Electronically delivered
September 28, 2022

Administrator
St Gertrudes Health & Rehabilitation Center
1850 Sarazin Street
Shakopee, MN 55379

RE: CCN: 245610
Cycle Start Date: September 15, 2022

Dear Administrator:

On September 15, 2022, 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 15, 2022 (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 15, 2023 (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:

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245610	A. BUILDING _____ B. WING _____	C 09/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST GERTRUDES HEALTH & REHABILITATION CENTER	1850 SARAZIN STREET SHAKOPEE, MN 55379

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E 000	Initial Comments On 9/12/22 to 9/15/22, a survey for compliance with CMS Appendix Z - Emergency Preparedness Requirements for Long Term Care (LTC) facilities was conducted during a standard recertification survey. St Gertrude's Health and Rehabilitation Center was found to be not in compliance. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulation has been attained.	E 000		
E 041 SS=C	Hospital CAH and LTC Emergency Power CFR(s): 483.73(e) §482.15(e) Condition for Participation: (e) Emergency and standby power systems. The hospital must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section and in the policies and procedures plan set forth in paragraphs (b)(1)(i) and (ii) of this section. §483.73(e), §485.625(e) (e) Emergency and standby power systems. The [LTC facility and the CAH] must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section. §482.15(e)(1), §483.73(e)(1), §485.625(e)(1) Emergency generator location. The generator must be located in accordance with the location	E 041		10/26/22

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

Electronically Signed | 10/06/2022

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

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E 041	Continued From page 1 requirements found in the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5, and TIA 12-6), Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4), and NFPA 110, when a new structure is built or when an existing structure or building is renovated. 482.15(e)(2), §483.73(e)(2), §485.625(e)(2) Emergency generator inspection and testing. The [hospital, CAH and LTC facility] must implement the emergency power system inspection, testing, and [maintenance] requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code. 482.15(e)(3), §483.73(e)(3), §485.625(e)(3) Emergency generator fuel. [Hospitals, CAHs and LTC facilities] that maintain an onsite fuel source to power emergency generators must have a plan for how it will keep emergency power systems operational during the emergency, unless it evacuates. *[For hospitals at §482.15(h), LTC at §483.73(g), and CAHs §485.625(g):] The standards incorporated by reference in this section are approved for incorporation by reference by the Director of the Office of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may obtain the material from the sources listed below. You may inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call	E 041		

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E 041	Continued From page 2 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the Federal Register to announce the changes. (1) National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169, www.nfpa.org, 1.617.770.3000. (i) NFPA 99, Health Care Facilities Code, 2012 edition, issued August 11, 2011. (ii) Technical interim amendment (TIA) 12-2 to NFPA 99, issued August 11, 2011. (iii) TIA 12-3 to NFPA 99, issued August 9, 2012. (iv) TIA 12-4 to NFPA 99, issued March 7, 2013. (v) TIA 12-5 to NFPA 99, issued August 1, 2013. (vi) TIA 12-6 to NFPA 99, issued March 3, 2014. (vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011. (viii) TIA 12-1 to NFPA 101, issued August 11, 2011. (ix) TIA 12-2 to NFPA 101, issued October 30, 2012. (x) TIA 12-3 to NFPA 101, issued October 22, 2013. (xi) TIA 12-4 to NFPA 101, issued October 22, 2013. (xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009.. This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to test and inspect their emergency generator per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.4.4.1.1.3, and NFPA 110 (2010 edition),	E 041	E041: Hospital CAH and LTC Emergency Power SPECIFIC RESIDENT: Weekly visual inspections and monthly testing to be completed per Life Safety Code.	

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E 041	Continued From page 3 Standard for Emergency and Standby Power Systems, section 8.4.1, 8.4.2, and 8.4.6. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 09/13/2022 between 10:15 AM and 02:00 PM, it was revealed by a review of available documentation that the facility has not been conducting weekly inspections of their emergency generator. On 09/13/2022 between 10:15 AM and 02:00 PM, it was revealed by a review of available documentation that the facility has not been conducting monthly testing of their emergency generator. An interview with the Interim Executive Director and the Campus Director of Plant Operations verified these deficient findings at the time of discovery. See LSC K-918 for additional information.	E 041	OTHER RESIDENT: Weekly visual inspections and monthly testing to be completed per Life Safety Code. MONITOR: The emergency generator will have weekly visual inspections and monthly testing completed by the Maintenance team. Facility TELS work order system will have a regulatory task added for inspections and testing. Executive Director or designee will audit generator testing logs weekly for 4 weeks, then twice a month for 1 month and then monthly for 1 month. Audit results will be reviewed by quality council monthly for further actions if needed.	
F 000	INITIAL COMMENTS On 9/12/22 to 9/15/22, a standard recertification survey was conducted at your facility. Multiple complaint investigations were also conducted. Your facility was found to be onot in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were found to be unsubstantiated: H5610114C (MN81325)	F 000		

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F 000	Continued From page 4 H5610115C (MN81337) H5610116C (MN82017) H56104523C (MN83226) H56104556C (MN86306) The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility	F 550		10/26/22

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F 550	Continued From page 5 must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure dignity was maintained for 1 of 1 residents (R63) who utilized a urinary catheter. Findings include: R63's admission Minimum Data Set (MDS) dated 8/11/22 identified R63 had severe cognition and required extensive assistance with toileting and personal hygiene, and a urinary catheter. R63's Face Sheet dated 9/15/22, indicated R63 had diagnoses of dementia, obstructive and reflux uropathy (condition in which the flow of urine is blocked), and retention of urine (inability	F 550	F550: Resident Rights/Exercise of Rights SPECIFIC RESIDENT: Resident R63 was immediately assessed and a privacy covering for urinary catheter bag was provided. R63 discharged from facility. OTHER RESIDENT: A facility wide audit was conducted to identify other residents who had a urinary catheter in place. Residents identified with a urinary catheter were offered a leg bag or provided a privacy covering for large urinary catheter bag. MONITOR: Upon admission, any resident who has been identified as having a urinary catheter will be offered a leg bag or provided a privacy covering for large	

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F 550	Continued From page 6 to voluntarily empty the bladder completely or partially). During observation on 9/12/22, at 3:38 p.m., and 9/13/22, at 9:15 a.m., R63's uncovered foley catheter drainage bag was seen connected to bed rail facing the hallway and partially laying on the floor while R63 was in bed napping. This was visible from the unit dining room. During observation on 9/13/22, at 1:29 p.m., R63 ' s uncovered foley catheter drainage bag was seen connected to wheelchair under the seat during lunch. R63 was sitting in dining room with several residents. The catheter tubing was laying on the floor and clearly visible. Interview with nursing assistant (NA)-A on 9/13/22, at 1:41 p.m., stated that there was no cover for R63 ' s foley drainage bag. Interview with licensed practical nurse (LPN)-A on 9/13/22, at 1:48 p.m., stated the foley drainage bag, "should be hiding" for privacy. Interview with registered nurse (RN)-A on 9/13/22, at 2:07 p.m., stated the foley catheter drainage bag should be placed in a covering for dignity. Interview with director of nursing (DON) on 9/15/22, at 9:15 a.m., stated expectation that foley catheter bags are to be covered due to dignity.	F 550	urinary catheter bag. Education was provided to all staff regarding resident rights and dignity specifically related to privacy of urinary catheters. Infection preventionist or designee will complete 3 audits of residents who utilize a urinary catheter for compliance of ensuring dignity is maintained with utilizing a urinary catheter weekly for 4 weeks, then twice a month for 1 month, then monthly for 1 month. Audit results will be reviewed by quality council monthly for further actions if needed.	
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment.	F 584		10/26/22

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F 584	Continued From page 7 The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels.	F 584		

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F 584	Continued From page 8 This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to ensure the tub and shower room was kept clean and sanitary which had the potential to affect all 13 residents identified by the facility who utilized that tub and shower room. In addition, the facility failed to maintain a comfortable room temperature for 3 of 3 residents reviewed for environment. Findings include: During an interview on 9/13/22, at 8:27 a.m. R31 stated the tub room was often unclean when he was brought in there by staff. R31 stated staff had not cleaned the tub room before bringing him in and he had noticed hair and feces in the shower. R31 stated he was "horrified" by the feces in the shower and brought this concern up at multiple care conferences with only slight improvement to the occurances. During an observation on 9/13/22, at 8:58 a.m. the location 250 tub room had no cleaning or disinfectant products visible. There were two empty cardboard boxes and a paper clip on the floor. During an observation on 9/15/22, at 2:51 p.m. the location 250 tub room had a used sanitary pad facing up in the open garbage can by the shower, two wet hand towels; one on the grab bar and one on the floor. The shower chair had two pencil easer sized areas of brown debris on the seat. There were wet rolled up towels and bath sheet on the foot stool. During an observation and interview on 9/15/22,	F 584	F584: Safe/Clean/Comfortable/Homelike Environment SPECIFIC RESIDENT: Tub room was immediately organized and disinfected. Tub room was prepared for use on the Resident R31's following shower day. OTHER RESIDENT: A facility wide audit was completed of the additional two tub rooms in house. Tub rooms were organized and disinfected. Disinfecting products were stocked for staff access. MONITOR: The facility has procedures in place to assure proper disinfection of tub room after each use is completed. Education was provided to nursing staff to disinfect tub room after each use. Director of Nursing or designee will complete 2 randomized audits of tub rooms post use weekly for 4 weeks, then twice a month for 1 month, then monthly for 1 month. Audit results will be reviewed by quality council monthly for further actions if needed. SPECIFIC RESIDENT: Resident R58 and R43's room temperatures were adjusted. R68 discharged from facility. OTHER RESIDENT: Education provided to all staff that if a resident verbalizes concern regarding room temperature to alert Maintenance Department timely. MONITOR: Education provided to all staff that if a resident verbalizes concern regarding room temperature to alert Maintenance Department timely. Director of Nursing or designee will complete 4	

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F 584	Continued From page 9 at 2:51 p.m. nursing assistant (NA)-D was observed reporting off to the oncoming nursing assistants. NA-D stated she was the last day shift NA to give a resident a shower today in the location 250 tub room and she was leaving now. NA-D was brought to the tub room and confirmed the above findings. NA-D stated she had not cleaned up the towels, sanitary pad or brown debris on the shower chair but it was time for her to leave. NA-D stated she normally would clean and disinfectant the tub room but could not find any disinfectants so she thought housekeeping would come do it. Another staff, NA-B then came over to help look for a disinfectant. NA-B stated stated the disinfectant is normally locked up in the tub room but was not able to describe the process or what the disinfectant looked like. NA-B stated it was the NA's responsibility to clean and disinfect the tub room after use, additionally, she thought housekeeping was gone for the day. During an interview on 9/15/22, at 2:54 p.m. registered nurse (RN)-B was brought to the tub room and verified the above concerns. RN-B stated she expected the tub room to be cleaned and disinfected between uses. RN-B also looked for cleaning and disinfectant supplies for the tub room and could not find any. During an interview on 9/15/22, at 2:55 p.m. housekeeper (HK)-A stated housekeeping was not responsible for cleaning up after a resident shower. During an interview on 9/15/22, at 2:57 p.m. the director of nursing (DON) stated she expected the nursing assistants to clean and disinfect the tub room between uses.	F 584	randomized audits of room temperature weekly for 4 weeks, then twice a month for 1 month and then monthly for 1 month. Audit results will be reviewed by quality council monthly for further actions if needed.	

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F 584	Continued From page 10 Facility policy Cleaning, Disinfection and Sterilization dated 6/17, indicated that cleaning, disinfection, and/or sterilization of equipment was done as necessary to decrease the risk of transmission of infectious organisms and maintain a clean and sanitary environment for the residents to reside. The policy lacked a process for cleaning and disinfection of the shared tub and shower rooms. R43's quarterly Minimum Data Set (MDS) dated 8/18/22, indicated R43 had moderate cognitive deficits and required extensive assistance for all activities of daily living (ADLs). R43 had diagnoses that included dementia, major depressive disorder, vitamin deficiency, anemia (low red blood cells), and fibromyalgia (chronic pain, fatigue and sleep disturbances). R58's quarterly MDS dated 8/25/22, indicated R58 had severe cognitive deficits and required extensive assistance for all ADLs and required oxygen (O2) therapy. R58's diagnoses included Alzheimer's disease, dementia without behavioral disturbance, chronic obstructive pulmonary disease (COPD, inflammation of the lung tissue causing difficulty breathing), vitamin B12 deficiency anemia, vitamin D deficiency, deficiency of other vitamins, unspecified asthma, and allergic rhinitis. R68's quarterly MDS dated 8/31/22, indicated R68 had intact cognition with diagnoses that included anemia, diabetes, depression, spinal fusion, and insomnia. During an observation on 9/12/22, at 2:26 p.m. in room 272, R58 was asleep in bed with blankets up to her chin. Room felt uncomfortably cold and	F 584		

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F 584	Continued From page 11 cold air was blowing out of a vent near the ceiling, directly above R58. During an observation and interview on 9/12/22, at 3:14 p.m. in room 286, R43 was laying on top of her made bed, fully clothed. R43 had the right side of her top blanket pulled to cover as much of her body as she could. Upon entry R43 stated "It's freezing in here." R43's stated she had her call light activated because she was cold. R43 stated her mood had been good until now because she was "frozen." During an observation and interview on 9/12/22, at 5:28 p.m. the director of maintenance (DM) recorded the following resident room temperatures: -room 272, 69 degrees Fahrenheit -room 274, 68 degrees Fahrenheit -room 282, 70 degrees Fahrenheit -room 286, 70 degrees Fahrenheit Upon entry to room 284, R68 stated she was cold and "shivered at night." The DM acknowledged R68's complaint, however, was unable to offer a solution. The DM stated 72 degrees Fahrenheit was a "safe number" and they needed to "winterize the system." The DM stated the heating and cooling of the resident rooms were separate systems. All resident rooms had a thermostat to control their heat, however, the DM was unsure which rooms had thermostats to control the cool air and was only able to locate one in room 272 which was set below 70 degrees Fahrenheit. The DM further stated the heat had not yet been turned on in the resident rooms as it was a lengthy process but that it was "on the docket" to get done.	F 584		

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F 584	Continued From page 12 During an observation on 9/13/22, at 1:41 p.m. room 272 felt uncomfortably cool, cool air was blowing out of the vent near the ceiling over the R58's bed and the cold air thermostat was set below 70 degrees. During an interview on 9/14/22, at 10:46 a.m. maintenance (MT) stated although he recently transferred to another location, he had done maintenance at the facility for 13 years. MT stated the boiler that provided heat was on all the time, however, the valves on the heat registers in each resident room may have needed to be opened allowing each resident to control their own heat. MT further stated the thermostat in room 272 which was below 70 degrees, should have been set at a higher temperature and the vent adjusted to prevent it from blowing cold air directly onto R58 while she was in bed. During an interview on 9/14/22, at 11:06 a.m. the DM stated he was new to the facility and was unaware that the heat could be controlled by opening the heat register valves in each resident's room, allowing them to control their heat individually. During an observation and interview on 9/15/22, at 10:29 a.m. upon entry to room 282, R58's family member (FM)-C was lying in a recliner with multiple blankets pulled up to her chin. FM-C stated she had spent the night and that the room was cold. A facility policy for resident room temperatures was requested but not provided. However, the facility provided a copy of the Minnesota Administrative Rules from the Office of the	F 584		

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F 584	Continued From page 13 Revisor Statutes dated 10/2/13, indicating the facility followed the following guidelines: A. For construction of a new physical plant, a nursing home must maintain a minimum temperature of 71 degrees Fahrenheit to 81 degrees Fahrenheit at all times. B. For existing facilities, a nursing home must maintain a minimum temperature of 71 degrees Fahrenheit during the heating season.	F 584		
F 676 SS=D	Activities Daily Living (ADLs)/Mntn Abilities CFR(s): 483.24(a)(1)(b)(1)-(5)(i)-(iii) §483.24(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that: §483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section ... §483.24(b) Activities of daily living. The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living: §483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care, §483.24(b)(2) Mobility-transfer and ambulation, including walking,	F 676		10/26/22

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F 676	Continued From page 14 §483.24(b)(3) Elimination-toileting, §483.24(b)(4) Dining-eating, including meals and snacks, §483.24(b)(5) Communication, including (i) Speech, (ii) Language, (iii) Other functional communication systems. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to implement interventions to maintain and/or prevent potential decline in ambulation for 1 of 2 residents (R25) reviewed for activities of daily living (ADLs). Findings include: R25's quarterly Minimum Data Set (MDS) dated 4/19/22, identified intact cognition. R25 had no documentation of rejecting care. R25's ability to walk in room or corridor had not been assessed. R25's prior functioning/admission indicated she required supervision or touching assistance to walk at least 150 feet. R25 had diagnoses of low back pain and non-alzheimers dementia. R25 had zero minutes listed for restorative nursing programs. R25's annual MDS dated 7/20/22, identified intact cognition, no rejection of care and R25's ability to walk in corridor had occurred once or twice with set up assistance. R25 had zero minutes listed for restorative nursing programs. R25's ADL Care Area assessment (CAA) dated 7/20/22, was triggered and indicated R25 had an	F 676	F676: Activities Daily Living SPECIFIC RESIDENT: Resident R25 was assessed by physical therapy services and is being treated by physical therapy. OTHER RESIDENT: Facility wide audit was completed of residents in house for appropriateness of physical therapy and/or walking program. MONITOR: Education provided to nursing and therapy on importance of physical therapy and walking programs as indicated by therapy. Interdisciplinary team reviews all residents at daily PDPM meeting and will add section to discuss residents coming off of therapy and refer to a walking program if appropriate. Restorative committee will review long term care residents quarterly for updates in care plan related to walking program/therapy evaluations. Director of Nursing or designee will audit 4 therapy to nursing communication forms weekly for 4 weeks, then twice a month for 1 month and then monthly for 1 month. Audit results will be reviewed by quality council monthly for further actions if needed.	

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F 676	Continued From page 15 ADL and mobility impairment related to dementia, weakness, diabetes, anemia, and high blood pressure. Staff were directed to assist with ADLs and mobility. R25 used a wheelchair and walker for mobility. R25's care plan dated 8/3/22, indicated R25 needed assist with transfers, ambulation and locomotion. Additionally, R25 was to progress with ADLs per therapy recommendations. The care plan lacked specific guidance for walking. R25's physical therapy (PT) summary of daily skilled services dated 7/14/22, indicated she was seen for gait training and was able to use a front wheeled walker to walk 125 feet, 100 feet and 120 feet with contact guard assistance (one or two hands on the resident's body but no other assistance provided to perform the functional mobility task) and wheelchair in tow. R25's gait was steady with flexed posture and she actively participated. R25's PT discharge summary dated 7/19/22, identified neither restorative program nor functional maintenance program was indicated at the date of discharge. R25's nursing assistant (NA) care guide dated 9/2/22, lacked guidance for walking. R25's progress notes indicated the following: -2/1/22, at 1:38 p.m. R25 walked 600 ft with wellness five days per week -4/19/22, at 7:35 a.m. R25 participated in therapy for walking and she "loved" walking. -R25's progress notes lacked documentation of walking after 4/19/22.	F 676		

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F 676	Continued From page 16 During interview on 9/12/22, at 4:01 p.m. R25 stated she used to walk with assistance routinely and was not being walked anymore. R25 said she walked last on 7/14/22, with therapy in the COVID-19 unit. R25 stated she mentioned she would like therapy again at her care conference in July but no one had followed up with her yet. During interview 9/13/22, at 2:13 p.m. NA-C stated the facility used to have staff designated for restorative walking programs but the program was canceled. NA-C reviewed the NA care card and stated R25 was not listed on an ambulation program. NA-C stated she had not seen R25 walking. During an observation and interview on 9/14/22, at 7:44 a.m. R25 was observed up in her wheelchair. R25 independently stood up, took a few steady steps and opened her curtains. She sat back down and self propelled in her wheelchair into the bathroom. Trained medication aide (TMA)-A was also in the room and stated R25 walked with therapy. TMA-A reviewed the computer and stated there were no walking programs in place for R25 to walk with nursing staff. During an interview on 9/14/22, at 2:55 p.m. the director of rehabilitation (DOR) stated he had worked with R25 in the spring and summer of this year for physical therapy and R25 had the ability to walk with staff assistance at least 200 feet. The DOR stated R25 should still have walked with nursing staff assistance to prevent a decline. The DOR stated a walking program was not set up upon her discharge from physical therapy and should have been. The DOR stated he was	F 676		

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F 676	Continued From page 17 unsure why this happened. During an interview on 9/15/22, at 1:06 p.m. the director of nursing (DON) stated therapy should have filled out a recommendation form to nursing for ambulation upon R25's discharge from PT. Facility policy titled Ambulation dated 8/08, indicated ambulation objectives were to assist the resident to achieve their maximum function. The procedure included to check the medical records for ambulation order and to note equipment and staff needed.	F 676		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to implement an occupational therapy (OT) ordered splint program to prevent potential worsening of contracture for 1 of 1 residents reviewed (R7) reviewed for splints and failed to implement ordered lymphedma wraps for 1 of 2 residents (R73) reviewed for edema. Additionally, the facility failed to ensure daily weights were completed and accurate for 2 of 2 residents (R378, R18) reviewed for daily weights.	F 684	F684: Quality of Care SPECIFIC RESIDENT: Resident R7 was assessed by occupational therapy and splint instructions were provided to nursing. R7's care plan was evaluated and updated with appropriate interventions. OTHER RESIDENT: Facility wide audit completed of residents in house with splints. No other residents in house	10/26/22

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F 684	Continued From page 18 Findings include: R7's quarterly Minimum Data Set (MDS) dated 6/21/22, indicated severely impaired cognition. R7 required extensive assist with bed mobility, dressing and hygiene. R7 had diagnoses of Alzheimers dementia and contracture of the right hand. R25 had zero minutes for splint/brace assistance listed under restorative nursing programs. R7's activities of daily living (ADLs) care plan dated 1/3/22, identified R25 required assistance with ADLs and mobility due to post polio syndrome resulting in right hand contracture. The care plan directed staff to follow physical therapy/occupational therapy (PT/OT) and restorative nursing programs as ordered. R7's orders dated 2/22/22, identified: OT evaluation and treat for diagnosis of finger contractures. R7's OT discharge summary dated 5/26/22, lacked indication for restorative or functional maintenace programs. R7 met all goals and tolerated the Rolyan WHFO (Wrist Hand Finger Orthosis) for three hours. R7's NA (nursing assistant) care sheet dated 9/2/22 lacked restorative nursing interventions or orders for splint program. During interview on 9/12/22, at 6:07 p.m. family member (FM)-B stated R7's hand had always been contracted due to polio. FM-B stated he was unaware of any type of splint that was in place. FM-B stated R7's hand contracture had not	F 684	identified to have an order for splint. MONITOR: Education provided to nursing and therapy on importance of splints and reasons for use. Interdisciplinary team reviews all residents at daily PDPM meeting and will add a section on splints to review care plan accordingly. Director of Nursing or designee will audit medical record of any resident identified with a splint for care plan and donning/doffing instructions weekly for 4 weeks, then twice a month for 1 month and then monthly for 1 month. Audit results will be reviewed by quality council monthly for further actions if needed. SPECIFIC RESIDENT: R73 lymphedema wraps were placed per provider orders. Order was moved from ETAR to EMAR. OTHER RESIDENT: Facility wide audit completed of all residents with orders for lymphedema wraps for donning/doffing procedures and appropriateness in medical record. MONITOR: Education provided to nursing staff on following lymphedema orders and documenting refusals in medical record. All lymphedema wraps will be placed on EMAR instead of ETAR. Director of Nursing or designee will complete 4 randomized audits of residents with lymphedema wraps weekly for 4 weeks, then twice a month for 1 month and then monthly for 1 month. Audit results will be reviewed by quality council monthly for further actions if needed. SPECIFIC RESIDENT: R378 and R18 orders for weights were assessed and	

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F 684	Continued From page 19 seemed worse. During an interview and observation on 9/13/22, at 2:13 p.m. NA-B stated R7 might have a splint on overnight but she never saw it on when she came in for the day shift. NA-B reviewed R7's nursing assistant orders and care plan and stated there was no splint program listed. NA-B entered R7's room and located a WHFO in the bedside table. R7 stated she had not worn it and was not aware why not. During an interview on 9/13/22, at 2:26 p.m. OT-A stated she had evaluated R7 for the splint and R7 should have a splint program in place. OT-A stated she provided the instructions to nursing. OT-A stated the purpose of the splint program was to prevent further hand contractures. During an interview on 9/15/22, at 1:06 p.m. the director of nursing (DON) stated therapy should have filled out a recommendation form to nursing and nursing should have implemented the program. A policy for splints and contractures was requested on survey and not provided. R73's quarterly Minimum Data Set (MDS) dated 9/1/22, staff assessment of cognition indicated he had modified independence in daily decision making. R73 had not rejected care and required extensive assist of one staff for dressing and hygiene. R73 had a diagnosis of heart disease. R73's active orders effective 6/27/22, indicated to apply compression garments Solaris Readywrap for 23/24 hours per day and to remove one time	F 684	ensured +/- was located on order to monitor weight fluctuations. R18's weight had fluctuated due to resident receiving new wheelchair. OTHER RESIDENT: Facility wide audit completed of all resident weight orders and added +/- orders to monitor weight fluctuations and to update provider appropriately. MONITOR: Education provided to nursing staff to ensure accuracy of weights, re-weights and following provider orders. Educated nurses on added +/- tasks to monitor weight fluctuations. Director of Nursing or designee will complete 4 audits of resident weight profiles weekly for 4 weeks, then twice a month for 1 month and then monthly for 1 month. Audit results will be reviewed by quality council monthly for further actions if needed.	

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ST GERTRUDES HEALTH & REHABILITATION CENTER	1850 SARAZIN STREET SHAKOPEE, MN 55379

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F 684	Continued From page 20 daily for skin inspection. R73's care plan dated 9/9/22, lacked a problem area for edema, goal or approach. R73's occupational therapy (OT) notes with a target date of 6/29/22, indicated a diagnosis of lymphedema and a goal to reduce the volume to BLE in order to improve the overall health of skin tissue and increase independence with functional tramsfers, ambulation and ADL (activity of daily living). R73's progress note dated 8/29/22, at 15:22 (3:22 p.m.), indicated no new skin issues were noted and R73 had BLE (bilateral lower extremity) edema. During an observation on 9/12/22 at 2:17 p.m. R73's leg wraps were on his bed. During an observation on 9/12/22, at 6:42 p.m. R73 stated he was not sure why he did not have his leg wraps on. R73 had edema noted in his ankles. During an interview on 9/12/22, at 7:16 p.m. trained medication aide (TMA)-A stated the nurse would apply any leg wraps as ordered. TMA-A was not aware of anyone that had refused to have them applied today. During an observation on 9/13/22, at 9:10 a.m. and again on 9/14/22, at 7:58 a.m., R73 was in his wheelchair in the dining room and no wraps were on his legs and edema was observed in his ankles through his socks. During an interview on 9/14/22, at 1:14 p.m.	F 684		

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F 684	Continued From page 21 licensed practical nurse (LPN)-B stated R73 she had not reviewed the treatments that needed to be done today and after reviewing the orders stated R73 should have had the leg wraps on today and he did not. LPN-B brought R73 to his room, put the wraps on and stated he had edema in BLE. During an interview on 9/15/22, at 1:11 p.m. the DON stated the wraps should have been applied as ordered. A policy for edema was requested on survey and not provided. Weights R378's entry tracking Minimum Data Set (MDS) dated 9/8/22, lacked documentation of cognition, functional status, and diagnoses. R378's Resident Face Sheet dated 9/15/22, indicated R378 was admitted on 9/8/22, with diagnoses of liver failure with abdominal fluid build-up, malnutrition, diabetes, and right hip fracture. R378's care plan dated 9/9/22, indicated R378 was cognitively intact. R378's orders dated 9/15/22, included furosemide (a diuretic), and lactulose (a laxative used in liver failure to reduce the amount of ammonia in the blood for people with liver disease). The orders also included daily weight for liver failure and ascites, and to document weight gain or weight lost.	F 684		

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F 684	Continued From page 22 R378's record lacked documentation of weights since admission on 9/9/22. During interview on 9/12/22, at 4:19 p.m. R378 stated he took medications which often caused diarrhea. During interview on 9/14/22, ay 9:31 a.m. nursing assistant (NA)-F stated nurses gave the NAs a list of residents who needed weights for the day, and NA-F confirmed R378 was on the list. She stated some of the rooms had a ceiling lift which could weigh residents, but others did not. The unit shared a standing scale with two other units, and if the scale was not on the floor staff had to go find it and bring it up to the unit. She stated if a resident could not stand, staff took them down to the long-term care unit, weighed the resident in their wheelchair, brought the resident back into bed, and then weighed the chair on its own to determine weight. She stated that process was probably why R378's weights were not completed. During interview on 9/14/22, at 9:48 a.m. NA-G stated nurses provided NAs with a list of residents who needed weights, and both the NA and the nurse recorded the results. She stated usually the scale was located at the nurse's desk. She stated the facility had a lift with a weight function on it for use with residents who could not stand. She stated she had not taken a weight for R378 since his admission but would get one that day. During interview on 9/14/22, at 9:54 a.m. registered nurse (RN)-D stated she checked the residents' electronic health record daily to determine who needed a weight and provided a	F 684		

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F 684	Continued From page 23 list to the NAs who took the weights and reported them back to the nurses. She stated the only time it could be missed was if a resident refused or was out for the day. RN-D confirmed R378 needed a daily weight and he had not had one taken since his admission on 9/9/22. She was unsure why. During interview on 9/14/22, at 11:12 a.m. RN-C stated if a resident had an order for daily weights, she expected staff to obtain the weight prior to breakfast. She stated staff tried to weigh R378 by using a lift first, however he did not like to use the lift and refused. She stated she expected staff to reapproach him later and document any refusal in the record. She stated R378 got regular paracentesis (removal of abdominal fluid) done and needed to be monitored for potential fluid overload. During interview on 9/14/22, at 11:26 a.m. family member (FM)-A stated she and R378 did not know what R378 weighed but knew he had been losing weight because of liver disease. She stated staff tried to weigh him once but could not because he could not put his foot down and the scale did not register unless he was fully standing. She stated he was about 156 pounds the last time he was weighed, but staff had not obtained a weight for R378 since his admission to the facility. During interview on 9/14/22, at 9:12 a.m. nurse practitioner (NP)-A stated R378 required daily weights due to liver failure, and NP-A needed to know whether his weight was going up or down. He stated if he was gaining weight, it could be due to fluid overload, and if it increased too much it could cause abdominal pain, nausea, vomiting,	F 684		

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F 684	Continued From page 24 and shortness of breath. He stated R378 was non-weight bearing on one leg due to a fracture, but he expected staff to figure out a way to weigh him. He stated R378 had fluid removed from his abdomen weekly and needed the weights to identify trends. The facility policy Weight Monitoring and Documentation (undated) indicated all residents are weighed upon admission and at least monthly, and a log of the resident's weight will be maintained within the medical record. Further, the licensed nurse is to verify the accuracy of weight changes. R18's quarterly MDS dated 9/5/22, indicated R18 had no cognitive deficits and required a wheelchair for mobility. R18's diagnoses included diabetes, chronic ulcer of the right foot with necrosis (tissue death) of bone, end stage kidney disease, dependence on kidney dialysis, chronic heart failure (CHF), high cholesterol, high blood pressure, quadruple coronary bypass, constipation, amputation of the right toe, below the knee left leg amputation, gastric ulcer with bleeding, stroke without residual deficits, myocardial infarction (heart attack), and cancer of the thyroid gland. R18's care plan dated 7/15/22, indicated R18 had a potential for alteration in vital signs due to a history of high blood pressure. Interventions included taking R18's weights as ordered and monitoring for increased edema and significant weight changes and reporting to the provider if occurs. R18's care plan also indicated R18 was at risk for edema due to dialysis. Interventions included obtaining R18's weight per dialysis	F 684		

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F 684	Continued From page 25 [order] and notifying the provider of weight gain and/or fluid volume excess (sudden weight gain). R18 also had a nutrition risk with a goal to maintain a weight between 105-115 pounds (lbs). Interventions included monitoring R18's weight. R18's Care Area Assessment (CAA) dated 4/1/22, indicated R18 triggered for nutritional status due to increased protein needs, dialysis, and diabetes. Staff were to monitor R18's weight. R18's physician orders dated 8/30/22, indicated R18 had a daily fluid restriction of 1500 fluid ounces (cc) and daily weights (due to diagnosis of CHF). "Call for weight gain greater than 2.5 lbs in 24 hours or greater than 5 lbs above admission weight." R18's weights were documented as: -8/30/22, admission, 100.1 lbs -9/1/22, 103.8 lbs -9/3/22, 101.8 lbs -9/4/22, 100.2 lbs -9/6/22, 101 lbs -9/7/22, at 5:36 a.m. 134.6 lbs -9/7/22, at 6:28 a.m. 134.6 lbs -9/9/22, 128.2 lbs -9/11/22, 123 lbs -9/12/22, 130.9 lbs -9/13/22, 103.3 lbs -9/14/22, 144.5 lbs The Resident Weights binder indicated R18's weights were as follows: -9/7/22, 105.0 -9/12/22, 102.2 -9/13/22, 103.3 No other weights were documented for R18 in the	F 684		

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F 684	Continued From page 26 Resident Weights binder from 9/5/22, to 9/15/22. R18 had no history of refusing weights and despite a physician order for daily weights, no weights were completed for R18 on: -8/31/22, -9/2/22, -9/5/22, -9/8/22, -9/10/22, During an interview on 9/15/22, at 9:09 a.m. R18 stated she had not yet been weighed that day. During an interview on 9/15/22, at 9:53 a.m. nursing assistant (NA)-B stated she documented a resident's weight in the Resident Weights binder, then a nurse would enter the weight into the electronic medical record (EMR). NA-B stated if a resident had a weight that was four or more pounds different from their previous weight, she would re-weigh the resident. If the weight remained significantly different NA-B would notify the nurse. NA-B stated although she hadn't worked with R18 for a few months, a 30-40 weight difference was significant and R18 should have been re-weighed. During an interview on 9/15/22, at 9:17 a.m. registered nurse (RN)-E stated NAs would weigh a resident then enter the weight into the computer or write it in the Resident Weight binder. The nurse would then review the weight and enter it into the residents EMR. RN-E stated a 30-40 lb difference would require the resident to be reweighed. During an interview on 9/15/22, at 11:03 a.m. RN-B stated staff should ensure a resident's	F 684		

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F 684	Continued From page 27 weight is accurate and re-weigh them if there was a significant difference from their previous weight. RN-B further stated it was important for R18 to have accurate weights because she was on dialysis. During an interview on 9/15/22, the DON stated she expected staff to re-weigh a resident who had a significant weight change to ensure the accuracy of the weight. NAs weighed the residents, and the nursing staff entered the weights into the resident's electronic medical record. Nursing staff should have compared R18's current weight to her previous weights and completed an assessment to ensure R18's weight was accurate. The DON further stated it was essential for R18 to have accurate weights in order to monitor R18 for fluid retention.	F 684		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to remove from service an assistive device identified not to be working properly to ensure resident safety during transfers for 1 of 2 residents (R58) reviewed for accidents and hazards.	F 689	F689: Free of Accident Hazards/Supervision/Devices SPECIFIC RESIDENT: Resident R58's ceiling lift was removed from resident's room and resident to use comparable device for transfer needs.	10/26/22

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F 689	Continued From page 28 Findings include: R58's quarterly Minimum Data Set (MDS) dated 8/25/22, indicated R58 had severe cognitive deficits and required extensive assistance for all activities of daily living (ADLs) and required oxygen (O2) therapy. R58's diagnoses included Alzheimer's disease, dementia without behavioral disturbance, chronic obstructive pulmonary disease (COPD, inflammation of the lung tissue causing difficulty breathing), vasovagal syncope (loss of consciousness due to a sudden drop in blood pressure), traumatic fracture of the lower extremity, glaucoma (degenerative eye disease), osteoporosis (low bone density), and non-traumatic bleeding in the brain. R58's Care Area Assessment (CAA) dated 3/3/22, indicated R58 triggered for cognitive loss/dementia due to Alzheimer's disease or dementia and had a decreased ability to make herself understood or to understand others and had a hearing or vision impairment that could have impacted R58's ability to process information. R58 also triggered for visual function which increased R58's risk for falls and a communication deficit related to hearing loss. R58 had difficulty speaking and making needs known, therefore, staff were to anticipate R58's needs. R58 also triggered for falls related to incontinence, visual and hearing impairment, pain, a history of falls, mobility and level of assistance required with transfers. R58's care plan dated 8/31/22, indicated R58 had a self-care deficit and required assistance with bed mobility, transfers, ambulation, and locomotion related to cognitive and mobility impairments. Interventions included two staff	F 689	OTHER RESIDENT: Facility wide audit conducted of ceiling lift rooms to ensure proper functioning. MONITOR: Education provided to nursing staff to complete “lock out/tag out” process if equipment is improperly functioning. Director of Nursing or designee will complete 4 randomized audits of ceiling lifts weekly for 4 weeks, then twice a month for 1 month and then monthly for 1 month. Audit results will be reviewed by quality council monthly for further actions if needed.	

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F 689	Continued From page 29 assist with all transfers using a ceiling lift (a powered hydraulic lift system that runs along a track on the ceiling, used for lifting and transferring residents), and staff to assist with transfers using a mechanical lift for support. R58 had cognitive and communication deficits related to Alzheimer's disease and was not able to understand or verbally communicate her needs. Goals included R58 remaining safe in her environment through her next review. An email correspondence dated 9/10/22, from R58's family member (FM)-D to registered nurse (RN)-B indicated the family did not want to move R58 to another room and preferred, if there was a concern regarding the operational status of R58's ceiling lift, that R58 be transferred using a Hoyer lift (a manual hydraulic lift) until the ceiling lift can be serviced/fixed. During an observation on 9/14/22, at 8:45 a.m. R58's ceiling lift in room 272 was docked in the charging station in the resident's bathroom. The wall mounted power box had a green light on, and the ceiling lift had a yellow light on, indicating it was charging. The ceiling lift had a "next service date" of 3/25/22. During an interview on 9/14/22, at 8:54 a.m. nursing assistant (NA)-B stated she did not transfer R58 out of bed the previous day because R58's ceiling lift had not been docked properly and therefore, was not charged. NA-B stated she did not like using the Hoyer lift because it was difficult to maneuver R58 onto the toilet and it required two staff to operate, unlike the ceiling lift which required only one staff to operate. NA-B also stated R58's ceiling lift was old, and parts were no longer available for the unit.	F 689		

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F 689	Continued From page 30 During an interview on 9/14/22, at 10:46 a.m. maintenance (MT) stated R58's ceiling lift was an older unit that was being phased out because it was one of the first units installed in the facility and parts were no longer available for it. During an interview on 9/14/22, at 11:56 a.m. NA-I stated R58's ceiling lift "comes and goes. Sometimes it works, and sometimes not." NA-I stated when the ceiling lift didn't work, staff used the Hoyer lift, but that required two staff members to operate it. NA-I stated she thought R58's ceiling didn't charge properly. NA-I stated when she started her afternoon shift a few weeks ago, the morning shift nurse told NA-I they had had difficulties with R58's ceiling lift and if she didn't feel safe using it, to use the Hoyer lift to transfer R58 instead. NA-I stated she was unable to get the ceiling lift unit to move along the track from the docking station, so she used the Hoyer lift to transfer R58 during the shift. However, since then, NA-I stated she had used the ceiling lift to transfer R58 because she had not been told she shouldn't. During an interview on 9/15/22, at 10:53 a.m. registered nurse (RN)-B stated R58's ceiling lift was reported to not be working last month because it wasn't holding a charge. RN-B stated because R58's ceiling lift unit did not charge properly, as a safety precaution, R58 should have been transferred using only the Hoyer lift and not the ceiling lift, even if it indicated it was charged. During an interview on 9/14/22, at 11:06 a.m. the director of maintenance (DM) stated R58's ceiling lift in room 272 was no longer able to be serviced and parts were no longer available to fix the unit	F 689		

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F 689	Continued From page 31 and therefore, the DM advised staff not to use it. DM stated the staff should have been using a Hoyer lift to transfer R58 and not the ceiling lift. During an interview on 9/15/22, at 12:42 p.m. the director of nursing (DON) stated she was advised that week that R58's ceiling lift was no longer serviceable. The DON also stated if there were concerns with the operation of the ceiling lift, staff should have been using the Hoyer lift for all of R58's transfers to ensure R58's safety during transfers . A facility policy on the proper use and/or maintenance of facility equipment or improperly functioning equipment was not received.	F 689		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 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 record review the facility failed to ensure respiratory equipment was maintained according to physician orders and professional standards of practice for 1 of 1 residents (R58) reviewed for respiratory care. Findings include:	F 695	F695: Respiratory/Tracheostomy Care and Suctioning SPECIFIC RESIDENT: Resident R58's oxygen tubing and humidifier were changed immediately. OTHER RESIDENT: Facility wide audit conducted of residents who utilize oxygen	10/26/22

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F 695	Continued From page 32 R58's quarterly Minimum Data Set (MDS) dated 8/25/22, indicated R58 had severe cognitive deficits and required extensive assistance for all activities of daily living (ADLs) and required oxygen (O2) therapy. R58's diagnoses included Alzheimer's disease, dementia without behavioral disturbance, chronic obstructive pulmonary disease (COPD, inflammation of the lung tissue causing difficulty breathing), vitamin B12 deficiency anemia, vitamin D deficiency, deficiency of other vitamins, unspecified asthma, and allergic rhinitis. R58's care plan dated 6/7/22, indicated R58 required continuous oxygen therapy due to end-stage COPD. Interventions included administering O2 per physician orders. R58's Physician Orders dated 8/21/22, indicated to change O2 tubing-date, time and initial new tubing once a day on Mondays between 6:30 a.m. and 2:30 p.m. During an observation on 9/12/22, at 2:26 p.m. R58 was asleep in bed with a nasal canula in place. R58's O2 tank was set to 2 liters per minute. O2 tubing connected to the tank was dated 8/29/22, and the humidifier container was dated 8/22/22. During an interview on 9/15/22, at 8:52 a.m. registered nurse (RN)-F stated R58's oxygen tubing and humidifier container were to be changed and dated every Monday during the day shift. RN-F had not worked the previous Monday on 9/7/22, because it was a holiday and therefore, could not verify if they had been changed since the oxygen tubing was dated 8/29/22, and the	F 695	tubing and humidifiers to ensure proper respiratory equipment was maintained per physician orders. MONITOR: Education provided to nursing staff to replace oxygen tubing and humidifier weekly per orders. An order to be placed in ETAR for signature sign off by nursing staff of weekly oxygen tubing and humidifier changes. Director of Nursing or designee will complete 6 randomized audits of oxygen tubing and humidifiers weekly for 4 weeks, then twice a month for 1 month and then monthly for 1 month. Audit results will be reviewed by quality council monthly for further actions if needed.	

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F 695	Continued From page 33 humidifier container was dated 8/22/22, when she changed them on 9/12/22. During an interview on 9/15/22, RN-B stated although R58's order was to change her O2 tubing, which included the humidifier container, every Monday, all staff were expected to verify the tubing and container had been changed and dated according to the order. If the date was incorrect, staff were expected to change the tubing and/or container to avoid any possible infection control concerns. A facility policy on the maintenance of respiratory equipment was not received. During an interview on 9/15/22, at 12:42 p.m. the director of nursing (DON) stated the oxygen tubing and humidifier container should have been changed every Monday according to the physician orders to avoid the development of infections.	F 695		
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph	F 756		10/26/22

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F 756	Continued From page 34 (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure consulting pharmacist recommendations were addressed or acted upon for 2 of 5 residents (R62 and R8) reviewed for unnecessary medications. Findings include: R62's significant change Minimum Data Set (MDS) dated 8/24/22, indicated R62 had severe cognitive deficits and required extensive assistance of one staff for bed mobility, transfers, dressing, toileting, and personal hygiene and was independent with eating. R62 had diagnoses that	F 756	F756 Drug Regimen Review, Report Irregular SPECIFIC RESIDENT: Resident R62's antipsychotic medication was updated to reflect 14 day end date. R8's allergy to gabapentin was clarified and allergy was removed from allergen list. OTHER RESIDENT: Facility wide audit was conducted of resident's medical records to ensure end dates were noted on any PRN psychotropic medication and resident allergy lists were up to date. MONITOR: Education provided to nursing	

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F 756	Continued From page 35 included Alzheimer's disease, dementia, and dysphagia (difficulty swallowing). R62's physician orders dated 6/2/22, indicated R62 had an order for Seroquel (an antipsychotic medication) 12.5 milligrams (mg) PRN (as needed) qd (daily) for agitation with a diagnosis of disorientation. The end date for the PRN antipsychotic was indicated as "open ended." R62's electronic Medication Administration Record (eMAR) dated 8/31/22, to 9/13/22, indicated R62 had not received any PRN Seroquel. R62's pharmacy Medication Regimen Review (MRR) progress note dated 6/26/22, indicated PRN clarification. R62's provider progress note dated 7/1/22, indicated R62 was ordered Seroquel 12.5 PRN beginning 6/2/22, with no end dated indicated. No changes to R62's medications were noted. R62's nurse practitioner (NP) progress note dated 7/7/22, indicated to continue with current medications and treatments. R62's pharmacy MRR progress note dated 7/27/22, indicated PRN clarification. R62's Consultant Pharmacist Recommendation to Physician form dated 7/27/22, indicated R62 was prescribed the antipsychotic Seroquel to be taken PRN. Per regulatory guidelines, orders for antipsychotic medications on a PRN basis must be limited to 14 days with no exceptions. If a new order for the antipsychotic was to be written, a direct examination of the resident by the	F 756	staff that PRN psychotropic medications need to have a 14 day end date. List of psychotropic medications placed at nursing station. Education provided to nursing staff when inputting medication order to verify allergies. Provider to be updated if medication allergy is flagged and document in medical record. Director of Nursing or designee will complete 4 randomized audits of resident medication lists weekly for 4 weeks, then twice a month for 1 month and then monthly for 1 month. Audit results will be reviewed by quality council monthly for further actions if needed.	

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F 756	Continued From page 36 attending physician or prescribing practitioner was required to determine if the medication was still needed. R62's provider note dated 8/1/22, indicated R62 was ordered Seroquel 12.5 PRN beginning 6/2/22, with no end dated indicated. No changes to R62's medications were noted. R62's pharmacy MRR progress note dated 8/26/22, indicated PRN clarification. R62's Consultant Pharmacist Recommendation to Physician form dated 8/28/22, indicated R62 was prescribed the antipsychotic Seroquel to be taken PRN. Per regulatory guidelines, orders for antipsychotic medications on a PRN basis must be limited to 14 days with no exceptions. If a new order for the antipsychotic was to be written, a direct examination of the resident by the attending physician or prescribing practitioner was required to determine if the medication was still needed. During an interview on 9/15/22, at 10:44 a.m. registered nurse (RN)-B stated R62's PRN Seroquel medication order should have been reviewed every 14 days and should not have been entered without an end date. During an interview on 9/15/22, at 12:01 p.m. the consulting pharmacist (CP) stated he had recommended a review of R62's PRN Seroquel in June, July, and August, but had not received a response. The CP stated if he did not receive a response to his next recommendation in September, he would escalate the concern to the medical director. The CP also stated PRN antipsychotics were to have a face-to-face	F 756		

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F 756	Continued From page 37 reassessment every 14 days to determine the need to continue the medication. The CP further stated since R62 had not used the medication it should have been discontinued. During an interview on 9/15/22, at 12:31 p.m. the director of nursing (DON) stated PRN antipsychotics such as Seroquel should have an end date 14 days after their start date so a face-to-face assessment could be done to determine if the resident still requires the medication. The DON confirmed R62 had not taken the PRN Seroquel for at least the last 14 days. The DON stated pharmacy recommendations were printed out and put on the NP's desk for them to review, then the recommendation was scanned into the resident's electronic medical record. R8's Resident Face Sheet printed 9/14/22, indicated R8 was allergic to gabapentin. R8's quarterly Minimum Data Set (MDS) dated 6/23/22, indicated R8 had severe cognitive deficits and required an extensive assist of one staff for all activities of daily living (ADLs) but was independent for eating. R8's diagnoses included diabetes, asthma, chronic obstructive pulmonary disease (COPD, inflammation of the lung tissue resulting in difficulty breathing, and microcystic adnexal carcinoma (MAC) of the skin (cancer of the sweat glands). R8's Hospitalist Admission History and Physical (H&P) dated 12/7/21, indicated R8 had an allergy to gabapentin. Severity: unknown, Reaction: nausea only. R8's H&P also indicated R8 took	F 756		

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F 756	Continued From page 38 300 milligrams of gabapentin twice a day. R8's physician orders dated 3/8/22, indicated R8's gabapentin was increased to 300 mg at morning (AM) and afternoon (PM) and 400mg at bedtime (HS). R8's orders also indicated R8 was allergic to gabapentin. R8's 14-day Medication Administration Record (MAR) dated 9/2/22, to 9/15/22, indicated R8 received all doses of her scheduled gabapentin with no indication of an allergic reaction. During an interview on 9/14/22, at 7:32 a.m. licensed practical nurse (LPN)-B stated R8's gabapentin was administered however, LPN-B did not notice that gabapentin was listed as an allergy for R8 also. LPN-B stated she would need to check with the provider because, although R8 has been taking gabapentin and the provider would know what R8 was allergic to, her medical record should be accurate. During an interview on 9/15/22, at 12:23 p.m. the director of nursing (DON) stated upon admission, when the order for gabapentin was entered, the staff entering the order should have clarified the discrepancy with the provider. The DON stated there also should have been a progress note and/or a note in R8's order comments explaining the discrepancy, however, no explanation was indicated in R8's progress notes or orders. The DON further stated the discrepancy should have been corrected during R8's quarterly reviews, during medication administration by the nursing staff and/or on 3/8/22, when R8's gabapentin was increased. During interview on 9/15/22, at 2:15 p.m.	F 756		

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F 756	Continued From page 39 consulting pharmacist (CP) stated since R8 had been on gabapentin for many years and R8's listed reaction to it was only nausea, R8 was not allergic to gabapentin and the medication should have been removed from R8's allergy list. CP stated the discrepancy should have been reconciled during her monthly medication regimen reviews (MRRs). The facility Medication Monitoring: Medication Regimen Review policy dated August 2017, indicated as needed (PRN) orders needed to include stop dates and/or review and renewal by the provider (i.e., every 14 days for PRN antipsychotic orders). Resident specific irregularities and/or clinically significant risks resulting from or associated with medications are documented in the resident's active record and reported to the DON, attending physician, and the Medical Director. In addition, recommendations are acted upon and documented by the facility staff and/or the prescriber. The prescriber will act upon recommendations by the pharmacist or reject and provide and explanation for disagreeing. If an irregularity does not require urgent action but should be addressed before the next monthly MRR, facility staff and the CP will confer on the timeliness of attending physician responses to identified irregularities based on the clinical condition of the specific resident. Timeframes for Monthly MRR: The CP provides recommendations to the facility by the next business day after completing the MRR or as agreed upon by the facility. Recommendations and/or MRR reports are provided to the attending physicians and medical director (MD) within 72 hours or receipt or within three business days (unless the facility states otherwise). Responses to monthly MRR by attending physicians may be	F 756		

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F 756	Continued From page 40 completed upon the next physician visit to the facility.	F 756		
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, 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	F 758		10/26/22

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F 758	Continued From page 41 are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure a gradual dose reduction (GDR) was attempted, or a provider rationale which clinically contraindicated a GDR, for an antipsychotic medication was completed for 1 of 5 residents (R46). Findings include: R46 had a quarterly Minimum Data Set (MDS) dated 8/9/22, which identified R46 was rarely/never understood, had no behaviors and no rejection of care. R46 required extensive assist of two staff for bed mobility and was totally dependent on two staff for transfers. R46 received an antipsychotic seven days in the seven day look back period and there was no gradual dosage reduction (GDR) attempt nor physician documentation that a GDR was clinically contraindicated. R46 had diagnoses of unspecified psychosis, Parkinson's disease and dementia. R46 had active orders printed 9/15/22, for the	F 758	F758 Free from Unnec Psychotropic Meds/PRN Use SPECIFIC RESIDENT: Resident R46's medical record was assessed for GDR of antipsychotic medication by Nurse Practitioner. Nurse Practitioner did not recommend antipsychotic medication reduction. OTHER RESIDENT: Facility wide audit was conducted of resident's medical records to ensure GDRs had been answered and no outstanding GDR recommendations noted. MONITOR: Education provided to nursing leadership team to print off pharmacy recommendations and give to providers. Nursing leadership team will track pharmacy GDR recommendations and ensure providers are addressing in a timely manner. Monthly psychotropic meetings will be initiated to assist with tracking. Director of Nursing or designee will review previous monthly pharmacy	

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F 758	Continued From page 42 medication Seroquel 6.25 milligrams (mg) twice daily by mouth and an order for the medication carbidopa-levadopa (Sinemet) 25-100 mg tablet take one tablet twice daily by mouth. R46 had a consultant pharmacist (CP) recommendation to the physician form dated 6/27/22, which indicated R46 took two medications (Sinemet and Seroquel) which counteracted each other. The Sinemet was for the Parkinson's diagnosis and the Seroquel was for psychosis. The two medications together could "greatly" increase the risk of adverse outcomes such as falls. The CP form indicated R46 had no documented psychosis, depression or anxiety. The CP form presented the option for a trial discontinuation of Seroquel or at least decrease it to 6.125 mg Q HS (at bedtime). Under the physician/prescriber response it was indicated they physician would review next follow up visit with her with an illegible signature dated 7/28/22. R46 had a physician progress note dated 8/29/22, which lacked documentation the Seroquel was reviewed for a potential discontinuation or GDR. During an interview on 9/15/22, at 11:58 a.m. the CP stated the recommendation to discontinue or start a GDR of R46's Seroquel was not followed up on and he would have expected it to be. The CP stated R46 was still on antipsychotics, however, R46 was not behavioral and since the physician/prescriber had not addressed the recommendation he would re-issue it on his next visit. During an interview on 9/15/22, at 1:15 p.m. the director of nursing (DON) stated their process to	F 758	recommendations to ensure all recommendations had received a response for 4 months. Audit results will be reviewed by quality council monthly for further actions if needed.	

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F 758	Continued From page 43 review antipsychotics was for the pharmacist to review monthly and the nurse manager would watch for recommendations. The DON stated the physician/prescriber was here every week to follow up on recommendations. The DON stated they were going to start doing psychotropic meetings with the pharmacist to work on a new process.	F 758		
F 803 SS=D	Menus Meet Resident Nds/Prep in Adv/Followed CFR(s): 483.60(c)(1)-(7) §483.60(c) Menus and nutritional adequacy. Menus must- §483.60(c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.; §483.60(c)(2) Be prepared in advance; §483.60(c)(3) Be followed; §483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups; §483.60(c)(5) Be updated periodically; §483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and §483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices. This REQUIREMENT is not met as evidenced	F 803		10/26/22

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F 803	Continued From page 44 by: Based on interview, observation and document review, the facility failed to accommodate dietary preferences for 2 of 2 residents (R51 and R17) reviewed for food. Findings include: R51's admission MDS dated 8/17/22 identified intact cognition. R51 was independent with eating after set up. R51 had diagnoses of anemia, and hip/knee replacement. During an interview on 9/12/22, at 2:12 p.m. R51 stated the food was cold and he was not able to choose what he wanted for breakfast or lunch because he had not received his meal tickets to fill out. R17 had a quarterly Minimum Data Set (MDS) dated 7/7/22, which indicated he had intact cognition, was independent after set-up for eating. R17 had diagnoses of end stage renal disease and diabetes and was on dialysis. R17's nutritional care plan dated 7/19/22, indicated R17 had increased protein needs due to protein depletion at dialysis and R17 had instances of hypoglycemia. Staff were directed to provide supplements, encourage compliance with diet and provide education as needed. R17 had a fluid restriction and was on a CSC diet (controlled carbohydrates). During an interview on 9/12/22, at 2:00 p.m. R17 stated he was not provided with his choice at meals. R17 stated this morning for breakfast he ordered four french toast, four sausage links per the menu, and he only received one french toast	F 803	F803 Menus Meet Resident Nds/Prep in Adb/Followed SPECIFIC RESIDENT: R51 and R17 were verbally educated that if they did not receive a menu in the morning hours or did not get what they requested on meal tray to notify culinary or nursing staff immediately for assistance. R51 discharged from facility. OTHER RESIDENT: Will discuss at October resident council that if residents are missing items on food tray or do not receive a menu in the morning hours to fill out to notify culinary or nursing staff immediately. MONITOR: Education given to all staff that if resident is missing a food item on tray that culinary is to be notified for item. Nursing staff educated to confirm at point of delivery that all items requested are present on resident tray. All staff educated that if a resident does not receive a menu in the morning hours to notify nursing or culinary staff. Menus will be distributed to residents in the morning hours for them to fill out. Nursing and Wellness staff will assist residents as needed. If resident fills out anything on menu that is above or lower than standard portions, nursing or wellness staff will clearly indicate portions on menu selection. Culinary staff will review all menus and circle with a highlighter the items that are requested above or below the normal portion; if there are any items in question, culinary staff will attempt to contact resident for	

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F 803	Continued From page 45 and one sausage patty instead of link. During observation and interview on 9/12/22, at 6:38 p.m. R17 had his meal tray delivered to his room. R17 picked up his meal ticket and indicated where he circled kielbasa on the ticket and wrote down "2" however, R17 had only received one kielbasa. R17 showed where he also indicated sauerkraut "4" for a total of one cup and only got 1/4 cup. R17 showed where he indicated brussel sprouts count "2" for a total of one cup and only got 1/2 cup. R17 also ordered 2 magic bars and got none but got one chocolate ice cream and one strawberry ice cream which he had not ordered. During an interview on 9/12/22, at 6:42 p.m. dietary aide (DA)-A confirmed what R17 had on the tray did not match his selections on the meal ticket. DA-A stated she had not prepared that tray. During an interview on 9/12/22, at 7:12 p.m. dietary director (DD) reviewed R17's meal ticket and the numbers next to the order. The DD stated R17 was not on a calorie restriction and if a resident indicated they wanted multiple food portions, then the dietary department would provide it. The DD stated R17's meal ticket selections must not have been read properly by dietary staff. The DD stated resident food items should be provided in accordance with resident choices and the meal tickets. Facility policy titled Resident Menus dated 9/21, identified that resident preferred changes would be made to the menus throughout the year but lacked specification for day to day individual menu food choices.	F 803	clarification. Culinary Director or designee will complete 2 breakfast, 2 lunch and 2 dinner randomized tray accuracy audits weekly for 4 weeks, then twice a month for 1 month and then monthly for 1 month. Audit results will be reviewed by quality council monthly for further actions if needed.	

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F 804 SS=D	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure food was served at hot, palatable temperatures for 2 of 2 residents (R51 and R31) who were observed to be served and/or complained about inappropriate food temperature. R51's admission MDS dated 8/17/22 identified intact cognition. R51 was independent with eating after set up. R51 had diagnoses of anemia, and hip/knee replacement. During an interview on 9/12/22, at 2:12 p.m. R51 stated the hot food was served cold. R31 had a quarterly Minimum Data Set (MDS) dated 8/4/22, which indicated he was cognitively intact and independent with eating after set-up. During an interview 9/13/22, at 8:50 a.m. R31 also stated the hot meals was served cold. During an observation and interview on 9/13/22, at 9:01 a.m. R31 was observed to have scrambled eggs, bacon, toast and oatmeal on his room tray. R31 stated his food was lukewarm and	F 804	F804 Nutritive Value/Appear, Palatable/Prefer Temp SPECIFIC RESIDENT: Purchased additional food thermometers and posted food temperature guidelines for culinary staff in kitchen. OTHER RESIDENT: Purchased additional food thermometers and posted food temperature guidelines for culinary staff in kitchen. MONITOR: Education provided to culinary staff on how to use food thermometer and the appropriate guidelines for food temperatures. Food temperature guidelines posted in kitchen for reference. Director of Culinary or designee will send unassigned tray to unit for 1 breakfast, 1 lunch and 1 dinner to audit food temperatures weekly for 4 weeks, then twice a month for 1 month and then monthly for 1 month. Audit results will be reviewed by quality council monthly for further actions if needed.	10/26/22

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F 804	Continued From page 47 he would have wanted it hotter. However, he was diabetic and needed to eat now. On 9/14/22, the following observations were made: - 12:03 p.m. dietary aides (DA)-D and DA-E were observed to begin to prepare meals for room trays. Meals were placed on heated plates with insulated covers room trays. The trays were then placed in an uninsulated metal cart. - 12:13 p.m. temperatures were reviewed for the food items on the steam table. The Salisbury steak was 169 degrees Fahrenheit (F), mashed potatoes were 166 F, vegetables were 176 F, and gravy was 166 F. - 12:17 p.m. the dietary director (DD) was asked to make an extra meal and put it in the metal cart and that meal temperature would be checked once all the meal trays had been served - 12:18 p.m. DA-B left the kitchen with the meal trays - 12:20 p.m. the meal cart arrived on the resident dining room. Several unidentified nursing staff members delivered trays to residents in the dining room and to their rooms - 12:33 p.m. the last resident tray was delivered, and the extra meal tray was delivered back to the kitchen for a temperature check - 12:34 p.m. DA-E uncovered the test tray and took the food temperatures: the Salisbury steak was 132.7 F, mashed potatoes with gravy were 139.8 F, vegetables were 128.6 F. During an interview on 9/14/22, at 12:36 p.m. the DD stated hot food should initially have a temperature of 165 F and would expect 140 F and higher for when the food was delivered to the residents for palatability. The DD stated he expected the serving temperatures to be hotter	F 804		

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F 804	Continued From page 48 than the test tray temperatures for palatability. Facility policy titled Monitoring and Recording Food, undated, indicated the standard food temperature at plate should be 130 F or greater for the hot entrée and vegetables.	F 804		
F 883 SS=C	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure	F 883		10/26/22

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F 883	Continued From page 49 that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure 1 of 5 residents (R45) were offered or received the pneumococcal pneumonia vaccine in accordance with the Center for Disease Control (CDC) recommendations. Findings include: R45's significant change Minimum Data Set (MDS) dated 9/12/22, indicated she was cognitively impaired and had diagnoses of heart disease, high blood pressure, and Alzheimer's disease. The Pneumococcal Vaccine section of	F 883	F883: Influenza and Pneumococcal Immunizations SPECIFIC RESIDENT: R45 was eligible for the pneumococcal vaccine and was provided education and vaccine offered. OTHER RESIDENT: Facility wide audit completed and any resident that was eligible for the pneumococcal vaccine to be provided education and vaccine offered. Influenza immunization to be offered to all new admissions and current residents during the determined Influenza	

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F 883	Continued From page 50 the MDS lacked responses to the questions of "Is the resident's Pneumococcal vaccination up to date?" and If Pneumococcal vaccine not received, state reason." R45's Resident Face Sheet dated 9/15/22, indicated she was admitted to the facility on 4/27/22. R45's orders included an order for Agency Standing Orders. The facility Standing Orders for Skilled Nursing Facilities dated 7/2019, included per CDC guidelines, administer pneumococcal vaccinations (PPSV23 or PCV13) to patients who have not already received it unless contraindicated. An email dated 9/14/22, at 3:58 p.m. from registered nurse (RN)-A indicated R45 did not receive the pneumococcal vaccine. R45's medical record lacked evidence of pneumococcal immunizations, education, contraindication, and/or documentation of refusal by resident or resident representative. During interview on 9/15/22, at 9:32 a.m. infection preventionist (IP) stated staff screened new residents before admission and she reviewed the resident's Minnesota Immunization Information Connection (MIIC) report to determine which, if any, vaccines were due. She stated residents were educated and offered and given the appropriate pneumococcal vaccine at the facility per resident (or resident representative) request. She stated all documentation of vaccine education, administration, and any refusal was	F 883	Season. MONITOR: Education provided to nursing staff to offer pneumococcal and Influenza (When in Season) vaccination education and administration upon admission to facility unless medically contraindicated, resident already been immunized or resident refuses. Result to be documented in the medical record appropriately. Infection preventionist or designee will audit 4 new admission vaccination records weekly for 4 weeks, then twice a month for 1 month and then monthly for 1 month. Audit results will be reviewed by quality council monthly for further actions if needed.	

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F 883	Continued From page 51 recorded in the medical record. She was unsure why R45 did not have documentation. During interview on 9/15/22, at 12:27 p.m. licensed practical nurse (LPN)-C stated staff asked residents if they had the pneumococcal pneumonia immunization upon admission but did not offer it. During interview on 9/15/22, at 12:33 p.m. LPN-D stated there was a section to complete on the admission form for immunizations which she filled out when she had the information from hospital records or other documentation, but she did not ask the residents about them. She stated resident immunizations were up to the provider. During interview on 9/15/22, at 1:46 p.m. director of nursing (DON) stated her expectation is residents are offered and provided the pneumococcal pneumonia vaccine as appropriate upon admission based upon CDC guidance to protect staff, residents, and visitors. The facility policy Pneumococcal Vaccines for Residents updated 2/7/22, indicated it is the policy of the facility to provide education and administration of the pneumococcal vaccine to the residents of the facility according to the CDC recommendations.	F 883		
F 886 SS=F	COVID-19 Testing-Residents & Staff CFR(s): 483.80 (h)(1)-(6) §483.80 (h) COVID-19 Testing. The LTC facility must test residents and facility staff, including individuals providing services under arrangement and volunteers, for COVID-19. At a minimum, for all residents and facility staff, including	F 886		10/26/22

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F 886	Continued From page 52 individuals providing services under arrangement and volunteers, the LTC facility must: §483.80 (h)((1) Conduct testing based on parameters set forth by the Secretary, including but not limited to: (i) Testing frequency; (ii) The identification of any individual specified in this paragraph diagnosed with COVID-19 in the facility; (iii) The identification of any individual specified in this paragraph with symptoms consistent with COVID-19 or with known or suspected exposure to COVID-19; (iv) The criteria for conducting testing of asymptomatic individuals specified in this paragraph, such as the positivity rate of COVID-19 in a county; (v) The response time for test results; and (vi) Other factors specified by the Secretary that help identify and prevent the transmission of COVID-19. §483.80 (h)((2) Conduct testing in a manner that is consistent with current standards of practice for conducting COVID-19 tests; §483.80 (h)((3) For each instance of testing: (i) Document that testing was completed and the results of each staff test; and (ii) Document in the resident records that testing was offered, completed (as appropriate to the resident's testing status), and the results of each test. §483.80 (h)((4) Upon the identification of an individual specified in this paragraph with	F 886		

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F 886	Continued From page 53 symptoms consistent with COVID-19, or who tests positive for COVID-19, take actions to prevent the transmission of COVID-19. §483.80 (h)((5) Have procedures for addressing residents and staff, including individuals providing services under arrangement and volunteers, who refuse testing or are unable to be tested. §483.80 (h)((6) When necessary, such as in emergencies due to testing supply shortages, contact state and local health departments to assist in testing efforts, such as obtaining testing supplies or processing test results. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to test staff for COVID-19 according to Centers for Medicare and Medicaid (CMS) guidance for routine testing requirements for 2 of 3 staff (NA-H, LPN-E) reviewed for COVID-19 testing. This deficient practice had the potential to affect all 82 residents in the facility, all staff, and any visitors to the facility. Findings include: The CMS QSO-20-38-Nursing Home memo revised 3/10/22, directed all facilities located within a high or substantial county community transmission level to conduct twice weekly routine COVID-19 testing for all staff who were not up to date with the required COVID-19 vaccinations... "Up-to-Date" means a person has received all recommended COVID-19 vaccines, including any booster dose(s) when eligible. The facility should test all staff, who are not up-to-date, at the	F 886	F886: COVID-19 Testing-Residents and Staff SPECIFIC RESIDENT: NA-H and LPN-E were instructed to test twice weekly per the CDC guidelines and country transmission rate. Educations were given to NA-H and LPN-E on testing guidelines. OTHER RESIDENT: Facility wide audit was completed and all staff not up to date or with an exemption were provided education on testing guidelines per the CDC and country transmission rate. MONITOR: Education provided to all staff that they are to test if symptoms of COVID-19 are present and if staff are not up to date or have an exemption they are to test per the CDC and country transmission rate. Infection preventionist	

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F 886	Continued From page 54 frequency prescribed in the Routine Testing table based on the level of community transmission reported in the past week and facilities should use their community transmission level as the trigger for staff testing frequency. The Center for Disease Control and Prevention (CDC) identified the Scott County community transmission rate was at the level of "high" for 9/1/22, through 9/11/22, and was at the level of "substantial" for 9/12/22 through 9/15/22, which indicated any staff who were not up to date with the COVID-19 vaccine were expected to be tested twice weekly. Review of the facility Healthcare Personnel COVID-19 Vaccination Summary Tracking Worksheet undated identified nursing assistant (NA)-H and licensed practical nurse (LPN)-E were not up to date with COVID-19 vaccinations. An email from registered nurse (RN)-A dated 9/15/22, indicated NA-H was on leave from 7/5/22, through 9/1/22. Review of NA-H's schedule from 9/1/22 through 9/14/22, identified NA-H provided direct care services to residents of the facility on the following dates: -9/2/22 -9/3/22 -9/4/22 -9/5/22 -9/7/22 -9/8/22 -9/12/22 Evidence of testing for NA-H was requested but not provided.	F 886	or designee will ensure all staff not up to date or have an exemption are testing per the CDC guidelines and country transmission rates weekly. Director of Nursing or designee will audit 4 staff files for testing requirements weekly for 4 weeks, then twice a month for 1 month and then monthly for 1 month. Audit results will be reviewed by quality council monthly for further actions if needed.	

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F 886	Continued From page 55 During interview on 9/15/22, at 11:55 a.m. NA-H stated he received covid vaccine education upon hire in 4/22, was not fully vaccinated, and had been working four days per week. He stated he had not completed any covid testing because he submitted a "paper" to human resources and testing was not required. An email from RN-A dated 9/15/22, indicated LPN-E was on leave from 7/19/22, through 9/4/22. Review of LPN-E's schedule from 9/1/22 through 9/14/22, identified LPN-E provided direct care services to residents of the facility on the following dates: -9/5/22 -9/6/22 -9/7/22 -9/9/22 -9/10/22 -9/11/22 -9/13/22 -9/14/22 The facility produced evidence of testing dated 9/7/22, 9/9/22, and 9/14/22, however could not produce evidence of testing prior to returning to work on 9/5/22. During interview on 9/15/22, at 1:40 p.m. infection preventionist (IP) stated staff who were not up to date were verbally told they needed to self-test twice per week when first hired, and she reminded them periodically. She stated she audited the testing weekly, and if any staff member was not compliant, she removed them	F 886		

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F 886	Continued From page 56 from the schedule. IP confirmed NA-H had not tested since his return from leave on 9/2/22. She stated when she audited last week she asked NA-H about the vaccine and explained to him he needed the vaccine or an exemption and asked him to bring in the documentation. She stated he turned documentation into human resources, but it was not approved. She stated she did not know where the communication was missed, and did not have an answer as to why he did not test and was still working. During interview on 9/15/22, at 1:46 p.m. director of nursing (DON) stated her expectation was any staff who had an exemption or were not up to date needed to test per CDC guidelines, currently twice per week, to prevent the spread of infection and protect the residents and staff. The facility policy Benedictine COVID-19 Testing Procedure dated 3/17/22, indicated screening testing would be conducted twice per week when the county COVID-19 transmission level is substantial or high, and only up-to-date staff do not need to routinely test.	F 886		
F 887 SS=F	COVID-19 Immunization CFR(s): 483.80(d)(3)(i)-(vii) §483.80(d) (3) COVID-19 immunizations. The LTC facility must develop and implement policies and procedures to ensure all the following: (i) When COVID-19 vaccine is available to the facility, each resident and staff member is offered the COVID-19 vaccine unless the immunization is medically contraindicated or the resident or staff member has already been immunized; (ii) Before offering COVID-19 vaccine, all staff	F 887		10/26/22

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	245610	A. BUILDING _____ B. WING _____	C 09/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 887	Continued From page 57 members are provided with education regarding the benefits and risks and potential side effects associated with the vaccine; (iii) Before offering COVID-19 vaccine, each resident or the resident representative receives education regarding the benefits and risks and potential side effects associated with the COVID-19 vaccine; (iv) In situations where COVID-19 vaccination requires multiple doses, the resident, resident representative, or staff member is provided with current information regarding those additional doses, including any changes in the benefits or risks and potential side effects associated with the COVID-19 vaccine, before requesting consent for administration of any additional doses; (v) The resident or resident representative, has the opportunity to accept or refuse a COVID-19 vaccine, and change their decision; Note: States that are not subject to the Interim Final Rule - 6 [CMS-3415-IFC], must comply with requirements of 483.80(d)(3)(v) that apply to staff under IFC-5 [CMS-3414-IFC] and (vi) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident representative was provided education regarding the benefits and potential risks associated with COVID-19 vaccine; and (B) Each dose of COVID-19 vaccine administered to the resident; or (C) If the resident did not receive the COVID-19 vaccine due to medical contraindications or refusal; and (vii) The facility maintains documentation related	F 887		

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F 887	Continued From page 58 to staff COVID-19 vaccination that includes at a minimum, the following: (A) That staff were provided education regarding the benefits and potential risks associated with COVID-19 vaccine; (B) Staff were offered the COVID-19 vaccine or information on obtaining COVID-19 vaccine; and (C) The COVID-19 vaccine status of staff and related information as indicated by the Centers for Disease Control and Prevention's National Healthcare Safety Network (NHSN). This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure 4 of 5 residents (R21, R45, R48, R70) reviewed for COVID-19 vaccination status were offered the COVID-19 vaccine, and/or provided education regarding the risks, benefits, and potential side effects of COVID-19 vaccinations in accordance the Centers for Disease Control and Prevention (CDC) recommendations. Further, the facility failed to ensure 2 of 3 staff (NA-H and LPN-E) reviewed for COVID-19 vaccination status or exemption were fully vaccinated or had a valid exemption. Findings include: Residents: R21's significant change Minimum Data Set (MDS) Resident Face Sheet dated 7/12/22, indicated R21 was admitted on 12/16/21. R45's significant change MDS Resident Face Sheet dated 9/12/22, indicated R45 was admitted on 4/27/22.	F 887	F887: COVID-19 Immunization SPECIFIC RESIDENT: R21, R45, R48 and R70 were eligible for the COVID-19 vaccine. Education was provided and vaccine resources were offered. OTHER RESIDENT: Facility wide audit completed and any resident that was eligible for the COVID-19 vaccine and to be provided education and vaccine offered. MONITOR: Education provided to nursing staff to offer COVID-19 vaccination education and administration upon admission to facility unless medically contraindicated, resident already been immunized or resident refuses. Result to be documented in the medical record appropriately. Infection preventionist or designee will audit 4 new admission vaccination records weekly for 4 weeks, then twice a month for 1 month and then monthly for 1 month. Audit results will be reviewed by quality council monthly for	

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F 887	Continued From page 59 R48's admission MDS dated 8/15/22, indicated R48 was admitted on 8/9/22. R70's admission MDS dated 8/29/22, indicated 748 was admitted on 8/23/22. The facility Resident COVID-19 Vaccine Tracker indicated R21, R45, R48, and R70 had not received any COVID-19 vaccinations. The medical records of R21, R45, R48, and R70 lacked documentation they (and/or their representative) were offered the COVID-19 vaccine upon or after admission, or that they were provided education related to the risk and/or benefits of the vaccine. In addition, the medical records lacked documentation that COVID-19 vaccines were administered or contraindicated. During interview on 9/15/22, at 12:27 p.m. licensed practical nurse (LPN)-C stated nurses asked new residents if they were vaccinated for COVID-19, but they did not offer it. During interview on 9/15/22, at 12:33 p.m. LPN-D stated she reviewed vaccination status for newly admitted residents, but admissions staff screened for this before they arrived. She stated she did not ask the residents directly about vaccination status, but it was a question for the nurse practitioner or physician to address. During interview on 9/15/22, at 9:32 a.m. infection preventionist (IP) stated each new admission was pre-screened for vaccinations and previous admissions were reviewed through the Minnesota Immunization Information Connection (MIIC). She stated the information was documented on the tracking log, and once admitted she reviewed the	F 887	further actions if needed.	

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F 887	Continued From page 60 resident to determine whether additional doses were recommended. She stated the admitting nurse asked new residents if they wanted information regarding the vaccine but could not offer the COVID-19 vaccine on site as they did not have the ability to store the vaccine. She stated if a resident refused, either the admitting nurse or the IP followed up later to obtain documentation of refusal. She was unsure why there was no follow through with these residents. During interview on 9/15/22, at 1:46 a.m. DON stated her expectation was for residents to be offered the COVID-19 vaccine upon admission if they were not up to date. She stated they do not administer vaccinations at the facility, but could arrange for them with their primary provider, or take them to the clinic next door. She stated it was important to offer the COVID-19 vaccines to protect the other residents, staff, and visitors in the facility from getting the virus and spreading it. Staff: The facility Healthcare Personnel COVID-19 Vaccination Cumulative Summary Tracking Worksheet provided 9/13/22, indicated nursing assistant (NA)-H was hired on 4/11/22, and licensed practical nurse (LPN)-E was hired on 8/7/2013. The worksheet indicated both NA-H and LPN-E were not fully vaccinated. During interview on 9/15/22, at 11:55 a.m. NA-H stated he was hired 4/22, was not fully vaccinated, and sent a "paper" to human resources. Evidence of COVID-19 vaccination or valid exemption was requested for NA-H and LPN-E	F 887		

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F 887	Continued From page 61 but not provided. During interview on 9/15/22, at 9:32 a.m. (IP) stated staff were required to have a full series of COVID-19 vaccinations, and if not, they had to apply for an exemption with the human resources (HR) office. She stated if the exemption was approved, she was notified by HR. She stated she audited vaccine compliance the previous week, asked NA-H about the missing administration(s), and informed him he needed to complete the vaccinations or get a valid exemption. She stated he turned in "something," but it was not approved. She stated she was not sure where the communication was lost. During interview on 9/15/22, at 1:46 p.m. director of nursing (DON) stated her expectation was staff should be up to date with the COVID-19 vaccine recommendations or have an exemption to protect other residents and staff from the virus. The facility policy COVID-19 Vaccine and Booster for Residents dated 10/21, indicated the resident's medical record will include documentation that indicates, at a minimum; that the resident or the resident representative was provided education regarding the benefits and potential risks associated with COVID-19 vaccine/booster; and each dose of COVID-19 vaccine/booster administered to the resident, or; if the resident did not receive the COVID-19 vaccine/booster due to medical contraindications or refusal. The facility COVID Vaccine Policy date 2/18/22, indicated by 2/2/2022, SNF staff must either (a) complete the primary vaccination series; (b) be granted an exemption to the vaccine requirement;	F 887		

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F 887	Continued From page 62 or (c) be identified as needing a temporary delay in vaccination as recommended by the CDC due to clinical precautions and considerations.	F 887		

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	245610	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**09/13/2022**

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 09/13/2022. At the time of this survey, St. Gertrudes Health and Rehabilitation Center was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.	K 000		

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

Electronically Signed | 10/07/2022

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. GERTRUDES HEALTH CENTER & REHABILITATION CENTER was constructed at 4 different times. The original 1-story building with no basement was constructed in 1996 and was determined to be of Type V (111) construction. In 1999, an addition was constructed to the East Wing that was determined to be of Type V(111) construction. In 2007 a 1-story addition with no basement was constructed and was determined to be of Type V(111) construction. In 2011 a 2-story building with a full basement was	K 000		

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K 000	Continued From page 2 constructed and was determined to be of Type II(222). Because the original building and additions are compatible construction types allowed for existing buildings of this height, the facility was surveyed as one building as allowed in the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies. The facility has a capacity of 105 beds and had a census of 83 at the time of the survey. The requirements at 42 CFR, Subpart 483.70(a), are NOT MET as evidenced by:	K 000		
K 321 SS=F	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A	K 321		10/26/22

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K 321	Continued From page 3 a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain three hazardous rooms per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.2.1.2, 19.3.2.1.3, 8.4.3.5, and 7.2.1.8.1. These deficient findings could have a widespread impact on the residents within the facility. Findings include: 1. On 09/13/2022 between 10:15 AM and 02:00 PM, it was revealed by observation that the spa room 1011 was being used as a storage room, and the door did not have a self-closing device on it, so the door would not automatically close. 2. On 09/13/2022 between 10:15 AM and 02:00 PM, it was revealed by observation that the soiled utility room door 124 in the 300 section was not positively latching when closed. 3. On 09/13/2022 between 10:15 AM and 02:00 PM, it was revealed by observation that the latch on the soiled utility room door 143 was taped over causing the door to not positively latch, when the tape was removed the door would not positively latch when closed.	K 321	K321- Spa room 1011 will have a self-closing door device installed by 10.26.22. Soiled utility room 124 in the 300 section of the community was adjusted on 9.16.22 and latches. Soiled utility room 143 tape was removed and the door adjusted to latch when closed. Hazard room doors will latch and function per NFPA code. With daily preventative maintenance rounds the maintenance team will monitor and check doors for compliance. Education will be provided by 10.26.22 to staff regarding hazardous doors and requirements. The Executive Director and or designee will monitor yearly compliance of this inspection.	

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K 321	Continued From page 4 An interview with the Interim Executive Director and the Campus Director of Plant Operations verified these deficient findings at the time of discovery.	K 321		
K 324 SS=D	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 and staff interview, the facility failed to inspect	K 324	K324- Inspection of the community's kitchen hood will continue on a	10/26/22

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K 324	Continued From page 5 their kitchen hood per NFPA 101 (2012 edition), Life Safety Code, section 19.3.2.5.1 and 9.2.3, and NFPA 96 (2011 edition), Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, section 11.2.1. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 09/13/2022 between 10:15 AM and 02:00 PM, it was revealed by a review of available documentation that the facility provided me a kitchen hood inspection report dated 07/14/2022, but was not able to provide reports of inspections completed prior to that date. An interview with the Interim Executive Director and the Campus Director of Plant Operations verified these deficient findings at the time of discovery.	K 324	semi-annual basis. The last inspection was completed on 7.14.22. The company that inspects the kitchen hood was contacted and the prior inspection was completed in March of 2021. The company indicated they have us set to do another inspection in Jan of 2023 which is 6 months from 7.14.22 inspection. The inspection dates were entered into environmental database, TELS, which provides automated alerts of given inspection dates to ensure compliance. All other semi-annual inspection dates audited to ensure compliance and placed in TELS for compliance automation alerts. The Executive Director and or designee will monitor yearly compliance of this inspection.	
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 inspect the fire alarm system per NFPA 101 (2012 edition),	K 345	K345- The annual inspection of the fire alarm system was completed on September 30th 2022. The inspection	10/26/22

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K 345	Continued From page 6 Life Safety Code, section 9.6.1.5, and NFPA 72 (2010 edition), The National Fire Alarm and Signaling Code, section 14.3.1 and 14.4.5. This deficient finding could have a widespread impact on the residents within the facility. Findings include: 1. On 09/13/2022 between 10:15 AM and 02:00 PM, it was revealed by a review of available documentation that the facility could not provide an updated annual fire inspection report. The Campus Director of Plant Operations informed me that the last annual fire inspection was completed in July of 2021. 2. On 09/13/2022 between 10:15 AM and 02:00 PM, it was revealed by a review of available documentation that the facility was not conducting semi-annual fire alarm inspections. An interview with the Interim Executive Director and the Campus Director of Plant Operations verified these deficient findings at the time of discovery.	K 345	dates were entered into environmental database, TELS, which provides automated alerts of given inspection dates to ensure compliance. All other annual inspection dates audited to ensure compliance and placed in TELS for compliance automation alerts. The Executive Director and or designee will monitor yearly compliance of this inspection.	
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	K 353		10/26/22

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K 353	Continued From page 7 b) Who provided system test c) Water system supply source Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to inspect the fire sprinkler system per NFPA 101 (2012 edition), Life Safety Code, section 9.7.5, and NFPA 25 (2011 edition), Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, section 5.1.1.2. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 09/13/2022 between 10:15 AM and 02:00 PM, it was revealed by a review of available documentation that the facility did not perform quarterly fire sprinkler inspections during the first two quarters of 2022. An interview with the Interim Executive Director and the Campus Director of Plant Operations verified these deficient findings at the time of discovery.	K 353	K353- Quarterly fire sprinkler inspection was completed on Aug 18th 2022. Going forward the sprinklers will be inspected per code. Inspection dates entered into environmental database, TELS, which provides automated alerts of given inspection dates to ensure compliance. All other quarterly inspection dates audited to ensure compliance and placed in TELS for compliance automation alerts. The Executive Director and or designee will monitor yearly compliance of this inspection.	
K 355 SS=F	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed,	K 355		10/26/22

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K 355	Continued From page 8 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 and staff interview, the facility failed to maintain fire extinguishers per NFPA 101 (2012 edition), Life Safety Code sections 19.3.5.12 and 9.7.4.1, and NFPA 10 (2010 edition), Standard for Portable Fire Extinguishers, section 7.2.1.2. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 09/13/2022 between 10:15 AM and 02:00 PM, it was revealed by observation that the facility has not been completing monthly inspections of their fire extinguishers. According to the tags on the fire extinguishers and the Campaus Director of Plant Operations the last monthly inspection was completed in May of 2022. An interview with the Interim Executive Director and the Campus Director of Plant Operations verified these deficient findings at the time of discovery.	K 355	K355- September's monthly fire extinguishers checks were completed the week of 9.26.22. Ongoing monthly checks of the fire extinguishers was added to the facility TELS system. The Executive Director and or designee will monitor monthly visual compliance of this inspection.	
K 363 SS=E	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for	K 363		10/26/22

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K 363	Continued From page 9 at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain corridor doors per NFPA 101 (2012 edition), Life Safety Code, section 19.3.6.3.5. This deficient finding could have a patterned impact on the residents within the facility.	K 363	K363- Resident room 272 door handled was fixed on 9.13.22. Resident room 282 door prop was removed at the time of the fire marshal tour on 9.13.22. Corridor doors will be maintained per NFPA 101 (2012 edition). With the maintenance	

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K 363	Continued From page 10 Findings include: 1. On 09/13/2022 between 10:15 AM and 02:00 PM, it was revealed by observation that the door handle on resident room number 272 was removed and the latch for the door was taped over causing the door to not latch. 2. On 09/13/2022 between 10:15 AM and 02:00 PM, it was revealed by observation that the door for resident room number 282 was held open with a wooden wedge. An interview with the Interim Executive Director and the Campus Director of Plant Operations verified these deficient findings at the time of discovery.	K 363	teams preventive maintenance rounds random doors will be check to meet code. All staff will be reeducated of the communities work order process for any items that require maintenance attention. The Executive Director and or designee will monitor yearly compliance of this inspection.	
K 521 SS=F	HVAC CFR(s): NFPA 101 HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to inspect fire dampers per NFPA 101 (2012 edition), Life Safety Code, section 8.5.5.4.2, and NFPA 105 (2010 edition), Standard for Smoke Door Assemblies	K 521	K521- Paperwork regarding testing of fire dampers was located and the testing date was 8-13-20-8.14.20. Fire dampers will be inspected per code every 4 years. A task was added to TELs to remind the	10/26/22

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K 521	Continued From page 11 and Other Opening Protectives, section 6.5.2. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 09/13/2022 between 10:15 AM and 02:00 PM, it was revealed by a review of available documentation and staff interview that fire and smoke damper inspections have not been completed since 2013. The Campus Director of Plant Operations informed me that they currently have a company working on completing the fire and smoke damper inspections. An interview with the Interim Executive Director and the Campus Director of Plant Operations verified these deficient findings at the time of discovery.	K 521	maintenance team the next inspection needs to occur in 2024. The Executive Director and or designee will monitor the compliance of this inspection.	
K 712 SS=F	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to conduct	K 712	K712 – Fire drills will be conducted per code at least quarterly on each shift.	10/26/22

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K 712	Continued From page 12 fire drills system per NFPA 101 (2012 edition), Life Safety Code, section 19.7.1.4 and 19.7.1.6. This deficient finding could have a widespread impact on the residents within the facility. Findings include: 1. On 09/13/2022 between 10:15 AM and 02:00 PM, it was revealed by a review of available documentation that the facility did not have documentation showing that fire drills were conducted on the first, second, and third shifts of the first quarter of this year. 2. On 09/13/2022 between 10:15 AM and 02:00 PM, it was revealed by a review of available documentation that the facility did not have documentation showing that a fire drill was conducted on the second shift during the second quarter of this year. 3. On 09/13/2022 between 10:15 AM and 02:00 PM, it was revealed by a review of available documentation that the facility did not have documentation showing that a fire drill was conducted on the second and third shift during the third quarter of last year or the first part of the third quarter this year. 4. On 09/13/2022 between 10:15 AM and 02:00 PM, it was revealed by a review of available documentation that the facility did not have documentation showing that a fire drill was conducted on the second and third shifts of the fourth quarter last year. An interview with the Interim Executive Director and the Campus Director of Plant Operations verified these deficient findings at the time of	K 712	Documentation will verify compliance and the drill conductor has been retrained to meet this standard. The Executive Director or designee will monitor for compliance monthly when reviewing the fire drill report and log as entered into the TELS work order system.	

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K 712	Continued From page 13 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 a review of available documentation and staff interview, the facility failed to inspect fire doors per NFPA 101 (2012 edition), Life Safety Code section 8.3.3.1, and NFPA 80 (2010 edition), Standard for Fire Doors and Other Opening Protectives, section 5.2.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 09/13/2022 between 10:15 AM and 02:00 PM, it was revealed by a review of available documentation that the facility could not provide documentation showing that all of their fire doors have been inspected.	K 761	K761 – A facility TELS work order was added as an annual regulatory task to inspect and test fire doors annually in accordance with NFPA 80. Related documentation will be uploaded to the TELS work order system in order to close out the work order. Annual inspection will be completed by 10/26/2021. The Executive Director or designee will monitor the TELS work order system to assure compliance at the end of each month.	10/26/22

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K 761	Continued From page 14 An interview with the Interim Executive Director and the Campus Director of Plant Operations verified these deficient findings at the time of discovery.	K 761		
K 901 SS=F	Fundamentals - Building System Categories CFR(s): NFPA 101 Fundamentals - Building System Categories Building systems are designed to meet Category 1 through 4 requirements as detailed in NFPA 99. Categories are determined by a formal and documented risk assessment procedure performed by qualified personnel. Chapter 4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to provide a Risk Assessment per NFPA 99 (2012 edition), Health Care Facilities Code, section 4.2. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 09/13/2022 between 10:15 AM and 02:00 PM, it was revealed by a review of available documentation that the facility was unable to provide an NFPA 99 Risk Assessment. An interview with the Interim Executive Director and the Campus Director of Plant Operations verified these deficient findings at the time of discovery.	K 901	K901—The communities risk assessment will be completed by 10.26.22 per NFPA 99 and added to the communities emergency preparedness binder that all staff are educated on. The Executive Director and or designee will update the risk assessment as needed.	10/26/22

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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 the electrical testing and maintenance per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.3.3.2 , 6.3.4.1.3, and 6.3.4.2.1.2. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 09/13/2022 between 10:15 AM and 02:00 PM, it was revealed by a review of available documentation that the facility was unable to	K 914	K914 – Testing of all electrical receptacles will be completed on an annual basis by the Maintenance staff or designee. Appropriate tools will be made available to test for polarity and resistance. The Executive Director or designee will assign sections of the facility to be tested each quarter and will place this task into facility TELS work order system and will monitor for compliance at the end of each quarter.	10/26/22

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K 914	Continued From page 16 provide documentation showing that their electrical receptacles have been inspected. An interview with the Interim Executive Director and the Campus Director of Plant Operations verified these deficient findings at the time of discovery.	K 914		
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and	K 918		10/26/22

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K 918	Continued From page 17 separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to test and inspect their emergency generator per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.4.4.1.1.3, and NFPA 110 (2010 edition), Standard for Emergency and Standby Power Systems, section 8.4.1, 8.4.2, and 8.4.6. This deficient finding could have a widespread impact on the residents within the facility. Findings include: 1. On 09/13/2022 between 10:15 AM and 02:00 PM, it was revealed by a review of available documentation that the facility has not been conducting weekly inspections of their emergency generator. 2. On 09/13/2022 between 10:15 AM and 02:00 PM, it was revealed by a review of available documentation that the facility has not been conducting monthly testing of their emergency generator. An interview with the Interim Executive Director and the Campus Director of Plant Operations verified these deficient findings at the time of discovery.	K 918	K918- The emergency generator will have weekly inspections and monthly testing by the maintenance team per NFPA 99 code. In the facility TELS work order system a regulatory task was added for a weekly inspection and a monthly test of the generator. The Executive Director and or designee will monitor TELS for compliance.	
K 920 SS=D	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101	K 920		10/26/22

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	245610	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**09/13/2022**

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ST GERTRUDES HEALTH & REHABILITATION CENTER	**1850 SARAZIN STREET** **SHAKOPEE, MN 55379**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 920	Continued From page 18 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the usage of electrical adaptive devices NFPA 99 (2012 edition), Health Care Facilities Code, sections 10.5.2.3.1 and 10.2.4.2.1, NFPA 70, (2011 edition), National Electrical Code, sections 400.8, and UL 1363. These deficient findings could have an isolated impact on the residents within the facility. Findings include: 1. On 09/13/2022 between 10:15 AM and 02:00	K 920	K920 – The microwave in the administrator's office was plugged directly into the wall on 9.13.22. Staff were instructed to remove any non- essential related appliances from work spaces allowing work related items to be plugged directly into the wall or into a single power strip plugged directly into a wall. The Maintenance Department installed a new refrigerator cord long enough to reach the outlet on 10.5.22 for the 400's Unit refrigerator.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245610	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**09/13/2022**

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K 920	Continued From page 19 PM, it was revealed by observation that there was a microwave plugged into a power strip in the administrator's office that was removed at the time of discovery. 2. On 09/13/2022 between 10:15 AM and 02:00 PM, it was revealed by observation that there was a refrigerator plugged into a power strip in the 400 section. An interview with the Interim Executive Director and the Campus Director of Plant Operations verified these deficient findings at the time of discovery.	K 920		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
November 4, 2022

Administrator
St Gertrudes Health & Rehabilitation Center
1850 Sarazin Street
Shakopee, MN 55379

RE: CCN: 245610
Cycle Start Date: September 15, 2022

Dear Administrator:

On November 1, 2022, the Minnesota Department(s) of Health and Public Safety, completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

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