DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

October 12, 2023

Administrator
Tuff Memorial Home
505 East 4th Street
Hills, MN 56138

RE: CCN: 245548
Cycle Start Date: September 27, 2023

Dear Administrator:

On September 27, 2023, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

DEPARTMENT CONTACT

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, 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 27, 2023, (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by March 27, 2024, (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

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

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

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

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

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

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

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

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

Please contact me with any questions regarding this letter.

Sincerely,

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

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October 12, 2023

Administrator
Tuff Memorial Home
505 East 4th Street
Hills, MN 56138

Re: State Nursing Home Licensing Orders
Event ID: CKOV11

Dear Administrator:

The above facility was surveyed on September 25, 2023, through September 27, 2023, for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

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

the Suggested Method of Correction and the Time Period For Correction.

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

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

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

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

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

Please contact me with any questions regarding this letter.

Sincerely,

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245548	A. BUILDING _____ B. WING _____	C 09/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TUFF MEMORIAL HOME	505 EAST 4TH STREET HILLS, MN 56138

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments On 9/25/23 through 9/27/23, a survey for compliance with Appendix Z, Emergency Preparedness Requirements for Long Term Care facilities, §483.73(b)(6) was conducted during a standard recertification survey. The facility was NOT in compliance. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulation has been attained.	E 000		
E 004 SS=F	Develop EP Plan, Review and Update Annually CFR(s): 483.73(a) §403.748(a), §416.54(a), §418.113(a), §441.184(a), §460.84(a), §482.15(a), §483.73(a), §483.475(a), §484.102(a), §485.68(a), §485.542(a), §485.625(a), §485.727(a), §485.920(a), §486.360(a), §491.12(a), §494.62(a). The [facility] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section. The emergency preparedness program must include, but not be limited to, the following elements:	E 004		11/30/23

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

Electronically Signed | 10/20/2023

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

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E 004	Continued From page 1 (a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be [reviewed], and updated at least every 2 years. The plan must do all of the following: * [For hospitals at §482.15 and CAHs at §485.625(a):] Emergency Plan. The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. * [For LTC Facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. * [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least every 2 years. . This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to review the Emergency Preparedness program (EPP) annually in accordance with the requirements of CFR 483.73. This had the potential to affect all 39 residents currently residing in the facility and all staff and visitors to the facility. Findings include:	E 004	The emergency preparedness plan will be reviewed and updated annually with policies and procedures that comply with Federal, State, and local emergency requirements. The preparedness director, administrator and DON will be responsible for maintaining updates as needed. The emergency preparedness plan will be updated fully by the 11/30/2023. The	

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E 004	Continued From page 2 Review of Tuff Memorial Home Disaster Plan last updated 6/25/21, lacked a signature page or other indication the plan had been reviewed since June of 2021. Interview on 9/27/23 at 7:00 a.m., with adminsitrator identified that the maintenance director was in charge of the emergency disaster plan and he was unsure if he had reviewed the plan yet since starting at the facility. Interview on 9/27/23 at 9:30 a.m., with maintenance director identified he recently came from another facility a couple weeks ago and had not had time to review the emergency disaster plan yet but would be working on that soon.	E 004	preparedness director, administrator and DON will be responsible to update emergency preparedness annually by the review date.	
E 024 SS=F	Policies/Procedures-Volunteers and Staffing CFR(s): 483.73(b)(6) §403.748(b)(6), §416.54(b)(5), §418.113(b)(4), §441.184(b)(6), §460.84(b)(7), §482.15(b)(6), §483.73(b)(6), §483.475(b)(6), §484.102(b)(5), §485.68(b)(4), §485.542(b)(6), §485.625(b)(6), §485.727(b)(4), §485.920(b)(5), §491.12(b)(4), §494.62(b)(5). [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:]	E 024		10/20/23

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E 024	Continued From page 3 (6) [or (4), (5), or (7) as noted above] The use of volunteers in an emergency or other emergency staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency. *[For RNHCIs at §403.748(b):] Policies and procedures. (6) The use of volunteers in an emergency and other emergency staffing strategies to address surge needs during an emergency. *[For Hospice at §418.113(b):] Policies and procedures. (4) The use of hospice employees in an emergency and other emergency staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to ensure their emergency preparedness plan (EPP) addressed the use of volunteers in an emergency including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency. This had the potential to affect all 39 residents who resided in the facility. Findings include: During review of the facility EPP, the facility lacked a policy or procedure for the use of volunteers in an emergency, or other emergency staffing strategies that utilized volunteers to	E 024	As of 10/18/2023 The volunteer, volunteer from the community and staffing policy and procedure was updated to include how to utilize staff and(or) volunteers in an emergency. During the tabletop training on 9/28/2023 the discussion and verification from Hills Fire Department Chief that he will designate a number of his staff to the facility based on emergent situation. Non-nursing staff and volunteers will be asked to participate in an emergency training course for becoming a nurse aid at the approval of the state health department. In the means of an emergency and having to utilize volunteer staff residents will be equipped	

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E 024	Continued From page 4 address surge needs in an emergency. Interview on 9/27/23 at 9:30 a.m., with administrator and director of nursing agreed that the facility lacked a policy or procedure for the use of volunteers in an emergency.	E 024	with a personalized lanyard that addresses their specific needs. Color coding those who can be attended by non-trained personnel and those who would need trained medical personnel.	
E 036 SS=F	EP Training and Testing CFR(s): 483.73(d) §403.748(d), §416.54(d), §418.113(d), §441.184(d), §460.84(d), §482.15(d), §483.73(d), §483.475(d), §484.102(d), §485.68(d), §485.542(d), §485.625(d), §485.727(d), §485.920(d), §486.360(d), §491.12(d), §494.62(d). *[For RNCHIs at §403.748, ASCs at §416.54, Hospice at §418.113, PRTFs at §441.184, PACE at §460.84, Hospitals at §482.15, HHAs at §484.102, CORFs at §485.68, REHs at §485.542, CAHs at §486.625, "Organizations" under 485.727, CMHCs at §485.920, OPOs at §486.360, and RHC/FHQs at §491.12:] (d) Training and testing. The [facility] must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. *[For LTC facilities at §483.73(d):] (d) Training and testing. The LTC facility must develop and maintain an emergency preparedness training and testing program that is based on the	E 036		11/30/23

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E 036	Continued From page 5 emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually. *[For ICF/IIDs at §483.475(d):] Training and testing. The ICF/IID must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. The ICF/IID must meet the requirements for evacuation drills and training at §483.470(i). *[For ESRD Facilities at §494.62(d):] Training, testing, and orientation. The dialysis facility must develop and maintain an emergency preparedness training, testing and patient orientation program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training, testing and orientation program must be evaluated and updated at every 2 years. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to develop and maintain annual emergency preparedness training and testing	E 036	On 9/28/2023 a tabletop training for a hazardous situation of train derailment was completed with local community	

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E 036	Continued From page 6 based on the emergency plan, risk assessment, policies and procedures, and the communication plan for 1 of 1 Emergency Preparedness program. Findings include: Review of Tuff Memorial Home Disaster Plan last updated 6/25/21, lacked a policy or procedure for training and testing of the emergency preparedness plan. Review of the Emergency Preparedness disaster plan binder identified the facility had not provided annual training or testing of its EP plan as indicated required within the past year. Interview on 9/27/23 at 9:30 a.m., with administrator, maintenance, and director of nursing confirmed not all staff completed annual training of the emergency preparedness plan. Further, confirmed no testing of the emergency plan had been completed as required in the past year.	E 036	members and first responders. Documentation of that tabletop was taken, including notes and signatures of all who attended. On 10/24/2023 a live elopement training exercise on preparedness is to be done involving available members of the community and staff of facility. After the training exercise is complete the plan will be evaluated by department heads for improvements and updates will be made to the policy and procedures. These updates will be communicated to all staff to review. The policy and procedure book will be updated and reviewed by the end of November 30,2023. This is all to be done by the preparedness director, administrator, and DON and facility safety committee. This is to be done on an annual basis from the last review date. The Southwest Healthcare Emergency Preparedness coalition was contacted by the preparedness director of facility to help with assessment and training. The coalition will introduce different exercises that are done on an annual basis for staff education and training on emergent situations. The preparedness director, administrator and DON will meet to discuss when to have the training done by the coalition and put on calendar the first part of the new year.	
F 000	INITIAL COMMENTS On 9/25/23 through 9/27/23, a standard recertification survey was conducted at your facility. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities.	F 000		

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F 000	Continued From page 7 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 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs	F 657		10/20/23

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F 657	Continued From page 8 or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure care plans were revised for 2 of 12 residents (R7 and R35) related to use of digoxin (heart medication) and managing behaviors. Findings include: R7's September 2023, Medication Administration Report (MAR) identified R7 was admitted to the facility in August 2023 with diagnoses of heart disease, Type II diabetes, mild cognitive impairment, and atrial fibrillation (abnormal heart rhythm). R7 was being administered a warfarin (blood thinning medication) tablet 2.5 milligrams (mg) and a digoxin tablet 125 micrograms (mcg). Both medications were taken for his atrial fibrillation. R7's 6/24/23 physician progress notes identified R7 had a history of orthostatic hypotension (blood pressure drops suddenly when standing or switching positions). R7 was not being overseen by cardiologist. The family wanted his primary care physician (MD) to manage his care. The MD noted R7 should be seen by cardiology related to his diagnoses and medications and his frequent orthostatic hypotension episodes. R7's laboratory reports identified he last had a digoxin level drawn on 9/14/23 which was within normal limits per the report.	F 657	R7's care plan was revised on 9/28/2023 to identify digoxin medication, related diagnosis, adverse reactions, and last digoxin lab test. R7's physician was contacted via fax for orders when the next digoxin level should be checked. Physician orders received on 10/11/2023 to check digoxin level in 12 months. Family has declined further testing for R7 per progress noted 9/19/2023. The resident's care plan will identify the use of digoxin medication. The care plan will state the medication name, drug classification, related diagnosis, adverse reactions, and routine monitoring such as lab tests and/or EKG. The physician will be contacted for last digoxin level, how often digoxin level should be checked, last EKG and if continued monitoring is needed. The resident's care plan will reflect the preferences of the resident and/or family or representative. Admission checklist, hospital return checklist, and noting orders cheat sheet will have nursing staff check if any resident is receiving digoxin medication. Nursing staff will notify MDS coordinator and/or DON that resident is receiving digoxin medication. Newly admitted residents will have medication listed on care plan when developing resident's care plan. Current residents will have his/her	

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F 657	Continued From page 9 Review of the 11/21/19, MedScape Article: Digoxin Level, located at https://emedicine.medscape.com/article/2089975-overview?form=fpf, identified digoxin strengthens the force of contractions of weakened hearts and is absorbed quickly in the gastrointestinal tract and eliminated from the body though the kidneys. Therapeutic levels of digoxin are 0.8-2.0 ng/mL. The toxic level is >2.4 ng/mL. Review of the National Institute of Health (NIH) National Library of Medicine, 3/4/23 article Digoxin Toxicity, located at https://www.ncbi.nlm.nih.gov/books/NBK470568/#article-20525.s6, identified gastrointestinal upset is the most common symptom of digoxin toxicity. Patients also may report visual symptoms, which classically present as a yellow-green discoloration, and cardiovascular symptoms, such as palpitations, dyspnea, and syncope. Elderly patients frequently will present with vague symptoms, such as dizziness and fatigue and can lead to life threatening arrhythmias. Because digoxin toxicity can result in life threatening arrhythmias, prompt monitoring and treatment are vital. R7's September, 2023 Order Summary Report identified there were no physician's orders for routine monitoring of R7's digoxin therapy, such as a routine scheduled electrocardiogram (EKG), or kidney or liver function tests. R7's current, undated care plan identified there was no mention R7 was taking digoxin, nor what to look for with regard to digoxin toxicity, when to call the physician, or that R7 should have routing monitoring and testing to ensure no complications	F 657	care plan revised when medication is a new physician order. The MDS coordinator and/or DON will list this on the care plan. The MDS coordinator will monitor with each OBRA assessment that the resident's plan of care is being met in regards to receiving digoxin medication. On 10/16/2023, the admission checklist, hospital return checklist, and noting orders cheat sheet for nursing staff had been updated. Changes have been communicated to nursing staff. The comprehensive care plan policy has been updated. R35's care plan was revised on 9/27/2023 to reflect interventions to attempt if resident is calling out in dining room or other public area and disturbing the environment for other residents. Staff have been encouraged to propel to a different area and attempt interventions to redirect and reassure per resident's personal preferences: Elvis music, going outside, talking about past hobbies- golf, card games; talking about her family- Rod, Danette, Tracy. On 10/2/2023, a Behavior and Mood Non-Pharmacological binder book was developed to keep at the nurse's station. Inside the binder, is a list for each resident that all staff can use for behavior and mood non-pharmacological interventions. These interventions can be attempted to redirect and reassure the resident when he/she is having changes in his/her behavior or mood that affect himself/herself and/or others or living	

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F 657	Continued From page 10 arose. Interview on 9/26/23 at 10:42 a.m., with the director of nursing (DON) identified she was unaware R7's care plan lacked details about signs and symptoms to watch for related to potential digoxin toxicity. She was also unaware R7 should have routing scheduled monitoring tests like an EKG, and labs to ensure appropriate monitoring was achieved. The DON agreed those items needed to be addressed and care planned. R35's 7/18/23, quarterly Minimum Data Set (MDS) identified R35's cognition was moderately impaired and needed extensive assistance with bed mobility, transfers, dressing, and toileting. R35 had diagnosis of dementia, anxiety, repeated falls, heart failure, tremor, and sleep disorder. R35's current undated care plan identified behaviors of calling out repetitive statements in the dining room, resident room, and in hallways. Care plan identified staff should redirect by turning on TV, playing music, go for a ride around facility, going outside, or look through a magazine, engage in conversation, ensure basic needs are met, monitor and report to charge nurse, provide reassurance. Care plan lacked any interventions to ensure the comfort of other resident when R35 was displaying disruptive behaviors. Observations on: 1) 9/25/23 at 11:46 a.m., R35 was seated at dining room table with 3 other residents, R35 was yelling out repeatedly "Help! Help! Help!", R35 then looked at unknown resident to her right and	F 657	environment. Each list will have specific items listed according to each resident's favorites/preferences. The list will include but is not limited to current and previous hobbies and lifestyle, his/her family and friends, past work or educational experiences, religious preferences, favorite food/drink, animals, music, etc. Suggestions will be received from family, friends, facility staff, and others. If changes need to be made, the charge nurse will be notified. If changes have been made, the charge nurse will notify the MDS coordinator and/or DON. Instructions are listed in the front of the binder. Admission checklists, hospital return checklist, and noting orders cheat sheet will have nursing staff check if any resident is receiving psychotropic medication or if having behaviors. Nursing staff will notify MDS coordinator and/or DON. Newly admitted residents will have medication listed, along with non-pharmacological interventions to attempt redirection and reassurance, on care plan when developing resident's care plan. Current residents will have his/her care plan revised. The MDS coordinator and/or DON will list this on the care plan. The MDS coordinator will monitor with each OBRA assessment that the resident's plan of care is being met regarding non-pharmacological interventions. On 10/16/2023, the admission checklist, hospital return checklist, and noting orders cheat sheet for nursing staff had	

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F 657	Continued From page 11 yelled "what! what!" Other residents in dining room observed to be staring at R35, staff were walking by passing meal trays, no staff were observed to intervene. 2) 9/27/23 at 9:03 a.m., R35 was heard yelling out in dining room "Help! Help!" looking around at different staff and residents yelling "What! What!". Other unknown residents observed staring at R35. Staff were observed asking as they walked by if she needed anything, R35 did not answer, and no other interventions were observed to be attempted. Review of R35's nursing progress notes dated 8/29/23 through 9/27/23, identified R35 had behaviors of yelling out repeatedly during mealtime in the dining room daily. Progress notes identified staff were unable to redirect R35 and the current interventions were ineffective. Interview on 9/27/23 at 7:14 a.m., licensed practical nurse (LPN)-A identified R35 was moved to the assist dining room because when she was in the other dining room her yelling out was disruptive to other residents and they started to make rude comments to R35. LPN-A identified R35 continues to yell out repeatedly in the assist dining room and while there is more staff in the area, it continues to be disruptive to the residents who eat their meals in the assist dining room. Interview on 9/27/23 at 8:33 a.m., social service designee (SSD) identified R35 yells out more when she is in the dining room, she further identified that she has done 1:1's in her office with R35 using sensory techniques such as touching fabric and using stress balls that she felt were effective. The SSD identified she had not added those interventions to the care plan. The SSD	F 657	been updated. Changes have been communicated to nursing staff. The comprehensive care plan policy has been updated.	

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F 657	Continued From page 12 stated, "I know the yelling out is disruptive to other residents, but we don't take her out because we don't want to isolate her". Interview on 9/27/23 at 8:48 a.m., director of nursing (DON) identified she would expect herself and her SSD to identify and care plan meaningful and effective interventions to either redirect R35 or to ensure a comfortable dining experience was maintained for other residents. Review of the 12/14/22, Comprehensive Care Plans policy identified care plans were to be reviewed and revised after each comprehensive and quarterly assessment. The care plan was to describe at a minimum services to be furnished to attain or maintain the residents physical, mental and psychosocial well-being.	F 657		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately	F 761		11/30/23

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F 761	Continued From page 13 locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to limit access to medications awaiting destruction by the director of nursing (DON) and the consulting pharmacist (RPh), and ensure medication boxes were permanetly affixed to a physical structure during observation of 1 of 1 medication room. Findings include: Observation on 9/26/23 at 1:30 p.m., of the medication room identified there was a small black lock box sitting on the bottom shelf against the wall. The box contained Schedule II and Schedule IV narcotics with a high potential for diversion including drugs like Morphine, oxycodone, and lorazepam. The lock box was not affixed to a permanent surface and could easily be picked up. The key was also observed to be hanging on a hook next to the door on the wall. Interview on 9/26/23 at 1:40 p.m., registered nurse (RN)-A identified a licensed nurse removes unused or discontinued narcotics from the medication cart, takes the page from the narcotic count book and places them together inside the small black locked box in the medication room. RN-A identified the key for the lock box hangs on the wall in the medication room. RN-A identified	F 761	On 9/28/2023, RN, removed medications from the black boxes in med room and had DON secure in the permanently affixed lock box in med room. DON secured possession of the key for the permanently affixed lock box. DON will always keep the key in her possession. RN eliminated the black boxes from the med room. RN communicated to all nursing staff that controlled medications that are no longer needed for resident use will be secured in the lock box in the specified med cart for that resident. The medication will be counted every shift until the DON can safely secure the controlled medication in the permanently affixed lock box in med room. On 9/28/2023, the Destruction of Unused Drug Policy was revised. DON contacted the facility's pharmacist and notified of updates. The DON and pharmacist will destroy the controlled medications from the permanently affixed lock box in the med room monthly and as needed. On 10/16/2023, a flow sheet was placed in the med room at nurses' station to document when and by whom the medications in the permanently affixed lock box have been destroyed. The	

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F 761	Continued From page 14 they do not count the unused narcotics in the lock box awaiting destruction. Interview on 9/26/23 at 2:30 p.m., director of nursing (DON) identified she and the pharmacist destroys unused narcotics monthly, they have always stored the discontinued medications in the small lock box kept in the medication room, she identified they have a second box in case they have overflow. DON identified the key was kept hanging on the hook on the medication room wall, and the people who have access are the RN's, licensed practical nurses (LPN), trained medication assistant's (TMA), and herself. She identified she was not aware that the box needed to be affixed to a unmovable surface or that she could not leave the key in an area that others had access to. Review of the August 2021, Destruction of Unused Drugs policy provide by the facility identified facility was to remove unused medication from their storage area to a secured location until they can be destroyed. There was no mention the box should be permanently affixed to prevent potential diversion, nor keys secured to prevent potential unauthorized access.	F 761	Destruction of Unused Drug Policy was revised. On 10/16/2023, the noting orders cheat sheet was updated to have nursing staff check if any resident has had a controlled medication discontinued. The charge nurse will place the controlled medications that are no longer needed for resident use in the lock box in the specified med cart for that resident. The medication will be counted every shift until the DON can safely secure the controlled medication in the permanently affixed lock box in med room. On 10/31/2023, the flow sheet for destruction was revised. Medication placed in the permanently affixed lock box will be documented with date placed, Rx number, medication name and dose, quantity, and nurse initials. The nurse and pharmacist will sign and document the date when the medication is destroyed. The DON will monitor that the medication in the permanently affixed lock box remains in the lock box until destroyed with pharmacist. Monitoring will be weekly for 4 weeks, then every 2 weeks for 4 weeks, then monthly. The DON will also review monitoring at each QAPI meeting.	
F 851 SS=F	Payroll Based Journal CFR(s): 483.70(q)(1)-(5) §483.70(q) Mandatory submission of staffing	F 851		12/11/23

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F 851	Continued From page 15 information based on payroll data in a uniform format. Long-term care facilities must electronically submit to CMS complete and accurate direct care staffing information, including information for agency and contract staff, based on payroll and other verifiable and auditable data in a uniform format according to specifications established by CMS. §483.70(q)(1) Direct Care Staff. Direct Care Staff are those individuals who, through interpersonal contact with residents or resident care management, provide care and services to allow residents to attain or maintain the highest practicable physical, mental, and psychosocial well-being. Direct care staff does not include individuals whose primary duty is maintaining the physical environment of the long term care facility (for example, housekeeping). §483.70(q)(2) Submission requirements. The facility must electronically submit to CMS complete and accurate direct care staffing information, including the following: (i) The category of work for each person on direct care staff (including, but not limited to, whether the individual is a registered nurse, licensed practical nurse, licensed vocational nurse, certified nursing assistant, therapist, or other type of medical personnel as specified by CMS); (ii) Resident census data; and (iii) Information on direct care staff turnover and tenure, and on the hours of care provided by each category of staff per resident per day (including, but not limited to, start date, end date (as applicable), and hours worked for each individual).	F 851		

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F 851	Continued From page 16 §483.70(q)(3) Distinguishing employee from agency and contract staff. When reporting information about direct care staff, the facility must specify whether the individual is an employee of the facility, or is engaged by the facility under contract or through an agency. §483.70(q)(4) Data format. The facility must submit direct care staffing information in the uniform format specified by CMS. §483.70(q)(5) Submission schedule. The facility must submit direct care staffing information on the schedule specified by CMS, but no less frequently than quarterly. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to submit accurate and/or complete data for staffing information, including information for agency and contract staff, based on payroll and other verifiable and auditable data during 1 of 1 quarter reviewed (Quarter 3), to the Centers for Medicare and Medicaid Services (CMS), according to specifications established by CMS. Findings include: Review of the staffing schedules and timecard verifications for 42 randomly selected days from June 2023 through September 2023 identified the facility had licensed nursing staff, 24 hours per day 7 days per week, and 8 consecutive hours per 24 hours of registered nurse (RN) coverage documented.	F 851	The Administrator will train the business office manager on how to submit data for staffing information. The facility will utilize the current submission guidelines as described in the CMS Electronic Staffing Data Submission Payroll-Based Journal policy manual. The administrator and business office manager will submit accurate data and continue to carry out the task of submitting the PBJ. The facility will ensure all staffing data entered in the Payroll-Based Journal system is auditable and able to be verified through either payroll, invoices, and/or tied back to a contract. Submission will be made prior to or on the CMS submission due date. The next due date is 11/14 followed by 1/14, 5/15, and 8/14. Policy last updated on 9/12/2023.	

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F 851	Continued From page 17 Interview on 9/25/23 at 11:30 a.m., with the director (DON) and the interim administrator identified the DON was aware of concerns with Provider Based Journal (PBJ) submissions and lack thereof. She was unsure if the facility was "always" submitting data, but had no documentation to support data had been submitted at all, as it was triggered on the Casper 1705D report for Quarter 3, FY23. Review of the 9/12/23, Payroll Based Journal policy identified the facility was to submit timely and accurately, all direct care staff information, including agency and contracted staff to CMS per thier specifications.	F 851	Plan will be submitted to the Tuff Memorial Home Board of Directors at their next meeting on December 11, 2023. PBJ information will also be reported to the Board at each of their meetings. PBJ will also be part of the 5-STAR report at the monthly QAPI meeting.	
F 865 SS=F	QAPI Prgm/Plan, Disclosure/Good Faith Attmpt CFR(s): 483.75(a)(1)-(4)(b)(1)-(4)(f)(1)-(6)(h)(i) §483.75(a) Quality assurance and performance improvement (QAPI) program. Each LTC facility, including a facility that is part of a multiunit chain, must develop, implement, and maintain an effective, comprehensive, data-driven QAPI program that focuses on indicators of the outcomes of care and quality of life. The facility must: §483.75(a)(1) Maintain documentation and demonstrate evidence of its ongoing QAPI program that meets the requirements of this section. This may include but is not limited to systems and reports demonstrating systematic identification, reporting, investigation, analysis, and prevention of adverse events; and documentation demonstrating the development, implementation, and evaluation of corrective actions or performance improvement activities;	F 865		12/15/23

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F 865	Continued From page 18 §483.75(a)(2) Present its QAPI plan to the State Survey Agency no later than 1 year after the promulgation of this regulation; §483.75(a)(3) Present its QAPI plan to a State Survey Agency or Federal surveyor at each annual recertification survey and upon request during any other survey and to CMS upon request; and §483.75(a)(4) Present documentation and evidence of its ongoing QAPI program's implementation and the facility's compliance with requirements to a State Survey Agency, Federal surveyor or CMS upon request. §483.75(b) Program design and scope. A facility must design its QAPI program to be ongoing, comprehensive, and to address the full range of care and services provided by the facility. It must: §483.75(b)(1) Address all systems of care and management practices; §483.75(b)(2) Include clinical care, quality of life, and resident choice; §483.75(b)(3) Utilize the best available evidence to define and measure indicators of quality and facility goals that reflect processes of care and facility operations that have been shown to be predictive of desired outcomes for residents of a SNF or NF. §483.75(b) (4) Reflect the complexities, unique care, and services that the facility provides.	F 865		

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F 865	Continued From page 19 §483.75(f) Governance and leadership. The governing body and/or executive leadership (or organized group or individual who assumes full legal authority and responsibility for operation of the facility) is responsible and accountable for ensuring that: §483.75(f)(1) An ongoing QAPI program is defined, implemented, and maintained and addresses identified priorities. §483.75(f)(2) The QAPI program is sustained during transitions in leadership and staffing; §483.75(f)(3) The QAPI program is adequately resourced, including ensuring staff time, equipment, and technical training as needed; §483.75(f)(4) The QAPI program identifies and prioritizes problems and opportunities that reflect organizational process, functions, and services provided to residents based on performance indicator data, and resident and staff input, and other information. §483.75(f)(5) Corrective actions address gaps in systems, and are evaluated for effectiveness; and §483.75(f)(6) Clear expectations are set around safety, quality, rights, choice, and respect. §483.75(h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. §483.75(i) Sanctions.	F 865		

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F 865	Continued From page 20 Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure data submitted to the Quality Assurance and Performance Improvement (QAPI) committee was analyzed and documented to ensure areas identified had oversight for their perspective outcomes brought forth. This had the potential to affect all 39 residents. Findings include: Review of the monthly QAPI meeting minutes from March 2023 through July 2023 identified department heads were bringing data forth to QAPI on various topics such as infection control, falls, elopements, incident reports etc, however, there was no documented benchmarks for goals the facility was trying to achieve, nor analysis of data brought forth, identified actions the facility was going to take to achieve their goals, and monitoring to determine if goals were met or QAPI needed to continue monitoring to ensure compliance. Interview on 9/27/23 at 8:11 a.m., with the director of nursing identified she agreed the QAPI program was not thorough in its efforts to identify concerns, have benchmarks to know what goal was to be achieved, or appropriate analysis of the data brought forth each month, and identify corrective action. Review of the 1/1/23 QAPI policy identified QAPI was to develop and implement appropriate plans	F 865	On 10/18/2023 QAPI meeting was held with department heads, medical director, and pharmacist. There was discussion of implementing new template and updating policy to better address and analyze the full range of care and services provided by the facility. The program will continue to be set around safety, quality, rights, choice, and respect. The program will be updated using a SMART (Specific, Measurable, Achievable, Relevant, Time-based) goal format allowing for better benchmarks and analysis for performance improvements. QAPI meetings will continue to be held monthly for 5 months, starting November of 2023 ending April of 2024 to monitor and evaluate effectiveness and revise as needed. After 5 months when the new program is fully implemented QAPI meetings will then be held quarterly starting June 2024. Department heads, infection prevention nurse and QA nurse will continue to implement data ongoing to document benchmarks for goals and identify actions plans needed to achieve goals and maintain compliance. Quarterly meetings will be held with the medical director and pharmacist in attendance. Each category of focus in QAPI will be tracked and measured. This plan will be presented to the Board of Directors at their next meeting on December 11, 2023. In addition there will be a standing agenda	

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F 865	Continued From page 21 of action to correct identified quality deficiencies and regularly review and analyze data and act on that data to make improvements. QAPI was to: 1) Track and measuring its' performance. 2) Establish goals and thresholds for performance improvements. 3) Identify and prioritize quality deficiencies. 4) Systematically analyze underlying causes of systemic quality deficiencies. 5) Develop and implementing corrective action or performance improvement activities. 6) Monitor and evaluate the effectiveness of corrective action/performance improvement activities and revise as needed. The governing body and/or executive leadership was responsible and accountable for the QAPI program	F 865	item on the Boards monthly meetings for a QAPI update. This monthly report will begin at the January Board meeting on January 22, 2024.	
F 867 SS=F	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement. §483.75(c)(2) Facility maintenance of effective	F 867		11/20/23

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F 867	Continued From page 22 systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor performance indicators. §483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation. §483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events. §483.75(d) Program systematic analysis and systemic action. §483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained. §483.75(d)(2) The facility will develop and implement policies addressing: (i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems; (ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and	F 867		

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F 867	Continued From page 23 (iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained. §483.75(e) Program activities. §483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care. §483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility. §483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e). Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section. §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and	F 867		

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F 867	Continued From page 24 assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to have evidence of a Performance Improvement Project (PIP) which focused on high risk or problem-prone areas identified thorough and appropriate data collection and analysis and evaluation of the identified concern(s) during QAPI. This had the potential to affect all 39 residents. Findings include: Observation on 9/26/23 at 5:41 p.m. of the facility identified there was no information posted about any PIP project the facility was actively working on. Interview on 9/27/23 at 7:07 a.m., with the dietary manager (DM) identified she was unaware of any PIP project the facilities QAPI committee had in place. She attends QAPI. Department heads bring data, however she is unsure if the committee analyzed their data, or what goals were.	F 867	The Performance Improvement Project (PIP) is now included in the updated QAPI Change Process Policy for the facility and will continue to be tracked and monitored for improvement opportunities at each QAPI meeting. The QAPI program will follow a Plan, Do, Study, Act (PDSA) cycle of improvement for testing any changes within a PIP. Plan: developing a plan related to the change that will be tested. Do: carrying out the plan. Study: observing and analyzing data collected, learning from any consequences. Act: making a decision regarding the change, such as to adopt, modify, or abandon the change and start over. The facility PIP will be added to the standing agenda on Tuesday mornings interdisciplinary team meetings to ensure appropriate data collection. In the mandatory all staff QAPI training led by department heads staff will be educated on the PIP. Staff will be educated on what the facilities PIP is and how it is being analyzed and that the focus	

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F 867	Continued From page 25 Interview on 9/27/23 at 7:24 a.m., with the laundry supervisor identified she was also unsure of any specific PIP QAPI had determined it would apply a special focus to. Interview on 9/27/23 at 7:28 a.m., with the infection preventionist identified she was also unaware of any PIP project QAPI was overseeing. Review of the QAPI meeting minutes from March 2023 through July 2023 identified there was no mention of a PIP project identified through QAPI. Interview on 9/27/23 at 8:11 a.m., with the DON identified could not recall what her PIP project was. She could not find documentation to support a PIP project was identified and performed. Review of the 1/1/3, QAPI policy identified a PIP was the continuous study and improvement of processes with the intent to improve services or outcomes, and prevent or decrease the likelihood of problems, by identifying areas of opportunity and testing new approaches to fix underlying causes of persistent/systemic problems or barriers to improvement. There was no mention of the need to complete a PIP at least annually with a project that focused on high risk or problem-prone areas identified through the data collection and analysis.	F 867	of a PIP is to address high risk or problem prone areas in the facility that can affect residents care and quality of life. This will correspond with the QAPI in-service in November 2023 and ongoing each calendar year. Department heads will discuss the facility's PIP with their departmental staff after each QAPI meeting. Department heads will track on a flowsheet who has been educated and when about the PIP. Each flowsheet will then be filed with the minutes from the QAPI meeting reflecting training provided. This will be completed 1 week after each QAPI meeting has been held. New hires will be trained on the PIP during his/her orientation with their department head. PRN staff will review the PIP prior to his/her next scheduled shift. The DON will monitor that all department heads complete training for their departmental staff. The DON will review completion of training at each QAPI meeting. The facility's QAPI policy has been updated with QAPI change process policy to meet requirements and be implemented. Staff will be trained by 11/20/2023.	
F 883 SS=E	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-	F 883		11/20/23

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F 883	Continued From page 26 (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 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	F 883		

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F 883	Continued From page 27 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 3 of 5 sampled residents (R7, R16, and R35) were appropriately vaccinated against pneumonia by offering and/or providing updated vaccine to residents per Centers for Disease Control (CDC) vaccination recommendations. Findings include: Review of the current CDC pneumococcal vaccine guidelines located at https://www.cdc.gov/vaccines/vpd/pneumo/hcp/pneumo-vaccine-timing.html, identified for: 1) Adults 19-64 years old with specified immunocompromising conditions, staff were to offer and/or provide: a) the PCV-20 at least 1 year after prior PCV-13, b) the PPSV-23 (dose 1) at least 8 weeks after prior PCV-13 and PPSV-23 (dose 2) at least 5 years after first dose of PPSV-23. Staff were to review the pneumococcal vaccine recommendations again when the resident turns 65 years old. 2) Adults 65 years of age or older, staff were to	F 883	The facility's consulting pharmacist from Lewis Drug Long Term Care was contacted in regard to R7, R16, and R35's immunization records, specifically pneumococcal vaccines. The DON discussed with the pharmacist her procedure for monthly chart reviews. On 10/2/2023, the pharmacist and DON created a new policy and procedure to ensure compliance of chart reviews completed by the pharmacist. The pharmacist completed her monthly review on 10/2/2023. R16 was reviewed by consulting pharmacist who reports R16's Minnesota Immunization Information Connection (MIIC) record shows her vaccinations are complete. On 11/1/2023, the consulting pharmacist prepared a report for the physician to review if R16 should receive the Prevnar 20 vaccine. R7 was reviewed by consulting pharmacist who reports pneumonia vaccinations are considered complete as long as both Prevnar 13 before or after age 65 and PPSV23 after age 65 have been received. On 11/1/2023, the	

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F 883	Continued From page 28 offer and/or provide based off previous vaccination status as shown below: a) If NO history of vaccination, offer and/or provide: aa) the PCV-20 OR bb) PCV-15 followed by PPSV-23 at least 1 year later. b) For PPSV-23 vaccine ONLY (at any age): aa) PCV-20 at least 1 year after prior PPSV-23 OR bb) PCV-15 at least 1 year after prior PPSV-23 c) For PCV-13 vaccine ONLY (at any age): aa) PCV-20 at least 1 year after prior PCV13 OR bb) PPSV-23 at least 1 year after prior PCV13 d) For PCV-13 vaccine (at any age) AND PPSV-23 BEFORE 65 years: aa) PCV-20 at least 5 years after last pneumococcal vaccine dose OR bb) PPSV-23 at least 5 years after last pneumococcal vaccine dose e) Received PCV-13 at Any Age AND PPSV-23 AFTER Age 65 Years: aa) Use shared clinical decision-making to decide whether to administer PCV20. If so, the dose of PCV-20 should be administered at least 5 years after the last pneumococcal vaccine. Review of 3 of the 5 sampled residents for vaccinations identified: 1) R35 was 79 years old and was admitted to the facility in January 2023. R35's immunization documentation showed they had received the PCV-13 on 1/20/20, prior to admission. R35 had no documented PPSV-23. R35 should have been offered and/or provided the PCV-20 upon admission and at least 1 year after the prior	F 883	consulting pharmacist prepared a report for the physician to review if R7 should receive the Prevnar 20 vaccine. On 10/2/2023, R35, along with R33 and R4, received recommendations from the consulting pharmacist to receive the Prevnar 20 vaccine. R35, R33, and R4's responsible family members were contacted for consent. All were in favor of the Prevnar 20 vaccine. The resident's primary physicians were contacted and gave orders to administer. The consulting pharmacist will administer the Prevnar 20 vaccine to R35, R33, and R4 on 11/2/2023. Consulting pharmacist reports that shared clinical decision- making between the physician and patient determines whether a patient is to receive the Prevnar 20 vaccine. The pharmacist will review monthly and as needed the facility's residents if recommendations should be made for the resident to receive any vaccinations. Admission checklist and hospital return checklist will have Infection Control Nurse check if the resident has received influenza or pneumococcal immunizations. The nurse will enter immunizations into the resident's record. If the resident has not received influenza or pneumococcal immunizations, the Infection Control Nurse will review this with the facility's consulting pharmacist. The Infection Control Nurse will explain risks/benefits, obtain orders, and obtain consent if needed for vaccinations. The DON will oversee that the immunization record is complete on admission and	

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F 883	Continued From page 29 PCV-13 or the PPSV-23 at least 1 year after prior PCV-13. 2) R7 was 82 years of age and was admitted in August 2023. R7's immunization documentation identified they had received the PCV-13 on 10/27/15 and the PPSV-23 on 10/12/17. R7 should have been offered and/or administered the PCV-20 in October 2022. 3) R16 was 88 years of age and was admitted to the facility in January 2020. R16's immunization documentation showed they received the PCV-13 on 7/14/17 and the PPSV-23 on 5/13/18. R16 should have been offered and/or administered the PCV-20 in May 2023. There was no information in R35's, R7's, or R16's medical record indicating a PCV-20 would be contraindicated to be offered and/or administered. Interview on 9/27/23 at 8:11 a.m., with the director of nursing (DON) identified the local pharmacy was responsible to review residents records to identify if an updated immunization was needed. Review of the 2023, Pneumococcal Vaccine (Series) policy identified it also noted the above reference CDC guidelines. Each resident was to be offered a pneumococcal vaccine unless medically contraindicated.	F 883	hospital return. The MDS coordinator will monitor with each OBRA assessment that the resident's influenza and pneumococcal immunizations are up to date.	
F 944 SS=F	QAPI Training CFR(s): 483.95(d) §483.95(d) Quality assurance and performance improvement. A facility must include as part of its QAPI program mandatory training that outlines and informs staff of the elements and goals of the facility's QAPI program as set forth at § 483.75. This REQUIREMENT is not met as evidenced	F 944		11/20/23

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F 944	Continued From page 30 by: Based on interview and document review, the facility failed to provide mandatory training on 1 of 1 facility specific QAPI Program to include goals and various elements of the program, how the facility intends to implement the program, staff's role in the facility's QAPI program, or how to communicate concerns, problems, or opportunities for improvement to the facility's QAPI program. Findings include: Interview on 9/27/23 at 7:07 a.m., with the dietary manager (DM) identified she was unaware of training provided to staff on the facility's QAPI program. Staff received a yearly overall training about what QAPI was, however nothing specific to the facility was performed. Interview on 9/27/23 at 7:24 a.m., with the laundry supervisor identified she was unaware of training provided to staff on the facility's QAPI program. Staff received a yearly overall training about what QAPI was, however nothing specific to the facility was performed. Interview on 9/27/23 at 7:28 a.m., with the infection preventionist identified identified she was unaware of training provided to staff on the facility's QAPI program. Staff received a yearly overall training about what QAPI was, however nothing specific to the facility was performed. Review of the 1/1/23 QAPI policy identified QAPI training was to be provided that outlined and informs staff of the elements of QAPI and goals of the facility and was to be mandatory for all staff.	F 944	Social Services or other designated member of the QAPI team will document minutes after each QAPI meeting. Those minutes will be available for department heads to discuss with their departmental staff after each meeting. Department heads will provide those minutes to their departmental staff to educate and outline the elements and goals of the facility's QAPI program such as items discussed at the most recent QAPI meeting, staff roles in the program, communication of concerns and problems, and opportunities for improvement to the facility's program. Department heads will track on a flowsheet who has been educated and when. Each flowsheet will then be filed with the minutes from the QAPI meeting reflecting training provided. This will be completed 1 week after each QAPI meeting has been held. New hires will be trained during his/her orientation with their department head. PRN staff will review QAPI minutes prior to his/her next scheduled shift. The DON will monitor that all department heads complete training for their departmental staff. The DON will review completion of training at each QAPI meeting. The facility's QAPI policy has been updated with QAPI change process policy to meet requirements and be implemented. Trainings will occur prior to 11/20/2023	

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	245548	A. BUILDING _____ B. WING _____	C 09/27/2023

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 9/25/23 through 9/27/23, a licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you have reviewed these orders and	2 000		

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

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2 000	Continued From page 2 IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES. http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm. The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		
2 250	MN Rule 4658.0065 Subp. 5 Resident Safety and Disaster Planning Subp. 5. Drills. Residents do not need to be evacuated during a drill except when an evacuation drill is planned in advance. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to develop and maintain annual emergency preparedness testing based on the emergency plan, risk assessment, policies and procedures, and the communication plan for 1 of	2 250	corrected	10/20/23

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2 250	Continued From page 3 1 Emergency Preparedness program. Findings include: Review of Tuff Memorial Home Disaster Plan last updated 6/25/21, lacked a policy or procedure for testing of the emergency preparedness plan. Review of the Emergency Preparedness disaster plan binder identified the facility had not provided annual testing of its EP plan as indicated required within the past year. Interview on 9/27/23 at 9:30 a.m., with administrator, maintenance, and director of nursing confirmed no testing of the emergency plan had been completed as required in the past year. SUGGESTED METHOD OF CORRECTION: The administrator or designee should ensure required drills occur, designate the frequency of those drills. Staff should be re-educated to the importance of and participating in emergency preparedness drills. The administrator or designee should should ensure components of thier drills include protection and evacuation of all persons in the case of fire or explosion or in the event of floods, tornadoes, or other emergencies. The plan must include information and procedures about the location of alarm signals and fire extinguishers, frequency of drills, assignments of specific tasks and responsibilities of the personnel on each shift. The results of those drills should be taken to the QAPI committee to determine compliance or the need for further monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 250		

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2 255	MN Rule 4658.0070 Quality Assessment and Assurance Committee A nursing home must maintain a quality assessment and assurance committee consisting of the administrator, the director of nursing services, the medical director or other physician designated by the medical director, and at least three other members of the nursing home's staff, representing disciplines directly involved in resident care. The quality assessment and assurance committee must identify issues with respect to which quality assurance activities are necessary and develop and implement appropriate plans of action to correct identified quality deficiencies. The committee must address, at a minimum, incident and accident reporting, infection control, and medications and pharmacy services. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure data submitted to the Quality Assurance and Performance Improvement (QAPI) committee was analyzed and documented to ensure areas identified had oversight for their perspective outcomes brought forth. This had the potential to affect all 39 residents. Findings include: Review of the monthly QAPI meeting minutes from March 2023 through July 2023 identified department heads were bringing data forth to QAPI on various topics such as infection control, falls, elopements, incident reports etc, however, there was no documented benchmarks for goals the facility was trying to achieve, nor analysis of	2 255	CORRECTED	10/20/23

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2 255	Continued From page 5 data brought forth, identified actions the facility was going to take to achieve their goals, and monitoring to determine if goals were met or QAPI needed to continue monitoring to ensure compliance. Interview on 9/27/23 at 8:11 a.m., with the director of nursing identified she agreed the QAPI program was not thorough in its efforts to identify concerns, have benchmarks to know what goal was to be achieved, or appropriate analysis of the data brought forth each month, and identify corrective action. Review of the 1/1/23 QAPI policy identified QAPI was to develop and implement appropriate plans of action to correct identified quality deficiencies and regularly review and analyze data and act on that data to make improvements. QAPI was to: 1) Track and measuring its' performance. 2) Establish goals and thresholds for performance improvements. 3) Identify and prioritize quality deficiencies. 4) Systematically analyze underlying causes of systemic quality deficiencies. 5) Develop and implementing corrective action or performance improvement activities. 6) Monitor and evaluate the effectiveness of corrective action/performance improvement activities and revise as needed. The governing body and/or executive leadership was responsible and accountable for the QAPI program SUGGESTED METHOD OF CORRECTION: The quality assurance committee could identify issues with respect to which quality assurance activities are necessary and develop and implement appropriate plans of action to correct identified quality deficiencies. The committee will monitor	2 255		

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2 255	Continued From page 6 these area on a regular basis and make recommendations for any changes. The administratior will be reponsible for implementation. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 255		
21610	MN Rule 4658.1340 Subp. 1 Medicine Cabinet and Preparation Area;Storage Subpart 1. Storage of drugs. A nursing home must store all drugs in locked compartments under proper temperature controls, and permit only authorized nursing personnel to have access to the keys. This MN Requirement is not met as evidenced by: Based on observation and interview, the facility failed to limit access to medications awaiting destruction by the director of nursing (DON) and the consulting pharmacist (RPh) during observation of 1 of 1 medication room. Findings include: Observation on 9/26/23 at 1:30 p.m., of the medication room identified there was a small black lock box sitting on the bottom shelf against the wall. The box contained Schedule II and Schedule IV narcotics with a high potential for diversion including drugs like Morphine, oxycodone, and lorazepam. The lock box was not affixed to a permanent surface and could easily be picked up. The key was also observed to be hanging on a hook next to the door on the wall. Interview on 9/26/23 at 1:40 p.m., registered	21610	CORRECTED	10/16/23

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21610	Continued From page 7 nurse (RN)-A identified a licensed nurse removes unused or discontinued narcotics from the medication cart, takes the page from the narcotic count book and places them together inside the small black locked box in the medication room. RN-A identified the key for the lock box hangs on the wall in the medication room. RN-A identified they do not count the unused narcotics in the lock box awaiting destruction. Interview on 9/26/23 at 2:30 p.m., director of nursing (DON) identified she and the pharmacist destroys unused narcotics monthly, they have always stored the discontinued medications in the small lock box kept in the medication room, she identified they have a second box in case they have overflow. DON identified the key was kept hanging on the hook on the medication room wall, and the people who have access are the RN's, licensed practical nurses (LPN), trained medication assistant's (TMA), and herself. She identified she was not aware that the box needed to be affixed to a unmovable surface or that she could not leave the key in an area that others had access to. Review of the August 2021, Destruction of Unused Drugs policy provide by the facility identified facility was to remove unused medication from their storage area to a secured location until they can be destroyed. There was no mention the box should be permanently affixed to prevent potential diversion, nor keys secured to prevent potential unauthorized access. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON) and consulting pharmacist should review and revise policies and procedures for securing and storage of controlled narcotic medication awaiting	21610		

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21610	Continued From page 8 destruction to prevent unauthorized access to those medications. Licensed nursing staff should be educated to the importance of properly securing medication from unauthorized access. The pharmacist and DON should perform measurable audits to ensure security is attained. The pharmacist and DON should conduct audits and report the results of those audits to the QAPI committee to determine compliance or the need for further monitoring. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21610		
21615	MN Rule 4658.1340 Subp. 2 MedicineCabinet & Preparation Area;ScheduleII Subp. 2. Storage of Schedule II drugs. A nursing home must provide separately locked compartments, permanently affixed to the physical plant or medication cart for storage of controlled drugs listed in Minnesota Statutes, section 152.02, subdivision 3. This MN Requirement is not met as evidenced by: Based on observation and interview, the facility failed to ensure medication boxes were permanetly affixed to a physical structure during observation of 1 of 1 medication room. Findings include: Observation on 9/26/23 at 1:30 p.m., of the medication room identified there was a small black lock box sitting on the bottom shelf against the wall. The box contained Schedule II and Schedule IV narcotics with a high potential for	21615	CORRECTED	10/16/23

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21615	Continued From page 9 diversion including drugs like Morphine, oxycodone, and lorazepam. The lock box was not affixed to a permanent surface and could easily be picked up. The key was also observed to be hanging on a hook next to the door on the wall. Interview on 9/26/23 at 2:30 p.m., director of nursing (DON) identified she was not aware that the box needed to be affixed to a unmovable surface or that she could not leave the key in an area that others had access to. Review of the August 2021, Destruction of Unused Drugs policy provide by the facility identified facility was to remove unused medication from their storage area to a secured location until they can be destroyed. There was no mention the box should be permanently affixed to prevent potential diversion, nor keys secured to prevent potential unauthorized access. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON) and consulting pharmacist should review and revise policies and procedures for proper storage of controlled narcotic medications in a permanently affixed cabinet and ensure existing cabinetry is secured in that manner to prevent potential diversion. Nursing staff should be educated on the importance of properly securing medications. The DON or designee, along with the pharmacist, should conduct audits on a regular basis to ensure compliance and report the results of those audits to the QAPI committee for ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21615		

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21942	Continued From page 10	21942		
21942	MN St. Statute 144A.10 Subd. 8b Establish Resident and Family Councils Resident advisory council. Each nursing home or boarding care home shall establish a resident advisory council and a family council, unless fewer than three persons express an interest in participating. If one or both councils do not function, the nursing home or boarding care home shall document its attempts to establish the council or councils at least once each calendar year. This subdivision does not alter the rights of residents and families provided by section 144.651, subdivision 27. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to attempt to establish a family council within the past 12 months. This had the potential to affect all 39 residents residing in the facility and their representatives. Findings include: Interview on 9/26/23 at 3:20 p.m., with social service designee (SSD)-A identified the facility had no family council however, she did send out surveys each year and families like that they can respond anonymously to questions and make statements to the survey questions, however no response to a family council. Review of the 2/11/22 and 6/29/23, communication sent out to families via email identified that the facility attached a survey for families geared towards Family Council and was wanting some feedback since there was current	21942	The social services designee will be responsible to make an attempt in establishing family council annually. These efforts will be documented. It is the policy of this facility to support the rights of residents and residents' family memembers to organize and participate in family groups within the facility. The social services designee will respect the rights of families to organize, maintain and participate in family council and only attend upon invite. On 10/9/2023 the social services designee sent out an email regarding an educational event and included the question to families: Do you have intrest in organizing, maintaining and participating in family council? Families will continue to receive information upon admission about family council and asked annually if they have intrest in forming a family council.	10/20/23

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21942	Continued From page 11 limits on social gathering and with everyone's busy schedules. The cover letter identified that a survey had been sent out in 2020 and again in 2021 with the common response of families wanting to continue with the emails and surveys. The cover letter identified Family council as a group that meets regularly to discuss and offer suggestions about facility policies and procedures affecting residents' care, treatment, and quality of life. Support each other, plan resident and family activities, participate in educational activities; or any other purpose. Review of the survey attached to the email identified 10 questions. 1) Any thoughts on continued changes we have all faced with COVID, and how the facility was doing with communication. 2) Are there policies you would like clarification or information about. 3) Any input or ideas on way to improve the quality of life at our facility for your loved one. Any area's we can improve on. 4) Do you have any questions or concerns with the care and treatment of your loved one. 5) Overall, how satisfied are you with personal care provided by staff. 6) How satisfied are you with the level of gentleness and respect shown to you and your loved one. 7) How satisfied are you with the activities that are offered daily. 8) How satisfied are you with the meals and snacks. 9) If you signed up to receive the monthly activity calendar or newsletter, are you receiving them. 10) Overall, comments, input or concerns for the facility that you would address. There was no mention of forming a family council or if anyone had an interest in forming a family council group.	21942		

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21942	Continued From page 12 Interview on 9/27/23 at 8:17 a.m., SSD-A identified she was aware of the definition of a family council and understood that she needed to reach out yearly to form one. She revealed she had just missed placing a question on her survey to see if families were interesting in forming a family council on her survey form that she sent out to families yearly. Interview on 9/27/23 at 8:25 a.m., with director of nursing (DON) identified that SSD had missed adding the question to the families if they were interested in forming a family council on the survey that was sent out to families yearly. No policy on forming or having a family council was provided. SUGGESTED METHOD OF CORRECTION: The administrator or designee could delegate an individual to be responsible for the annual attempt to establish a family council/group. That individual would need to document it's efforts at forming a council, and identify when the attempt occurred in the calendar year. TIME PERIOD OF CORRECTION: Twenty-one (21) days.	21942		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245548	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**09/26/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TUFF MEMORIAL HOME	**505 EAST 4TH STREET** **HILLS, MN 56138**

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

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

Electronically Signed | 10/20/2023

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245548	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**09/26/2023**

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TUFF MEMORIAL HOME	**505 EAST 4TH STREET** **HILLS, MN 56138**

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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. Tuff Memorial Home was constructed as follows: The original building was constructed in 1959, is one-story, has a partial basement, is fully fire sprinkler protected and is of Type II(111) construction; The 1st Addition was constructed in 1962, is one-story, has no basement, is fully fire sprinkler protected and is of Type II(111) construction; The 2nd Addition was constructed in 1975, is one-story, has no basement, is fully fire sprinkler protected and is of Type II(111) construction;	K 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245548	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**09/26/2023**

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TUFF MEMORIAL HOME	**505 EAST 4TH STREET** **HILLS, MN 56138**

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K 000	Continued From page 2 The 3rd Addition was constructed in 1988, is one-story, has a full basement, is fully fire sprinkler protected and is of Type V(111) construction; The 4th Addition was constructed in 1998, is one-story, has no basement, is fully fire sprinkler protected and is of Type V(000) construction. The facility has a capacity of 48 beds and had a census of 39 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 324 SS=E	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through	K 324		10/20/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TUFF MEMORIAL HOME	**505 EAST 4TH STREET** **HILLS, MN 56138**

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K 324	Continued From page 3 19.3.2.5.5, 9.2.3, TIA 12-2 This REQUIREMENT is not met as evidenced by: Based on observation or a review of available documentation and staff interview, the facility failed to inspect the kitchen fire suppression per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.2.5.1 through 19.3.2.5.5, and NFPA 96 (2011 Edition), Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, section number 9.2.3,. This deficient finding could have a patterned impact on the residents within the facility. Findings include: On 09/26/2023 at 11:00AM, it was revealed by a review of available documentation that inspection records could not be reviewed to indicate a timely inspection had occurred on the kitchen fire suppression system, Last inspection occurred on 02/12/2023. An interview with Facility Maintenance Director verified this deficient finding at the time of discovery.	K 324	On 9/27/23 Heimann Fire Equipment services came and inspected the kitchen fire suppression system. The inspection is now scheduled on a semi-annual basis to maintain compliance. Heimann Fire Equipment will present documentation of inspection for facility to keep on file. The next inspection is scheduled for 2/2024.	

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
January 11, 2024

Administrator
Tuff Memorial Home
505 East 4th Street
Hills, MN 56138

RE: CCN: 245548
Cycle Start Date: September 27, 2023

Dear Administrator:

On December 5, 2023, we notified you a remedy was imposed. On December 26, 2023 the Minnesota Departments of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of January 2, 2024.

As authorized by CMS the remedy of:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective December 27, 2023 be discontinued as of January 2, 2024. (42 CFR 488.417 (b))

In our letter of December 5, 2023, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from December 27, 2023. This does not apply to or affect any previously imposed NATCEP loss.

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

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
Email: Kamala.Fiske-Downing@state.mn.us

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

January 11, 2024

Administrator
Tuff Memorial Home
505 East 4th Street
Hills, MN 56138

Re: Reinspection Results
Event ID: CKOV12

Dear Administrator:

On December 26, 2023 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on September 27, 2023. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

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