 1x per week for 3 weeks to confirm deficient practice has been resolved. 5-year Maintenance and Inspection will be added to TELS PM system Maintenance Director or Designee will check TELS system for PMs due going forward to stay in compliance. In compliance as of: 10/24/2023	

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K 353	Continued From page 9 documentation that no documentation was presented for review to confirm that 5-year maintenance and inspection are occurring. An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K 353		
K 355 SS=F	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, a review of available documentation and staff interview, the facility failed to properly inspect, and maintain 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 7.1.1, 7.1.2.2, 7.2.1.2, 7.2.4.3, 7.2.4.4, 7.2.4.5,, 7.3.1.1.1, 7.3.2.4 These deficient findings could have a widespread impact on the residents within the facility. Findings include: 1. On 09/26/2023 between 10:15 AM and 3:15 PM, it was revealed by observation, that the fire extinguisher located in the Basement Laundry Room full obstructed and non-accessible 2. On 09/26/2023 between 10:15 AM and 3:15	K 355	K355 The fire extinguisher in the basement laundry has been relocated so as not to be obstructed and is accessible. The K-type fire extinguisher located adjacent to the hand-washing sink in the basement kitchen has been replaced and relocated away from the water source to avoid oxidization and rust. All the Fire Extinguishers were audited to confirm correct placement. Maintenance Director or Designee will audit Fire Extinguishers per TELS PM schedule going forward. In compliance as of: 10/13/2023	10/24/23

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K 355	Continued From page 10 PM, it was revealed by observation, that the K-type fire extinguisher located adjacent to the hand-washing sink in the Basement Kitchen was found to be oxidized / rusted on the handle assembly. An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K 355		
K 372 SS=F	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to maintain and inspect smoke / fire dampers per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.7.3, 8.5.5, and 8.6.7.1 This deficient finding could have a widespread impact on the residents within the facility. Findings include:	K 372	K372 Fire/smoke damper testing to be completed by Alvers Mechanical on 10/24/2023. The required fire/smoke damper testing will be added to the TELS PM system. Maintenance Director or Designee will check TELS system for PMs due going forward to stay in compliance. In compliance as of: 10/24/2023	10/24/23

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	245063	A. BUILDING **01 - MAIN BUILDING 01** B. WING ______	**09/26/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST ANTHONY PARK HOME	**2237 COMMONWEALTH AVENUE** **SAINT PAUL, MN 55108**

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K 372	Continued From page 11 On 09/26/2023 between 10:15 AM and 3:15 PM, it was revealed by a review of available documentation that no documentation was present to confirm that fire / smoke damper testing in occurring. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 372		
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. This deficient finding could have a widespread impact on the residents within the facility. Findings include:	K 374	K374 The fire/smoke barrier door assemblies exhibiting air-gap greater than 1/8 inch have been repaired. Door at 107 and 3rd door located at elevator were both resolved. Audit of doors will be put on a PM schedule as a part of fire drill testing and after-action review. Maintenance Director or Designee will confirm	10/24/23

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K 374	Continued From page 12 On 09/26/2023 between 10:15 AM and 3:15 PM, it was revealed by observation that the following fire / smoke barrier door assemblies exhibited and air-gap greater that 1/8 inch, allowing the movement and passage of smoke: 3rd Floor - door assembly located at the elevator; 1st Floor - door assembly adjacent to RM 107. An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K 374	compliance. Door in compliance as of 10/19/23	
K 712 SS=D	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. This deficient finding could have a isolated impact on the residents within the facility. Findings include: On 09/26/2023 between 10:15 AM and 3:15 PM,	K 712	K712 Third shift fire drill will be completed by the Maintenance Director on 10/24/2023. Fire Drill calendar will be updated to record this fire drill and fire drills will be conducted per the electronic maintenance system to ensure compliance. Maintenance Director or Designee will confirm on-going compliance. In compliance as of 10/24/23	10/24/23

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K 712	Continued From page 13 it was revealed by review of available documentation that there was no documentation presented to confirm that a fire drill was conducted in 1st quarter for 3rd Shift staff. An interview with Maintenance Director verified this deficient finding at the time of discovery.	K 712		
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 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, 5.2.15, 6.1, 6.1.4.2. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 09/26/2023 between 10:15 AM and 3:15 PM,	K 761	F761 The exit door located in the basement breakroom servicing the exit stairwell is scheduled to be replaced by NTL Construction on 10/30/2023. Audit of all other EXIT doors have been audited with no other issues. Maintenance Director or Designee will ensure compliance. In compliance as of: 10/09/2023. Exit doors will be monitored as part of the fire drill testing process.	10/24/23

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K 761	Continued From page 14 it was revealed by observation that the fire rated door exit door located in the Basement Break Room servicing the EXIT stairwell did not self-close and latch, to seal the vertical stairwell. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 761		
K 914 SS=F	Electrical Systems - Maintenance and Testing CFR(s): NFPA 101 Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to conduct electrical receptacle testing in resident rooms per	K 914	F 914 Electrical outlet testing completed. Testing will be added to TELS maintenance	10/24/23

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K 914	Continued From page 15 NFPA 99 (2012 edition), Health Care Facilities Code, section(s) 6.3.3.2, 6.3.4, 6.3.4.2. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 09/26/2023 between 10:15 AM and 3:15 PM, it was revealed by a review of available documentation that the facility failed to conduct electrical outlet testing. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 914	system to have inspection completed per regulation. Maintenance Director or Designee will check TELS system for PMs due going forward to stay in compliance. In compliance as of: 10/24/2023	
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	K 920		10/24/23

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K 920	Continued From page 16 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: Based on observation and staff interview, the facility failed to manage usage electrical devices in accordance with NFPA 99 (2012 edition), Health Care Facilities Code, section 10.2.3.6, 10.2.4, 10.5.2.3 and NFPA 70, (2011 edition), National Electrical Code, sections 110.3(B), 400.8 (1) and UL 1363. These deficient findings could have a widespread impact on the residents within the facility. Findings include: 1. On 09/26/2023 between 10:15 AM and 3:15 PM, it was revealed by observation that in RM 303 two electrical adapters (1 to 3 plug) were found in use. 2. On 09/26/2023 between 10:15 AM and 3:15 PM, it was revealed by observation that in RM 303 an appliance was connected to electrical adapter (1 to 3 plug). 3. On 09/26/2023 between 10:15 AM and 3:15 PM, it was revealed by observation that in RM 212 an appliance was connected to a relocatable power tap. 4. On 09/26/2023 between 10:15 AM and 3:15 PM, it was revealed by observation that in the Basement - Laundry that an extension cord was providing power to a relocatable power tap. An interview with the Maintenance Director	K 920	K920 All Electrical cords being used improperly in rooms 303, 212 and the laundry room were removed. Audit of all rooms found no other issues. The use of extension cord information was posted for all staff, and resident in 303 was educated regarding the use of extension cords. This information will also be shared at Resident Council as well as a mass email to families and responsible parties. Monthly and as needed, facility areas will be audited to ensure electrical cords are not being used. Maintenance Director or Designee will ensure compliance. In compliance as of: 10/19/2023	

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K 920	Continued From page 17 verified these deficient findings at the time of discovery.	K 920		
K 923 SS=F	Gas Equipment - Cylinder and Container Storag 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	K 923		10/24/23

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K 923	Continued From page 18 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) 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 11.6.5. These deficient findings could have a widespread impact on the residents within the facility. Findings include: 1. On 09/26/2023 between 10:15 AM and 3:15 PM, it was revealed by observation in the 3rd Floor, 2nd Floor, and 1st Floor Med Gas (O2) Storage Rooms there was mixed storage of empty / full cylinders. 2. On 09/26/2023 between 10:15 AM and 3:15 PM, it was revealed by observation that the 3rd Floor Med Gas (O2) Storage Room was found unsecured. An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K 923	K923 Oxygen tanks in all storage rooms were secured via crates and empty tanks were separated from full tanks. Maintenance and Licensed Nurses will be in-serviced on the Medical Gas Storage Procedure with emphasis on page 2 that oxygen must be used in the order in which they were received, and they must be placed into cylinder stand that is used to receive and hold cylinders. Maintenance Director is responsible for compliance. Audits on oxygen storage units daily x 5 days, weekly x 2 weeks then monthly to ensure compliance. Compliance: 10/24/2023	

Electronically delivered
December 1, 2023

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

RE: CCN: 245063
Cycle Start Date: September 28, 2023

Dear Administrator:

On November 13, 2023, we notified you a remedy was imposed. On October 26, 2023 the Minnesota Departments of Health and Public Safety completed a revisit and on November 22, 2023, the Department of Public Safety completed a second revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of November 6, 2023.

As authorized by CMS the remedy of:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective December 28, 2023, did not go into effect. (42 CFR 488.417 (b))

In our letter of November 13, 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 was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from December 28, 2023, due to denial of payment for new admissions. Since your facility attained substantial compliance on November 6, 2023, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

The CMS 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
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E-Mail: Lori.Hagen@state.mn.us