Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
January 3, 2025

Administrator
Hopkins Health Services
725 Second Avenue South
Hopkins, MN 55343

RE: CCN: 245293
Cycle Start Date: December 16, 2024

Dear Administrator:

On December 16, 2024, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Stefanie Salberg, Regional Operations Supervisor
Metro B District Office
Health Regulation Division
Minnesota Department of Health
625 Robert Street N
P.O. Box 64975
Saint Paul, Minnesota 55164-0975
Email: stefanie.salberg@state.mn.us
Office: 651-201-4393 Mobile: 651-279-5602

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 March 16, 2025 (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 June 16, 2025 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 **and Minnesota Statute 144A.10 subd 15**, 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: https://forms.web.health.state.mn.us/form/NHDisputeResolution

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. 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.

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. 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:
https://forms.web.health.state.mn.us/form/NHDisputeResolution

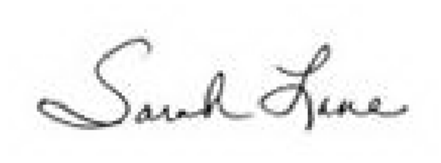
A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

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

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

Feel free to contact me if you have questions.

Sincerely,



Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us

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Electronically delivered
January 3, 2025

Administrator
Hopkins Health Services
725 Second Avenue South
Hopkins, MN 55343

Re: State Nursing Home Licensing Orders
Event ID: DVSD11

Dear Administrator:

The above facility was surveyed on December 9, 2024 through December 16, 2024 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

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

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

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

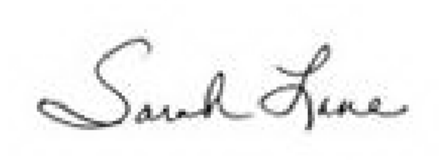
Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting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

Stefanie Salberg, Regional Operations Supervisor
Metro B District Office
Health Regulation Division
Minnesota Department of Health
625 Robert Street N
P.O. Box 64975
Saint Paul, Minnesota 55164-0975
Email: stefanie.salberg@state.mn.us
Office: 651-201-4393 Mobile: 651-279-5602

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

Please feel free to call me with any questions.

Sincerely,



Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245293	A. BUILDING _____ B. WING _____	C 12/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOPKINS HEALTH SERVICES	725 SECOND AVENUE SOUTH HOPKINS, MN 55343

(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 12/9/24 to 12/16/24, a survey for compliance with Appendix Z, Emergency Preparedness Requirements for Long Term Care facilities, §483.73 was conducted during a standard recertification survey. The facility was NOT in compliance. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulation has been attained.	E 000		
E 037 SS=F	EP Training Program CFR(s): 483.73(d)(1) §403.748(d)(1), §416.54(d)(1), §418.113(d)(1), §441.184(d)(1), §460.84(d)(1), §482.15(d)(1), §483.73(d)(1), §483.475(d)(1), §484.102(d)(1), §485.68(d)(1), §485.542(d)(1), §485.625(d)(1), §485.727(d)(1), §485.920(d)(1), §486.360(d)(1), §491.12(d)(1). *[For RNCHIs at §403.748, ASCs at §416.54, Hospitals at §482.15, ICF/IIDs at §483.475, HHAs at §484.102, REHs at §485.542, "Organizations" under §485.727, OPOs at §486.360, RHC/FQHCs at §491.12:] (1) Training program. The [facility] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing	E 037		1/31/25

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

Electronically Signed | 01/13/2025

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

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E 037	Continued From page 1 staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the [facility] must conduct training on the updated policies and procedures. *[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles. (ii) Demonstrate staff knowledge of emergency procedures. (iii) Provide emergency preparedness training at least every 2 years. (iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others. (v) Maintain documentation of all emergency preparedness training. (vi) If the emergency preparedness policies and procedures are significantly updated, the hospice must conduct training on the updated policies and procedures.	E 037		

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E 037	Continued From page 2 *[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) After initial training, provide emergency preparedness training every 2 years. (iii) Demonstrate staff knowledge of emergency procedures. (iv) Maintain documentation of all emergency preparedness training. (v) If the emergency preparedness policies and procedures are significantly updated, the PRTF must conduct training on the updated policies and procedures. *[For PACE at §460.84(d):] (1) The PACE organization must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, contractors, participants, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Demonstrate staff knowledge of emergency procedures, including informing participants of what to do, where to go, and whom to contact in case of an emergency. (iv) Maintain documentation of all training. (v) If the emergency preparedness policies and procedures are significantly updated, the PACE must conduct training on the updated policies and procedures. *[For LTC Facilities at §483.73(d):] (1) Training	E 037		

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E 037	Continued From page 3 Program. The LTC facility must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. *[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following: (i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment. (v) If the emergency preparedness policies and procedures are significantly updated, the CORF must conduct training on the updated policies and procedures. *[For CAHs at §485.625(d):] (1) Training program.	E 037		

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E 037	Continued From page 4 The CAH must do all of the following: (i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the CAH must conduct training on the updated policies and procedures. *[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least every 2 years. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure initial and annual training on the facility's comprehensive Emergency Preparedness Plan (EPP) was provided to 1 of 5 existing employees. This had potential to affect all	E 037	The current facility employees must receive annual training on the comprehensive Emergency Preparedness Plan. The facility will have a mandatory staff meeting on 1/22/25 and 1/23/25	

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E 037	Continued From page 5 37 residents, as well as staff, volunteers, and visitors at the facility. Findings include: When interviewed on 12/16/24 at 9:49 a.m., the administrator stated staff received training about the facility's EPP through Relias (national electronic learning management system). The administrator was asked to provide documentation of NA-H's EPP training. When interviewed on 12/16/24 at 11:58 a.m., the administrator stated they could not find NA-H's EPP training and had to check if NA-H was registered for the required trainings. The facility did not provide EPP training information for NA-H. Review of the Emergency Preparedness Plan Policy dated 3/26/21, indicated training would be provided on the contents of the plan.	E 037	where employees will be informed of the requirement to complete Relias training on Workplace Emergencies and Natural Disasters by 1/31/25. Failure to complete this training will result in removal from schedule until completion is confirmed. Staff will also be shown the EPP notebook and where it can be located on the units and public spaces.	
E 039 SS=F	EP Testing Requirements CFR(s): 483.73(d)(2) §416.54(d)(2), §418.113(d)(2), §441.184(d)(2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2), §483.475(d)(2), §484.102(d)(2), §485.68(d)(2), §485.542(d)(2), §485.625(d)(2), §485.727(d)(2), §485.920(d)(2), §491.12(d)(2), §494.62(d)(2). *[For ASCs at §416.54, CORFs at §485.68, REHs at §485.542, OPO, "Organizations" under §485.727, CMHCs at §485.920, RHCs/FQHCs at §491.12, and ESRD Facilities at §494.62]: (2) Testing. The [facility] must conduct exercises	E 039		1/31/25

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E 039	Continued From page 6 to test the emergency plan annually. The [facility] must do all of the following: (i) Participate in a full-scale exercise that is community-based every 2 years; or (A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or (B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event. (ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed. *[For Hospices at 418.113(d):] (2) Testing for hospices that provide care in the patient's home. The hospice must conduct	E 039		

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E 039	Continued From page 7 exercises to test the emergency plan at least annually. The hospice must do the following: (i) Participate in a full-scale exercise that is community based every 2 years; or (A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full scale community-based exercise or individual facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (3) Testing for hospices that provide inpatient care directly. The hospice must conduct exercises to test the emergency plan twice per year. The hospice must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual	E 039		

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	245293	A. BUILDING _____ B. WING _____	C 12/16/2024

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E 039	Continued From page 8 facility-based functional exercise; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospice is exempt from engaging in its next required full-scale community based or facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop led by a facilitator that includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the hospice's emergency plan, as needed. *[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):] (2) Testing. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the [PRTF, Hospital, CAH] experiences an actual natural or man-made emergency that	E 039		

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E 039	Continued From page 9 requires activation of the emergency plan, the [facility] is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the [facility's] emergency plan, as needed. *[For PACE at §460.84(d):] (2) Testing. The PACE organization must conduct exercises to test the emergency plan at least annually. The PACE organization must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the PACE experiences an actual natural or man-made emergency that requires activation of the emergency plan, the PACE is exempt from engaging in its next required full-scale community	E 039		

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E 039	Continued From page 10 based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the PACE's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the PACE's emergency plan, as needed. *[For LTC Facilities at §483.73(d):] (2) The [LTC facility] must conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The [LTC facility, ICF/IID] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. (B) If the [LTC facility] facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next	E 039		

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E 039	Continued From page 11 required a full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [LTC facility] facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [LTC facility] facility's emergency plan, as needed. *[For ICF/IIDs at §483.475(d)]: (2) Testing. The ICF/IID must conduct exercises to test the emergency plan at least twice per year. The ICF/IID must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or. (B) If the ICF/IID experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID is exempt from engaging in its next required full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following:	E 039		

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E 039	Continued From page 12 (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the ICF/IID's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID's emergency plan, as needed. *[For HHAs at §484.102] (d)(2) Testing. The HHA must conduct exercises to test the emergency plan at least annually. The HHA must do the following: (i) Participate in a full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise every 2 years; or. (B) If the HHA experiences an actual natural or man-made emergency that requires activation of the emergency plan, the HHA is exempt from engaging in its next required full-scale community-based or individual, facility based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is	E 039		

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E 039	Continued From page 13 community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the HHA's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the HHA's emergency plan, as needed. *[For OPOs at §486.360] (d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following: (i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. If the OPO experiences an actual natural or man-made emergency that requires activation of the emergency plan, the OPO is exempt from engaging in its next required testing exercise following the onset of the emergency event. (ii) Analyze the OPO's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. *[RNCHIs at §403.748]: (d)(2) Testing. The RNHCI must conduct	E 039		

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E 039	Continued From page 14 exercises to test the emergency plan. The RNHCI must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the RNHCI's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the RNHCI's emergency plan, as needed. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to conduct a full-scale community-based exercise, or to document activation of their emergency preparedness plan or incident command system in response to an actual emergency event the facility experienced during the last year. This had the potential to affect all 37 residents who currently resided in the facility, along with staff and volunteers who worked in the facility. Findings include: Review of the Emergency Preparedness Plan Policy dated 3/26/21, directed the facility to conduct drills and exercises to test the plan. When interviewed on 12/16/24 at 9:49 a.m., the administrator stated they conducted a cyberattack tabletop exercise on 2/15/24 and that was all the facility needed, since they still had time to complete additional exercises. The administrator confirmed the facility had not conducted a full-scale community -based exercise and had not	E 039	On 1/13/2025 the Facility IDT reviewed State Statute 483.73 -Emergency Preparedness, Requirements for LTC Facilities and completed the Optional Self-Assessment Tool. As a result, a Testing and Training plan has been developed. The Executive Director has contacted the Hopkins Fire Department and has scheduled a HFD Local Response team to participate in a full-scale exercise at the facility during the week of January 27th -January 31, 2025. The plan is for this to be a facility wide and community-based tornado drill. Following the exercise the IDT will convene to complete and review an event after action report and improvement plan. Results will be presented to QAPI at the next scheduled meeting.	

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E 039	Continued From page 15 documented efforts to identify a full-scale community-based exercise or an after-action review in response to an actual emergency event the facility experienced during the last year.	E 039		
F 000	INITIAL COMMENTS On 12/9/24 to 12/16/24, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed with NO deficiencies cited: H52932262C (MN00108866), (MN00108868) H52932129C (MN00105994) H52932126C (MN00102367) H52932128C (MN00107291) H52932130C (MN00108710) H52932127C (MN00107045) H52932124C (MN00102351) H52932603C (MN00109024) H52932262C (MN00108863) H52932183C (MN00108640) H52932123C (MN00106337) The following complaints were reviewed: H52932125C (MN00106681) with a deficiency cited at F584 and F921. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are	F 000		

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F 000	Continued From page 16 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 574 SS=C	Required Notices and Contact Information CFR(s): 483.10(g)(4)(i)-(vi) §483.10(g)(4) The resident has the right to receive notices orally (meaning spoken) and in writing (including Braille) in a format and a language he or she understands, including: (i) Required notices as specified in this section. The facility must furnish to each resident a written description of legal rights which includes - (A) A description of the manner of protecting personal funds, under paragraph (f)(10) of this section; (B) A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment of resources under section 1924(c) of the Social Security Act. (C) A list of names, addresses (mailing and email), and telephone numbers of all pertinent State regulatory and informational agencies, resident advocacy groups such as the State Survey Agency, the State licensure office, the State Long-Term Care Ombudsman program, the protection and advocacy agency, adult protective services where state law provides for jurisdiction in long-term care facilities, the local contact agency for information about returning to the community and the Medicaid Fraud Control Unit;	F 574		1/31/25

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F 574	Continued From page 17 and (D) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community. (ii) Information and contact information for State and local advocacy organizations including but not limited to the State Survey Agency, the State Long-Term Care Ombudsman program (established under section 712 of the Older Americans Act of 1965, as amended 2016 (42 U.S.C. 3001 et seq) and the protection and advocacy system (as designated by the state, and as established under the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (42 U.S.C. 15001 et seq.) (iii) Information regarding Medicare and Medicaid eligibility and coverage; (iv) Contact information for the Aging and Disability Resource Center (established under Section 202(a)(20)(B)(iii) of the Older Americans Act); or other No Wrong Door Program; (v) Contact information for the Medicaid Fraud Control Unit; and (vi) Information and contact information for filing grievances or complaints concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community.	F 574		

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F 574	Continued From page 18 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide contact information for the Ombudsman (resident advocate) to 3 of 3 residents (R36, R30, R37) who attended the resident council group meeting. This had the potential to affect all 37 residents residing in the facility. Findings include: During the resident group meeting on 12/11/24 at 10:00 a.m., R36, R30, and R37 were in attendance. R36 and R37 stated they were not aware of the Ombudsman, their telephone number, nor the advocacy services they provided. R30 stated they researched the Internet and obtained the information from the website as it was not posted in the facility. During an observation on 12/10/24, at 9:30 a.m., the Ombudsman information was not visible in the facility. During an interview on 12/12/24, at 2:06 p.m., licensed practical nurse (LPN)-D stated the Ombudsman phone number was in the copier room, and the residents could not access the information. During an interview on 12/13/24, at 12:09 p.m., LPN-C stated the Ombudsman information was not posted in the facility. During an interview on 12/16/24, at 10:15 a.m., director of nursing (DON) stated the Ombudsman contact information was in administrator's office, and confirmed it was not posted in the facility in a	F 574	Ombudsman□s Name and contact information was provided to Current Residents posted in vacant and occupied rooms and included in the welcome packet for all new coming residents: staff have been educated on the importance of providing this information to residents. Current Residents were potentially affected by this deficiency. The ombudsman□s Name and Contact information will be included in welcome packets on 1/13/25 and ongoing. The posting in occupied rooms will be checked on a 1x weekly basis for 6 weeks, then 1x monthly for 3 months. If compliance is not met at this time, audits will be repeated. Audits will be performed by the ED, DON or designee, with documentation of each audit logged to be reviewed by QAPI on a quarterly basis. Re-education will be provided using Relias □ Safeguarding Resident Rights for Current Center staff	

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F 574	Continued From page 19 place accessible to residents and families. The facility policy on Resident Rights 9/2017, reviewed/revised 7/2022, stated the purpose was to ensure that resident rights are respected, protected, and promoted, and to inform residents of their rights and provide an environment in which they can be exercised. Residents do not leave their individual personalities or basic human rights behind when they move to a long-term care facility. Residents will be treated with respect and dignity and care for each resident will be given in a manner and in an environment that promotes maintenance or enhancement of his/her quality of life and recognizes each resident ' s individuality. This facility must provide a notice of rights and services to the resident prior to or upon admission and during the resident ' s stay. The information must be presented both orally and in writing in a language the resident understands. The resident has the right to receive a list of the names, addresses (mail and email) and telephone numbers of all pertinent state regulatory and informational agencies.	F 574		
F 577 SS=C	Right to Survey Results/Advocate Agency Info CFR(s): 483.10(g)(10)(11) §483.10(g)(10) The resident has the right to- (i) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility; and (ii) Receive information from agencies acting as client advocates, and be afforded the opportunity to contact these agencies. §483.10(g)(11) The facility must-- (i) Post in a place readily accessible to residents,	F 577		1/21/25

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 577	Continued From page 20 and family members and legal representatives of residents, the results of the most recent survey of the facility. (ii) Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request; and (iii) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public. (iv) The facility shall not make available identifying information about complainants or residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the most recent State agency survey results were available to review. This had potential to affect all 37 residents who resided on the second floor who wished to review this information without having to ask. Findings include: During an observation on 12/10/24, at 12:30 p.m., the postings of the State Survey results were in a red three-ring binder attached to the wall near the main entrance on the 1st floor. During an observation on 12/12/24 at 2:06 p.m., the 2nd floor, where all residents resided, did not have State Survey results posted, nor any indication they existed and were available elsewhere in the building for review. During the resident group meeting held on 12/11/24 at 10:00 a.m., 3 out of 3 residents (R30,	F 577	Survey results will be made available at each active nurses station where residents have physical access to the information; staff have re-educated on the importance of providing this information to residents. Current residents were potentially affected by this alleged deficiency. The Survey results will continue to be posted on the resident floors and the Main Entry Way; staff have been educated on the importance of providing this information to residents. The survey results will be checked for placement on a 1x weekly basis for 6 weeks, then 1x monthly for 3 months. If compliance is not met at this time, audits will be repeated. Audits will be performed by the ED, DON or designee, with documentation of each audit logged to be reviewed by QAPI on a quarterly basis. Re-education will be provided using	

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F 577	Continued From page 21 R36, R37) stated they did not know where the State Survey results were posted and were not aware they were allowed to see them. During an interview on 12/13/24 at 12:09 p.m., licensed practical nurse (LPN)-C stated the three-ring State Survey results binder was located on the 1st floor by the business office. They confirmed the State Survey results were not easily accessible to all residents. The policy for Availability of Survey Results dated 6/16/22, stated the purpose of the policy is to uphold a resident's right to examine the results of the most recent survey of the facility conducted by federal or state surveyors and any plan of correction in effect with respect to the facility. Definitions: is a place (such as a lobby or other area frequented by most residents, visitors, or other individuals) where individuals wishing to examine survey results do not have to ask to see them. The policy for Residents Rights dated 9/2017 reviewed/revised on 7/2022 stated the resident has the right to examine the results of the most recent Federal or State survey as well as this facility ' s plan of correction. These documents must be posted in an accessible location. The facility will make available for review, upon request, any surveys, certification, and complaint investigations made during the 3 preceding years as well as any plan of correction. Information that identifies residents or complainants well not be available for review. Based on observation, interview and document review, the facility failed to ensure the most recent State agency survey results were available to review. This had potential to affect 2nd floor	F 577	Safeguarding Resident Rights Review for DON, SS, ED	

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F 577	Continued From page 22 residents, who wished to review this information without having to ask.	F 577		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law.	F 578		1/31/25

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F 578	Continued From page 23 (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure resident-specific resuscitation wishes were clear and evident throughout the electronic medical record (EMR) and physical paper chart for 1 of 1 resident (R22) reviewed for advance directives. Findings include: R22's admission Minimum Data Set (MDS) dated 11/21/24, indicated R22 had short- and long-term memory problems, severely impaired cognitive skills for daily decision making, and continuous inattention and disorganized thinking. R22's diagnoses included hypertension, renal failure, hip fracture, osteoporosis, depression, Alzheimer's disease, and dementia. During record review on 12/9/24 at 6:00 p.m., R22 did not have an order for code status. R22's banner in the EMR had a link to "Advance Directives" which was blank and did not have a POLST (a medical order indicating treatments a person would like to receive in case of serious illness and/or cardiac arrest) uploaded in the EMR. Progress notes and care conference summaries indicated R22's code status was reviewed but did not specify R22's wishes. R22's Physician Discharge Orders/Instructions dated 11/15/24, indicated R22's code status as	F 578	" A full house audit was conducted on 1.14.2025 to ensure code status orders are accurately reflected in the electronic medical record and match the POLST forms on file. " R22□s medical record was updated to reflect the code status order and a POLST form was added to the medical record. " Center staff were re-educated regarding the process for uploading advanced directives including POLST forms and code status orders for accurate reflection in the electronic medical record. " Center staff are re-educated on where to find a code status in an emergency as well as the difference between a POLST form and advanced directives. " Audits will be conducted of new admissions to ensure that code status orders match the POLST forms in the medical record. Audits will be conducted monthly of five current residents to ensure code status orders match the POLST forms in the medical record. " Audits of new admissions will be conducted once weekly for 6 weeks then	

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F 578	Continued From page 24 "DNAR/DNI" (do not attempt resuscitation/do not intubate). R22's Statutory Short Form Power of Attorney document dated 11/1/18, indicated R22 agreed to be kept comfortable and allow natural death to occur under the section of "Terminal Condition/Life-Prolonging Treatment" section. When interviewed on 12/9/24 at 6:11 p.m., nursing assistant (NA)-G indicated they would notify a charge nurse if they found a resident unconscious. When interviewed on 12/9/24 at 6:12 p.m., licensed practical nurse (LPN)-I indicated they would activate a code to get help right away if they found a resident unresponsive and would check resident's paper chart first to review their code status. LPN-I stated they would assume resident as a full code and start CPR (cardiopulmonary resuscitation) if there were no POLST in the resident's chart. LPN-I reviewed R22's paper chart and face sheet and confirmed the face sheet did not indicate R22's code status and there was no POLST. R22's Statutory Short Form Power of Attorney document was in R22's physical, paper chart. LPN-I stated the director of nursing (DON), floor managers, and social worker (SW) assisted with admissions and verified residents' code status and related paperwork. LPN-I stated they would check with the floor manager. During subsequent interview, LPN-I reviewed R22's Medication Administration Record (MAR), and the MAR indicated DNR/DNI under the "Special Instruction" section of the banner. LPN-I stated most residents have a POLST, but staff looked in the MAR when a POLST was not in the resident chart.	F 578	once monthly for 3 months. Audits of five current residents will be conducted once monthly. If compliance is not met at this time, audits will be repeated. Audits will be performed by the ED, DON or designee, with documentation of each audit logged to be reviewed by QAPI on a quarterly basis.	

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F 578	Continued From page 25 When interviewed on 12/9/24 at 6:23 p.m., LPN-B stated R22 was not capable of making their own decisions and had called R22's family member (FM)-A to confirm R22's code status when R22 first admitted. LPN-B stated they mailed R22's POLST to FM-A for them to sign and forgot to make a copy for R22's chart. LPN-B stated the physician would sign the POLST after the family signed the POLST. LPN-B reviewed R22's Care Conference Summary dated 11/25/24 and confirmed the summary indicated R22's code status was reviewed but did not specify what R22's code status was. LPN-B stated R22 came from the hospital with orders for code status, and staff used the hospital ordered code status until they confirmed code status with resident or family within 48 hours of admission. LPN-B stated they or the director of nursing entered in admission orders, which included code status, and verified R22 did not have a code status in the EMR's orders. When interviewed on 12/9/24 at 7:32 p.m., LPN-K stated they would check resident's code status in the paper chart or EMR prior to initiating CPR or not if they found a resident pulseless and not breathing. LPN-K stated the director of nursing or other managers reviewed and entered residents' orders and POLST during admissions. During additional interview on 12/9/24 at 7:40 p.m., LPN-B stated code status orders were part of ancillary orders when residents first admitted. Staff used the template to add in the code status and another nurse verified the admission orders. The code status showed up in the EMR banner when the orders were entered using the template. LPN-B stated the process was missed for R22,	F 578		

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and the facility did not use an admission checklist. LPN-B reviewed R22's Statutory Short Form Power of Attorney document and reviewed the section which described to keep R22 comfortable and allow natural death to occur but stated the statement still was not a POLST.

When interviewed on 12/19/24 at 7:49 p.m., LPN-J stated they checked resident's code status under the advance directives section in the EMR's miscellaneous section and the paper chart before initiating CPR on a resident who was pulseless and not breathing. LPN-J stated the health unit coordinator scanned in the POLSTs into the miscellaneous section of the EMR. LPN-J stated they would initiate CPR if a POLST or code status was not in place.

When interviewed on 12/10/24 at 9:23 a.m., FM-A stated they verbally spoke with staff to confirm R22's code status as DNR and did not receive a POLST in the mail to sign.

When interviewed on 12/10/24 at 9:26 a.m., LPN-D stated they would initiate CPR if they found a resident pulseless and not breathing and would call a second nurse to check the resident's code status. LPN-D stated residents' code status was listed in the banner of the MAR and in the front tab of residents' paper charts.

When interviewed on 12/10/24 at 9:32 a.m., LPN-L stated they would call a second nurse to check if a resident was pulseless and not breathing and would verify the resident's code status in their paper chart or EMR on the face sheet or miscellaneous section where POLSTs were scanned.

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F 578	Continued From page 27 When interviewed on 12/10/24 at 9:45 a.m., registered nurse (RN)-C stated they would first check resident's code status if they were pulseless and not breathing. RN-C checked for resident code status in the paper chart or checked the EMR, such as the resident face sheet, if not in the paper chart. When further interviewed on 12/10/24 at 9:54 a.m., LPN-B stated they reviewed resident POLSTs when first admitted and at quarterly care conferences. When interviewed on 12/10/24 at 10:05 a.m., SW stated they facilitated conversations about code status with nursing on admission, quarterly, annually, and with hospitalizations or other changes. SW updated code status in resident care plans if nursing had other tasks to complete. SW stated the facility did not have a medical records person right now, so SW helped with scanning POLSTs into EMRs or sent out POLSTs for family members to sign if they were out of state and then notified the provider to sign the POLST or have a conversation with the resident's family. SW stated R22 had a health care directive which indicated DNR/DNI. When interviewed on 12/10/24 at 1:20 p.m., DON expected staff to call for help if a resident was unresponsive and verify code status immediately and assess the resident. DON stated code status was indicated on POLST found in residents' paper charts or the EMR had a banner which reflected residents' code status. DON stated they had monthly code status drills, and code statuses were in the EMR if not in the paper chart. DON stated staff reviewed POLST and code status when residents first admitted and quarterly at	F 578		

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F 578	Continued From page 28 care conferences. DON expected a code status to be entered into residents' orders immediately during the admission process and reviewed by or at the 48-hour admission care conference. DON or floor managers entered residents' orders in a que, and a second nurse checked and confirmed the orders into the EMR. DON stated they emailed or faxed POLSTs for family to sign. DON expected a chart to have a copy of a POLST with verbal confirmation until a signed POLST returned. DON expected the resident or guardian preferred provider to review and sign POLST within 72 hours. When interviewed on 12/10/24 at 1:59 p.m., the vice president of success stated the facility did not have a POLST policy and procedure and followed state guidance. The CPR policy dated 6/30/23, directed staff to provide basic life support, including CPR, prior to the arrival of emergency medical services, and: a. In accordance with the resident's advance directives, or b. In the absence of advance directives or a Do Not Resuscitate order; and c. If the resident does not show obvious sings of clinical death (e.g., rigor mortis, dependent lividity, decapitation, transection, or decomposition.	F 578		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is-	F 580		1/31/25

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F 580	Continued From page 29 (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various	F 580		

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F 580	Continued From page 30 locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to notify providers about a resident's weight status while on a prescribed diuretic (water pill) for 1 of 1 residents reviewed for edema (swelling). Findings include: R5's significant change Minimum Data Set (MDS) dated 11/5/24, indicated she had severe cognitive impairment with diagnoses of heart failure, kidney failure, respiratory failure, anxiety, depression, and lymphedema (a chronic condition causing swelling from lymph or protein-rich fluid in the body's tissues). The MDS further indicated R5 received hospice care. R5's Care Area Assessment (CAA) for functional abilities dated 11/5/24, identified her need for assistance with all activities of daily living (ADLs) and mobility, directing staff to provide "max assist" with all cares and dependent assistance with toileting and transfer cares. The CAA directed staff to proceed to the plan of care "with goal of comfort and dignity with end of life cares." R5's unsigned order summary was reviewed 12/13/24, and included the following orders: - "furosemide oral tablet, Give 40 milligrams (mg) by mouth one time a day" for pulmonary edema (fluid buildup the lungs), heart failure with chronic kidney disease and failure, dated 3/12/24.	F 580	" R5□s physician was updated on 1.15.25 regarding current weight and weights from previous 30 days as well as current diuretic orders and treatment plan. " Current residents□ medical records were reviewed to ensure physicians were notified as required for any changes in condition. " Staff have been reeducated on the requirements for physician notification for changes in " condition and where to document this communication. " Residents experiencing a change in condition will be reviewed once weekly for six weeks then once monthly for three months by DON or designee to ensure timely physician notification. If compliance is not met at this time, audits will be repeated. Audits will be performed by the ED, DON or designee, with documentation of each audit logged to be reviewed by QAPI on a quarterly basis. " Re-education will be provided using Relias - Recognizing a change in condition for current nurses.	

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- "weight and vitals weekly (obtain re-weight if change of 5 lbs (pounds) since last weight every Thursday", dated 5/28/24.

R5's treatment administration record (TAR) dated 8/2024, reflected the following documented weights:
- 8/8/24: 170 [lbs].
- 8/15/24: 171 [lbs].
- 8/22/24: 165 [lbs].
- 8/28/24: lacked documentation of weight and referred to the progress notes.

R5's TAR dated 9/2024 reflected the following documented weights:
- 9/5/24: "NA".
-9/12/24: 164 [lbs].
9/19/24: 164.3 [lbs].
9/26/24: lacked documentation of weight with rationale "refused".

R5's TAR dated 10/2024 reflected the following documented weights:
- 10/17/24: "NA".
- 10/31/24: 164.2 [lbs].
The dates of 10/3/24, 10/10/24, and 10/24/24, lacked documentation of weights and referred to the progress notes.

R5's TAR dated 11/2024 reflected the following documented weights:
- 11/14/24: "NA".
- 11/28/24: "NA".
The dates of 11/7/24, and 11/21/24, lacked documentation of weights and referred to the progress notes.

R5's TAR dated 12/2024 reflected the following

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documented weights:
- 12/5/24: 162.5 [lbs].
- 12/12/24: "NA".

R5's care plan dated 7/28/23 identified she was on diuretic therapy to treat her lower extremity edema. The care plan guided staff to report signs and symptoms of "dehydration, hypotension, dizziness, etc." to meet her goal of having no adverse effects. Additionally, the care plan identified her risk for excess fluid volume due to her lower extremity swelling (edema) and directed staff to report signs and symptoms edema or fluid overload, including weight gain.

Per progress note dated 8/1/24 at 1:07 p.m., for the order to "weight and vitals - weekly obtain re-weight if change of 5 lbs since last weight)", two attempts were made to collect R5's weight and/or vital signs and would be attempted again later. The progress note lacked documentation on provider notification of refusals.

Per progress note dated 8/13/24 at 11:43 a.m., the interdisciplinary team (IDT) discussed R5's weight loss "of approx. 25 lbs over last 4 months" and potential causative factors. The progress note lacked documentation if her provider was updated on her weight loss.

A progress note dated 8/29/24 at 9:47 a.m., indicated R5 refused her weekly weight three times. The progress note lacked documentation on provider notification of refusals.

A progress note dated 10/17/24 at 9:44 a.m., lacked documentation regarding why weight was not documented in R5's TAR as ordered. The progress note lacked documentation on provider

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F 580	Continued From page 33 notification. A progress note dated 10/24/24 at 9:32 a.m., indicated R5 refused weekly weight but other "vitals completed." The progress note lacked documentation on provider notification of refusals. Per a nutrition assessment note dated 11/5/24 at 3:02 p.m., R5 was at risk for fluid shifts and weight fluctuations related to diuretic use. The note directed staff to continue the current nutrition plan of care. Per progress note dated 11/7/24 at 9:41 a.m., R5 refused to get out of bed for her ordered weekly weight check. The progress note lacked documentation on provider notification. Per progress note dated 11/21/24 at 9:41 a.m., R5 refused to get out of bed for her ordered weekly weight check. The progress note lacked documentation on provider notification. A provider progress note dated 9/20/24, identified R5's "abnormal weight loss" with her self-reported "anorexia" (medical term for loss of appetite) and weight loss for "a few months". The provider progress note indicated under the "Assessment and Plan" for abnormal weight loss staff should continue to trend weight. A request for further primary care provider visit documentation or provider progress notes was requested but not received. R5's electronic medical record (EMR) was reviewed on 12/12/24, and lacked documentation on provider notification of her refusal to be	F 580		

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F 580	Continued From page 34 weighed. Per observation on 12/10/24 at 9:08 p.m., R5 was laying in her bed on her back. She had mild swelling to both legs and did not have any stockings or wraps on her legs. Per interview on 12/12/24 at 10:00 a.m., with the registered dietitian (RD), R5 was being followed because she was a high-risk for her weight. RD reviewed her weights in R5's EMR and stated she followed her monthly and confirmed weight loss. RD verified she was due for another "risk charting note soon" and stated R5's weight had been stable "for about a month," but was unsure what was "currently going on." RD identified her diuretic use could affect her weight but stated she was on hospice and did not like to "demand things" when a resident was on hospice care. RD expected documentation of a resident's refusals of weights and stated it would be "preferable" for monthly weights to be obtained. RD identified a weight on 12/5/24, and stated, "She's down a couple of pounds" but expected this for a resident on hospice cares. RD denied concern for R5's weight loss. Per interview on 12/12/24 at 10:14 a.m. with R5's hospice registered nurse (HRN), R5 appeared "well-cared for" during hospice visits and assessments at the facility. HRN reported assessing R5's respiratory status and fluid retention/edema during visits and denied concern beyond R5's baseline. HRN stated R5 was "really short of breath with exertion and even in conversation" and "her legs have always been very swollen." HRN verified a lack of notification regarding R5's refusals to be weight and a lack of documented weekly weights. HRN stated, "it is	F 580		

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something I am monitoring but not necessarily something I expect to be updated" on, however, endorsed concern for staff not monitoring weights because "if they are not monitoring weights, then I wouldn't be able to monitor them either." HRN deferred to R5's primary care provider (PCP) for management of her weights and diuretic orders.

Per interview on 12/12/24 at 4:23 p.m., R5's primary care provider and nurse practitioner (NP) confirmed not receiving updates on R5's lack of documented weights and her refusals to be weighed. NP expected to be updated and stated if staff had provided updates, "I would have reassessed the orders and the need for the Lasix, particularly because she's on hospice." NP indicated there had not been any observed changes to R5's baseline edema and denied concern regarding R5's weights, stating they "seem stable for her baseline."

Per interview on 12/13/24 at 9:50 a.m., with licensed practical nurse (LPN)-D, R5's edema in her legs were "much improved now" with a decrease in her fluid retention. LPN-D explained for residents at risk for fluid retention and/or on a diuretic, staff should watch for respiratory changes, edema, and weight changes. LPN-D stated, "If I saw those things, I would notify the unit manager, update the doctor and request they assess the resident." LPN-D stated if a resident was weighed and it looked off, "we would encourage a reweigh", and if a resident was consistently refusing, staff were expected to reapproach, distraction and if the refusals continued, staff were expected to update the provider about the refusals.

During interview on 12/16/24 at 9:50 a.m., with

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F 580	Continued From page 36 LPN-A, also the unit manager, R5's EMR was reviewed for notification of change to the provider regarding her refusal to be weighed and lack of documented weekly weights. LPN-A verified there was no documentation in the EMR or provider portal on her refusals and lack of weights. LPN-A expected staff to report refusals to the nurse and expected nurses to reapproach the resident. If a resident continued to refuse the treatment or order, LPN-A expected staff to update the provider and resident's representative. During interview on 12/16/24 at 12:01 p.m., the director of nursing (DON) hoped staff would bring concerns with residents refusing to be weight to IDT to be discussed. The DON expected staff to report R5's refusals to both her hospice provider and her primary provider teams "so we can make a better plan for that resident." Per facility policy titled Change in Condition of the Resident revised 9/20/22, the facility should immediately inform the resident; consult with the resident's physician; and notify , consistent with his or her authority, the resident representative(s) when there is a need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment). The policy explained when a resident presented with a possible change of condition, staff should notify a resident's physician and for non-immediate notifications, staff were guided to provide the notification via the phone, fax, or method preferred by the physician being contact. Additionally, the policy directed staff to ensure the resident's change in condition was included on the 24-hour report to be reviewed later by the IDT and to updated the plan of care as needed.	F 580		

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F 582 SS=D	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any	F 582		1/31/25

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F 582	Continued From page 38 deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provided Notice of Medicare Non-Coverage (NOMNC) in the required time frame for 1 of 3 residents (R143) reviewed for beneficiary notices. Findings include: R143 admission minimum data set (MDS) dated 10/6/24, included R143 had moderate cognitive impairment and diagnosis of dementia. Facility progress note dated 10/7/24, included R143's power of attorney (POA) discussed a discharge for resident on 10/9/24. R143's NOMNC dated 10/9/24, included skilled nursing/therapy services will end 10/8/24. Handwritten note on document read "resident elects early discharge with benefit days remaining." NOMNC was signed by resident. No evidence of POA reviewing or signing document. During interview on 12/12/24 at 11:17 a.m., family	F 582	The resident affected by the deficiency received notification; administrative staff were re-educated on the need for this notification and the process by which resident should be notified. Current residents were potentially affected by this alleged deficiency. The MDS nurse will keep a log of required notifications with date due, last covered day, who is to be informed and whether contact was made with the responsible party; this log will be reviewed by IDT weekly at our Medicare meetings. The notifications Audit will be reviewed on a weekly basis for 6 weeks, then monthly for 3 months. If compliance is not met at this time, audits will be repeated. Audits will be performed by the ED, DON or designee, with documentation of each audit logged to be reviewed by QAPI on a quarterly basis.	

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F 582	Continued From page 39 member (FM)-B stated she did not remember ever being informed about a notice of Medicare non-coverage, but was updated that therapy would be ending. During interview on 12/13/24 at 10:45 a.m., registered nurse (RN)-D confirmed the discharge NOMNC was signed the day R143 was discharged by R143 himself. RN-D confirmed R143 did have a POA but stated sometimes she had the resident sign the form even if there was a POA if she felt they were cognitively intact. She stated she did not do any formal assessment to determine cognitive status other than observation. RN-D confirmed there was discussion with R143's POA two days prior to discharge but the form was not discussed at that time. During interview on 12/13/24 at 11:19 a.m., the administrator stated there are no exceptions for the NOMNC being given two days prior to discharge. The administrator stated the POA should be given the notice to sign. Facility denied having a policy on NOMNC and stated they follow Medicare regulations.	F 582	Re-education will be provided using Relias □ Beneficiary Notices in the SNF, for MDS, SS, Business office.	
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and	F 584		2/15/25

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F 584	Continued From page 40 homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and documentation review, the facility failed to ensure a safe, clean, comfortable homelike environment when the facility failed to address maintenance issues identified in the dining areas, resident rooms, and throughout the building for 2 of 8	F 584	" A deep clean of resident areas including hallways, kitchen and dining room will be completed on or before 1/20/25. " An assessment of the environment including electrical, bed lights, ceiling tiles,	

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F 584	Continued From page 41 residents (R30, R36) reviewed for homelike environment. Findings include: R30's admission record printed 12/16/24, indicated he admitted to the facility on 9/30/22. A complaint/incident investigation reported by R30 and dated 9/16/24, was reviewed and indicated "the facility itself is very unsanitary." The report included, "one part of the walls at the facility is currently missing," and staff did not appear "to be doing anything to fix this." A complaint/incident investigation reported by R30 and dated 10/8/24, was reviewed and indicated the facility had environmental issues but lacked specificity on where the alleged "mold" was. A complaint/incident investigation reported by R30 and dated 11/27/24, was reviewed and identified a "fire hazard and electrical hazard" in the facility. A TELS closed work orders report printed 12/13/24 for the dates of 3/1/24 - 12/12/24 identified the following closed work orders: - "the dining room baseboard trims fell off" in the dining, created 4/8/24, completed 4/9/24. - "walls behind bed are scratched/gauged (needs repair-puttying)" for R30's room, created 8/22/24, completed 9/4/24. - "LTC [sic, long-term care] dining room" in second floor dining, created 2/16/24, completed 3/11/24.	F 584	the ice water machine, and windowsills will be conducted on 1/16/25 by North Shore maintenance and life safety professionals. " Corrective action identified during the assessment on 1/16/25 related to the resident environment will be completed on or before 2/15/25. " An offer was extended and accepted for a full time maintenance director on 1/15/25. " On-site maintenance support will be provided 2x/week until a full time maintenance director has been on-boarded at Hopkins Health Services. " Audits will be conducted 3x weekly by the ED or designee to ensure the environment is in compliance. " Three residents or visitors will be interviewed each week by the ED or designee to ensure the environment feels home-like. " Audits and interviews will be conducted for six weeks and will be reviewed by the QAPI committee. The need for ongoing audits will be determined at that time.	

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F 584	Continued From page 42 Per observation on 12/9/24 at 2:18 p.m. of the second-floor dining room, the following environmental concerns were identified: - the corner of the wall near the dining room entrance had gouge marks with large parts of the wall missing as well as a loose baseboard. - across from the wall with the gouge marks and missing wall, there was a wall with baseboards missing. - at the serving line in front of the steam table, there was another missing baseboard. - multiple ceiling tiles with large tan-to-light brown stains that covered approximately half of the ceiling tile's surface area. - the wall on the opposite side of the room's doorway had a long, dark black and gray scuff mark that ran along the side of the wall. - throughout the dining room, multiple baseboards had black and green taped areas. - the first window across from the steamtable and serving line had brown blinds and had thick white, web-like material on the blinds and above them onto the wall. - the second window's bottom ledge showed dried white chips and dark brown flecks coming off the ledge of the wall. On one spot of the window ledge, there was an area approximately 8-inches across and 2-inches down, that had long dried white and brown chips and was nearly coming off the wall entirely. - white, web-like material was in the corner of dining room by the two windows, as well as dried white chips flaked off the walls. - the baseboard and tile on the floor across from window in the back of the dining room was warped. - the ice and water machine behind the steam table had thick white buildup around the ice	F 584		

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F 584	Continued From page 43 dispenser, and dried white buildup in the drain area and gates. Per interview on 12/9/24 at 2:46 p.m. with dietary aide (DA)-A, the areas noted during the second-floor dining room observation had been present for the duration of DA-A's employment. DA-A reported working in the facility for two weeks. During dining observation on 12/9/24 at 5:54 p.m., R30 was eating supper in the dining room with two other unidentified residents. During observation on 12/10/24 at 3:34 p.m., the baseboard on the wall outside the door of the second-floor dining room was falling off the wall. There were dried white chips flaking off the wall underneath where the baseboard once was. The baseboard was attached only at the corner of the wall and the rest of the slab of baseboard rested on the floor. It spanned the entire wall length, which was approximately 6-feet in length. During observation on 12/11/24 at 11:09 a.m., the dining room and baseboard outside the dining room remained unchanged. During observation and interview on 12/9/24 at 5:58 p.m., R30 confirmed filing the complaint/incident investigation reports and stated he reported these grievances in resident council. He pointed to the wall behind his bed and nightstand and observed were 9 scuff marks and an electrical outlet that was coming out/detached from the wall. R30 ate his meals in the second-floor dining room and confirmed the various scuff marks, gouges in the walls, black marks, and baseboards falling off. He stated the	F 584		

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F 584	Continued From page 44	F 584		

dining room had "been like that since I've been here." R30 said the overall condition of his room and the dining room made him "think the building isn't healthy and safe."

Per interview on 12/10/24 at 1:37 p.m. with family member (FM)-C, the facility's maintenance department was "really lacking" and the facility only repaired something when it was broken. FM-C reported a privacy curtain was falling off the tracks in a resident room and stated it was reported before, but the facility had not done anything to repair it. Additionally, FM-C reported "I've seen mold around the dining room area." FM-C did not believe the second-floor dining room, R3's room, or the facility itself felt homelike.

Per interview on 12/11/24 at 7:24 a.m. with housekeeper (H)-B, any staff were able to enter a maintenance request through the facility's TELS system if they identified a concern.

Per interview on 12/11/24 at 7:31 a.m., nursing assistant (NA)-D confirmed the dining room was something staff had been working on. NA-D stated the administrator made daily rounds in the morning to assess the facility "for things that might be wrong."

During interview on 12/13/24 at 10:03 a.m., licensed practical nurse (LPN)-C confirmed staff reported their environmental concerns and submitted TELS requests for the second-floor dining room and staff did not do anything about them. LPN-C was unable to recall how long ago the requests were made, however, stated they were submitted when the previous maintenance director was still in the facility, in September, "and

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F 584	Continued From page 45 now, we do not have a maintenance person at all, so you can imagine how that works." During interview on 12/13/24 at 10:31 a.m., housekeeper (H)-A stated they had a checklist for cleaning rooms but not the dining areas and did not wipe down ice machines, walls, or windows. During interview and environmental tour on 12/13/24 at 1:19 p.m., the administrator and housekeeping director (HD), verified the second-floor dining room needed improvement. The administrator stated the dining room "needs a good look" and was "a project" for the facility. The environmental tour continued, and the administrator verified the gouges in the wall behind R18's head of bed and stated staff "have been running the bed into that." In R30's room, the administrator stated the "whole wall needs to be looked at" and verified being aware of the scuff marks and headboard. The administrator confirmed the electrical outlet was detached/coming out of the wall and stated it was discussed during the LifeSafety survey. R36 R36 ' s Minimum Data Set (MDS) dated 11/14/24, indicated intact cognitive function, and included diagnosis of mechanical complication of internal fixation device of right humerus (surgery to repair a right broken shoulder). The MDS indicated R36 was ambulatory with use of rolling walker with seat. The record review on 12/13/24 at 2:24 p.m., on 11/8/24 a deep clean of room check off sheet completed. It did not state unstable cabinetry.	F 584		

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F 584	Continued From page 46 During an observation and interview of R36's room on 12/9/24 at 3:35 p.m., R36 stated there was no heat vent in the bathroom and they needed to leave bathroom door open for heat. Four bath blankets were rolled up on the windowsill next to the glass. R36 stated they were there to prevent cold air from entering the room. The wall adjacent from window had 2 large gouges out of it, approximately 4 inches wide, 24 inches long and two inches deep, it had unpainted patchwork around the area. A privacy curtain hung with missing hooks and unable to fully close. The dull blue/gray curtain was covered in brown splotchy areas of unknown substance ranging in size from 1 inch by 1 inch to 4 inches by 3 inches. The floor to ceiling cabinetry was not securely affixed to the wall. It was very unstable, wiggled and moved with any activity. R36 stated they did not consider it a homelike environment, that the place is falling down, and no one cares. During an interview on 12/12/24 at 9:51 a.m., licensed practical nurse (LPN)-D stated the process for a concern in a resident ' s room was to discuss concern(s) with administrator. There was not a maintenance department in the facility. LPN-D observed the cabinetry and confirmed there was a safety concern and reported that to administrator. During an interview on 12/12/24 at 2:49 p.m., registered nurse (RN)-A stated any concern with a resident ' s room was brought to the administrator. RN-A stated that safety of the residents was the number one concern, and verbalized the cabinetry would be shown to the management.	F 584		

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F 584	Continued From page 47 During an interview on 12/13/24 at 11:48 a.m., administrator discussed the maintenance policy and procedure of rooms and facility. He verified there was not a maintenance department in the facility. A corporate maintenance person came to facility once a month. The facility policy on Safe and Homelike Environment Policy dated 6/16/22 stated Policy: In accordance with residents' rights, the facility will provide a safe and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk.	F 584		
F 645 SS=D	PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3) §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires	F 645		1/31/25

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F 645	Continued From page 48 specialized services; or (ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission- (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability. §483.20(k)(2) Exceptions. For purposes of this section- (i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital. (ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual- (A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital, (B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and (C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services. §483.20(k)(3) Definition. For purposes of this section-	F 645		

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F 645	Continued From page 49 (i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1). (ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure a Level II Pre-Admission Screening and Resident Review (PASARR) was completed to screen for mental health needs for 1 of 1 residents (R8) reviewed for PASARR. Findings include: R8 admission Minimum Data Set (MDS) dated 2/25/24, included diagnosis of schizophrenia. R8's order summary report dated 4/3/24, included diagnoses of mild cognitive impairment, schizoaffective disorder (a mental health disorder with symptoms of both schizophrenia and a mood disorder), depression, bipolar disorder (extreme mood swings), and hoarding disorder. R8's preadmission screening results (PAS) dated 1/11/24, included the R8 would need a Level II assessment for mental illness. During interview on 12/11/24 at 9:11 a.m., social services (SS)-A stated she did an audit of all PAS results when she was hired and R8's previous PAS was unclear, but she thought she may have needed a Level II. SS-A resubmitted R8's PAS information at that time. SS-A stated she did not realize the PAS results indicated a Level II	F 645	" A level II PASSR was obtained for the effected individual and the results have been implemented into his care plan; administrative staff have been re-educated on the importance of obtaining this information and the process by which to do so. " A review of current residents was completed to ensure appropriate PASSRs on file. " Current Residents have the potential to be affected by this alleged deficiency. " This item is listed on a new Admission Audit that will be required for new coming Residents, which will be required to be presented at our Weekly At Risk meeting for IDT review. " The Admissions Audit will be reviewed on a 1x weekly basis for 6 weeks, then 1x monthly for 3 months. If compliance is not met at this time, audits will be repeated. Audits will be performed by the ED, DON or designee, with documentation of each audit logged to be reviewed by QAPI on a quarterly basis.	

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F 645	Continued From page 50 assessment was needed. SS-A confirmed upon review of PAS results dated 1/11/24, a Level II assessment was required. During interview on 12/12/24 at 1:50 p.m., SS-A state it was important to know if there was a mental health or developmental disorder so the facility would know how to care of them. Facility policy requested and not provided.	F 645	" Re-education will be provided using PASSR website by DON for SS and Unit Managers.	
F 676 SS=D	Activities Daily Living (ADLs)/Mntn Abilities CFR(s): 483.24(a)(1)(b)(1)-(5)(i)-(iii) §483.24(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that: §483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section ... §483.24(b) Activities of daily living. The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living: §483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care, §483.24(b)(2) Mobility-transfer and ambulation,	F 676		1/31/25

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F 676	Continued From page 51 including walking, §483.24(b)(3) Elimination-toileting, §483.24(b)(4) Dining-eating, including meals and snacks, §483.24(b)(5) Communication, including (i) Speech, (ii) Language, (iii) Other functional communication systems. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a shower was offered or provided for 1 of 3 residents (R30) reviewed for bathing. Findings include: R30's quarterly Minimum Data Set (MDS) dated 9/24/24, indicated he had moderately impaired cognition with a memory deficit following a cerebrovascular accident (CVA, or a stroke), weakness and paralysis or inability to move his left dominant side after a stroke, depression, and dementia (a condition causing a decline in cognitive function, memory, and behavior). His MDS indicated he displayed no rejection of cares and required substantial to maximal staff assistance for bathing/showering cares and mobility and transfers. R30's annual MDS dated 6/24/24, identified bathing preferences were "very important" to him. R30's functional abilities Care Area Assessment (CAA) dated 6/24/24, was triggered due to his need for assistance with ADL cares and identified he was at risk for ADL decline and directed staff	F 676	" R30 was offered and received a shower. R30□s care plan was updated to reflect his preferred shower schedule. " Current Residents were subject to an audit of their care plans to ensure they were properly scheduled for showers; staff was re-educated on the necessity of resident showering and the process by which to document each shower. " Unit managers or designee will audit resident showers and refusals on weekly basis and will continue to do so until compliance is met. " Unit managers or designee will perform an audit of 5 medical records per week for 6 weeks, then monthly for 3 months to ensure baths/showers are offered and given as appropriate. If compliance is not met at this time, audits will be repeated. Audits will be performed by the ED, DON or designee, with documentation of each audit logged to be reviewed by QAPI on a quarterly basis " Re-education will be provided using PCC, by DON for Unit Managers	

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F 676	Continued From page 52 to the plan of care. R30's care plan revised 7/5/24, identified his self-care deficit and directed staff to provide assist of 1 with bathing and showering cares to meet his goal of receiving assistance necessary to meet his ADL needs. R30's Kardex indicated his shower was scheduled for Tuesday mornings. R30's PointOfCare (POC) ADL - Shower on Tuesday Am's Task was reviewed 12/13/24, and lacked documentation of showering/bathing cares for the last 30 days. R30's progress notes were reviewed on 12/16/24, and lacked documentation of shower refusals. During interview on 12/09/24 at 6:36 p.m., R30 stated he was last offered a shower "a couple months back," but it was during a time when the facility had turned off the hot water, so he declined. R30 reported this was the last time he could recall staff offering him a shower, and he believed that to be sometime in October 2024. R30 vocalized a wish to be offered a shower "at least monthly." During interview on 12/13/24 at 3:09 p.m., nursing assistant (NA)-B was unable to find documentation of R30's last shower. During interview on 12/13/24 at 3:15 p.m., licensed practical nurse (LPN)-J reviewed R30's skin assessments and explained weekly skin assessments coincided with resident's scheduled showers. LPN-J stated R30's last skin assessment was done on 12/5/24, and his most	F 676		

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F 676	Continued From page 53	F 676		

recent was completed 12/13/24. LPN-J used the skin assessment to report R30's last shower was "today."

During interview and observation on 12/16/24 at 8:16 a.m., R30, sat in his wheelchair in his room. His hair appeared shiny and slick. R30 stated he did not take and was not offered a shower throughout the survey week of 12/9/24 - 12/16/24.

Per interview on 12/16/24 at 9:16 a.m., with nursing assistant (NA)-A, resident showers were documented in POC and if a resident refused, NAs should document the refusal in addition to reporting it to the nurse.

Per interview on 12/16/24 at 9:33 a.m., with licensed practical nurse (LPN)-D, R30's shower day was Tuesday. LPN-D reviewed his electronic medical record (EMR) and was unable to locate R30's last documented shower. LPN-D verified there was no documentation in the progress notes about him refusing a shower. LPN-D expected NAs to report any concerns identified during a bath or shower, including a refusal, to the nurse. LPN-D stated if the NAs reported anything of concern or a refusal, "I'll document that."

During interview on 12/16/24 at 9:20 a.m., LPN-C stated the resident shower schedule was posted in the nurse's station and verified the posted schedule. LPN-C expected NAs to notify the nurse on duty if a resident refused a shower and stated the nurse should document the refusal as well.

During interview on 12/16/24 at 9:43 a.m., LPN-A (also the unit manager) stated NAs were

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F 676	Continued From page 54 expected to document in POC under the tasks section if a resident had a shower and if a resident refused, NAs were expected to report to the nurse on duty and the nurse expected to document in the progress notes. LPN-A stated NAs should be aware of scheduled showers/baths because the schedule was printed and posted at the nurse's station, the schedule as discussed during shift report, and it was on their POC tasks. LPN-A expected R30's last shower date to be 12/10/24 and expected to see documentation in POC or a refusal documented in the progress notes. LPN-A confirmed there were no documented refusals in the progress notes. LPN-A was unable to provide documentation of R30's last shower in POC. Per interview on 12/16/24 at 12:01 p.m., with the director of nursing (DON), NAs were expected to offer a shower on resident's scheduled shower/bathing day and document in POC. If the resident refused a shower, NAs were expected to report to the nurse on duty, and the nurse was expected to document in progress notes. The DON reviewed R30's EMR and confirmed there was no documentation of a shower or of a refusal. The DON explained staff may have offered his shower as a part of his morning cares and if he refused, it may not be reflected as a "true refusal" because the "skin check may or may not be done." The DON endorsed staff "may not be the greatest" at documenting when a bed bath was performed. The DON stated it was important to offer showering to residents to promote dignity and overall health. Per facility policy titled Resident Rights last revised 7/2022, residents would be treated with respect and dignity and care. The policy identified	F 676		

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F 676	Continued From page 55 the resident's right to request, refuse and/or discontinue treatment, and the right to make choices about aspects of his/her life in the facility that are significant to the resident including the choice of healthcare consistent with the resident's interests, assessments, plan of care and other choices. Per facility policy titled NSG - Activities of Daily Living (ADLS) dated 7/26/22, the facility would, based on the resident's comprehensive assessment and consistent with the resident's needs and choices, ensure a resident's abilities in ADLs do not deteriorate unless avoidable. The policy identified care and services would be provided for ADLs including bathing, dressing, grooming and oral care.	F 676		
F 679 SS=D	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a resident's preferred activities for individual entertainment were offered for 1 of 1 residents (R26) reviewed for activities.	F 679	The Resident affected has been reassessed for their activity preferences. The Activity Preference survey was updated on 1/10/25 with her daughter on the telephone for interpretation. The	1/16/25

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F 679	Continued From page 56 Findings include: R26's quarterly Minimum Data Set (MDS) dated 9/26/24, indicated she had severely impaired cognition and was marked "not applicable" for transfers. The MDS identified diagnoses of muscle weakness, depression, and high blood pressure. R26's significant change MDS dated 1/3/24, indicated it was "very important" to R5 to participate in her favorite activities and to go outside and get fresh air when the weather is good. R26's Care Area Assessment (CAA) for communication dated 1/3/24, indicated R5 was "usually" understood and "usually" understands. The CAA identified she was at risk for missed information and unmet needs as her primary language was Russian, but she did know "some English." The CAA indicated she was able to make her needs known and guided staff to proceed the plan of care. An activity participation review dated 9/26/24, indicated R5 did not attend any small or large group activities, rather preferred 1:1's and attended those "2-3 x a week". The review indicated R5 "spends much of her time in bed," and watched TV, read books, had visits from a "family friend and daughter". Furthermore, the review indicated life enrichment or activities staff visited 2-3 times per week and because R5 spoke Russian, she was able to "socialize some when visited" by staff" and "she smiles and giggles at times and appears to enjoy the visits." The review indicated R5 participated in individual	F 679	Activity Director also completed the Activity Preference Survey with other current residents on 1/10/25. The information received by survey will become part of the Activity planning for each resident going forward. The ED met with Residents on1/9/25 with the agenda containing a Survey review, activity questionnaire, staffing, Prioritization on Home Like environment projects and Ombudsman contact information. There was open discussion related to any other issues and Residents were satisfied with the plans and invited the ED back for an update as plans proceed. Current residents were potentially affected by this alleged deficiency. The Activities Director or designee will bring a list of residents who are not participating in activities to the Weekly at Risk meeting, Those residents who are consistently not participating in activities will have their activity care plan reviewed for possible goals and interventions by the WAR committee members and updated plan of care if deemed appropriate. This will be audited on a 1x weekly basis for 6 weeks, then monthly for 1x monthly for 3 months. If compliance is not met at this time, audits will be repeated. Audits will be performed by the ED, DON or designee, with documentation of audit logs to be reviewed by QAPI on a quarterly basis. Re-Re-education will be provided with Activities Director review of Facility Policy titled Activities.	

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F 679	Continued From page 57 activities "daily" and included family and friend visits and identified her favorite activities as cognitive (reads Russian books); Entertainment (Russian television); Spiritual (Jewish faith); Social (1:1, snack, socials and visits with staff, Family friend visits), and pet visits. The review lacked documentation of her preference to go outdoors for fresh air. The review identified R5's progress towards her activity goals were not met and had been revised in the care plan. Additionally, the review identified her activity-related IDT interventions/approaches had not been effective towards reaching her goals and new approaches were added to the care plan. R26's undated and unsigned order summary was reviewed 12/11/24 and reflected the following orders: - "up in w/c [sic, wheelchair] one time per day for core strengthening in the afternoon" for muscle wasting (a loss of muscle mass and strength), dated 9/9/24. R26's care plan last revised 9/26/24, indicated she preferred not to attend group activities due to her primary language being Russian, although she did speak and understand some English. The care plan identified she preferred to spend time in her room resting and watching television. The care plan included her "meaningful" interests last revised 3/18/23, of 1:1 visits with life enrichment or activities staff, television, and reading. The care plan identified interventions including the following: - "Provide 1;1 activity visit of potential interest (i.e. discussion of family, books) 2 - 3 x per week." - "Will respect choice in regard to limited/no activity participation."	F 679		

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F 679	Continued From page 58 - "Will visit to offer leisure supplies/materials as able. DTR [sic, daughter] to bring Russian specific supplies." Conversely, R5's care plan identified her difficulty communicating as she spoke Russian and little English. The goal was to use an alternative method to communicate needs/wants, including a translator. Additional goals included demonstrate understanding by completing task when requested and needs would be met with comfort and dignity. The care plan directed staff to call an interpreter for translation and provided a contact number with instructions, and to involve R5 in activities that did not rely on her ability to communicate or hear, such as parties, crafts, or movies. The care plan lacked resident preference for going outside to get fresh air when the weather was good as identified in her significant change MDS dated 1/3/24. A PointOfCare (POC) task record printed 12/10/24, to "make sure resident is up in wheelchair every day for one hour during lunch. Inform nurse if resident refuses to get up", with a lookback period of 30 days reflected, "No Data Found". The record lacked documentation staff attempted or offered to get resident up in wheelchair every day. A POC task record printed 12/10/24, for "ADL - transferring Hoyer with two staff," with a look-back period of 30 days indicated out of 84 opportunities, R5 required limited assistance ("resident highly involved in activity, staff provide guidance maneuvering of limbs or other	F 679		

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F 679	Continued From page 59	F 679		

non-weight-bearing assistance) on 8 instances; total-dependence ("full staff performance") on 11 instances; required extensive assistance ("resident involved activity, staff provide weight-bearing assistance") on 3 instances; and staff documented "not applicable" on 61 instances.

A POC task record printed 12/10/24, for "ADL [sic, Activities of Daily Living]- Activity Participation, Which Activity?", with a look-back period of 30 days indicated R5 participated in "move/TV" activities on 5 instances and a "family/friend visit" on 1 instance. The record lacked documentation of R5's preferred activity of going outside for fresh air.

A POC task record printed 12/10/24, for "ADL - Activity Participation - Activity", with a look-back period of 30 days indicated R5 was "independent" for 6 out of the 7 instances and a "1:1" for 1 of the 7 instances on the record.

R5's Kardex, printed on 12/16/24, lacked documentation of her preferred activity of going outside for fresh air. The Kardex included directions to staff to "make sure resident is up in wheelchair every day for one hour during lunch. Inform nurse if resident refuses to get up."

During observation on 12/9/24 at 2:58 p.m., R5 was lying in bed wearing a hospital gown. R5 stated she wished staff would bring her outside more often. Her family member (FM)-D was at bedside visiting and R5 said something in Russian to FM-D, and FM-D translated back, "she said, 'they do not take me outside.'"

During observation on 12/10/24 at 8:27 a.m., R5

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F 679	Continued From page 60 was lying in bed wearing a hospital gown with the television on. During observation on 12/11/24 at 7:34 a.m., nursing assistant (NA)-D performed morning ADL cares and stated R5 was able to "listen clearly" and could point to things she wanted if she did not know the word for it. NA-D stated R5 knew a little English and was able to make her basic needs known. NA-D stated, "we offer sometimes" to get her up for a meal or "if she wants to get up", but R5's family "says if she doesn't want to, we don't need to push it. We were in the meeting, some of the nurses, and that's what they want us to do." NA-D stated R5 got out of bed "once or twice a week," and if she refused, NAs were expected to report the refusal to the nurse. NA-D exited the room after morning cares without offer to reposition, get R5 up in the wheelchair, or offer of activity. There was a calendar taped to R5's closet door for "September" and it listed some "speech eval" dates but no activities identified. There was no activities calendar in R5's room. During follow-up interview on 12/11/24 at 7:54 a.m., NA-D stated R5's family brought her outside for activities and thought activities (A)-A "sometimes" brought her "around the unit to look at things", but stated R5 was not "someone who goes to other activities" and would tell staff if she wanted to go. During observation on 12/13/24 at 9:53 a.m., R5 was lying in bed wearing a hospital gown with the television on. Per interview on 12/13/24 at 9:11 a.m. with A-A, residents were assessed for their activity preferences quarterly, annually, and with	F 679		

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F 679	Continued From page 61 significant changes, and those preferences were documented in the care plan. A-A stated R5 slept "at intervals throughout the day" and didn't want to wake her if she was asleep. A-A indicated R5 had a history of refusing to get up and refusing activities. A-A stated for special occasions, like parties or Bingo, staff offered to get R5 out of bed for the activity, "but she refuses". A-A identified R5 liked 1:1 visits and "used to" like reading Russian books, but stated that went in streaks. A-A confirmed, "the language barrier can be an issue, but I try and articulate in English, and I will comment about her Russian television programs," and added, R5 "sure likes" the visits, as evidenced by her smiles during the visit. A-A stated during "warmer months" when R5's family visited, they would bring her outside and verified staff would notify activities if she was up in her wheelchair. A-A could not recall R5 asking to go outside directly but confirmed being unable to meet R5's activity preferences stating, "I have not been able to get her up and in the wheelchair to go seeing the building." A-A believed activities helped with resident engagement, potentially reducing accidents like falls, improve resident satisfaction and helped "residents feel good." A-A confirmed being the only activities staff in the facility and stated, "when I'm not here, its independent activities" adding having more staff in the department would "definitely" be helpful. A-A indicated on scheduled days off, "the staff pretty much know what I do from seeing what I do, they know what the residents like from seeing what I do," and stated there was a basket of puzzles, coloring sheets, card games, and magazines in the unit manager's office on the memory care unit. A-A stated the residents off the memory care unit were more independent and some preferred to stay in bed and were not	F 679		

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F 679	Continued From page 62 engaged. Per interview on 12/13/24 at 10:24 a.m. with the administrator, also acting as the interim co-scheduler with the director of nursing (DON), confirmed the facility's activities department "could be more robust," but believed residents overall were "enjoying themselves." They verified A-A was the only activities staff and stated there was capability for other staff to provide activities for residents to do when A-A was not scheduled. The administrator stated A-A visited the residents and did not believe the facility had "lonely" residents. The administrator believed, "you can always use more resources around" activities and believed this to be true for all facilities "throughout the system." During interview on 12/16/24 at 12:01 p.m., the DON stated activities were "super important" because it helped residents feel like they were "a part of something" and was good for their mental health. The DON wished the facility could provide more activities and believed A-A was "pushed past her limit". The DON was not aware of R5's request to go outdoors for fresh air and stated, "if she's communicating, I've never heard she's communicated that to staff." The DON stated, "it's difficult to know how much R5 knows about activities." The DON stated R5 could be agreeable to get up in the wheelchair for "a good reason" like an appointment but could decline to get up for a "party." The DON expected staff to offer activities and opportunities to get up out of bed and document refusals but was unsure of nursing staff were documenting R5's refusals as they "should be". Per facility policy titled Activities last revised	F 679		

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F 679	Continued From page 63 7/11/22, the facility would provide an ongoing program to support residents in their choice of activities based on their comprehensive assessment, care plan, and preferences. Per the policy, each resident's interests and needs would be assessed on a routine basis and would include an activity assessment to include a resident's interests, preferences and needed adaptations. Furthermore, the policy identified activities could include indoor and outdoor activities and directed staff to assist residents to and from activities when necessary. Additionally, the policy indicated the facility would consider accommodations in schedules, supplies and timing in order to optimize a resident's ability to participate in an activity of choice.	F 679		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon	F 690		1/31/25

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F 690	Continued From page 64 as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a resident was comprehensively assessed for appropriate treatment and services to prevent urinary tract infections (UTIs) and to restore continence to the extent possible for 1 of 1 residents (R3) reviewed for toileting programs. Findings include: R3's quarterly Minimum Data Set (MDS) dated 12/06/24, reported she had intact cognition, no hallucinations, delusions, or verbal, physical or other behavioral symptoms towards herself or others. The MDS identified R3 was dependent on staff for toileting hygiene and transfers, required substantial to maximal assist for mobility and all other transfers, had no urinary catheters, had not trialed a urinary or bowel toileting training program and was frequently incontinent of urine and bowel. Additionally, the MDS identified R3 was at risk for pressure injury wound.	F 690	The affected resident has had a comprehensive bowel and bladder assessment performed and their care plan updated. Current Residents will complete a new bowel and bladder assessment within the quarter. Current Residents were potentially affected by this alleged deficiency. Bowel and bladder assessments are scheduled per MDS either annually or after a significant change. The MDS nurse will audit the complete of these assessments 1x weekly for six weeks, then 1x monthly for three months. If compliance is not met at this time, audits will be repeated. Audits will be performed by the ED, DON or designee, with documentation of each audit logged to be reviewed by QAPI on a quarterly basis. Re-education will be provided using Relias □ Restorative Nursing: Bowel and Bladder for current CNA and Nurses	

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F 690	Continued From page 65 R3's Care Area Assessment (CAA) for urinary incontinence dated 11/8/24, confirmed the risk for skin breakdown and stated, "she is at risk for MSAD [sic, moisture associated skin dermatitis] and infection." Furthermore, the CAA identified R3's history of urinary tract infections and listed preventative interventions staff implemented, including "thorough peri care [sic, perineal] provided and barrier cream applied by staff as needed." R3's diagnosis report dated 12/12/24, indicated she had arthritis (inflammation of the joints causing pain, stiffness, and impaired mobility), muscle weakness, reduced mobility, right hip replacement, unsteadiness on feet, history of UTIs, depression, unspecified psychosis (a cluster of symptoms causing a person to lose touch or have a break with reality) not due to a substance or known physiological condition, anxiety, sleep apnea (a disorder that can cause people to stop breathing when they are asleep), and chronic pain syndrome. A bladder/incontinence evaluation dated 10/16/24, identified R3 took a narcotic/sedative/hypnotic medication that might have contributed to her bladder dysfunction. The evaluation summary reported, "resident stable." The evaluation was otherwise blank, and lacked further documentation of other potential risk factors contributing to her bladder incontinence. A bladder/incontinence evaluation dated 11/5/24, identified R3's risk factors for incontinence included impaired mobility and her dependence on 2 persons for transfers. The evaluation identified R3 was currently incontinent of bladder	F 690		

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F 690	Continued From page 66 and the signs and symptoms exhibited included urgency, daytime frequency, and nocturia (a medical term for waking up at night to urinate, in this evaluation, it means greater than 2 times per night). Additional risk factors identified included polypharmacy (taking many medications), a history of UTIs, and taking antidepressant and antianxiety medications. The evaluation indicated a physical examination had not been performed, no post void residual (PVR) studies had been attempted, and no treatment program initiated. The evaluation cited R3's impaired cognition and mobility in determining her mixed incontinence (stress and urge) but lacked documented treatment programs and/or interventions that may promote R3's continence or improve her current level of function. The evaluation summarized the assessment, "incontinence both bowel and bladder." R3's care plan revised on 11/15/24, identified R3's activities of daily living (ADL) self-care deficit and directed staff to provide 2 staff assist with toileting, bed mobility, and transfers. Additionally, the care plan indicated staff should use a "hoyer large sling" for transfers to meet R3's goal to improve current level of function in ADLs. R3's care plan also identified her urinary and bowel incontinence related to "deconditioning secondary to UTI" lasted revised 11/15/24. The care plan outlined her goal to have no complications due to incontinence and directed staff to provide assistance with toileting and incontinence cares, use absorbent products as needed, and report signs and symptoms of UTI and skin breakdown. The care plan lacked interventions to promote R3's continence or improve current level of function.	F 690		

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F 690	Continued From page 67 R3's care plan furthermore identified her risk for alteration in skin integrity related to her impaired mobility and incontinence. The goal, last revised 11/15/24, was to decrease and/or minimalize skin breakdown risks and resolve yeast (fungal) infection. The care plan guided staff to apply barrier cream as needed, encourage her to reposition as needed, float heels as able, observe for and report skin changes and utilize pressure redistributing devices in her bed and chair. The care plan focus lacked interventions to promote continence and/or improve her current level of functioning to reduce her risk of skin breakdown. R3's hard chart was reviewed on 12/11/24 and included the following orders: - Diflucan (antifungal) for vaginitis (inflammation of the vagina), dated 12/10/24. - cefuroxime (antibiotic) for UTI, dated 12/7/24. - urinalysis/urine culture (UA/UC, a lab test performed to diagnose and treat a UTI), dated 12/6/24. - UA (a urine lab test to preliminarily diagnose a UTI), dated 12/4/24. Per a lab report dated 12/6/24, the urine culture showed an abnormal growth of greater than 100,000 colony forming units (CFU)/milliliter (mL) Klebsiella pneumoniae (a bacteria). Copies of these orders and lab reports were requested but not received. A provider note dated 12/10/24, confirmed the hard chart orders and lab report and indicated she was "seen for urinary tract infection" and indicated she was started on Bactrim. Later UC resulted to be UC +> 1000,000 [sic] CFU/mL	F 690		

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F 690	Continued From page 68 Klebsiella pneumoniae. The provider note indicated an improvement of symptoms of dysuria (painful urination), urgency, and increased incontinence. Additionally, the provider note indicated, the patient's unspecified urinary incontinence is reportedly stable. Under the Assessment and Plan:, the provider issued new orders, including the Diflucan 150 milligrams (mg) by mouth (po) x 1 dose, may repeat in 72 hours if remains symptomatic (vaginal itching). A PlanOfCare (POC) for R3's task sign-off for transferring with a lookback period of 30 days, dated 11/12/24 - 12/11/24, indicated staff documented R3 required 2 person assistance with transfers on 33 instances, 1 person assisstance on 4 instances, "response not required" on 44 instances, and required no physical help or set-up on 1 instance out of 85 opportunities. Per physical therapy PT evaluation and plan of treatment note dated 11/22/24, R3 was referred to physical therapy for evaluation and treatment of a decline in her functional mobility per her provider. Per a physical therapy PT progress report dated 11/22/24 - 12/9/24, R3 met her goals of improved ability to transfer to a standing position from sitting with partial to moderate assistance with a front wheeled walker (FWW); to improve her ability to safely transfer and efficiently transfer to and from a bed to a chair (or wheelchair) with substantial to maximal assistance; and to safely ambulate on level surfaces 10 feet using two-wheeled walker with partial/moderate assistance to increase independence within the facility and to facilitate participation in functional	F 690		

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F 690	Continued From page 69	F 690		

activity. The progress report identified new goals, included ambulation goals at longer distances and less staff assistance with transfers. The report indicated R3 was making consistent progress towards reaching short-term and long-term goals and her condition has potential to improve as a result of skilled rehab and patient's functional performance is progressing as a result of exercises.

Per physical therapy treatment encounter note(s) dated 12/12/24, staff and R3 were trained on safe transfers using the EZ stand from the edge of her bed to the wheelchair and back again using 2 staff assistance. The note reported it was okay to downgrade the transfers to hoyer and notify therapy if R3 was deemed unsafe for any reason with the transfers. The note indicated R3 and staff confirmed they have not had safety concerns with EZ stand transfers, but confirm knowledge of ability to downgrade to ensure patient safety if concern were to arise. Made repeat rehab communication form to confirm continued EZ stand transfer status of assist of 2 staff for nursing staff.

During observation on 12/9/24 at 2:59 p.m., R3 was in her bed and appeared asleep.

During observation on 12/10/24 at 8:29 a.m., R3's room was dark, and the shades were pulled. She was in bed with the covers over her and her eyes were closed.

A continuous observation on 12/11/24 between 10:48 a.m. and 11:37 a.m. included:

10:48 a.m.: R3's call light was put on.
10:49 a.m.: nursing assistant (NA)-A entered R3's

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HOPKINS HEALTH SERVICES	725 SECOND AVENUE SOUTH HOPKINS, MN 55343

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 690	Continued From page 70 room to answer the call light and was heard stating she would be back to help her. Per interview at 10:49 a.m., R3 verified NA-A stated she would be back to help clean her up. 11:09 a.m.: the director of nursing (DON) walked down the hallway and asked where NA-A was. Within 2 minutes, the DON left the unit and was observed walking onto the elevator leaving the second floor. 11:13 a.m.: NA-A was not back to assist. An overhead page was heard announcing, "2 west, you have a resident call." 11:14 a.m.: There were no staff observed on the 2 East of the unit. An overhead page was heard announcing, "2 west nurse please call" and a call-back number was read aloud. 11:18 a.m.: No staff were present on the 2 east unit. 11:20 a.m.: Licensed practical nurse (LPN)-H walked onto the 2 east unit to the medication cart. 11:22 a.m.: LPN-H left the medication cart and walked off the 2 east unit. No staff have attempted to enter R3's room. 11:26 a.m.: Activities-(A) pushed another resident into his room and walked back out and off the 2 east unit without addressing other residents within a minute. 11:30 a.m.: NA-A walked off the elevator, walked through the nurse's station and into the nurse manager's office. No visible staff observed down the 2 west hallway or the 2 east hallway. 11:38: a.m.: An unidentified staff walked off the elevator and back to the nurse manager's office. 11: 41 a.m.: LPN-H and NA-A walk back to the 2 east unit and hallway. 11:42 a.m.: LPN-H and NA-A entered R3's room to assist with cares requested from call light request at start of observation.	F 690		

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F 690	Continued From page 71 During interview on 12/10/24 at 1:37 p.m., R3's family member (FM)-C verbalized concerns about the staffing in the facility and stated, "I think they're understaffed, and they don't have the time to respond to call lights or calls." FM-C identified evenings and mealtimes as the longest wait times when R3 puts her call light on for assistance. FM-C stated on numerous occasions while visiting during mealtimes, R3 put her call light on and staff "won't respond at all" and FM-C would have to go and find someone to talk to get help. FM-C reported during the evening, if R3 put her call light on and waited an extended period, she would call FM-C at home. FM-C would then call the facility using a personal phone to get staff to assist with R3's toileting cares. During interview on 12/11/24 at 9:13 a.m., R3 reported the call light wait times were "just horrible, weekends are the worst." R3 believed the longest she waited was an hour and was unable to recall any times where she had waited for her call light to be answered and become incontinent or had fallen. R3 stated she was not aware of her urge to void. During follow-up interview at 10:45 a.m., R3 stated she did "mind the bedpan," and had not attempted to use the bedside commode since her admission because "it just doesn't work". R3 stated felt like she "needs to have a bowel movement." During interview on 12/11/24 at 2:22 p.m., physical therapist (PT) verified R3 was working with physical therapy and was "picked back up" on 11/21/24 for "decline in strength with transfers". PT stated R3 was working on transfers and gait during their sessions and she "made a big jump" in her progress. PT confirmed R3 could	F 690		

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F 690	Continued From page 72 safely transfer with moderate to maximal assistance with 2 staff and a FWW, but expected NAs to use an EZ stand for transfers. PT verified R3's goals were to transfer without the EZ stand and to ambulate with staff safely. PT stated the obstacles for R3 in attaining her goals included her forgetting the "sequencing side of things", for example, the confusion in what she can do and in what order. PT stated the recommendations to nursing staff were to provide verbal cueing on what steps to perform and in what order and for R3 to call for help in getting out of bed. Per interview on 12/12/24 at 4:14 p.m., R3's nurse practitioner (NP) explained that Klebsiella pneumoniae, the bacteria found growing in her UC, was a "common bacteria in the gut" and verified the UTI diagnosis on 12/10 with the Ceftin antibiotic order on 12/7/24. NP further explained that Klebsiella pneumoniae was a common bacterium that could cause UTIs, stating "it could be common with poor hygiene. She has told me takes awhile to get cleaned up at the facility. Incontinence and poor hygiene could contribute to developing a UTI that showed Klebsiella growth". NP elaborated it could be "difficult for her to be entirely dry, being incontinent and with her mobility issues. I think she has had a delay in care due to her restricted mobility with not being able to get up and out of bed or move much." Per interview on 12/16/24 at 9:57 a.m. with LPN-A, R3 had not trialed and was not currently on a bowel or bladder toileting program. LPN-A stated occupational therapy initiated those programs and would only do so if a resident had awareness of their urge to use the bathroom, stating occupational therapy usually assessed a resident's awareness of continence during	F 690		

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F 690	Continued From page 73 admission, and if they did not identify that as a goal, "then we do not start" a toileting program. LPN-A stated if a resident was in the facility long-term and staff observed they were unable to do daily tasks they were once able to do for themselves but were currently unable to perform and the resident verbalized a desire to perform those ADLs, staff could request an occupational therapy evaluation. LPN-A stated R3 would not be a candidate for a toileting program because she could not stand and because she "admitted incontinent" of both bowel and bladder. LPN-A confirmed she was working with physical therapy and stated, "they've been trying to stand with her but we have not been." Per interview on 12/16/24 at 12:01 p.m. with the DON, a bowel and/or bladder toileting program can be initiated with an assessment or screener. The "biggest things" reviewed during the assessment include a resident's therapy status, transfer abilities, and skills. The DON stated it was "definitely an IDT discussion" and contradicted LPN-A, stating any staff person was able to bring up a concern or recommendation for a toileting program. The DON agreed occupational therapy could be responsible for guiding the program, but indicated the facility did not have an occupational therapist. The DON stated the benefits of a toileting program for residents included increased self-esteem and self-worth, decreased risk of UTIs and skin breakdown, and the potential for increased mobility for residents, and task and workload reduction for staff. The DON stated R3 "could be someone we could consider" for a toileting program at first glance, but "digging deeper, she might not be." The DON reported R3's cognitive issues, stating she "has hallucinations," and her	F 690		

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F 690	Continued From page 74 unawareness of her urge to void as the reasons a toileting program would not appropriate. The DON believed R3 would need therapy involved directly for a toileting program to be effective, stating, "saying the words 'therapy ending' to her" stopped her standing with nursing staff. The DON confirmed toileting a resident at the same time every day "is a good thing," and believed R3 could use a bedside commode with the "EZ stand". The DON verified the facility's staffing was "not ideal". The DON verified resident needs were exceeding staffing levels and agreed resident outcomes were suffering. The DON stated, "our staffing is not meeting the needs of our residents. If we're only meeting bare minimum, that's not good customer service." A facility assessment dated 8/8/24, indicated it evaluated the facility's resident population and identified resources needed to provide the necessary care and services to residents during day-to-day operations and emergencies. The assessment tool identified itself as a resource for the facility's leadership to use when making decisions for purposes regarding sufficient staffing numbers, competent staff, recruitment, and retention of staff, and continency planning for emergency events. The assessment indicated input form residents, their representatives, staff, and resident council meeting minutes were reviewed for applicable input. The assessment identified other pertinent facts or descriptions of the resident population to be considered when determining staffing and resource needs which included the following: - require a Hoyer or Sit-to-Stand lift (2-person transfer). - are on increased monitoring for behaviors or are	F 690		

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F 690	Continued From page 75 Cares in Pairs. - require hands-on transfer assistance. - have mixed preferences for eating in the dining room, versus resident room. - needs of ancillary staff (readying those residents who receive therapy by a certain time each, for instance). The assessment indicated physical therapy and specific rehabilitation services provided services such as ADL cares to support a resident's independence in doing as much of the ADLs by himself/herself. Furthermore, the assessment indicated it provided bowel and bladder care, including incontinence prevention and care and responding to requests for assistance to the bathroom or toilet promptly in order to maintain continence and promote dignity. A request for policies pertaining to toileting programs, incontinence, and staffing were requested but not received.	F 690		
F 725 SS=F	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.71.	F 725		1/31/25

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F 725	Continued From page 76 §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident as determined by the resident assessments, plans of care, and facility assessment. This had the potential to affect all residents residing in the facility. Bowel and Bladder - See F690 - R3 Findings include: R3's quarterly Minimum Data Set (MDS) dated 12/06/24, reported she had intact cognition, had no hallucinations, delusions, rejections of care, and no verbal, physical or other behavioral symptoms towards herself or others. The MDS identified R3 was dependent on staff for toileting hygiene and transfers, required substantial to maximal assist for mobility and all other transfers, had no urinary catheters, had not trialed a urinary	F 725	" A review of the nursing department schedule will be conducted once weekly by the NHA or designee to ensure a sufficient number of nursing staff is scheduled for work. " Nursing staff receiving re-education on the expectation to take break or lunch periods individually to ensure there are a sufficient number of staff available on the floor. Nursing staff must sign out and back in with the nurse to avoid having multiple staff on break during the same time. " Break/Lunch sign out sheets will be audited against the staff daily schedules on a 1x weekly basis for 6 weeks 2x monthly for 3 months to ensure there is sufficient staff on the unit. The results will be presented to QAPI at least quarterly. " Observations, including interviews with residents, will be conducted 3x weekly by the NHA or designee to ensure resident needs are being met timely. " DON to provide Re-education for	

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F 725	Continued From page 77 or bowel toileting training program and was frequently incontinent of urine and bowel. Additionally, the MDS identified R3 was at risk for pressure injury wound. During a continuous observation on 12/11/24 between 10:48 a.m. and 11:37 a.m., the following was observed: - 10:48 a.m.: R3's call light was put on. - 10:49 a.m.: nursing assistant (NA)-A entered R3's room to answer the call light and was heard stating she would be back to help her. Per interview at 10:49 a.m., R3 verified NA-A stated she would be back to help clean her up. - 11:09 a.m.: the director of nursing (DON) walked down the hallway and asked where NA-A was. Within 2 minutes, the DON left the unit and was observed walking onto the elevator leaving the second floor. - 11:13 a.m.: NA-A was not back to assist. An overhead page was heard announcing, "2 west, you have a resident call." - 11:14 a.m.: There were no staff observed on the 2 East of the unit. An overhead page was heard announcing, "2 west nurse please call" and a call-back number was read aloud. - 11:18 a.m.: No staff were present on the 2 east unit. - 11:20 a.m.: Licensed practical nurse (LPN)-H walked onto the 2 east unit to the medication cart. - 11:22 a.m.: LPN-H left the medication cart and walked off the 2 east unit. No staff have attempted to enter R3's room. - 11:26 a.m.: Activities-(A) pushed another resident into his room and walked back out and off the 2 east unit without addressing other	F 725	current nursing staff.	

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F 725	Continued From page 78	F 725		

residents within a minute.
- 11:30 a.m.: NA-A walked off the elevator, walked through the nurse's station and into the nurse manager's office. No visible staff observed down the 2 west hallway or the 2 east hallway.
- 11:38: a.m.: An unidentified staff walked off the elevator and into to the nurse manager's office. There were no nursing staff on either the 2 west hallway or 2 east hallway.
- 11: 41 a.m.: LPN-H and NA-A walk back to the 2 east unit and hallway.
- 11:42 a.m.: LPN-H and NA-A entered R3's room to assist with cares requested from call light request at start of observation.

Per interview on 12/9/24 at 3:19 p.m. with nursing assistant (NA)-F, there was "no staffing, no management and no one to do the scheduling right now." NA-F stated if someone called out of their shift, they normally find a replacement by asking nurses to overlap and help with the NA work. NA-F stated, "it happens that we [are] short but not often."

R23

The quarterly Minimum Data Set (MDS) dated 12/13/24, for R23 indicated moderately impaired cognition. MDS indicated on 10/12/24 cognitive loss, dementia, with decrease of functional abilities, falls, nutritional status, pressure ulcer/injury, and pain. R23 diagnosis on 1/25/24 peripheral vascular disease, absence of other left toes acquired absence of other right toes. R23 is full assist of two, non-weight bearing, has an air mat, reposition every 2 to 3 hours. Heel boot and float heels.

During an observation of R23 on 12/11/24 at 8:11

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F 725	Continued From page 79 a.m., nursing assistant (NA)-A completed hand hygiene, donned enhanced barrier precautions (EBP) and cleaned face and arms of R23. NA-A doffed EBP, left room, found another staff member to do peri cares and reposition. NA-D was in the dining room assisting residents with breakfast. The licensed practical nurse (LPN)-A was interrupted during a medication pass, washed hands, donned EBP performed cares and repositioned resident. During a continuous observation of R23 on 12/11/24 between 10:48 a.m. and 11:37 a.m.: - 10:48 a.m., call light on, no staff were observed in hallways - 11:10 a.m., no staff observed in hallway, call light remained on. - 11:20 a.m., no staff observed in hallway, call light remained on. - 11:36 a.m., a staff member was observed walking to the medicine cart and within one minute, walked away and off the unit. - 11:37 a.m., a staff member was observed walking in room and able to assist with cares per her call light request initiated at 10:48 a.m. Grievance/complaints A grievance/complaint report on 5/21/24, indicated R36 reported they were wet for 2.5 hours. They put on their call light at approximately 4:30 a.m., nursing assistant (NA)-A told R36 that they were the only NA on the floor, and they were taking a 2.5-hour break because of a 16-hour shift. R36 stated they were still wet at 6:00 a.m., and could not be changed as the day shift wasn't on yet. The follow up indicated the concern was discussed with staff their responsibility to provide cares.	F 725		

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F 725	Continued From page 80 A grievance/complaint report on 6/4/24, R19 told licensed practical nurse (LPN)-A that nursing assistant (NA)-A did not finish changing resident, NA-A walked out of room and left R19 unattended for 35 minutes without coming back or saying anything to resident. The follow up indicated LPN-A found nursing assistants (NA)-D and NA A, on break together. The staff were brought back to the floor and completed the cares for R19. A group meeting was held with registered nurse (RN)-B, LPN-A, LPN-D, NA-A and NA-D. The result of actions where two NAs were verbally counseled. The resolution of grievance included R19 was very upset, and staff explained R19 was able to report situations at any time. A grievance/complaint report on 6/28/24, identified the interdisciplinary team (IDT) held a quarterly meeting, and R19 reported she was upset that she was not being assisted up in wheelchair due to being short staffed. The report indicated nursing confirmed staffing was insufficient. The follow up for R19 included the administration discussed care plan, observed staffing on the floor, and provided the ability to transfer R19 into wheelchair. A grievance/complaint report on 7/31/24, included R19 informed the facility they were not changed after a bowel movement. They indicated they waited for 3 hours because there was not enough staff to provide cares. R19 put on call light at least two times an hour, and was repeatedly told by staff, they were not able to provide cares. The follow up was a staff meeting, and R19 should notify the manager each time this type of incident happens. Staff involved were unnamed.	F 725		

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A grievance/complaint report on 8/21/24, indicated R37 stated they put on their call light at 12:30 a.m. for a brief change. A staff member came into room, turned off call light, and told R37 it will get done. The staff did not return, and R37 reported they did not get changed until 6:15 a.m. The facility follow up included providing coaching for staff members.

A grievance/complaint report on 8/30/24, indicated at approximately 2:00 a.m., R37 put on their call light to request a brief change and water. Licensed practical nurse (LPN)-G answered the call light, left, and did not come back for approximately 2 hours to change him. R37 put call light on, requested to sit in chair, and a staff member told him they aren't going to get him up. The follow up included a staff meeting to explain requirement to provide cares, answer call lights promptly, and honor resident wishes.

A grievance/complaint report on 9/19/24, indicated R37 put their call light on at 7:30 p.m. to request a brief change for bowel movement. R37 was banging on the foot of bed to get help. Licensed practical nurse (LPN)-I told R37 that the nursing assistant (NA) left at 8:30 pm, and R37 needed to wait to be changed. R37 asked LPN-I to change him. LPN-I turned off call light and did not change him. R37 put light on again, was changed at 11:30 pm. The facility follow up was to remind staff to answer call lights and resolve the issue.

Resident council meetings minutes 10/20/24, were reviewed on 12/16/24, and identified call light wait times were brought up as a concern. Resident council meeting minutes dated 9/18/24, were reviewed on 12/16/24, and identified call

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F 725	Continued From page 82 light wait times was discussed. Resident council meeting minutes dated 10/20/24, were reviewed on 12/16/24, and identified call light wait times were brought up as a concern." A resident council meeting was held on 12/10/24 at 10:00 a.m., R36 reported call lights take "a long time" to answer. R37 stated call lights wait times take the longest to be answered "in the evening and at night". R30 reported the facility had been without a maintenance worker and "the facility needs so much work" because "the place is falling down". R30 verbalized they did not feel the facility had enough staff to take care of the building or to take care of residents. During an interview on 12/11/24 at 8:34 a.m., nursing assistant (NA)-A stated, when the cares are difficult to complete when residents are an assist of two. The staff were interrupted during medication passes, and during meals. One staff member was in the dining room. There was not enough staff to complete morning cares on time. During an interview on 12/12/24 at 2:19 p.m., licensed practical nurse (LPN)- D confirmed there was 9 out of 18 residents on 2 east and 2 west hallways required assist of two to provide safe cares. It is difficult to complete cares when interrupted with phone calls, mealtimes, and medication pass. During an interview on 12/13/24 at 10:21 a.m., administrator, stated the staff schedule has double shifts built in. In case of a no show/sick call or emergencies, bonuses were offered to other staff. The management and ancillary staff assisted with tasks that were necessary for the residents. He verbalized the staffing for cares in	F 725		

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pairs was a concern. The staff, residents and families brought workload concerns to facility by email, phone number, able to submit anonymously. The system to address concerns were quality assurance and performance improvement (QUAPI), interdisciplinary team (IDT) and meetings.

During an interview on 12/16/24 at 10:10 a.m., director of nursing (DON) verified insufficient staffing. The DON stated the resident needs outweigh the staff available. DON stated, lack of support from corporate, and being a new DON, mentorship was needed but fell by the wayside. The DON confirmed the acuity for the residents is high, 9 out of 18 residents required assist of two staff for cares. Staffing and management were working with corporate to get staffing numbers up. The facility was actively recruiting for a health unit coordinator or receptionist to assist in tasks in the facility. This facility did not utilize pool, contract or agency nursing. The maintenance director resigned; no daily maintenance is completed. Corporate sent someone out once a month to do repairs. The system was in place for workload concerns are phone number for grievances, and email, anonymously if desired.

During interview on 12/13/24 at 10:24 a.m., the administrator verified being responsible for the scheduling with the DON. The administrator reflected on the facility's recent self-reported investigations and requirement to remove staff from the schedule and verified it had not been easy to schedule around their absences but stated "we've been able to provide cares." The administrator stated the levels of care were assessed during interdisciplinary team (IDT) meetings "every day", including resident

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F 725	Continued From page 84 behaviors. The administrator believed the staffing approaches covered the acuity needs of the residents. When asked about the continuous observation on 12/11/24, and if that was a demonstration of appropriate staffing, the administrator stated, "I expect a call light to be answered ideally within 10-15 minutes," and stated the expectation was to provide cares in an appropriate and safe manner. The administrator stated they discuss resident acuity and case mix daily but stated residents requiring cares in pairs are not always considered in their case mix or acuity count. The DON verified the facility's staffing was "not ideal" and stated the administrator had received the "short end of the stick". The DON stated they both were "taking hits" and had received "discipline" by corporate management for "staffing the way we do and we're still not meeting the acuity needs." The DON stated they are urging families to file formal grievances to aid in their efforts to support their staffing needs. The DON stated they did not have employees to call on as back-ups for instances of no-call/no-shows and did not have the permission to set that up. The DON verified resident needs were exceeding staffing levels and agreed resident outcomes were suffering. The DON stated, "Our staffing is not meeting the needs of our residents. If we're only meeting bare minimum, that's not good customer service." A facility assessment dated 8/8/24, indicated it evaluated the facility's resident population and identified resources needed to provide the necessary care and services to residents during day-to-day operations and emergencies. The assessment tool identified itself as a resource for	F 725		

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F 725	Continued From page 85 the facility's leadership to use when making decisions for purposes regarding sufficient staffing numbers, competent staff, recruitment, and retention of staff, and continency planning for emergency events. The assessment indicated input from residents, their representatives, staff, and resident council meeting minutes were reviewed for applicable input. The assessment identified other "pertinent facts or descriptions of the resident population to be considered when determining staffing and resource needs" which included the following: - "require a Hoyer or Sit-to-Stand lift (2-person transfer)". - "are on increased monitoring for behaviors or are Cares in Pairs". - "require hands-on transfer assistance". - "Have mixed preferences for eating in the dining room, versus resident room". - "needs of ancillary staff (readying those residents who receive therapy by a certain time each, for instance)". The assessment indicated physical therapy and specific rehabilitation services provided services such as ADL cares to support a resident's independence in doing as much of the ADLs by himself/herself. Furthermore, the assessment indicated it provided bowel and bladder care, including incontinence prevention and care and responding to requests for assistance to the bathroom or toilet promptly in order to maintain continence and promote dignity. The assessment concluded the staffing level process was to consider the corporate staffing requirements and identified the facility-specific requirements at a census of 43 residents or more, the staffing levels should be 3 licensed	F 725		

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nurses on the day and evening shifts and 2 nurses on the overnight shift; 4 NAs on the day and evening shifts and 2 NAs overnight with 2 nurse managers at least 8 hours per day Monday through Friday. Additionally, the assessment indicated an acuity consideration of "over one third of our residents require two-person assistance with transfers, either stand-by assist or Hoyer or EZ stand lifts" and "due to behavioral issues, one third of our residents are care planned to be Cares in Pairs and require two individuals to be present during all cares". Additionally, the assessment always included memory care's requirement of 2 staff on the floor at all times for safety with wandering residents.

Meal Service

The facility assessment dated 8/8/24, indicated "meals are served from the same dining room at the same time for all units, delivering meals that are hot and palatable is best done with full staff". The assessment also indicated meals were delivered in a space preferred by the resident, either in their room or in the dining room and "staff must accommodate both preferences and deliver meals in a timely manner to ensure food safety be maintained."

During observation and interview on 12/10/24 at 8:15 a.m., residents were seated in the memory care dining area, and a resident asked where breakfast was at. The resident stated breakfast was supposed to start at 8 a.m. and stated the current time. At 8:17 a.m., another resident asked when the food was going to arrive. Nursing assistant (NA)-G stated breakfast was coming soon and gave the resident some drinks. At 8:19

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a.m., the nurse stated the food would arrive in a few minutes. At 8:24 a.m., dietary aide (DA)-A entered the memory care area with breakfast in a closed container and a cart of juice and coffee.

When interviewed on 12/11/24 at 8:56 a.m., NA-G stated breakfast was usually served around 8:10 and 8:15 a.m. and was an improvement.

During meal observation and interviews on 12/11/24 at 11:59 a.m., cook (C)-A brought a serving cart with food and items to serve from the main kitchen on the first floor to the second floor. C-A placed food in the transitional care unit (TCU) and long-term care (LTC) dining room steamer and completed other tasks for meal service. At 12:07 p.m., dietary aid (DA)-A prepared silverware on meal trays and other tasks. Two residents were served in the dining area. At 12:11, culinary district manager (DM) stated they were waiting for nursing staff to be ready to serve before dishing up the plates. At 12:17 p.m., registered nurse (RN)-C entered the dining area from the memory care area, and DM stated they were waiting for staff to start meal service. At 12:22 p.m., licensed practical nurse (LPN)-B entered the dining area from the memory care area, and DM stated they were waiting for staff to start meal service. Then C-A started to plate lunch, and DA-A placed completed meal trays into an enclosed cart. At 12:31 p.m., multiple residents were sitting in the memory care area dining room and only a few residents had drinks in front of them. At 12:33 p.m., DA-A entered with the drink cart. At 12:37, nursing assistant (NA)-E entered the memory care area with the food cart. At 12:47 p.m., social worker (SW) was in the dining area between the TCU and LTC care area standing next to an enclosed cart filled with room

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trays and stated they were waiting for a juice cup. At 12:52 p.m., SW pushed the cart into the LTC hallway and served the first person their meal tray and continued serving the rest of the residents in the hallway room by room.

Medication administration

During medication observation and interview on 12/11/24 at 7:15 a.m., licensed practical nurse (LPN)-H had two medication cups with medications on the medication cart and then placed into the top drawer of the medication cart. LPN-H prepared medication for R2 and then added the prepared medications to one of the medication cups from the top drawer. LPN-H stated they were preparing medications for R2 now and for R2's next medication pass time when surveyor approached and panicked so checked the medications due now as given already and saved the medications to give R2 at the next medication pass in the top drawer. LPN-H stated they usually labeled the prepped medication cup with the resident's name and room number. LPN-H stated they often prepped residents' medications early or else they would not have their work completed until 4:00 p.m. each day. LPN-H stated the long-term care and transitional care units had a total of two nurses and two nursing assistants, but about twice a week had one nurse and one to two nursing assistants. LPN-H assisted with resident ADLs and other tasks when there was one nursing assistant for the transitional care unit and long-term care area. LPN-H felt pressured to find ways to save time when there was only one nurse and had appointments, labs, new orders, wounds, and intravenous medications to manage. LPN-H stated they spoke with management before, and

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F 725	Continued From page 89 management staffed according to resident census. When interviewed on 12/9/24 at 3:19 p.m., nursing assistant (NA)-F stated sometimes there were not enough staff, and there was no staffing coordinator and a lack of management in general.	F 725		
F 730 SS=F	Nurse Aide Peform Review-12 hr/yr In-Service CFR(s): 483.35(d)(7) §483.35(d)(7) Regular in-service education. The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the requirements of §483.95(g). This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to complete annual performance reviews for 5 of 5 nursing assistants (NA-B, NA-C, NA-D, NA-H, NA-M) whose employee files were reviewed. This had the potential to affect all 37 residents who resided at the facility. Findings include: A review of employee records on 12/12/24 between 1:24 p.m., and 2:37 p.m., lacked documentation of completed annual performance reviews. All 5 sampled employees were employed at the facility for greater than one year. Per interview on 12/12/24 at 2:11 p.m., the administrator stated it was their understanding the previous director of nursing (DON) completed competencies with annual reviews. The	F 730	" Current C.N.As assessed using the CMS/CMPRP Nursing Home Staff Competency Assessment and their RELIAS (online in servicing) transcripts audited for completion " Current Residents were potentially affected by this alleged deficiency. " DON has instituted the use of a C.N.A competency checklist to audit the re-education and competency of current C.N.As. These will be reviewed quarterly at QAPI. " Current C.N.A□s will have their Re-education logged on their checklist and receive individualized coaching to complete assigned training as needed.	1/31/25

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F 730	Continued From page 90 administrator stated, "I'm looking through file cabinets and if I can't find them, I can't say that we have them without them." Per interview on 12/16/24 at 12:01 p.m., the DON had "no luck" locating the annual performance reviews or recent completed competencies for the sampled NA's. The DON stated the facility would be "restarting those reviews" beginning January 1st and indicated it was important because staff needed to be aware of what they were doing well and what could be improved upon. Additionally, the DON stated annual reviews were a good way to build rapport with staff and helped build the team. The facility assessment last reviewed 8/8/24, indicated the facility's training program was based on the facility's resident population and was an ongoing training for all new and existing staff including managers, nursing, and other direct care staff. The assessment identified annual reviews were a part of the training sessions and would be completed to meet regulatory requirements. Furthermore, the assessment indicated, "skills and competencies were completed on hire and annually to test continued competence in assessment, safe patient handling, infection control, medication administration, wound care, feeding and bathing; skills competencies testing is based on the usual and customary duties performed by each staff member." The assessment also included the annual review process in staff recruitment and retention section. A policy pertaining to annual reviews was requested but not received.	F 730	" The DON or designee will present the checklists of competencies to QAPI for confirmation of tracking for each CNA staff. This will be standard practice at each QAPI meeting until compliance is achieved. " Due dates for CNA performance reviews and required education will be reviewed once weekly by the DON or designee to ensure timely completion. " Additional in-servicing will be provided to CNAs□ required education as necessary based on the results of their performance evaluation. Current C.N.A. staff will be made aware of the need to receive a performance evaluation. All C.N.A reviews will be completed by ED, DON or designee by 1/31/2025.	

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F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(f). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure prescription topical medications were applied and	F 755	" Staff have been re-educated on best practices for topical medication administration; the resident affected has	1/31/25

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F 755	Continued From page 92 documented in accordance with professional standards of practice for 1 of 2 residents (R26) observed during morning activities of daily living (ADL) cares. Findings include: R26's quarterly Minimum Data Set (MDS) dated 9/26/24, indicated severely impaired cognition and substantial to moderate staff assistance with personal and toileting hygiene cares. The MDS identified diagnoses of muscle weakness, depression, and high blood pressure. R26's undated and unsigned order summary was reviewed 12/11/24, and reflected the following active physician orders: - "Nystatin external powder 100000 unit/gm (gram) (Nystatin (Topical)) Apply to skin folds topically as needed for rash under breasts," dated 9/9/24. - "Nystatin powder (Nystatin (Bulk)) Apply to groin topically every 12 hours as needed for groin," dated 10/8/24 A request for R26's most recently signed order summary was requested but not received. R26's medication administration record (MAR) dated 10/2024, lacked documentation of as needed (PRN) Nystatin powder administration for "rash under breasts," as well as "groin". R26's MAR dated 11/2024, lacked documentation of as needed (PRN) Nystatin powder administration for "rash under breasts," as well as "groin". R26's MAR dated 12/2024, lacked documentation	F 755	also been educated on the necessity of keeping medications with the nurse " Observations were made of current residents rooms, with permission, to ensure no topical medication is present if not appropriate. " Observations will be conducted of 5 rooms each week by unit manager or designee to ensure no topical medications are present without proper orders and documentation. " Unit managers will perform a medication audit on a weekly basis for 6 weeks, then monthly for 3 months. If compliance is not met at this time, audits will be repeated. Audits will be performed by the ED, DON or designee, with documentation of each audit logged to be reviewed by QAPI on a quarterly basis. " Relias Medication Administration: Transdermal Topicals for Nurses	

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F 755	Continued From page 93 of as needed (PRN) Nystatin powder administration for "rash under breasts," as well as "groin". R26's treatment administration record (TAR) dated 10/2024, indicated an order for, "weekly skin review every evening shift every Fri [sic, Friday] if new area is identified follow protocol ...". This order was marked as completed on 10/3/24, 10/11/24, 10/18/24, and 10/25/24. R26's TAR dated 11/2024, indicated an order for, "weekly skin review every evening shift every Fri [sic, Friday] if new area is identified follow protocol ...". This order was marked as completed on 11/1/24, 11/8/24, 11/15/24, 11/22/24, and 11/29/24. R26's TAR dated 12/2024, indicated an order for, "weekly skin review every evening shift every Fri [sic, Friday] if new area is identified follow protocol ...". This order was marked as completed on 12/6/24. R26's care plan dated 9/9/24, identified her self-care deficit and guided staff to provide assistance with personal hygiene and bathing cares. Additionally, the care plan identified a risk for skin integrity concerns and indicated a head-to-toe assessment would be performed by a licensed nurse. During observation on 12/11/24 at 7:34 a.m., nursing assistant (NA)-D performed morning cares with R26. NA-D washed under R26's underarms and breasts and patted the areas dry with a clean hand towel. NA-D stated R26 had dry skin and "every morning" NA-D applied lotion and the "doctor ordered this powder" for under R26's	F 755		

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F 755	Continued From page 94 arms and breasts. NA-D showed the surveyor a bottle with a prescription label affixed to it that read, "Kaylesta (Nystatin) powder". NA-D stated "they gave me this to put on" for the dry skin and NA-D applied the powder from the bottle under R26's arms and breasts. NA-D further explained R26 had issues with her skin intermittently because "she's a large woman with a lot of skin there." NA-D stated NAs monitored the skin and would report when the areas were improving or worsening to the nurses as well if NAs used the powder on R26. Per interview on 12/13/24 at 9:46 a.m., licensed practical nurse (LPN)-D expected prescription medications, including topical powders like Nystatin, be applied by nurses because nurses were responsible for the "assessment piece" and to determine if a resident had reactions to the medication. Per interview on 12/13/24 at 9:53 a.m. with LPN-C, prescription topical medications, like Nystatin powder, should be kept in the locked medication cart and should be applied by a nurse unless a resident had been assessed to safely administer their own medications and had the order in place. LPN-C reviewed R26's MAR and confirmed there were no documented administrations of Nystatin powder on 12/11/24, or for the MAR dated 12/2024. LPN-C was unaware of any skin concerns for R26. LPN-C was unable to locate a skin assessment for R26 identifying any current skin concerns for R26. LPN-C stated a NA applying a prescription topical powder without a nurse's knowledge and keeping it at bedside "sounds like an educational piece." LPN-C verified the prescription bottle of Nystatin powder in R26's room before locking the bottle in	F 755		

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F 755	Continued From page 95 the medication cart. Per interview on 12/16/24 at 12:01 p.m., with director of nursing (DON), only the nurse should apply medications that are prescribed unless a resident had been assessed to administer them safely themselves and had an order to do so. The DON stated this was important because nurses needed to follow the rights of medication administration. The DON stated prescription medications, including topical powders like Nystatin, should be kept in the nurse's cart. Per facility policy titled Medication Administration dated 1/2024, medications were expected to be administered in accordance with manufacturer's specifications, good nursing principles and practices and only by persons legally authorized to do so. Personnel authorized to administer medications do so only after they have familiarized themselves with the medication. The policy directed staff to have medications prepared only by licensed nursing, medical, pharmacy or other personnel authorized by state regulations to prepare medications. Further, the policy directed the individual who administered the medication to record the administration on the resident's MAR immediately following the medication being given and if administer a PRN (as needed) medication, the individual administering the medication should also document the date and time, dose, route of administration, complaints or symptoms for which the medication was given, results achieved from giving the dose and the time the results were noted, and a signature or initials of person recording the administration and/or of the person recording effects.	F 755		
F 756 SS=E	Drug Regimen Review, Report Irregular, Act On	F 756		1/7/25

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F 756	Continued From page 96 CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that	F 756		

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F 756	Continued From page 97 requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure consultant pharmacist recommendations were acted upon timely for 4 of 5 residents (R1, R5, R8, R14) reviewed for unnecessary medications. Findings include: R1 R1's admission Minimum Data Set (MDS) dated 11/4/24, indicated R1 had severe cognitive impairment, inattention and disorganized thinking which fluctuated, did not have physical, verbal, or other behavioral symptoms, did not reject cares, had diagnoses of heart failure, hypertension (high blood pressure), thyroid disorder, arthritis (conditions which cause inflammation of the joints), osteoarthritis (chronic disease when cartilage which lines joints are worn down and bones rub against each other), and adjustment disorder with mixed anxiety and depressed mood. Further, R1 took an antipsychotic and antidepressant. R1's Order Summary Report dated 12/12/24, indicated the following orders: - 11/27/24, Depakote oral tablet delayed release 500 mg (used for manic depression). Give one tablet by mouth at bedtime. - 11/27/24, trazodone HCL [hydrochloride] oral tablet 150 mg (an antidepressant often used for sleep). Give 75 mg by mouth at bedtime . - 11/27/24, trazodone HCL oral tablet 50 mg. Give 25 mg by mouth as needed, with no end	F 756	Current and outstanding pharmacy recommendations have been routed to the appropriate provider; and a system of redundancy has been put in place to ensure at least two staff are receiving these recommendations and are able to act upon them at any time. Current Residents were potentially affected by this alleged deficiency. The ED, DON and one designee will receive the pharmacy recommendations from the pharmacist to ensure recommendations are routed to the providers in a timely fashion. Designee has been educated on the routing process and need for timeliness of response. ED, DON or designee will bring the pharmacy recommendations book to the Weekly At Risk meeting for audit on a 1x weekly basis for 6 weeks, then 1x monthly for 3 months. If compliance is not met at this time, audits will be repeated. Audits will be performed by the IDT, with documentation of each audit logged to be reviewed by QAPI on a quarterly basis. Consulting Pharmacist, DON, ED will meet to discuss and review monthly.	

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F 756	Continued From page 98 date noted. - 11/30/24, Seroquel oral tablet 25 mg (quetiapine fumarate) (an antipsychotic). Give one tablet by mouth as needed TID (three times a day), with end date of 12/13/24. - 12/10/24, Seroquel oral tablet 100 mg (quetiapine fumarate). Give one tablet by mouth at bedtime. - 12/10/24, quetiapine fumarate oral tablet 25 mg. Give 12.5 mg by mouth two times a day. - 12/11/24, Neurontin oral capsule 300 mg (gabapentin) (often used for pain). Give one capsule by mouth three times a daily. R1 did not have side effect and/or adverse effect monitoring in place. R1's Pharmacy Review assessment dated 11/4/24, indicated recommendations were made and to view Clinical Pharmacy Report. The section New Medications/General/Recommendation notes indicated: "Memory; migraines, chronic pain; HLD, HF, adjustment disorder 11/24 PRN". R1's Clinical Pharmacy Report dated 11/4/24, was reviewed onsite and directed nursing to identify an end date for trazodone or provider rationale and documentation for extended end date, and add in psychotropic side effect monitoring. A copy was not provided. R1's Pharmacy Review assessment dated 12/2/24, indicated recommendations were made and to view Clinical Pharmacy Report. The section New Medications/General/Recommendation notes indicated: "Memory; migraines, chronic pain; HLD, HF, adjustment disorder 12/24 REC:	F 756		

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F 756	Continued From page 99 clarifications 11/24 PRN". R1's Clinical Pharmacy Report dated 12/2/24, was reviewed onsite and noted to have repeated both recommendations from 11/4/24. A copy was not provided. R5 R5's significant change Minimum Data Set (MDS) dated 11/5/24, indicated she had severe cognitive impairment with diagnoses of heart failure, kidney failure, respiratory failure, anxiety, depression, and lymphedema (a chronic condition causing swelling from lymph or protein-rich fluid in the body's tissues). The MDS further indicated R5 received hospice care. R5's unsigned order summary was reviewed 12/13/24, and included the following orders: - albuterol-budesonide inhalation 90-80 micrograms (mcg) / actuation (ACT), 2 puff inhale orally every 6 hours as needed for shortness of breath, dated 10/29/24. - furosemide oral tablet, Give 40 milligrams (mg) by mouth one time a day for pulmonary edema (fluid buildup the lungs), heart failure with chronic kidney disease and failure, dated 3/12/24. - lorazepam oral concentrate 0.125 milligrams (mg) / milliliter (mL), Give 0.25mL every 4 hours as needed for agitation 0.5mg=0.25mL, dated 11/05/24. - lorazepam oral tablet 0.5mg, Give 1 tablet sublingually every 3 hours as needed for anxiety, dated 10/29/24. - morphine sulfate (concentrate) oral solution 20	F 756		

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F 756	Continued From page 100 mg/mL, Give 0.25mL by mouth every 4 hours as needed for shortness of breath/pain, dated 12/13/24. - quetiapine fumarate oral tablet, Give 150mg by mouth at bedtime, for anxiety, depression, dated 2/29/24. - sertraline hydrochloride (HCl) oral tablet 50mg, Give 50mg by mouth one time a day for depression, dated 10/14/24. A request R5's most recent signed order summary was requested during survey and not received. R5's care plan last revised 11/18/24, identified her use of psychotropic medications (antidepressants, antianxiety, and antipsychotics) and diuretic therapy to treat her lower extremity therapy. The care plan directed staff to perform medication regimen reviews (MRRs) as needed, identify available resources and needs for treatment, and attempt GDRs per orders. A pharmacy review notes dated 9/5/24, 10/14/24, and 11/4/24, indicated recommendations were made. The notes referred to the clinical recommendations reports. A PharMerica note to attending Physician/Prescriber MRR dated 9/5/24, provided a recommendation for periodic lipid panel for R5's medications. The provider signed the MRR on 10/31/24 and deferred to R5's hospice team. A PharMerica note to attending Physician/Prescriber MRR dated 11/4/24, provided a recommendation regarding "duplicative therapy". The MRR lacked provider signature or follow-up.	F 756		

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F 756	Continued From page 101 A PharMerica note to attending Physician/Prescriber MRR dated 11/4/24, provided a recommendation regarding R5's lorazepam order. The note stated as needed (PRN) psychotropic orders required no more than 14 days duration or, if deemed necessary beyond, a clinical rationale and specific duration documented by provider. The MRR lacked provider signature or follow-up. A PharMerica nursing recommendations for the recommendations created between 11/4/24 and 11/6/24, indicated R5's albuterol-budesonide inhalation aerosol order should NOT be a combination product and directed staff to review data entry. The MRR lacked nursing signature or follow-up. A PharMerica note to attending Physician/Prescriber MRR dated 12/3/24, provided a recommendation regarding R5's lorazepam orders. The note requested the provider add parameters for when to use the lorazepam tablets versus the concentrate. Additionally, the note repeated the request for the PRN lorazpem order to include an end date of no more than 14 days, and if deemed necessary to include a clinical rationale and a specific duration. The MRR lacked provider signature and follow-up. R5's EMR was reviewed and lacked documentation of MRR follow-up. A request was made for provider response and/or documentation of MRR follow-up and was not received.	F 756		

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F 756	Continued From page 102 R8 R8 admission Minimum Data Set (MDS) dated 2/25/24, included an admission date of 2/20/13. R8's diagnosis included schizophrenia. R8's order summary report dated 4/3/24, included diagnosis of mild cognitive impairment, schizoaffective disorder (a mental health disorder with symptoms of both schizophrenia and a mood disorder), depression, bipolar disorder (extreme mood swings), and hording disorder. PharMerica Nursing Recommendations dated 8/9/24, included a recommendation to complete labs that were ordered in May but not completed and to place results in the chart. No facility notes were placed in the "follow-Through" section of the form. PharMerica Nursing Recommendations dated 10/11/24, again recommended completion of labs ordered in May that were never completed. Again, the facility failed to place notes in the "follow-through" section of the form. When interviewed on 12/16/24 at 11:11 a.m., the consulting pharmacist (CP) stated they were unsure if R8 declined the labs or the provider did not order. CP stated they needed to be able to see the provider's follow-up to their recommendations or labs drawn on residents. R14	F 756		

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F 756	Continued From page 103 R14's quarterly Minimum Data Set (MDS) dated 11/13/24, identified intact cognition and reported no behaviors, hallucinations, or delusions. The MDS indicated R14 had heart failure, high blood pressure, kidney failure, obstructive sleep apnea (sleep disorder causing your breathing to repeatedly stop or be reduced while you sleep), respiratory failure, anxiety, depression, bipolar disorder, and dementia (a neurological condition causing a decline in thinking, memory, and behavior). The MDS indicated she was diabetic and received insulin injections over the lookback period, in addition to antidepressants and antianxiety medications. The MDS lacked documentation on if a drug regimen review was assessed and if issues were found. Furthermore, the MDS confirmed medication follow-up was "not assessed/no information" and the MDS lacked documentation on medication intervention assessment. R14's Care Area Assessment (CAA) for psychotropic drug use dated 8/13/24, indicated the consultant pharmacist (CP) reviewed her medications and made recommendations to the interdisciplinary team (IDT) monthly and as needed. A signed order summary dated 6/6/24, identified the following orders: - carvedilol oral tablet milligram (mg), Give 6.25mg by mouth two times a day, for heart failure, dated 2/12/24. - doxepin hydrochloride (HCl) oral capsule 10mg, Give 20mg by mouth at bedtime for insomnia related to obstructive sleep apnea, dated 2/12/24. - fluoxetine HCl oral capsule 20mg, Give 20mg by mouth in the morning for depression, dated	F 756		

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F 756	Continued From page 104 2/12/24. - furosemide oral tablet, Give 40mg by mouth one time a day dated 2/12/24. - novolog injection solution 100 unit/milliliter (mL) (Insulin Aspart), Inject 17 unit subcutaneously before meals for diabetes, dated 4/8/24. - Remeron tablet (Mirtazapine) Give 7.5mg by mouth at bedtime for depression, dated 2/12/24. - Wellbutrin Sustained-Release (SR) oral tablet Extended Release (ER) 12 Hour 100mg (bupropion HCl), Give 100mg by mouth one time a day for depression, dated 2/12/24. A request for R14's most recent signed order summary prior to survey entrance was requested but not received. R14's medication administration record (MAR) dated 12/2024 reflected the following active and administered medication orders: - carvedilol oral tablet milligram (mg), Give 6.25mg by mouth two times a day, for heart failure, dated 9/13/24. - fluoxetine HCl oral capsule 20mg, Give 20mg by mouth in the morning for depression, dated 6/19/24. - furosemide oral tablet 20mg, Give 3 tablet orally one time a day, for heart failure, give 3 tablets (60mg), dated 11/14/24. - isosorbide mononitrate ER 24 Hour oral tablet, Give 60mg by mouth one time a day, for high blood pressure and chronic kidney disease, dated 11/16/24. - lidocaine external gel 4%, Apply to right shoulder topically every 12 hours for shoulder pain, dated 11/25/24. - mirtazapine oral tablet 7.5mg, Give 1 tablet my mouth at bedtime for depression, dated 11/19/24.	F 756		

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F 756	Continued From page 105 - novolog FlexPen Subcutaneous Solution Pen-injector 100 unit/mL (Insulin Aspart), Inject 14 unit subcutaneously with meals for diabetes with chronic kidney disease, dated 10/31/24. - Wellbutrin SR oral tablet Extended Release 12 Hour 100mg (bupropion HCl), Give 100mg by mouth one time a day for depression, dated 6/19/24. R14's care plan, last revised on 8/21/24, identified her use of antidepressants and dependence on insulin and risks associated with each medication. The care plan included goals to be free of complications related to the use of the medications and directed staff to administer medications per orders. The care plan lacked documentation or guidance for staff related to R14's use of furosemide, a diuretic (water pill). A pharmacy review note dated 10/11/24 indicated recommendations were made. The review indicated R14 had previous gradual dose reductions (GDRs) of her doxepin on 10/4/24 and mirtazapine on 9/25/24. The note referred to the clinical recommendations report. R14's progress notes were reviewed and lacked documentation of medication regimen review (MRR) follow-up by provider and/or nursing staff. A pharmacy review note dated 12/3/24, indicated recommendations were made. The review indicated an increase to R14's mirtazapine on 11/19/24, and referred to the clinical recommendations report. The progress notes were review and lacked documentation of MRR follow-up by provider and/or nursing staff. A PharMerica Nursing Recommendations report	F 756		

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F 756	Continued From page 106 dated 10/11/24, identified three recommendations or clarifications pertaining to R14's carvediolol medication administration instructions, isosorbide medication formulation, and a clarification regarding the lidocaine formulation. The nursing recommendation lacked documentation of MRR follow-up by provider and/or nursing staff. A PharMerica MRR Recommendation Summary: Medical Director and Director of Nuring (DON) dated 10/11/24, identified three recommendations or clarifications pertaining to R14's carvediolol medication administration instructions, isosorbide medication formulation, and a clarification regarding the lidocaine formulation. The MRR summary lacked documentation of MRR follow-up by provider and/or nursing staff. A PharMerica Nursing Recommendations report dated 11/4/24, was received and indicated the resident was out of the facility during the MRR and requested staff evaluated the need for MRR. The report lacked documentation of follow-up. A request for R14's MRRs, clinical recommendations and related follow-up for 6 months were requested but not received. When interviewed on 12/13/24 at 10:57 a.m., licensed practical nurse (LPN)-A stated they received recommendations from the pharmacist and followed up with the primary care physicians to ask if they approved of the pharmacy recommendations or not. LPN-A followed through with what the primary care physician approved. When interviewed on 12/13/24 at 2:26 p.m., LPN-B stated they sometimes received emails from the pharmacist about recommendations they	F 756		

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F 756	Continued From page 107 had after order review and followed up on the recommendations right away. LPN-B stated the director of nursing (DON) received the pharmacist recommendation forms, then the managers followed up on the recommendations and returned the pharmacist form to the DON after completion. LPN-B confirmed R1's trazodone did not have an end date and did not have side effect monitoring in place for psychotropic medication. When interviewed on 12/16/24 at 11:01 a.m., the DON stated they printed out the pharmacist recommendation forms and made copies in green. DON gave the original copy to the doctors and nurses to address and placed the green copy in a binder, so they knew the recommendation still needed to be followed up on. DON stated if providers do not follow up on pharmacy recommendations within one month, they asked the provider again. DON received emails and followed up immediately on anything "dire". When interviewed on 12/16/24 at 11:11 a.m., the consulting pharmacist (CP) expected pharmacist recommendations to be followed up on within 30 days or by the next visit. CP gave recommendations again when not completed, but the timing on when to give the second reminder depended on what the initial recommendation was, since the providers liked to see the residents before acting or not on some recommendations. CP confirmed the facility had not placed in an end date for R1's trazodone and would have expected them to complete after the recommendation in November of 2024, since they needed to know why trazodone was administered and needed to re-evaluate the use per regulations. CP also confirmed R1 did not have side effect monitoring	F 756		

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F 756	Continued From page 108 for psychotropic medication in place as was recommended previously. Per facility policy titled Medication Reconciliation last revised 10/24/22, the facility reconciled medication throughout a resident's stay to ensure the resident was free of any significant medication errors. The policy indicated the monthly process was the provide the consultant pharmacist access to all medication areas and records for completion of pharmacy services activities. Furthermore, the policy directed staff to respond to any medication irregularities reported by the pharmacist within relevant time frames.	F 756		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic	F 758		1/31/25

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F 758	Continued From page 109 drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide appropriate side effect monitoring (including vital and orthostatic blood pressure monitoring) and obtain informed consent for psychotropic medication and ensure a PRN (as needed) psychotropic medication order included an end date for 1 of 5 resident (R1) reviewed for unnecessary medication use. Findings include: R1's admission Minimum Data Set (MDS) dated	F 758	" R1□s medications were reviewed to ensure PRN medications have stop dates if appropriate. R1□s record was reviewed to ensure that consents are signed and on file for each necessary medication. " Current residents were reviewed to ensure psychotropic monitoring is in place where required. " Current Residents have undergone an audit to ensure that their prn medication stop date is appropriate and consistent with guidelines and that an appropriate	

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F 758	Continued From page 110 11/4/24, indicated R1 had severe cognitive impairment, inattention and disorganized thinking which fluctuated, did not have physical, verbal, or other behavioral symptoms, did not reject cares, had diagnoses of heart failure, hypertension (high blood pressure), thyroid disorder, arthritis (conditions which cause inflammation of the joints), osteoarthritis (chronic disease when cartilage which lines joints are worn down and bones rub against each other), and adjustment disorder with mixed anxiety and depressed mood. Further R1 took an antipsychotic and antidepressant. R1's Order Summary Report dated 12/12/24 indicated the following orders: - 11/27/24, Depakote (anticonvulsant used to treat seizure and bipolar disorders) oral tablet delayed release 500 mg. Give one tablet by mouth at bedtime related to adjustment disorder with mixed anxiety and depressed mood. - 11/27/24, trazodone HCL [hydrochloride] (antidepressant used to treat depressed mood and other depression-related symptoms) oral tablet 150 mg. Give 75 mg by mouth at bedtime for trouble sleeping. - 11/27/24, trazodone HCL oral tablet 50 mg. Give 25 mg by mouth as needed for trouble sleeping, with no end date noted. - 11/30/24, Seroquel (quetiapine fumarate; antipsychotic used to treat schizophrenia, bipolar disorder, and depression) oral tablet 25 mg. Give one tablet by mouth as needed TID (three times a day) for anxiety, restlessness and agitation related to adjustment disorder with mixed anxiety and depressed mood, with end date of 12/13/24. - 12/10/24, Seroquel oral tablet 100 mg. Give one tablet by mouth at bedtime for insomnia.	F 758	diagnosis is listed for each medication. Current Residents on psychotropics have also been audited to ensure they have signed a consent to have each medication administered. " Stop dates for PRN psychotropics will be reviewed weekly during the weekly at risk meeting beginning 1/14/25. This will be ongoing. " Audits will be conducted weekly of new admissions to ensure medication consents are obtained as required. " Psychotropic orders for current residents will be reviewed by the DON or designee weekly for six weeks then monthly for three months. If compliance is not met at this time, audits will be repeated. Audit findings will be reviewed during QAPI meetings. " Re-education will be provided using Relias □ Psychotropic Meds in LTC □ Current Unit Managers and SS.	

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F 758	Continued From page 111 - 12/10/24, quetiapine fumarate oral tablet 25 mg. Give 12.5 mg by mouth two times a day for agitation and/or impulsiveness. - 12/11/24, Neurontin (gabapentin; anticonvulsant used to treat seizures and nerve pain) oral capsule 300 mg. Give one capsule by mouth three times a daily for anxiety and/or pain. R1's care plan printed on 12/16/24, indicated R1 was at risk for adverse effects related to use of psychotropic medications, which was initiated 10/29/24. The care plan included an intervention revised on 10/20/24 to evaluate effectiveness and side effects of medications for possible decrease and/or elimination of psychotropic drugs. The care plan did not indicate vital or orthostatic blood pressure monitoring. R1's MAR/TAR (medication administration record; treatment administration record) dated November and December 2024, indicated R1 received trazodone PRN on 11/27/24, 12/2/24, and 12/7/24. R1's MAR/TAR for November 2024, directed staff to enter R1's vital signs weekly every Tuesday PM [evening] with start date of 11/5/24 and end date of 11/27/24. Vitals were recorded on 11/5/24, 11/12/24, 11/19/24, and 11/26/24 indicated R1 was hospitalized. R1's medical record had no indication of vital monitoring after 11/27/24. Further, R1's medical record had no indication of orthostatic blood pressure monitoring. R1's medical record had no indication of consent by the resident, family, or guardian for use of gabapentin.	F 758		

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F 758	Continued From page 112 When interviewed on 12/13/24 at 10:57 a.m., licensed practical nurse (LPN)-A stated nursing spoke with resident or family member to give education about psychotropic medications and obtained consent and signed a form placed in residents' paper chart. LPN-A stated orthostatic blood pressures were taken every few months and scheduled in the MAR/TAR. LPN-A stated nursing wrote progress notes if residents refused orthostatic blood pressure monitoring. LPN-A stated they monitored residents' vitals daily when first admitted and then weekly vitals with bathing and skin assessment unless resident acutely ill. LPN-A stated vitals were recorded in the MAR/TAR and transferred over to the medical record's vitals tab. LPN-A stated they observed for side effects of psychotropic medications daily per the MAR and TAR. LPN-A stated trazodone prn should be scheduled for 14 days, and prn trazodone use would be evaluated after the set time frame to see if still needed and document a reason to uphold the order. When interviewed on 12/13/24 at 2:26 p.m., LPN-B stated R1 entered the facility on psychotropic medications, and they reviewed R1's medications with R1's family member and filled out the consent form for R1. LPN-B confirmed they did not get a consent for gabapentin and was not sure if they needed to and stated nursing needed to monitor for side effects of gabapentin such as drowsiness, dry mouth, and tremors. LPN-B stated not all psychotropics required orthostatic blood pressure monitoring and were scheduled once a month if needed on the TAR. LPN-B confirmed R1 did not have orthostatic blood pressure monitoring, and R1 may need orthostatic blood pressure	F 758		

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F 758	Continued From page 113 monitoring for use of Seroquel. LPN-B stated resident vitals were checked once a week with their shower and skin assessment. LPN-B stated vitals were entered into the MAR/TAR and automatically went to the vitals tab. LPN-B confirmed R1 did not have weekly vital monitoring scheduled. LPN-B stated they placed in orders to monitoring for psychotropic medication side effects every shift per the medical record order set. LPN-B confirmed R1 did not have psychotropic monitoring in the MAR/TAR or vital or orthostatic blood pressure monitoring in the care plan. LPN-B confirmed R1's order for prn trazodone did not have an end date and did not have a provider documented reason for the indefinite order. DON expected prn trazodone to have a 14 day stop date. DON stated it was important for prn psychotropics to have a stop date to ensure the providers were evaluating the medications use and side effect monitoring. When interviewed on 12/16/24 at 11:01 a.m., the director of nursing (DON) expected nursing to obtain consent for psychotropic medication, which included gabapentin depending on if used for a psychological change. DON agreed gabapentin used for anxiety and/or pain needed a consent for administration. DON stated obtaining consents were important to ensure resident or responsible party were aware of side effects, which included irreversible side effects. DON expected nursing to have orthostatic blood pressures recorded monthly for R1, unless R1 had issues with blood pressure. DON expected residents' vitals to be taken at least once a week. DON stated R1 was noncompliant and expected to see notes of refusals. DON expected R1 to have three days of vital monitoring when returned from hospital on 12/27/24. DON expected nursing to monitor for	F 758		

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F 758	Continued From page 114 psychotropic side effects according to pharmacist recommendations. When interviewed on 12/16/24 at 11:11 a.m., the consulting pharmacist (CP) CP expected nursing to obtain consent for R1's gabapentin use after a risk and benefit education. CP verified R1's prn trazodone did not have a stop date and an end date was important to have to ensure the medication was re-evaluated per regulations. CP expected staff to monitoring for orthostatic blood pressures for antipsychotics and confirmed R1 should have psychotropic medication side effect monitoring in place but did not. The Psychotropic Medications policy dated 10/24/22, indicated a psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. Psychotropic drugs included but were not limited to antipsychotics, antidepressant, anti-anxiety, and hypnotics. The policy directed staff to educate residents and/or representative on the risks and benefits of psychotropic drug use. Further, the policy indicated prn orders for all psychotropic drugs would be used only when the medication was necessary to treat a diagnosed specific condition, which was documented in the clinical record, and for a limited duration, such as 14 days. Additionally, the policy directed staff to monitor effects of psychotropic medications on residents' physical, mental, and psychosocial well-being on an ongoing basis.	F 758		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an	F 880		1/31/25

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F 880	Continued From page 115 infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and	F 880		

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F 880	Continued From page 116 (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure staff performed appropriate hand hygiene during medication administration for 2 of 3 residents (R2, R6) observed during medication administration, and failed to implement enhanced barrier precautions (EBP) for 6 of 7 residents (R4, R9, R14, R18, R26, R29) reviewed for precautions. Further, the facility failed to develop and implement a Legionella risk assessment and plan to mitigate the growth of Legionella. This had the potential to affect all 37 residents, staff and visitors. Findings include:	F 880	" Records of current residents were reviewed to ensure enhanced barrier precautions are in place as required. " Nursing staff re-educated regarding hand hygiene practices and the requirements for enhanced barrier precautions upon admission or change in condition. " Audits will be conducted once weekly of five residents medical records to ensure enhanced barrier precautions are in place as required. Audits will be conducted by the DON or designee and will continue for six weeks. If compliance	

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F 880	Continued From page 117 Hand Hygiene R2's quarterly Minimum Data Set (MDS) dated 11/16/24, indicated R2 was cognitively intact with diagnoses of coronary artery disease (arteries which supply blood to the heart become narrowed or blocked), heart failure, hypertension, and diabetes mellitus. R6's quarterly MDS dated 12/7/24, indicated R6 was cognitively intact with diagnoses of hypertension, urinary tract infection, diabetes mellitus, dementia, anxiety, and depression. During a medication observation and interview on 12/11/24 at 7:15 a.m., licensed practical nurse (LPN)-H prepared medication for R2 at the medication cart outside of R2's room. LPN-H entered R2's room and took R2's temperature and oxygen saturation level. LPN-H exited the room and did not perform hand hygiene and typed information into the computer, then LPN-H locked the cart and gave medication cup to R2. R2 took medication independently. LPN-H returned to the medication cart, did not perform hand hygiene, and prepared medication for R6. LPN-H found a tray to place R6's medication on, placed on gloves to clean the tray, removed gloves, and performed hand hygiene. LPN-H brought medication to R6 and observed R6 take medication independently. R6 stated they had a cream LPN-H to apply. LPN-H exited the room, did not perform hand hygiene, and looked at R6's orders on the computer. LPN-H returned to R6's room and touched and looked at the tube of cream in R6's room. LPN-H stated they would confirm and apply the appropriate cream later and left R6's room. LPN-H returned to the	F 880	is not met at this time, audits will be repeated. Findings will be reviewed by QAPI committee. " Hand hygiene audits will be conducted three times per week for six weeks by the DON or designee. If compliance is not met at this time, audits will be repeated. Findings will be reviewed by QAPI committee. " The facility□s water management plan will be finalized in writing by 1/27/25.	

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F 880	Continued From page 118 medication cart to chart the medications given to R6 and did not perform hand hygiene. LPN-H started to look at another resident's medication list and readied a new medication cup. LPN-H confirmed they performed hand hygiene after cleaning the tray and removing gloves but missed opportunities to perform hand hygiene between giving medications to one resident and preparing medications for a different resident. When interview on 12/13/24 at 2:25 p.m., LPN-B stated staff should perform hand hygiene when leaving a resident room before preparing another resident's medications. LPN-B stated staff did not want to transfer germs from one resident to another. When interviewed on 12/16/24 at 11:01 a.m., the director of nursing (DON) expected staff to perform hand hygiene in between medication passes to lessen the risk of germs spreading from one resident to another. The Hand Hygiene policy dated 11/2/22, directed staff to perform hand hygiene when indicated, using proper techniques consistent with accepted standards of practice. The policy included a Hand Hygiene Table which directed staff to perform hand hygiene before preparing or handling medications. EBP R4's admission record printed 12/13/24, included an admission date of 6/6/24. R4's care plan printed 12/13/24, included R4 had a pressure ulcer (wound caused by pressure) on his coccyx (tailbone). The care plan failed to	F 880		

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F 880	Continued From page 119 include interventions for EBP. Observation of R4's room did now show evidence of signage or personal protective equipment (PPE) for EBP on 12/9/24, and 12/10/24. R9's admission record printed 12/13/24, included an admission date of 11/15/24, and a diagnosis of pressure ulcer of the right heel. R9's care plan printed 12/13/24, failed to include interventions for EBP. Observation of R9's room did now show evidence of signage or personal protective equipment (PPE) for EBP on 12/9/24, and 12/10/24. R14's admission record printed 12/13/24, included an admission date of 6/18/24, and a diagnosis of neuromuscular dysfunction of bladder (causes a person to not be able to control their bladder emptying). R14's care plan printed 12/13/24, included R14 had a Foley catheter. R14's care plan failed to include interventions for EBP. Observation of R14's room did now show evidence of signage or personal protective equipment (PPE) for EBP on 12/9/24, and 12/10/24. R18's significant change Minimum Data Set (MDS) dated 10/25/24, included an admission date of 10/27/24, and an active diagnosis of benign prostatic hyperplasia (enlargement of the prostate gland). R18's MDS included he had an indwelling catheter.	F 880		

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F 880	Continued From page 120 Observation of R18's room did now show evidence of signage or personal protective equipment (PPE) for EBP on 12/9/24, and 12/10/24. R26's admission record dated 12/13/24, included an admission date of 12/27/23. R26's care plan printed 12/13/24, included R26 has a urostomy (an opening in her stomach for urine to leave the body). R26's care plan failed to include interventions for EBP. Observation of R26's room did now show evidence of signage or personal protective equipment (PPE) for EBP on 12/9/24, and 12/10/24. R29's admission record printed 12/13/24, included an admission date of 9/1/24, and diagnosis of neuromuscular dysfunction of the bladder. R29's care plan printed 12/13/24, included R29 had an indwelling catheter. R29's care plan failed to include interventions for EBP. Observation of R29's room did now show evidence of signage or personal protective equipment (PPE) for EBP on 12/9/24, and 12/10/24. When interviewed on 12/11/24 at 9:49 a.m., nursing assistant (NA)-D stated nursing assistants did not follow enhanced barrier precautions, and enhanced barrier precautions were for nurses. During interview on 12/11/24 at 2:00 p.m., director	F 880		

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F 880	Continued From page 121 of nursing (DON) was unable to state when a resident should be placed on EBP. She states she would follow the CDC guidelines. When the DON referred to the printout of CDC guideline in the infection control binder, she confirmed the guidelines were to implement EBP whenever a resident had an open wound are an indwelling medical device, such as a catheter. The DON confirmed they were not following EBP correctly in the facility and provided a list of residents who had either an indwelling medical device or an open wound. Facility policy titled Enhanced Barrier Precautions dated 8/8/24, included the facility would initiate EBP for residents with wounds and/or indwelling medical devices. Legionella The facility is not required to do testing unless a concern is identified. They are required to have a schematic of the water system and a program to mitigate growth of legionella. During entrance conference on 12/9/24 at 1:52 p.m., administrator was asked to provide a copy of the facility Legionella risk assessment and plan to mitigate the growth of Legionella. A plan was not provided. On 12/10/24, a 2nd request was placed to the administrator for a copy of the Legionella plan and evidence of implementation. No documentation was provided. On 12/11/24 at 8:49 a.m., a requested for	F 880		

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F 880	Continued From page 122 information on the Legionella water management plan was sent to the director of nursing (DON). No documentation was provided. O 12/11/24 at 2:30 p.m., the administrator requested clarification on what was needed for evidence of Legionella plan. The administrator stated, "we flush toilets and run the water on first floor weekly." The administrator was unable to provide a schematic of the buildings water flow and no additional documentation was provided. Facility document titled Legionella Surveillance Policy dated 10/24/22, included the facility would establish a primary and secondary strategy to prevent and control Legionella infections.	F 880		
F 908 SS=D	Essential Equipment, Safe Operating Condition CFR(s): 483.90(d)(2) §483.90(d)(2) Maintain all mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure a bed remote control was monitored and kept in safe condition for 1 of 1 resident (R16) reviewed for bed controls. Findings include: R16's quarterly Minimum Data Set (MDS) dated 9/20/24, indicated R16 had severely impaired cognition and diagnoses of heart failure, diabetes mellitus, depression, and dementia. R16 had no impairment to upper and lower extremity and was independent with mobility, such as rolling left and	F 908	The affected bed control unit was inspected and replaced on 12/16/25 current bed controls in use have been inspected for safety on 12/17/25. Current Residents were potentially affected by this deficiency. A bed control and electronics audit has been developed and shall be the standard duty of the maintenance director or designee to be performed on each resident bed on a monthly basis. The Maintenance Director or designee will	1/13/25

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F 908	Continued From page 123 right, sit to lying, and lying to sitting on side of bed and required more assistance with transfers and dressing. During observation and interview on 12/9/24 at 2:42 p.m., R16 laid in bed with the bed controller within reach. The bed controller cord had a black covering which had a half inch or less gap between the controller with the buttons and insulated wires were visible and not frayed. R16 stated they used their bed controller independently. When interviewed on 12/13/24 at 2:12 p.m., nursing assistant (NA)-G stated R16 required extensive assistance for most ADLs but was able to turn herself side to side in bed and used the bed controller independently. NA-G did not notice wires on R16's bed controller but would report to nursing and maintenance if observed. NA-G stated the facility had a TELS (a building management platform) system to report concerns to maintenance. When interviewed on 12/13/24 at 2:16 p.m., licensed practical nurse (LPN)-I stated they had not heard about any bed controller concerns recently but would report to maintenance or director of nursing if such a concern occurred. LPN-I stated electrical concerns caused risk of shock and at times have needed to disconnect residents' bed and move them to another room to ensure safety. When interviewed on 12/13/24 at 2:18 p.m., LPN-B expected staff to place a maintenance request in TELS if they saw exposed wires to protect resident safety. LPN-B observed R16's bed controller and ensured it worked. LPN-B	F 908	bring any bed control issues to the Facility Safety meeting for audit on a 1x weekly basis for 6 weeks, then 1x monthly for 3 months. If compliance is not met at this time, audits will be repeated. Audits will be performed by the IDT, with documentation of each audit logged to be reviewed by QAPI on a quarterly basis	

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F 908	Continued From page 124	F 908		

stated there were exposed wires but were not frayed so would let the administrator know the controller needed to be replaced.

The TELS Work Orders dated 3/1/24 to 12/12/24, did not indicate R16's bed controller needed repair.

When interviewed on 12/16/24 at 10:02 a.m., the administrator stated they saw the bed controller and replaced it. Administrator expected staff to enter a TELS request if a bed controller needed replacement.

The Work History Report dated January to October 2024, indicated "Bed-Electric audits were completed 8/10/24 and described as "not good". The report described the beds as "shortage of good beds" on 8/17/24, "very short" on 8/24/24, "short on good beds" on 8/31/24, "beds are poor condition, and we are low" on 9/7/24. The task was indicated as "skipped" with description "no maintenance director at this time on 9/14/24. The "Perform Bed Inventory Check" for "Beds-Electric" indicated "no action recorded" on 9/21/24 and 9/28/24. Bed safety audits were completed on 9/30/24. The task did not record any action on 10/5/24. The task indicated "no maintenance director at this time" and action "skipped" on 10/12/24. The task did not record any action on 10/19/24 and 10/26/24.

The Physical Environment: Electrical Equipment Policy dated 6/16/22, indicated the maintenance director would maintain schedules for routine inspection and maintenance of all machinal, electrical, and patient care equipment. The policy directed inspection, testing, and maintenance of electrical equipment to be tracked in the TELs

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F 908	Continued From page 125 building management platform.	F 908		
F 921 SS=F	Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i) §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure structural issues and items in disrepair throughout the facility were addressed to help promote a functional, sanitary, and safe environment. Additionally, the facility failed to ensure an ice and water dispensing machine in the second floor TCU and LTC (transitional care unit and long-term care) dining room was clean and free of excess mineral build up and properly functioning. This had the potential to affect all 37 residents residing in, visitors, and staff working in the facility. Findings include: A resident council meeting was held on 12/10/24 at 10:00 a.m., and residents in attendance reported the condition of the facility was "a shithole". The residents stated they were aware there was no maintenance in the building to fix the "multiple problems" in resident rooms, dining rooms, hallways, and the holes in the walls. MAIN KITCHEN During observation on 12/11/24 at 11:37 a.m., the	F 921	" A deep clean of resident areas including hallways, kitchen and dining room will be completed on or before 1/20/25. " An assessment of the environment including electrical, bed lights, ceiling tiles, the ice water machine, and windowsills will be conducted on 1/16/25 by North Shore maintenance and life safety professionals. " Corrective action identified during the assessment on 1/16/25 related to the resident environment will be completed on or before 2/15/25. " An offer was extended and accepted for a full time maintenance director on 1/15/25. " On-site maintenance support will be provided 2x/week until a full time maintenance director has been on-boarded at Hopkins Health Services. " Audits will be conducted 3x weekly by the ED or designee to ensure the environment is in compliance. " Three residents or visitors will be interviewed each week by the ED or designee to ensure the environment feels home-like.	2/15/25

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F 921	Continued From page 126 wall across from the main kitchen refrigerator had multiple blackish-brownish colored speckles. The area under the three-compartment sink had multiple crumbs on the floor and the wall below the sanitizer end of the three-compartment sink had brownish colored speckles. The wall next to an oven-like compartment used keep food at holding temperature had streaks of tannish colored substance down the wall. When interviewed on 12/13/24 at 10:01 a.m., a.m., dietary manager (DM) stated staff have daily cleaning assignments. Account manager (AM - serving as director of culinary services) and DM verified the wall across from the refrigerator with the blackish-brownish colored speckles, and DM stated black colored serving carts must bump against the wall. The speckles on the wall were throughout an area of approximately five feet across and two feet vertical. MEMORY CARE DINING AREA When interviewed on 12/10/24 at 8:37 a.m., family member (FM)-A stated the memory care dining area had missing appliances, cabinet pieces missing, and other mismatched items. FM-A stated the dining area did not feel like a "home", and the whole interior of the building appeared "tired". During observation and interview on 12/11/24 at 9:03 a.m., the memory care dining area had orange-yellow-colored splotches about the size of a quarter at the entrance to the right on the wall. About six air vents lined the wall near the ceiling on both sides of the dining room and had grayish-blackish colored fuzzy substance	F 921	" Audits and interviews will be conducted for six weeks and will be reviewed by the QAPI committee. The need for ongoing audits will be determined at that time.	

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F 921	Continued From page 127 speckled throughout various areas of each vent. One vent near one corner of the dining room had brownish-black speckled color particles and streaks extending on the wall from each of the four corners of the vent. The valance which hung above the window next to the vent was darker colored by brownish-black speckles. The other corner of the dining area had another valance above a window and had thick, grayish colored particles covering the side of the valance closest to a vent. There was a sink on top of a brown cabinet. One side of the cabinet had a missing brown area about one and a quarter foot by one inch and a circular area of cabinet missing the outer brown area about one inch by one and half inches and two other similar missing areas. Two sides of a blue wall had various white scuff marks, with one spot eight inches by one inch and others were similar in size or less. A spot of cabinetry near the refrigerator was missing and a yellowish tan area with areas of white plaster shown on the wall about three feet down and two feet across. A spot of the cabinetry liner was missing. Other various parts of the walls had faint tannish color streaks down them. When interviewed on 12/11/24 at 9:32 a.m., nursing assistant (NA)-G stated the area missing in between cabinets near the refrigerator used to be an oven and had been so for a year or more. NA-G confirmed the condition of the wall where the oven used to be and stated they would not want their home looking that way. NA-G confirmed the other memory care area dining observations and stated they focused attention to the residents so had not noticed the dining room appearance but would not want their home to have the appearance of the dining room.	F 921		

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F 921	Continued From page 128 During environmental tour on 12/13/24 at 1:17 p.m. with the administrator and housekeeping director (HD), the administrator stated there was a stove which was removed from the memory care dining area and had been that way a couple months or more. The administrator verified the area needed repainting or to be blocked. Administrator and HD verified the other conditions of the memory care dining area, and the administrator stated the scuffs on the wall were most likely from food carts or wheelchairs. The administrator stated the dining room was not "horrible" but needed a "make-over". Upon review of the main kitchen on the first floor, the administrator and HD confirmed the wall looked like it had splatter, grime, or evidence of rubbing from a caret, and stated the wall needed to be wiped down. When interview on 12/13/24 at 2:56 p.m., licensed practical nurse (LPN)-B stated they have seen the HD steam clean the valances before. LPN-B stated the memory care residents were calm and conversed as able in the dining area so in that sense was homelike, but family members and staff had concerns about the appearance of the dining area for at least two years. LPN-B stated housekeeping cleaned in the dining room after meals but not much of other actions were taken to fix the appearance of the dining area. ICE MACHINE During interview on 12/10/24 at 1:37 p.m., family member (FM)-C reported getting water and ice from the machine behind the steamtable in the second-floor dining room independently without staff assistance. FM-C stated the machine was	F 921		

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F 921	Continued From page 129	F 921		

malfunctioning and stated, "the ice machine needs maintenance, it sprays everywhere, and it goes everywhere."

During observation on 12/11/24 at 12:11 p.m., dietary aide (DA)-A raised one water pitcher, which was already nearly full, to the water dispenser in the second-floor TCU and LTC dining area and held the pitcher so the mouth of the pitcher almost touched the water dispenser. After a second, DA-A stopped and moved the pitcher to the ice machine to add ice which raised the water line to fill the rest of the pitcher. DA-A used the ice machine to fill up two more water pitchers in this manner. White sediment was around the ice spout, on the grate, and speckled on the back splash.

When interviewed on 12/13/24 at 10:08 a.m., DM stated staff tried to wipe down the ice and water dispensing machine as much as possible to keep clean. The machine had preventative maintenance, but the facility needed a new maintenance director. DM stated the facility had hard water and the grate and other areas of the ice machine needed to be broken down for a deep cleaning. DM attempted to fill a cup with water, and the water dispenser spurted water in different directions and filled the cup when the cup was held closer to the spout. DM stated the nozzle needed to be cleaned or placed correctly, so one stream of water could fill the cup.

During interview on 12/13/24 at 10:31 a.m., housekeeper (H)-A stated they had a checklist for cleaning rooms but not the dining areas and they did not wipe down ice machine.

The Work History Report created 12/12/24 with

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F 921	Continued From page 130 due date timeframe of 1/24 to 10/24, indicated the ice machine and/or ice bins task was completed on 8/26/24 and included check filter, clean coils, sanitize interior, delime as necessary. The same task was marked as completed on 3/8/24. The report lacked indication the exterior surfaces were cleaned. Per interview on 12/12/24 at 2:11 p.m. with the administrator, the facility was without a maintenance director since 9/2024. The administrator stated, "I hear about things, and I just go fix them," and was unsure "how comprehensive" the maintenance reports were. The administrator explained the facility received help from a corporate maintenance person "every two weeks". The Physical Environment: Electrical Equipment Policy dated 6/16/22, indicated the maintenance director shall maintain schedules for routine inspection and maintenance of all mechanical, electrical, and patient care equipment. The policy indicated essential equipment shall be repaired or replaced as soon as practicable. The facility assessment last reviewed 8/8/24, indicated the process to ensure adequate supply, appropriate maintenance of or replacement of building and/or other physical structures and equipment was the TELS maintenance program and activities. The assessment identified the administrator was responsible for reviewing the TELS program and activity "daily, weekly, and monthly for preventative maintenance, Life Safety monitoring, and reporting along with daily work-order tracking." The assessment identified examples, including, "bathroom safety bars, sinks for residents and for staff, lifts, lift slings, room	F 921		

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F 921	Continued From page 131 and common space furniture, steam table, waste management, sliding doors, nurse call system, and emergency power". Per facility policy titled Resident Rights last revised 7/2022, residents would be treated with respect and dignity and care for each resident would be given in a manner and in an environment that promotes maintenance or enhancement of his/her quality of life.	F 921		
F 947 SS=E	Required In-Service Training for Nurse Aides CFR(s): 483.95(g)(1)-(4) §483.95(g) Required in-service training for nurse aides. In-service training must- §483.95(g)(1) Be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year. §483.95(g)(2) Include dementia management training and resident abuse prevention training. §483.95(g)(3) Address areas of weakness as determined in nurse aides' performance reviews and facility assessment at § 483.71 and may address the special needs of residents as determined by the facility staff. §483.95(g)(4) For nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure required in-service training based on annual performance reviews was	F 947	" Additional in-servicing, in addition to required 12 hours annually, will be provided to CNAs□ required education as	1/31/25

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 947	Continued From page 132 completed for 5 of 5 nursing assistants (NA-B, NA-C, NA-D, NA-H, NA-H) whose employee files were reviewed. This had the potential to affect all 37 residents who resided at the facility. Findings include: A review of employee records on 12/12/24 between 1:24 p.m. and 2:37 p.m., lacked documentation of completed annual performance reviews. Furthermore, the employee records lacked documentation of in-service training that addressed areas of weakness determined by performance reviews. All 5 sampled employees were employed at the facility for greater than one year. Per interview on 12/12/24 at 2:11 p.m. with the administrator, it was believed the previous director of nursing (DON) completed competencies with annual reviews. The administrator stated, "I'm looking through file cabinets and if I can't find them, I can't say that we have them without them." Per interview on 12/16/24 at 12:01 p.m., the DON had "no luck" locating the performance reviews, completed in-service trainings based on weaknesses determined by reviews, or competences for the sampled NAs. The DON stated the facility would be "restarting those reviews" beginning January 1st and indicated it was important because staff needed to be aware of what they were doing well and what could be improved upon. Additionally, the DON stated annual reviews were a good way to build rapport with staff and helped build the team. A policy pertaining to annual reviews or in-service	F 947	necessary based on the results of their performance evaluation. Dementia care and abuse education will continue to be included in the required 12 hours of annual in servicing.	

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	245293	A. BUILDING _____ B. WING _____	C 12/16/2024

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F 947	Continued From page 133 trainings was requested but not received. The facility assessment last reviewed 8/8/24, indicated the facility's training program included was based on the facility's resident population and was an ongoing training for all new and existing staff including managers, nursing, and other direct care staff. The assessment identified annual reviews were a part of the training sessions and would be completed to meet regulatory requirements. Furthermore, the assessment indicated, "skills and competencies were completed on hire and annually to test continued competence in assessment, safe patient handling, infection control, medication administration, wound care, feeding and bathing; skills competencies testing is based on the usual and customary duties performed by each staff member."	F 947		

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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 12/9/24 to 12/16/24, 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. The following complaints were reviewed during the survey: H52932262C (MN00108866), (MN00108868) H52932129C (MN00105994) H52932126C (MN00102367) H52932128C (MN00107291) H52932130C (MN00108710) H52932127C (MN00107045) H52932124C (MN00102351) H52932603C (MN00109024) H52932262C (MN00108863) H52932183C (MN00108640) NO licensing orders were issued. H52932125C (MN00106681) licensing order issued 1665. 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	2 000		

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2 000	Continued From page 2 https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 265	MN Rule 4658.0085 Notification of Chg in Resident Health Status A nursing home must develop and implement policies to guide staff decisions to consult physicians, physician assistants, and nurse practitioners, and if known, notify the resident's legal representative or an interested family member of a resident's acute illness, serious accident, or death. At a minimum, the director of nursing services, and the medical director or an attending physician must be involved in the development of these policies. The policies must have criteria which address at least the appropriate notification times for: A. an accident involving the resident which	2 265		1/27/25

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2 265	Continued From page 3 results in injury and has the potential for requiring physician intervention; B. a significant change in the resident's physical, mental, or psychosocial status, for example, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications; C. a need to alter treatment significantly, for example, a need to discontinue an existing form of treatment due to adverse consequences, or to begin a new form of treatment; D. a decision to transfer or discharge the resident from the nursing home; or E. expected and unexpected resident deaths. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to notify providers about a resident's weight status while on a prescribed diuretic (water pill) for 1 of 1 residents reviewed for edema (swelling). Findings include: R5's significant change Minimum Data Set (MDS) dated 11/5/24, indicated she had severe cognitive impairment with diagnoses of heart failure, kidney failure, respiratory failure, anxiety, depression, and lymphedema (a chronic condition causing swelling from lymph or protein-rich fluid in the body's tissues). The MDS further indicated R5 received hospice care. R5's Care Area Assessment (CAA) for functional	2 265	Corrected	

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2 265	Continued From page 4 abilities dated 11/5/24, identified her need for assistance with all activities of daily living (ADLs) and mobility, directing staff to provide "max assist" with all cares and dependent assistance with toileting and transfer cares. The CAA directed staff to proceed to the plan of care "with goal of comfort and dignity with end of life cares." R5's unsigned order summary was reviewed 12/13/24, and included the following orders: - "furosemide oral tablet, Give 40 milligrams (mg) by mouth one time a day" for pulmonary edema (fluid buildup the lungs), heart failure with chronic kidney disease and failure, dated 3/12/24. - "weight and vitals weekly (obtain re-weight if change of 5 lbs (pounds) since last weight every Thursday", dated 5/28/24. R5's treatment administration record (TAR) dated 8/2024, reflected the following documented weights: - 8/8/24: 170 [lbs]. - 8/15/24: 171 [lbs]. - 8/22/24: 165 [lbs]. - 8/28/24: lacked documentation of weight and referred to the progress notes. R5's TAR dated 9/2024 reflected the following documented weights: - 9/5/24: "NA". -9/12/24: 164 [lbs]. 9/19/24: 164.3 [lbs]. 9/26/24: lacked documentation of weight with rationale "refused". R5's TAR dated 10/2024 reflected the following documented weights: - 10/17/24: "NA".	2 265		

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2 265	Continued From page 5 - 10/31/24: 164.2 [lbs]. The dates of 10/3/24, 10/10/24, and 10/24/24, lacked documentation of weights and referred to the progress notes. R5's TAR dated 11/2024 reflected the following documented weights: - 11/14/24: "NA". - 11/28/24: "NA". The dates of 11/7/24, and 11/21/24, lacked documentation of weights and referred to the progress notes. R5's TAR dated 12/2024 reflected the following documented weights: - 12/5/24: 162.5 [lbs]. - 12/12/24: "NA". R5's care plan dated 7/28/23 identified she was on diuretic therapy to treat her lower extremity edema. The care plan guided staff to report signs and symptoms of "dehydration, hypotension, dizziness, etc." to meet her goal of having no adverse effects. Additionally, the care plan identified her risk for excess fluid volume due to her lower extremity swelling (edema) and directed staff to report signs and symptoms edema or fluid overload, including weight gain. Per progress note dated 8/1/24 at 1:07 p.m., for the order to "weight and vitals - weekly obtain re-weight if change of 5 lbs since last weight)", two attempts were made to collect R5's weight and/or vital signs and would be attempted again later. The progress note lacked documentation on provider notification of refusals. Per progress note dated 8/13/24 at 11:43 a.m., the interdisciplinary team (IDT) discussed R5's weight loss "of approx. 25 lbs over last 4 months"	2 265		

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2 265	Continued From page 6 and potential causative factors. The progress note lacked documentation if her provider was updated on her weight loss. A progress note dated 8/29/24 at 9:47 a.m., indicated R5 refused her weekly weight three times. The progress note lacked documentation on provider notification of refusals. A progress note dated 10/17/24 at 9:44 a.m., lacked documentation regarding why weight was not documented in R5's TAR as ordered. The progress note lacked documentation on provider notification. A progress note dated 10/24/24 at 9:32 a.m., indicated R5 refused weekly weight but other "vitals completed." The progress note lacked documentation on provider notification of refusals. Per a nutrition assessment note dated 11/5/24 at 3:02 p.m., R5 was at risk for fluid shifts and weight fluctuations related to diuretic use. The note directed staff to continue the current nutrition plan of care. Per progress note dated 11/7/24 at 9:41 a.m., R5 refused to get out of bed for her ordered weekly weight check. The progress note lacked documentation on provider notification. Per progress note dated 11/21/24 at 9:41 a.m., R5 refused to get out of bed for her ordered weekly weight check. The progress note lacked documentation on provider notification. A provider progress note dated 9/20/24, identified R5's "abnormal weight loss" with her self-reported "anorexia" (medical term for loss of appetite) and	2 265		

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2 265	Continued From page 7 weight loss for "a few months". The provider progress note indicated under the "Assessment and Plan" for abnormal weight loss staff should continue to trend weight. A request for further primary care provider visit documentation or provider progress notes was requested but not received. R5's electronic medical record (EMR) was reviewed on 12/12/24, and lacked documentation on provider notification of her refusal to be weighed. Per observation on 12/10/24 at 9:08 p.m., R5 was laying in her bed on her back. She had mild swelling to both legs and did not have any stockings or wraps on her legs. Per interview on 12/12/24 at 10:00 a.m., with the registered dietitian (RD), R5 was being followed because she was a high-risk for her weight. RD reviewed her weights in R5's EMR and stated she followed her monthly and confirmed weight loss. RD verified she was due for another "risk charting note soon" and stated R5's weight had been stable "for about a month," but was unsure what was "currently going on." RD identified her diuretic use could affect her weight but stated she was on hospice and did not like to "demand things" when a resident was on hospice care. RD expected documentation of a resident's refusals of weights and stated it would be "preferable" for monthly weights to be obtained. RD identified a weight on 12/5/24, and stated, "She's down a couple of pounds" but expected this for a resident on hospice cares. RD denied concern for R5's weight loss. Per interview on 12/12/24 at 10:14 a.m. with R5's	2 265		

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2 265	Continued From page 8 hospice registered nurse (HRN), R5 appeared "well-cared for" during hospice visits and assessments at the facility. HRN reported assessing R5's respiratory status and fluid retention/edema during visits and denied concern beyond R5's baseline. HRN stated R5 was "really short of breath with exertion and even in conversation" and "her legs have always been very swollen." HRN verified a lack of notification regarding R5's refusals to be weight and a lack of documented weekly weights. HRN stated, "it is something I am monitoring but not necessarily something I expect to be updated" on, however, endorsed concern for staff not monitoring weights because "if they are not monitoring weights, then I wouldn't be able to monitor them either." HRN deferred to R5's primary care provider (PCP) for management of her weights and diuretic orders. Per interview on 12/12/24 at 4:23 p.m., R5's primary care provider and nurse practitioner (NP) confirmed not receiving updates on R5's lack of documented weights and her refusals to be weighed. NP expected to be updated and stated if staff had provided updates, "I would have reassessed the orders and the need for the Lasix, particularly because she's on hospice." NP indicated there had not been any observed changes to R5's baseline edema and denied concern regarding R5's weights, stating they "seem stable for her baseline." Per interview on 12/13/24 at 9:50 a.m., with licensed practical nurse (LPN)-D, R5's edema in her legs were "much improved now" with a decrease in her fluid retention. LPN-D explained for residents at risk for fluid retention and/or on a diuretic, staff should watch for respiratory changes, edema, and weight changes. LPN-D stated, "If I saw those things, I would notify the	2 265		

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2 265	Continued From page 9 unit manager, update the doctor and request they assess the resident." LPN-D stated if a resident was weighed and it looked off, "we would encourage a reweigh", and if a resident was consistently refusing, staff were expected to reapproach, distraction and if the refusals continued, staff were expected to update the provider about the refusals. During interview on 12/16/24 at 9:50 a.m., with LPN-A, also the unit manager, R5's EMR was reviewed for notification of change to the provider regarding her refusal to be weighed and lack of documented weekly weights. LPN-A verified there was no documentation in the EMR or provider portal on her refusals and lack of weights. LPN-A expected staff to report refusals to the nurse and expected nurses to reapproach the resident. If a resident continued to refuse the treatment or order, LPN-A expected staff to update the provider and resident's representative. During interview on 12/16/24 at 12:01 p.m., the director of nursing (DON) hoped staff would bring concerns with residents refusing to be weight to IDT to be discussed. The DON expected staff to report R5's refusals to both her hospice provider and her primary provider teams "so we can make a better plan for that resident." Per facility policy titled Change in Condition of the Resident revised 9/20/22, the facility should immediately inform the resident; consult with the resident's physician; and notify , consistent with his or her authority, the resident representative(s) when there is a need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment). The policy explained when a resident	2 265		

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2 265	Continued From page 10 presented with a possible change of condition, staff should notify a resident's physician and for non-immediate notifications, staff were guided to provide the notification via the phone, fax, or method preferred by the physician being contact. Additionally, the policy directed staff to ensure the resident's change in condition was included on the 24-hour report to be reviewed later by the IDT and to updated the plan of care as needed. SUGGESTED METHOD OF CORRECTION: The facility could review policies and procedures related to notification of change in resident health status and who to notify. The Director of Nursing (or designee) could conduct measurable audits on residents health records to verify change in health status is being completed and bring to the Quality Assurance Performance Improvement (QAPI) committee to determine compliance or the need for further monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 265		
2 280	MN Rule 4658.0100 Subp. 1 Employee Orientation and In-Service Education Subpart 1. Orientation and initial training. All personnel must be instructed in the requirements of the law and the rules pertaining to their respective duties and the instruction must be documented. All personnel must be informed of the policies of the nursing home, and procedure manuals must be readily available to guide them in the performance of their duties. This MN Requirement is not met as evidenced	2 280		1/27/25

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2 280	Continued From page 11 by: Based on interview and document review, the facility failed to complete annual performance reviews for 5 of 5 nursing assistants (NA-B, NA-C, NA-D, NA-H, NA-M) whose employee files were reviewed. This had the potential to affect all 37 residents who resided at the facility. Findings include: A review of employee records on 12/12/24 between 1:24 p.m., and 2:37 p.m., lacked documentation of completed annual performance reviews. All 5 sampled employees were employed at the facility for greater than one year. Per interview on 12/12/24 at 2:11 p.m., the administrator stated it was their understanding the previous director of nursing (DON) completed competencies with annual reviews. The administrator stated, "I'm looking through file cabinets and if I can't find them, I can't say that we have them without them." Per interview on 12/16/24 at 12:01 p.m., the DON had "no luck" locating the annual performance reviews or recent completed competencies for the sampled NA's. The DON stated the facility would be "restarting those reviews" beginning January 1st and indicated it was important because staff needed to be aware of what they were doing well and what could be improved upon. Additionally, the DON stated annual reviews were a good way to build rapport with staff and helped build the team. The facility assessment last reviewed 8/8/24, indicated the facility's training program was based on the facility's resident population and was an ongoing training for all new and existing staff	2 280	Corrected	

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	00872	A. BUILDING: _____ B. WING _____	C 12/16/2024

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HOPKINS HEALTH SERVICES	725 SECOND AVENUE SOUTH HOPKINS, MN 55343

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2 280	Continued From page 12 including managers, nursing, and other direct care staff. The assessment identified annual reviews were a part of the training sessions and would be completed to meet regulatory requirements. Furthermore, the assessment indicated, "skills and competencies were completed on hire and annually to test continued competence in assessment, safe patient handling, infection control, medication administration, wound care, feeding and bathing; skills competencies testing is based on the usual and customary duties performed by each staff member." The assessment also included the annual review process in staff recruitment and retention section. A policy pertaining to annual reviews was requested but not received. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON) or designee could review and revise policies and procedures related to nurse aide annual performance review. The administrator, director of nursing, or designee could develop a system to educate staff and develop a monitoring system to ensure compliance. The facility could report those findings to the Quality Assurance Performance Improvement (QAPI) committee for further recommendations to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 280		
2 285	MN Rule 4658.0100 Subp. 2 Employee Orientation and In-Service Education Subp. 2. In-service education. A nursing home	2 285		1/27/25

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2 285	Continued From page 13 must provide in-service education. The in-service education must be sufficient to ensure the continuing competence of employees, must address areas identified by the quality assessment and assurance committee, and must address the special needs of residents as determined by the nursing home staff. A nursing home must provide an in-service training program in rehabilitation for all nursing personnel to promote ambulation; aid in activities of daily living; assist in activities, self-help, maintenance of range of motion, and proper chair and bed positioning; and in the prevention or reduction of incontinence. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure required in-service training based on annual performance reviews was completed for 5 of 5 nursing assistants (NA-B, NA-C, NA-D, NA-H, NA-H) whose employee files were reviewed. This had the potential to affect all 37 residents who resided at the facility. Findings include: A review of employee records on 12/12/24 between 1:24 p.m. and 2:37 p.m., lacked documentation of completed annual performance reviews. Furthermore, the employee records lacked documentation of in-service training that addressed areas of weakness determined by performance reviews. All 5 sampled employees were employed at the facility for greater than one year. Per interview on 12/12/24 at 2:11 p.m. with the administrator, it was believed the previous director of nursing (DON) completed	2 285	Corrected	

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2 285	Continued From page 14 competencies with annual reviews. The administrator stated, "I'm looking through file cabinets and if I can't find them, I can't say that we have them without them." Per interview on 12/16/24 at 12:01 p.m., the DON had "no luck" locating the performance reviews, completed in-service trainings based on weaknesses determined by reviews, or competences for the sampled NAs. The DON stated the facility would be "restarting those reviews" beginning January 1st and indicated it was important because staff needed to be aware of what they were doing well and what could be improved upon. Additionally, the DON stated annual reviews were a good way to build rapport with staff and helped build the team. A policy pertaining to annual reviews or in-service trainings was requested but not received. The facility assessment last reviewed 8/8/24, indicated the facility's training program included was based on the facility's resident population and was an ongoing training for all new and existing staff including managers, nursing, and other direct care staff. The assessment identified annual reviews were a part of the training sessions and would be completed to meet regulatory requirements. Furthermore, the assessment indicated, "skills and competencies were completed on hire and annually to test continued competence in assessment, safe patient handling, infection control, medication administration, wound care, feeding and bathing; skills competencies testing is based on the usual and customary duties performed by each staff member."	2 285		

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2 285	Continued From page 15 SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON) or designee could review and revise policies and procedures related to nurse aide annual training. The administrator, director of nursing, or designee could develop a system to educate staff and develop a monitoring system to ensure compliance The facility could report those findings to the Quality Assurance Performance Improvement (QAPI) committee for further recommendations to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 285		
2 800	MN Rule 4658.0510 Subp. 1 Nursing Personnel; Staffing requirements Subpart 1. Staffing requirements. A nursing home must have on duty at all times a sufficient number of qualified nursing personnel, including registered nurses, licensed practical nurses, and nursing assistants to meet the needs of the residents at all nurses' stations, on all floors, and in all buildings if more than one building is involved. This includes relief duty, weekends, and vacation replacements. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident as determined by the resident assessments, plans of care, and facility	2 800	Corrected	1/27/25

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2 800	Continued From page 16 assessment. This had the potential to affect all residents residing in the facility. Bowel and Bladder - See F690 - R3 Findings include: R3's quarterly Minimum Data Set (MDS) dated 12/06/24, reported she had intact cognition, had no hallucinations, delusions, rejections of care, and no verbal, physical or other behavioral symptoms towards herself or others. The MDS identified R3 was dependent on staff for toileting hygiene and transfers, required substantial to maximal assist for mobility and all other transfers, had no urinary catheters, had not trialed a urinary or bowel toileting training program and was frequently incontinent of urine and bowel. Additionally, the MDS identified R3 was at risk for pressure injury wound. During a continuous observation on 12/11/24 between 10:48 a.m. and 11:37 a.m., the following was observed: - 10:48 a.m.: R3's call light was put on. - 10:49 a.m.: nursing assistant (NA)-A entered R3's room to answer the call light and was heard stating she would be back to help her. Per interview at 10:49 a.m., R3 verified NA-A stated she would be back to help clean her up. - 11:09 a.m.: the director of nursing (DON) walked down the hallway and asked where NA-A was. Within 2 minutes, the DON left the unit and was observed walking onto the elevator leaving the second floor. - 11:13 a.m.: NA-A was not back to assist. An overhead page was heard announcing, "2 west,	2 800		

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2 800	Continued From page 17 you have a resident call." - 11:14 a.m.: There were no staff observed on the 2 East of the unit. An overhead page was heard announcing, "2 west nurse please call" and a call-back number was read aloud. - 11:18 a.m.: No staff were present on the 2 east unit. - 11:20 a.m.: Licensed practical nurse (LPN)-H walked onto the 2 east unit to the medication cart. - 11:22 a.m.: LPN-H left the medication cart and walked off the 2 east unit. No staff have attempted to enter R3's room. - 11:26 a.m.: Activities-(A) pushed another resident into his room and walked back out and off the 2 east unit without addressing other residents within a minute. - 11:30 a.m.: NA-A walked off the elevator, walked through the nurse's station and into the nurse manager's office. No visible staff observed down the 2 west hallway or the 2 east hallway. - 11:38: a.m.: An unidentified staff walked off the elevator and into to the nurse manager's office. There were no nursing staff on either the 2 west hallway or 2 east hallway. - 11: 41 a.m.: LPN-H and NA-A walk back to the 2 east unit and hallway. - 11:42 a.m.: LPN-H and NA-A entered R3's room to assist with cares requested from call light request at start of observation. Per interview on 12/9/24 at 3:19 p.m. with nursing assistant (NA)-F, there was "no staffing, no management and no one to do the scheduling right now." NA-F stated if someone called out of their shift, they normally find a replacement by asking nurses to overlap and help with the NA work. NA-F stated, "it happens that we [are] short but not often." R23	2 800		

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2 800	Continued From page 18 The quarterly Minimum Data Set (MDS) dated 12/13/24, for R23 indicated moderately impaired cognition. MDS indicated on 10/12/24 cognitive loss, dementia, with decrease of functional abilities, falls, nutritional status, pressure ulcer/injury, and pain. R23 diagnosis on 1/25/24 peripheral vascular disease, absence of other left toes acquired absence of other right toes. R23 is full assist of two, non-weight bearing, has an air mat, reposition every 2 to 3 hours. Heel boot and float heels. During an observation of R23 on 12/11/24 at 8:11 a.m., nursing assistant (NA)-A completed hand hygiene, donned enhanced barrier precautions (EBP) and cleaned face and arms of R23. NA-A doffed EBP, left room, found another staff member to do peri cares and reposition. NA-D was in the dining room assisting residents with breakfast. The licensed practical nurse (LPN)-A was interrupted during a medication pass, washed hands, donned EBP performed cares and repositioned resident. During a continuous observation of R23 on 12/11/24 between 10:48 a.m. and 11:37 a.m.: - 10:48 a.m., call light on, no staff were observed in hallways - 11:10 a.m., no staff observed in hallway, call light remained on. - 11:20 a.m., no staff observed in hallway, call light remained on. - 11:36 a.m., a staff member was observed walking to the medicine cart and within one minute, walked away and off the unit. - 11:37 a.m., a staff member was observed walking in room and able to assist with cares per her call light request initiated at 10:48 a.m.	2 800		

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2 800	Continued From page 19 Grievance/complaints A grievance/complaint report on 5/21/24, indicated R36 reported they were wet for 2.5 hours. They put on their call light at approximately 4:30 a.m., nursing assistant (NA)-A told R36 that they were the only NA on the floor, and they were taking a 2.5-hour break because of a 16-hour shift. R36 stated they were still wet at 6:00 a.m., and could not be changed as the day shift wasn't on yet. The follow up indicated the concern was discussed with staff their responsibility to provide cares. A grievance/complaint report on 6/4/24, R19 told licensed practical nurse (LPN)-A that nursing assistant (NA)-A did not finish changing resident, NA-A walked out of room and left R19 unattended for 35 minutes without coming back or saying anything to resident. The follow up indicated LPN-A found nursing assistants (NA)-D and NA A, on break together. The staff were brought back to the floor and completed the cares for R19. A group meeting was held with registered nurse (RN)-B, LPN-A, LPN-D, NA-A and NA-D. The result of actions where two NAs were verbally counseled. The resolution of grievance included R19 was very upset, and staff explained R19 was able to report situations at any time. A grievance/complaint report on 6/28/24, identified the interdisciplinary team (IDT) held a quarterly meeting, and R19 reported she was upset that she was not being assisted up in wheelchair due to being short staffed. The report indicated nursing confirmed staffing was insufficient. The follow up for R19 included the administration discussed care plan, observed staffing on the floor, and provided the ability to transfer R19 into wheelchair.	2 800		

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2 800	Continued From page 20 A grievance/complaint report on 7/31/24, included R19 informed the facility they were not changed after a bowel movement. They indicated they waited for 3 hours because there was not enough staff to provide cares. R19 put on call light at least two times an hour, and was repeatedly told by staff, they were not able to provide cares. The follow up was a staff meeting, and R19 should notify the manager each time this type of incident happens. Staff involved were unnamed. A grievance/complaint report on 8/21/24, indicated R37 stated they put on their call light at 12:30 a.m. for a brief change. A staff member came into room, turned off call light, and told R37 it will get done. The staff did not return, and R37 reported they did not get changed until 6:15 a.m. The facility follow up included providing coaching for staff members. A grievance/complaint report on 8/30/24, indicated at approximately 2:00 a.m., R37 put on their call light to request a brief change and water. Licensed practical nurse (LPN)-G answered the call light, left, and did not come back for approximately 2 hours to change him. R37 put call light on, requested to sit in chair, and a staff member told him they aren't going to get him up. The follow up included a staff meeting to explain requirement to provide cares, answer call lights promptly, and honor resident wishes. A grievance/complaint report on 9/19/24, indicated R37 put their call light on at 7:30 p.m. to request a brief change for bowel movement. R37 was banging on the foot of bed to get help. Licensed practical nurse (LPN)-I told R37 that the nursing assistant (NA) left at 8:30 pm, and R37 needed to wait to be changed. R37 asked LPN-I	2 800		

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2 800	Continued From page 21 to change him. LPN-I turned off call light and did not change him. R37 put light on again, was changed at 11:30 pm. The facility follow up was to remind staff to answer call lights and resolve the issue. Resident council meetings minutes 10/20/24, were reviewed on 12/16/24, and identified call light wait times were brought up as a concern. Resident council meeting minutes dated 9/18/24, were reviewed on 12/16/24, and identified call light wait times was discussed. Resident council meeting minutes dated 10/20/24, were reviewed on 12/16/24, and identified call light wait times were brought up as a concern." A resident council meeting was held on 12/10/24 at 10:00 a.m., R36 reported call lights take "a long time" to answer. R37 stated call lights wait times take the longest to be answered "in the evening and at night". R30 reported the facility had been without a maintenance worker and "the facility needs so much work" because "the place is falling down". R30 verbalized they did not feel the facility had enough staff to take care of the building or to take care of residents. During an interview on 12/11/24 at 8:34 a.m., nursing assistant (NA)-A stated, when the cares are difficult to complete when residents are an assist of two. The staff were interrupted during medication passes, and during meals. One staff member was in the dining room. There was not enough staff to complete morning cares on time. During an interview on 12/12/24 at 2:19 p.m., licensed practical nurse (LPN)- D confirmed there was 9 out of 18 residents on 2 east and 2 west hallways required assist of two to provide safe cares. It is difficult to complete cares when	2 800		

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2 800	Continued From page 22 interrupted with phone calls, mealtimes, and medication pass. During an interview on 12/13/24 at 10:21 a.m., administrator, stated the staff schedule has double shifts built in. In case of a no show/sick call or emergencies, bonuses were offered to other staff. The management and ancillary staff assisted with tasks that were necessary for the residents. He verbalized the staffing for cares in pairs was a concern. The staff, residents and families brought workload concerns to facility by email, phone number, able to submit anonymously. The system to address concerns were quality assurance and performance improvement (QUAPI), interdisciplinary team (IDT) and meetings. During an interview on 12/16/24 at 10:10 a.m., director of nursing (DON) verified insufficient staffing. The DON stated the resident needs outweigh the staff available. DON stated, lack of support from corporate, and being a new DON, mentorship was needed but fell by the wayside. The DON confirmed the acuity for the residents is high, 9 out of 18 residents required assist of two staff for cares. Staffing and management were working with corporate to get staffing numbers up. The facility was actively recruiting for a health unit coordinator or receptionist to assist in tasks in the facility. This facility did not utilize pool, contract or agency nursing. The maintenance director resigned; no daily maintenance is completed. Corporate sent someone out once a month to do repairs. The system was in place for workload concerns are phone number for grievances, and email, anonymously if desired. During interview on 12/13/24 at 10:24 a.m., the administrator verified being responsible for the	2 800		

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2 800	Continued From page 23 scheduling with the DON. The administrator reflected on the facility's recent self-reported investigations and requirement to remove staff from the schedule and verified it had not been easy to schedule around their absences but stated "we've been able to provide cares." The administrator stated the levels of care were assessed during interdisciplinary team (IDT) meetings "every day", including resident behaviors. The administrator believed the staffing approaches covered the acuity needs of the residents. When asked about the continuous observation on 12/11/24, and if that was a demonstration of appropriate staffing, the administrator stated, "I expect a call light to be answered ideally within 10-15 minutes," and stated the expectation was to provide cares in an appropriate and safe manner. The administrator stated they discuss resident acuity and case mix daily but stated residents requiring cares in pairs are not always considered in their case mix or acuity count. The DON verified the facility's staffing was "not ideal" and stated the administrator had received the "short end of the stick". The DON stated they both were "taking hits" and had received "discipline" by corporate management for "staffing the way we do and we're still not meeting the acuity needs." The DON stated they are urging families to file formal grievances to aid in their efforts to support their staffing needs. The DON stated they did not have employees to call on as back-ups for instances of no-call/no-shows and did not have the permission to set that up. The DON verified resident needs were exceeding staffing levels and agreed resident outcomes were suffering. The DON stated, "Our staffing is not meeting the needs of our residents. If we're only meeting bare minimum, that's not good	2 800		

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2 800	Continued From page 24 customer service." A facility assessment dated 8/8/24, indicated it evaluated the facility's resident population and identified resources needed to provide the necessary care and services to residents during day-to-day operations and emergencies. The assessment tool identified itself as a resource for the facility's leadership to use when making decisions for purposes regarding sufficient staffing numbers, competent staff, recruitment, and retention of staff, and continency planning for emergency events. The assessment indicated input from residents, their representatives, staff, and resident council meeting minutes were reviewed for applicable input. The assessment identified other "pertinent facts or descriptions of the resident population to be considered when determining staffing and resource needs" which included the following: - "require a Hoyer or Sit-to-Stand lift (2-person transfer)". - "are on increased monitoring for behaviors or are Cares in Pairs". - "require hands-on transfer assistance". - "Have mixed preferences for eating in the dining room, versus resident room". - "needs of ancillary staff (readying those residents who receive therapy by a certain time each, for instance)". The assessment indicated physical therapy and specific rehabilitation services provided services such as ADL cares to support a resident's independence in doing as much of the ADLs by himself/herself. Furthermore, the assessment indicated it provided bowel and bladder care, including incontinence prevention and care and responding to requests for assistance to the bathroom or toilet promptly in order to maintain	2 800		

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2 800	Continued From page 25 continence and promote dignity. The assessment concluded the staffing level process was to consider the corporate staffing requirements and identified the facility-specific requirements at a census of 43 residents or more, the staffing levels should be 3 licensed nurses on the day and evening shifts and 2 nurses on the overnight shift; 4 NAs on the day and evening shifts and 2 NAs overnight with 2 nurse managers at least 8 hours per day Monday through Friday. Additionally, the assessment indicated an acuity consideration of "over one third of our residents require two-person assistance with transfers, either stand-by assist or Hoyer or EZ stand lifts" and "due to behavioral issues, one third of our residents are care planned to be Cares in Pairs and require two individuals to be present during all cares". Additionally, the assessment always included memory care's requirement of 2 staff on the floor at all times for safety with wandering residents. Meal Service The facility assessment dated 8/8/24, indicated "meals are served from the same dining room at the same time for all units, delivering meals that are hot and palatable is best done with full staff". The assessment also indicated meals were delivered in a space preferred by the resident, either in their room or in the dining room and "staff must accommodate both preferences and deliver meals in a timely manner to ensure food safety be maintained." During observation and interview on 12/10/24 at 8:15 a.m., residents were seated in the memory care dining area, and a resident asked where	2 800		

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2 800	Continued From page 26 breakfast was at. The resident stated breakfast was supposed to start at 8 a.m. and stated the current time. At 8:17 a.m., another resident asked when the food was going to arrive. Nursing assistant (NA)-G stated breakfast was coming soon and gave the resident some drinks. At 8:19 a.m., the nurse stated the food would arrive in a few minutes. At 8:24 a.m., dietary aide (DA)-A entered the memory care area with breakfast in a closed container and a cart of juice and coffee. When interviewed on 12/11/24 at 8:56 a.m., NA-G stated breakfast was usually served around 8:10 and 8:15 a.m. and was an improvement. During meal observation and interviews on 12/11/24 at 11:59 a.m., cook (C)-A brought a serving cart with food and items to serve from the main kitchen on the first floor to the second floor. C-A placed food in the transitional care unit (TCU) and long-term care (LTC) dining room steamer and completed other tasks for meal service. At 12:07 p.m., dietary aid (DA)-A prepared silverware on meal trays and other tasks. Two residents were served in the dining area. At 12:11, culinary district manager (DM) stated they were waiting for nursing staff to be ready to serve before dishing up the plates. At 12:17 p.m., registered nurse (RN)-C entered the dining area from the memory care area, and DM stated they were waiting for staff to start meal service. At 12:22 p.m., licensed practical nurse (LPN)-B entered the dining area from the memory care area, and DM stated they were waiting for staff to start meal service. Then C-A started to plate lunch, and DA-A placed completed meal trays into an enclosed cart. At 12:31 p.m., multiple residents were sitting in the memory care area dining room and only a few residents had drinks in front of them. At 12:33 p.m., DA-A entered with	2 800		

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2 800	Continued From page 27 the drink cart. At 12:37, nursing assistant (NA)-E entered the memory care area with the food cart. At 12:47 p.m., social worker (SW) was in the dining area between the TCU and LTC care area standing next to an enclosed cart filled with room trays and stated they were waiting for a juice cup. At 12:52 p.m., SW pushed the cart into the LTC hallway and served the first person their meal tray and continued serving the rest of the residents in the hallway room by room. Medication administration During medication observation and interview on 12/11/24 at 7:15 a.m., licensed practical nurse (LPN)-H had two medication cups with medications on the medication cart and then placed into the top drawer of the medication cart. LPN-H prepared medication for R2 and then added the prepared medications to one of the medication cups from the top drawer. LPN-H stated they were preparing medications for R2 now and for R2's next medication pass time when surveyor approached and panicked so checked the medications due now as given already and saved the medications to give R2 at the next medication pass in the top drawer. LPN-H stated they usually labeled the prepped medication cup with the resident's name and room number. LPN-H stated they often prepped residents' medications early or else they would not have their work completed until 4:00 p.m. each day. LPN-H stated the long-term care and transitional care units had a total of two nurses and two nursing assistants, but about twice a week had one nurse and one to two nursing assistants. LPN-H assisted with resident ADLs and other tasks when there was one nursing assistant for the transitional care unit and long-term care area. LPN-H felt pressured to find ways to save time	2 800		

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2 800	Continued From page 28 when there was only one nurse and had appointments, labs, new orders, wounds, and intravenous medications to manage. LPN-H stated they spoke with management before, and management staffed according to resident census. When interviewed on 12/9/24 at 3:19 p.m., nursing assistant (NA)-F stated sometimes there were not enough staff, and there was no staffing coordinator and a lack of management in general. SUGGESTED METHOD OF CORRECTION: The administrator, DON or designee should ensure adequate policy and programs are developed for sufficient staffing based on the resident population to staffing availability so residents received safe, adequate and timely assistance with toileting, bathing, repositioning, pressure ulcer care, medication administration, meals, and eating assistance. The facility should educate staff on these policies and perform audits of resident care to ensure residents are receiving care and services with adequate staffing. The facility should report the findings of these audits to the quality assurance performance improvement (QAPI) committee for further recommendations to determine compliance or the need for further monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 800		
2 915	MN Rule 4658.0525 Subp. 6 A Rehab - ADLs Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing	2 915		1/27/25

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2 915	Continued From page 29 home must ensure that: A. a resident is given the appropriate treatments and services to maintain or improve abilities in activities of daily living unless deterioration is a normal or characteristic part of the resident's condition. For purposes of this part, activities of daily living includes the resident's ability to: (1) bathe, dress, and groom; (2) transfer and ambulate; (3) use the toilet; (4) eat; and (5) use speech, language, or other functional communication systems; and This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a shower was offered or provided for 1 of 3 residents (R30) reviewed for bathing. Findings include: R30's quarterly Minimum Data Set (MDS) dated 9/24/24, indicated he had moderately impaired cognition with a memory deficit following a cerebrovascular accident (CVA, or a stroke), weakness and paralysis or inability to move his left dominant side after a stroke, depression, and dementia (a condition causing a decline in cognitive function, memory, and behavior). His MDS indicated he displayed no rejection of cares and required substantial to maximal staff assistance for bathing/showering cares and mobility and transfers. R30's annual MDS dated	2 915	Corrected	

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2 915	Continued From page 30 6/24/24, identified bathing preferences were "very important" to him. R30's functional abilities Care Area Assessment (CAA) dated 6/24/24, was triggered due to his need for assistance with ADL cares and identified he was at risk for ADL decline and directed staff to the plan of care. R30's care plan revised 7/5/24, identified his self-care deficit and directed staff to provide assist of 1 with bathing and showering cares to meet his goal of receiving assistance necessary to meet his ADL needs. R30's Kardex indicated his shower was scheduled for Tuesday mornings. R30's PointOfCare (POC) ADL - Shower on Tuesday Am's Task was reviewed 12/13/24, and lacked documentation of showering/bathing cares for the last 30 days. R30's progress notes were reviewed on 12/16/24, and lacked documentation of shower refusals. During interview on 12/09/24 at 6:36 p.m., R30 stated he was last offered a shower "a couple months back," but it was during a time when the facility had turned off the hot water, so he declined. R30 reported this was the last time he could recall staff offering him a shower, and he believed that to be sometime in October 2024. R30 vocalized a wish to be offered a shower "at least monthly." During interview on 12/13/24 at 3:09 p.m., nursing assistant (NA)-B was unable to find documentation of R30's last shower.	2 915		

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2 915	Continued From page 31 During interview on 12/13/24 at 3:15 p.m., licensed practical nurse (LPN)-J reviewed R30's skin assessments and explained weekly skin assessments coincided with resident's scheduled showers. LPN-J stated R30's last skin assessment was done on 12/5/24, and his most recent was completed 12/13/24. LPN-J used the skin assessment to report R30's last shower was "today." During interview and observation on 12/16/24 at 8:16 a.m., R30, sat in his wheelchair in his room. His hair appeared shiny and slick. R30 stated he did not take and was not offered a shower throughout the survey week of 12/9/24 - 12/16/24. Per interview on 12/16/24 at 9:16 a.m., with nursing assistant (NA)-A, resident showers were documented in POC and if a resident refused, NAs should document the refusal in addition to reporting it to the nurse. Per interview on 12/16/24 at 9:33 a.m., with licensed practical nurse (LPN)-D, R30's shower day was Tuesday. LPN-D reviewed his electronic medical record (EMR) and was unable to locate R30's last documented shower. LPN-D verified there was no documentation in the progress notes about him refusing a shower. LPN-D expected NAs to report any concerns identified during a bath or shower, including a refusal, to the nurse. LPN-D stated if the NAs reported anything of concern or a refusal, "I'll document that." During interview on 12/16/24 at 9:20 a.m., LPN-C stated the resident shower schedule was posted in the nurse's station and verified the posted schedule. LPN-C expected NAs to notify the nurse on duty if a resident refused a shower and	2 915		

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2 915	Continued From page 32 stated the nurse should document the refusal as well. During interview on 12/16/24 at 9:43 a.m., LPN-A (also the unit manager) stated NAs were expected to document in POC under the tasks section if a resident had a shower and if a resident refused, NAs were expected to report to the nurse on duty and the nurse expected to document in the progress notes. LPN-A stated NAs should be aware of scheduled showers/baths because the schedule was printed and posted at the nurse's station, the schedule as discussed during shift report, and it was on their POC tasks. LPN-A expected R30's last shower date to be 12/10/24 and expected to see documentation in POC or a refusal documented in the progress notes. LPN-A confirmed there were no documented refusals in the progress notes. LPN-A was unable to provide documentation of R30's last shower in POC. Per interview on 12/16/24 at 12:01 p.m., with the director of nursing (DON), NAs were expected to offer a shower on resident's scheduled shower/bathing day and document in POC. If the resident refused a shower, NAs were expected to report to the nurse on duty, and the nurse was expected to document in progress notes. The DON reviewed R30's EMR and confirmed there was no documentation of a shower or of a refusal. The DON explained staff may have offered his shower as a part of his morning cares and if he refused, it may not be reflected as a "true refusal" because the "skin check may or may not be done." The DON endorsed staff "may not be the greatest" at documenting when a bed bath was performed. The DON stated it was important to offer showering to residents to promote dignity and overall health.	2 915		

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2 915	Continued From page 33 Per facility policy titled Resident Rights last revised 7/2022, residents would be treated with respect and dignity and care. The policy identified the resident's right to request, refuse and/or discontinue treatment, and the right to make choices about aspects of his/her life in the facility that are significant to the resident including the choice of healthcare consistent with the resident's interests, assessments, plan of care and other choices. Per facility policy titled NSG - Activities of Daily Living (ADLS) dated 7/26/22, the facility would, based on the resident's comprehensive assessment and consistent with the resident's needs and choices, ensure a resident's abilities in ADLs do not deteriorate unless avoidable. The policy identified care and services would be provided for ADLs including bathing, dressing, grooming and oral care. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) and/or designee could educate responsible staff to provide care to residents' not totally dependent on facility staff, based on residents' comprehensively assessed needs. The DON or designee could conduct audits of residents who are not totally dependent on staff to ensure their personal hygiene needs, including shower and bathing cares, are met and documented consistently. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 915		
21390	MN Rule 4658.0800 Subp. 4 A-I Infection Control Subp. 4. Policies and procedures. The infection	21390		1/27/25

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21390	Continued From page 34 control program must include policies and procedures which provide for the following: A. surveillance based on systematic data collection to identify nosocomial infections in residents; B. a system for detection, investigation, and control of outbreaks of infectious diseases; C. isolation and precautions systems to reduce risk of transmission of infectious agents; D. in-service education in infection prevention and control; E. a resident health program including an immunization program, a tuberculosis program as defined in part 4658.0810, and policies and procedures of resident care practices to assist in the prevention and treatment of infections; F. the development and implementation of employee health policies and infection control practices, including a tuberculosis program as defined in part 4658.0815; G. a system for reviewing antibiotic use; H. a system for review and evaluation of products which affect infection control, such as disinfectants, antiseptics, gloves, and incontinence products; and I. methods for maintaining awareness of current standards of practice in infection control. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure staff performed appropriate hand hygiene during medication administration for 2 of 3 residents (R2, R6) observed during medication administration, and failed to implement enhanced barrier precautions (EBP) for 6 of 7 residents (R4, R9, R14, R18, R26, R29) reviewed for precautions. Further, the facility failed to develop and implement a	21390	Corrected	

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21390	Continued From page 35 Legionella risk assessment and plan to mitigate the growth of Legionella. This had the potential to affect all 37 residents, staff and visitors. Findings include: Hand Hygiene R2's quarterly Minimum Data Set (MDS) dated 11/16/24, indicated R2 was cognitively intact with diagnoses of coronary artery disease (arteries which supply blood to the heart become narrowed or blocked), heart failure, hypertension, and diabetes mellitus. R6's quarterly MDS dated 12/7/24, indicated R6 was cognitively intact with diagnoses of hypertension, urinary tract infection, diabetes mellitus, dementia, anxiety, and depression. During a medication observation and interview on 12/11/24 at 7:15 a.m., licensed practical nurse (LPN)-H prepared medication for R2 at the medication cart outside of R2's room. LPN-H entered R2's room and took R2's temperature and oxygen saturation level. LPN-H exited the room and did not perform hand hygiene and typed information into the computer, then LPN-H locked the cart and gave medication cup to R2. R2 took medication independently. LPN-H returned to the medication cart, did not perform hand hygiene, and prepared medication for R6. LPN-H found a tray to place R6's medication on, placed on gloves to clean the tray, removed gloves, and performed hand hygiene. LPN-H brought medication to R6 and observed R6 take medication independently. R6 stated they had a cream LPN-H to apply. LPN-H exited the room, did not perform hand hygiene, and looked at R6's orders on the computer. LPN-H returned to R6's	21390		

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21390	Continued From page 36 room and touched and looked at the tube of cream in R6's room. LPN-H stated they would confirm and apply the appropriate cream later and left R6's room. LPN-H returned to the medication cart to chart the medications given to R6 and did not perform hand hygiene. LPN-H started to look at another resident's medication list and readied a new medication cup. LPN-H confirmed they performed hand hygiene after cleaning the tray and removing gloves but missed opportunities to perform hand hygiene between giving medications to one resident and preparing medications for a different resident. When interview on 12/13/24 at 2:25 p.m., LPN-B stated staff should perform hand hygiene when leaving a resident room before preparing another resident's medications. LPN-B stated staff did not want to transfer germs from one resident to another. When interviewed on 12/16/24 at 11:01 a.m., the director of nursing (DON) expected staff to perform hand hygiene in between medication passes to lessen the risk of germs spreading from one resident to another. The Hand Hygiene policy dated 11/2/22, directed staff to perform hand hygiene when indicated, using proper techniques consistent with accepted standards of practice. The policy included a Hand Hygiene Table which directed staff to perform hand hygiene before preparing or handling medications. EBP R4's admission record printed 12/13/24, included an admission date of 6/6/24.	21390		

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21390	Continued From page 37 R4's care plan printed 12/13/24, included R4 had a pressure ulcer (wound caused by pressure) on his coccyx (tailbone). The care plan failed to include interventions for EBP. Observation of R4's room did now show evidence of signage or personal protective equipment (PPE) for EBP on 12/9/24, and 12/10/24. R9's admission record printed 12/13/24, included an admission date of 11/15/24, and a diagnosis of pressure ulcer of the right heel. R9's care plan printed 12/13/24, failed to include interventions for EBP. Observation of R9's room did now show evidence of signage or personal protective equipment (PPE) for EBP on 12/9/24, and 12/10/24. R14's admission record printed 12/13/24, included an admission date of 6/18/24, and a diagnosis of neuromuscular dysfunction of bladder (causes a person to not be able to control their bladder emptying). R14's care plan printed 12/13/24, included R14 had a Foley catheter. R14's care plan failed to include interventions for EBP. Observation of R14's room did now show evidence of signage or personal protective equipment (PPE) for EBP on 12/9/24, and 12/10/24. R18's significant change Minimum Data Set (MDS) dated 10/25/24, included an admission date of 10/27/24, and an active diagnosis of benign prostatic hyperplasia (enlargement of the prostate gland). R18's MDS included he had an	21390		

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21390	Continued From page 38 indwelling catheter. Observation of R18's room did now show evidence of signage or personal protective equipment (PPE) for EBP on 12/9/24, and 12/10/24. R26's admission record dated 12/13/24, included an admission date of 12/27/23. R26's care plan printed 12/13/24, included R26 has a urostomy (an opening in her stomach for urine to leave the body). R26's care plan failed to include interventions for EBP. Observation of R26's room did now show evidence of signage or personal protective equipment (PPE) for EBP on 12/9/24, and 12/10/24. R29's admission record printed 12/13/24, included an admission date of 9/1/24, and diagnosis of neuromuscular dysfunction of the bladder. R29's care plan printed 12/13/24, included R29 had an indwelling catheter. R29's care plan failed to include interventions for EBP. Observation of R29's room did now show evidence of signage or personal protective equipment (PPE) for EBP on 12/9/24, and 12/10/24. When interviewed on 12/11/24 at 9:49 a.m., nursing assistant (NA)-D stated nursing assistants did not follow enhanced barrier precautions, and enhanced barrier precautions were for nurses.	21390		

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21390	Continued From page 39 During interview on 12/11/24 at 2:00 p.m., director of nursing (DON) was unable to state when a resident should be placed on EBP. She states she would follow the CDC guidelines. When the DON referred to the printout of CDC guideline in the infection control binder, she confirmed the guidelines were to implement EBP whenever a resident had an open wound are an indwelling medical device, such as a catheter. The DON confirmed they were not following EBP correctly in the facility and provided a list of residents who had either an indwelling medical device or an open wound. Facility policy titled Enhanced Barrier Precautions dated 8/8/24, included the facility would initiate EBP for residents with wounds and/or indwelling medical devices. Legionella The facility is not required to do testing unless a concern is identified. They are required to have a schematic of the water system and a program to mitigate growth of legionella. During entrance conference on 12/9/24 at 1:52 p.m., administrator was asked to provide a copy of the facility Legionella risk assessment and plan to mitigate the growth of Legionella. A plan was not provided. On 12/10/24, a 2nd request was placed to the administrator for a copy of the Legionella plan and evidence of implementation. No documentation was provided. On 12/11/24 at 8:49 a.m., a requested for information on the Legionella water management	21390		

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21390	Continued From page 40 plan was sent to the director of nursing (DON). No documentation was provided. O 12/11/24 at 2:30 p.m., the administrator requested clarification on what was needed for evidence of Legionella plan. The administrator stated, "we flush toilets and run the water on first floor weekly." The administrator was unable to provide a schematic of the buildings water flow and no additional documentation was provided. Facility document titled Legionella Surveillance Policy dated 10/24/22, included the facility would establish a primary and secondary strategy to prevent and control Legionella infections. SUGGESTED METHOD OF CORRECTION: The DON (Director of Nursing) or designee should review/revise facility policies to ensure they contain all components of an infection control program to mitigate transmission of potential infections. The DON or designee could educate all staff on existing or revised policies and perform audits to ensure the policies are being followed. The results of those audits should be taken to Quality Assurance Performance Improvement committee to determine compliance and the need for further monitoring. Time Period for Correction: Twenty-one (21) days.	21390		
21426	MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most	21426		1/27/25

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21426	Continued From page 41 current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure tuberculosis (TB) screening and testing was completed for 5 of 5 staff {registered nurse (RN)-B, licensed practical nurse (LPN)-E, LPN-F, nursing assistant (NA)-B, NA-C} and 5 of 5 residents (R1, R14, R23, R26, R32) reviewed for TB testing. The Centers for Disease Control (CDC) guidelines for preventing the transmission of mycobacterium tuberculosis in Health Care Settings, 2005, directed that all residents and staff must receive a baseline TB screening which should consist of an assessment for TB risk factors and history, assessment for current symptoms of active TB, and testing for the presence of infection with mycobacterium tuberculosis.	21426	Corrected	

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21426	Continued From page 42 Facility document titled Active Employees dated 12/9/24, included the following start dates: RN-B start date of 3/16/23 LPN-E start date of 7/27/22 LPN-F start date of 6/22/22 NA-B start date of 6/22/22 NA-C start date of 3/2/22 R1's admission record dated 12/13/24, included an admission date of 10/29/24. R1's record included diagnosis of dementia and congestive heart failure. R14's admission record dated 12/13/24, included an admission date of 6/18/24. R14's admission record included diagnosis of vascular dementia (type of memory loss) and chronic kidney disease (kidney failure). R26's admission record dated 12/13/24, included an admission date of 12/27/24. R26's admission record included intermittent asthma and generalized muscle weakness. R23's admission Minimum Data Set (MDS) dated 2/13/24, included an admission date of 2/6/24. R23's diagnosis included heart failure and malnutrition. The facility failed to provide documentation of TB screening and TB testing for R1, R14, R26, and R23. R32's admission record dated 12/13/24, included an admission date of 7/26/23. R32's record included diagnosis of dysphasia (difficulty swallowing) and aphasia (difficulty processing language). Facility failed to provide TB symptom screening completed at admission.	21426		

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21426	Continued From page 43 R32's record did include a negative QuantiFERON gold plus (blood test to check for TB) dated 7/27/23. During interview on 12/11/24 at 2:00 p.m., the director of nursing (DON) confirmed she was unable to provide proof of complete TB testing and screening for all 5 of the staff members listed and all 5 residents reviewed. The DON confirmed it was important to complete screening upon hire and upon admission to protect all residents and staff in the facility. Facility TB screening and testing policy requested and not provided. SUGGESTED METHOD OF CORRECTION: The infection control nurse (ICN), director of nursing (DON) and/or designee should review policies and procedures related to the screening and testing for tuberculosis for residents and/or employees (staff). Facility staff could be educated on the TB regulations, symptom screening, and the two-step Mantoux process. The ICN, DON and/or designee could audit resident admissions and/or staff new hires as well as current residents and/or staff records to ensure compliance. The ICN, DON and/or designee should take those findings/education to the Quality Assurance Performance Improvement (QAPI) committee for a determined amount of time until the QAPI committee determines successful compliance or the need for ongoing monitoring. TIME PERIOD FOR CORRECTION: Twenty one-(21) days.	21426		
21435	MN Rule 4658.0900 Subp. 1 Activity and Recreation Program; General	21435		1/27/25

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21435	Continued From page 44 Subpart 1. General requirements. A nursing home must provide an organized activity and recreation program. The program must be based on each individual resident's interests, strengths, and needs, and must be designed to meet the physical, mental, and psychological well-being of each resident, as determined by the comprehensive resident assessment and comprehensive plan of care required in parts 4658.0400 and 4658.0405. Residents must be provided opportunities to participate in the planning and development of the activity and recreation program. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a resident's preferred activities for individual entertainment were offered for 1 of 1 residents (R26) reviewed for activities. Findings include: R26's quarterly Minimum Data Set (MDS) dated 9/26/24, indicated she had severely impaired cognition and was marked "not applicable" for transfers. The MDS identified diagnoses of muscle weakness, depression, and high blood pressure. R26's significant change MDS dated 1/3/24, indicated it was "very important" to R5 to participate in her favorite activities and to go outside and get fresh air when the weather is good. R26's Care Area Assessment (CAA) for	21435	Corrected	

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21435	Continued From page 45 communication dated 1/3/24, indicated R5 was "usually" understood and "usually" understands. The CAA identified she was at risk for missed information and unmet needs as her primary language was Russian, but she did know "some English." The CAA indicated she was able to make her needs known and guided staff to proceed the plan of care. An activity participation review dated 9/26/24, indicated R5 did not attend any small or large group activities, rather preferred 1:1's and attended those "2-3 x a week". The review indicated R5 "spends much of her time in bed," and watched TV, read books, had visits from a "family friend and daughter". Furthermore, the review indicated life enrichment or activities staff visited 2-3 times per week and because R5 spoke Russian, she was able to "socialize some when visited" by staff" and "she smiles and giggles at times and appears to enjoy the visits." The review indicated R5 participated in individual activities "daily" and included family and friend visits and identified her favorite activities as cognitive (reads Russian books); Entertainment (Russian television); Spiritual (Jewish faith); Social (1:1, snack, socials and visits with staff, Family friend visits), and pet visits. The review lacked documentation of her preference to go outdoors for fresh air. The review identified R5's progress towards her activity goals were not met and had been revised in the care plan. Additionally, the review identified her activity-related IDT interventions/approaches had not been effective towards reaching her goals and new approaches were added to the care plan. R26's undated and unsigned order summary was reviewed 12/11/24 and reflected the following	21435		

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21435	Continued From page 46 orders: - "up in w/c [sic, wheelchair] one time per day for core strengthening in the afternoon" for muscle wasting (a loss of muscle mass and strength), dated 9/9/24. R26's care plan last revised 9/26/24, indicated she preferred not to attend group activities due to her primary language being Russian, although she did speak and understand some English. The care plan identified she preferred to spend time in her room resting and watching television. The care plan included her "meaningful" interests last revised 3/18/23, of 1:1 visits with life enrichment or activities staff, television, and reading. The care plan identified interventions including the following: - "Provide 1;1 activity visit of potential interest (i.e. discussion of family, books) 2 - 3 x per week." - "Will respect choice in regard to limited/no activity participation." - "Will visit to offer leisure supplies/materials as able. DTR [sic, daughter] to bring Russian specific supplies." Conversely, R5's care plan identified her difficulty communicating as she spoke Russian and little English. The goal was to use an alternative method to communicate needs/wants, including a translator. Additional goals included demonstrate understanding by completing task when requested and needs would be met with comfort and dignity. The care plan directed staff to call an interpreter for translation and provided a contact number with instructions, and to involve R5 in activities that did not rely on her ability to communicate or hear, such as parties, crafts, or movies.	21435		

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21435	Continued From page 47 The care plan lacked resident preference for going outside to get fresh air when the weather was good as identified in her significant change MDS dated 1/3/24. A PointOfCare (POC) task record printed 12/10/24, to "make sure resident is up in wheelchair every day for one hour during lunch. Inform nurse if resident refuses to get up", with a lookback period of 30 days reflected, "No Data Found". The record lacked documentation staff attempted or offered to get resident up in wheelchair every day. A POC task record printed 12/10/24, for "ADL - transferring Hoyer with two staff," with a look-back period of 30 days indicated out of 84 opportunities, R5 required limited assistance ("resident highly involved in activity, staff provide guidance maneuvering of limbs or other non-weight-bearing assistance) on 8 instances; total-dependence ("full staff performance") on 11 instances; required extensive assistance ("resident involved activity, staff provide weight-bearing assistance") on 3 instances; and staff documented "not applicable" on 61 instances. A POC task record printed 12/10/24, for "ADL [sic, Activities of Daily Living]- Activity Participation, Which Activity?", with a look-back period of 30 days indicated R5 participated in "move/TV" activities on 5 instances and a "family/friend visit" on 1 instance. The record lacked documentation of R5's preferred activity of going outside for fresh air. A POC task record printed 12/10/24, for "ADL - Activity Participation - Activity", with a look-back period of 30 days indicated R5 was "independent"	21435		

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21435	Continued From page 48 for 6 out of the 7 instances and a "1:1" for 1 of the 7 instances on the record. R5's Kardex, printed on 12/16/24, lacked documentation of her preferred activity of going outside for fresh air. The Kardex included directions to staff to "make sure resident is up in wheelchair every day for one hour during lunch. Inform nurse if resident refuses to get up." During observation on 12/9/24 at 2:58 p.m., R5 was lying in bed wearing a hospital gown. R5 stated she wished staff would bring her outside more often. Her family member (FM)-D was at bedside visiting and R5 said something in Russian to FM-D, and FM-D translated back, "she said, 'they do not take me outside.'" During observation on 12/10/24 at 8:27 a.m., R5 was lying in bed wearing a hospital gown with the television on. During observation on 12/11/24 at 7:34 a.m., nursing assistant (NA)-D performed morning ADL cares and stated R5 was able to "listen clearly" and could point to things she wanted if she did not know the word for it. NA-D stated R5 knew a little English and was able to make her basic needs known. NA-D stated, "we offer sometimes" to get her up for a meal or "if she wants to get up", but R5's family "says if she doesn't want to, we don't need to push it. We were in the meeting, some of the nurses, and that's what they want us to do." NA-D stated R5 got out of bed "once or twice a week," and if she refused, NAs were expected to report the refusal to the nurse. NA-D exited the room after morning cares without offer to reposition, get R5 up in the wheelchair, or offer of activity. There was a calendar taped to R5's closet door for "September" and it listed some	21435		

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21435	Continued From page 49 "speech eval" dates but no activities identified. There was no activities calendar in R5's room. During follow-up interview on 12/11/24 at 7:54 a.m., NA-D stated R5's family brought her outside for activities and thought activities (A)-A "sometimes" brought her "around the unit to look at things", but stated R5 was not "someone who goes to other activities" and would tell staff if she wanted to go. During observation on 12/13/24 at 9:53 a.m., R5 was lying in bed wearing a hospital gown with the television on. Per interview on 12/13/24 at 9:11 a.m. with A-A, residents were assessed for their activity preferences quarterly, annually, and with significant changes, and those preferences were documented in the care plan. A-A stated R5 slept "at intervals throughout the day" and didn't want to wake her if she was asleep. A-A indicated R5 had a history of refusing to get up and refusing activities. A-A stated for special occasions, like parties or Bingo, staff offered to get R5 out of bed for the activity, "but she refuses". A-A identified R5 liked 1:1 visits and "used to" like reading Russian books, but stated that went in streaks. A-A confirmed, "the language barrier can be an issue, but I try and articulate in English, and I will comment about her Russian television programs," and added, R5 "sure likes" the visits, as evidenced by her smiles during the visit. A-A stated during "warmer months" when R5's family visited, they would bring her outside and verified staff would notify activities if she was up in her wheelchair. A-A could not recall R5 asking to go outside directly but confirmed being unable to meet R5's activity preferences stating, "I have not been able to get her up and in the wheelchair to	21435		

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21435	Continued From page 50 go seeing the building." A-A believed activities helped with resident engagement, potentially reducing accidents like falls, improve resident satisfaction and helped "residents feel good." A-A confirmed being the only activities staff in the facility and stated, "when I'm not here, its independent activities" adding having more staff in the department would "definitely" be helpful. A-A indicated on scheduled days off, "the staff pretty much know what I do from seeing what I do, they know what the residents like from seeing what I do," and stated there was a basket of puzzles, coloring sheets, card games, and magazines in the unit manager's office on the memory care unit. A-A stated the residents off the memory care unit were more independent and some preferred to stay in bed and were not engaged. Per interview on 12/13/24 at 10:24 a.m. with the administrator, also acting as the interim co-scheduler with the director of nursing (DON), confirmed the facility's activities department "could be more robust," but believed residents overall were "enjoying themselves." They verified A-A was the only activities staff and stated there was capability for other staff to provide activities for residents to do when A-A was not scheduled. The administrator stated A-A visited the residents and did not believe the facility had "lonely" residents. The administrator believed, "you can always use more resources around" activities and believed this to be true for all facilities "throughout the system." During interview on 12/16/24 at 12:01 p.m., the DON stated activities were "super important" because it helped residents feel like they were "a part of something" and was good for their mental health. The DON wished the facility could provide	21435		

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21435	Continued From page 51 more activities and believed A-A was "pushed past her limit". The DON was not aware of R5's request to go outdoors for fresh air and stated, "if she's communicating, I've never heard she's communicated that to staff." The DON stated, "it's difficult to know how much R5 knows about activities." The DON stated R5 could be agreeable to get up in the wheelchair for "a good reason" like an appointment but could decline to get up for a "party." The DON expected staff to offer activities and opportunities to get up out of bed and document refusals but was unsure of nursing staff were documenting R5's refusals as they "should be". Per facility policy titled Activities last revised 7/11/22, the facility would provide an ongoing program to support residents in their choice of activities based on their comprehensive assessment, care plan, and preferences. Per the policy, each resident's interests and needs would be assessed on a routine basis and would include an activity assessment to include a resident's interests, preferences and needed adaptations. Furthermore, the policy identified activities could include indoor and outdoor activities and directed staff to assist residents to and from activities when necessary. Additionally, the policy indicated the facility would consider accommodations in schedules, supplies and timing in order to optimize a resident's ability to participate in an activity of choice. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing, activities director or designee, could engage the interdisciplinary team (IDT) to ensure residents in	21435		

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21435	Continued From page 52 the facility were provided meaningful activities to meet thier interests and include activities on evenings and weekends. Activities selected should be resident-centered. The administrator or designee could seek advice from resident council on likes and dislikes of types and kinds of activities offered in the facility. Activities should incorporate the resident's interests, hobbies and cultural preferences, integral to maintaining and/or improving a resident's physical, mental, and psychosocial well-being and independence and promote self-esteem, pleasure, comfort, education, creativity, success, and independence. ADL-related activities, such as manicures or pedicures, hair styling, and makeovers, may be considered part of the activities program. Activities selected should be individualized and customized based on the resident's previous lifestyle (occupation, family, hobbies), preferences and comforts. Activities should not be confined to a department, but rather may involve all staff interacting with residents. Activities could be non-structured. The administrator or designee could ensure any activities supplied to residents in this manner be care-planned and documented in the residents ' medical record and audited. The results of those audits should be taken to QAPI to determine compliance or the need for continued monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21435		
21530	MN Rule 4658.1310 A.B.C Drug Regimen Review A. The drug regimen of each resident must be reviewed at least monthly by a pharmacist currently licensed by the Board of Pharmacy.	21530		1/27/25

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21530	Continued From page 53 This review must be done in accordance with Appendix N of the State Operations Manual, Surveyor Procedures for Pharmaceutical Service Requirements in Long-Term Care, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system. It is not subject to frequent change. B. The pharmacist must report any irregularities to the director of nursing services and the attending physician, and these reports must be acted upon by the time of the next physician visit, or sooner, if indicated by the pharmacist. For purposes of this part, "acted upon" means the acceptance or rejection of the report and the signing or initialing by the director of nursing services and the attending physician. C. If the attending physician does not concur with the pharmacist's recommendation, or does not provide adequate justification, and the pharmacist believes the resident's quality of life is being adversely affected, the pharmacist must refer the matter to the medical director for review if the medical director is not the attending physician. If the medical director determines that the attending physician does not have adequate justification for the order and if the attending physician does not change the order, the matter must be referred for review to the quality assessment and assurance committee required by part 4658.0070. If the attending physician is the medical director, the consulting pharmacist must refer the matter directly to the quality assessment and assurance committee. This MN Requirement is not met as evidenced by: Based on interview and document review, the	21530	Corrected	

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21530	Continued From page 54 facility failed to ensure consultant pharmacist recommendations were acted upon timely for 4 of 5 residents (R1, R5, R8, R14) reviewed for unnecessary medications. Findings include: R1 R1's admission Minimum Data Set (MDS) dated 11/4/24, indicated R1 had severe cognitive impairment, inattention and disorganized thinking which fluctuated, did not have physical, verbal, or other behavioral symptoms, did not reject cares, had diagnoses of heart failure, hypertension (high blood pressure), thyroid disorder, arthritis (conditions which cause inflammation of the joints), osteoarthritis (chronic disease when cartilage which lines joints are worn down and bones rub against each other), and adjustment disorder with mixed anxiety and depressed mood. Further, R1 took an antipsychotic and antidepressant. R1's Order Summary Report dated 12/12/24, indicated the following orders: - 11/27/24, Depakote oral tablet delayed release 500 mg (used for manic depression). Give one tablet by mouth at bedtime. - 11/27/24, trazodone HCL [hydrochloride] oral tablet 150 mg (an antidepressant often used for sleep). Give 75 mg by mouth at bedtime . - 11/27/24, trazodone HCL oral tablet 50 mg. Give 25 mg by mouth as needed, with no end date noted. - 11/30/24, Seroquel oral tablet 25 mg (quetiapine fumarate) (an antipsychotic). Give one tablet by mouth as needed TID (three times a day), with end date of 12/13/24.	21530		

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21530	Continued From page 55 - 12/10/24, Seroquel oral tablet 100 mg (quetiapine fumarate). Give one tablet by mouth at bedtime. - 12/10/24, quetiapine fumarate oral tablet 25 mg. Give 12.5 mg by mouth two times a day. - 12/11/24, Neurontin oral capsule 300 mg (gabapentin) (often used for pain). Give one capsule by mouth three times a daily. R1 did not have side effect and/or adverse effect monitoring in place. R1's Pharmacy Review assessment dated 11/4/24, indicated recommendations were made and to view Clinical Pharmacy Report. The section New Medications/General/Recommendation notes indicated: "Memory; migraines, chronic pain; HLD, HF, adjustment disorder 11/24 PRN". R1's Clinical Pharmacy Report dated 11/4/24, was reviewed onsite and directed nursing to identify an end date for trazodone or provider rationale and documentation for extended end date, and add in psychotropic side effect monitoring. A copy was not provided. R1's Pharmacy Review assessment dated 12/2/24, indicated recommendations were made and to view Clinical Pharmacy Report. The section New Medications/General/Recommendation notes indicated: "Memory; migraines, chronic pain; HLD, HF, adjustment disorder 12/24 REC: clarifications 11/24 PRN". R1's Clinical Pharmacy Report dated 12/2/24, was reviewed onsite and noted to have repeated both recommendations from 11/4/24. A copy was not provided.	21530		

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21530	Continued From page 56 R5 R5's significant change Minimum Data Set (MDS) dated 11/5/24, indicated she had severe cognitive impairment with diagnoses of heart failure, kidney failure, respiratory failure, anxiety, depression, and lymphedema (a chronic condition causing swelling from lymph or protein-rich fluid in the body's tissues). The MDS further indicated R5 received hospice care. R5's unsigned order summary was reviewed 12/13/24, and included the following orders: - albuterol-budesonide inhalation 90-80 micrograms (mcg) / actuation (ACT), 2 puff inhale orally every 6 hours as needed for shortness of breath, dated 10/29/24. - furosemide oral tablet, Give 40 milligrams (mg) by mouth one time a day for pulmonary edema (fluid buildup the lungs), heart failure with chronic kidney disease and failure, dated 3/12/24. - lorazepam oral concentrate 0.125 milligrams (mg) / milliliter (mL), Give 0.25mL every 4 hours as needed for agitation 0.5mg=0.25mL, dated 11/05/24. - lorazepam oral tablet 0.5mg, Give 1 tablet sublingually every 3 hours as needed for anxiety, dated 10/29/24. - morphine sulfate (concentrate) oral solution 20 mg/mL, Give 0.25mL by mouth every 4 hours as needed for shortness of breath/pain, dated 12/13/24. - quetiapine fumarate oral tablet, Give 150mg by mouth at bedtime, for anxiety, depression, dated 2/29/24. - sertraline hydrochloride (HCl) oral tablet 50mg,	21530		

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21530	Continued From page 57 Give 50mg by mouth one time a day for depression, dated 10/14/24. A request R5's most recent signed order summary was requested during survey and not received. R5's care plan last revised 11/18/24, identified her use of psychotropic medications (antidepressants, antianxiety, and antipsychotics) and diuretic therapy to treat her lower extremity therapy. The care plan directed staff to perform medication regimen reviews (MRRs) as needed, identify available resources and needs for treatment, and attempt GDRs per orders. A pharmacy review notes dated 9/5/24, 10/14/24, and 11/4/24, indicated recommendations were made. The notes referred to the clinical recommendations reports. A PharMerica note to attending Physician/Prescriber MRR dated 9/5/24, provided a recommendation for periodic lipid panel for R5's medications. The provider signed the MRR on 10/31/24 and deferred to R5's hospice team. A PharMerica note to attending Physician/Prescriber MRR dated 11/4/24, provided a recommendation regarding "duplicative therapy". The MRR lacked provider signature or follow-up. A PharMerica note to attending Physician/Prescriber MRR dated 11/4/24, provided a recommendation regarding R5's lorazepam order. The note stated as needed (PRN) psychotropic orders required no more than 14 days duration or, if deemed necessary beyond, a clinical rationale and specific duration	21530		

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21530	Continued From page 58 documented by provider. The MRR lacked provider signature or follow-up. A PharMerica nursing recommendations for the recommendations created between 11/4/24 and 11/6/24, indicated R5's albuterol-budesonide inhalation aerosol order should NOT be a combination product and directed staff to review data entry. The MRR lacked nursing signature or follow-up. A PharMerica note to attending Physician/Prescriber MRR dated 12/3/24, provided a recommendation regarding R5's lorazepam orders. The note requested the provider add parameters for when to use the lorazepam tablets versus the concentrate. Additionally, the note repeated the request for the PRN lorazpem order to include an end date of no more than 14 days, and if deemed necessary to include a clinical rationale and a specific duration. The MRR lacked provider signature and follow-up. R5's EMR was reviewed and lacked documentation of MRR follow-up. A request was made for provider response and/or documentation of MRR follow-up and was not received. R8 R8 admission Minimum Data Set (MDS) dated 2/25/24, included an admission date of 2/20/13. R8's diagnosis included schizophrenia. R8's order summary report dated 4/3/24, included diagnosis of mild cognitive impairment,	21530		

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21530	Continued From page 59 schizoaffective disorder (a mental health disorder with symptoms of both schizophrenia and a mood disorder), depression, bipolar disorder (extreme mood swings), and hording disorder. PharMerica Nursing Recommendations dated 8/9/24, included a recommendation to complete labs that were ordered in May but not completed and to place results in the chart. No facility notes were placed in the "follow-Through" section of the form. PharMerica Nursing Recommendations dated 10/11/24, again recommended completion of labs ordered in May that were never completed. Again, the facility failed to place notes in the "follow-through" section of the form. When interviewed on 12/16/24 at 11:11 a.m., the consulting pharmacist (CP) stated they were unsure if R8 declined the labs or the provider did not order. CP stated they needed to be able to see the provider's follow-up to their recommendations or labs drawn on residents. R14 R14's quarterly Minimum Data Set (MDS) dated 11/13/24, identified intact cognition and reported no behaviors, hallucinations, or delusions. The MDS indicated R14 had heart failure, high blood pressure, kidney failure, obstructive sleep apnea (sleep disorder causing your breathing to repeatedly stop or be reduced while you sleep), respiratory failure, anxiety, depression, bipolar disorder, and dementia (a neurological condition causing a decline in thinking, memory, and	21530		

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21530	Continued From page 60 behavior). The MDS indicated she was diabetic and received insulin injections over the lookback period, in addition to antidepressants and antianxiety medications. The MDS lacked documentation on if a drug regimen review was assessed and if issues were found. Furthermore, the MDS confirmed medication follow-up was "not assessed/no information" and the MDS lacked documentation on medication intervention assessment. R14's Care Area Assessment (CAA) for psychotropic drug use dated 8/13/24, indicated the consultant pharmacist (CP) reviewed her medications and made recommendations to the interdisciplinary team (IDT) monthly and as needed. A signed order summary dated 6/6/24, identified the following orders: - carvedilol oral tablet milligram (mg), Give 6.25mg by mouth two times a day, for heart failure, dated 2/12/24. - doxepin hydrochloride (HCl) oral capsule 10mg, Give 20mg by mouth at bedtime for insomnia related to obstructive sleep apnea, dated 2/12/24. - fluoxetine HCl oral capsule 20mg, Give 20mg by mouth in the morning for depression, dated 2/12/24. - furosemide oral tablet, Give 40mg by mouth one time a day dated 2/12/24. - novolog injection solution 100 unit/milliliter (mL) (Insulin Aspart), Inject 17 unit subcutaneously before meals for diabetes, dated 4/8/24. - Remeron tablet (Mirtazapine) Give 7.5mg by mouth at bedtime for depression, dated 2/12/24. - Wellbutrin Sustained-Release (SR) oral tablet Extended Release (ER) 12 Hour 100mg (bupropion HCl), Give 100mg by mouth one time	21530		

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21530	Continued From page 61 a day for depression, dated 2/12/24. A request for R14's most recent signed order summary prior to survey entrance was requested but not received. R14's medication administration record (MAR) dated 12/2024 reflected the following active and administered medication orders: - carvedilol oral tablet milligram (mg), Give 6.25mg by mouth two times a day, for heart failure, dated 9/13/24. - fluoxetine HCl oral capsule 20mg, Give 20mg by mouth in the morning for depression, dated 6/19/24. - furosemide oral tablet 20mg, Give 3 tablet orally one time a day, for heart failure, give 3 tablets (60mg), dated 11/14/24. - isosorbide mononitrate ER 24 Hour oral tablet, Give 60mg by mouth one time a day, for high blood pressure and chronic kidney disease, dated 11/16/24. - lidocaine external gel 4%, Apply to right shoulder topically every 12 hours for shoulder pain, dated 11/25/24. - mirtazapine oral tablet 7.5mg, Give 1 tablet my mouth at bedtime for depression, dated 11/19/24. - novolog FlexPen Subcutaneous Solution Pen-injector 100 unit/mL (Insulin Aspart), Inject 14 unit subcutaneously with meals for diabetes with chronic kidney disease, dated 10/31/24. - Wellbutrin SR oral tablet Extended Release 12 Hour 100mg (bupropion HCl), Give 100mg by mouth one time a day for depression, dated 6/19/24. R14's care plan, last revised on 8/21/24, identified her use of antidepressants and dependence on insulin and risks associated with each medication.	21530		

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21530	Continued From page 62 The care plan included goals to be free of complications related to the use of the medications and directed staff to administer medications per orders. The care plan lacked documentation or guidance for staff related to R14's use of furosemide, a diuretic (water pill). A pharmacy review note dated 10/11/24 indicated recommendations were made. The review indicated R14 had previous gradual dose reductions (GDRs) of her doxepin on 10/4/24 and mirtazapine on 9/25/24. The note referred to the clinical recommendations report. R14's progress notes were reviewed and lacked documentation of medication regimen review (MRR) follow-up by provider and/or nursing staff. A pharmacy review note dated 12/3/24, indicated recommendations were made. The review indicated an increase to R14's mirtazapine on 11/19/24, and referred to the clinical recommendations report. The progress notes were review and lacked documentation of MRR follow-up by provider and/or nursing staff. A PharMerica Nursing Recommendations report dated 10/11/24, identified three recommendations or clarifications pertaining to R14's carvediolol medication administration instructions, isosorbide medication formulation, and a clarification regarding the lidocaine formulation. The nursing recommendation lacked documentation of MRR follow-up by provider and/or nursing staff. A PharMerica MRR Recommendation Summary: Medical Director and Director of Nuring (DON) dated 10/11/24, identified three recommendations or clarifications pertaining to R14's carvediolol medication administration instructions, isosorbide	21530		

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21530	Continued From page 63 medication formulation, and a clarification regarding the lidocaine formulation. The MRR summary lacked documentation of MRR follow-up by provider and/or nursing staff. A PharMerica Nursing Recommendations report dated 11/4/24, was received and indicated the resident was out of the facility during the MRR and requested staff evaluated the need for MRR. The report lacked documentation of follow-up. A request for R14's MRRs, clinical recommendations and related follow-up for 6 months were requested but not received. When interviewed on 12/13/24 at 10:57 a.m., licensed practical nurse (LPN)-A stated they received recommendations from the pharmacist and followed up with the primary care physicians to ask if they approved of the pharmacy recommendations or not. LPN-A followed through with what the primary care physician approved. When interviewed on 12/13/24 at 2:26 p.m., LPN-B stated they sometimes received emails from the pharmacist about recommendations they had after order review and followed up on the recommendations right away. LPN-B stated the director of nursing (DON) received the pharmacist recommendation forms, then the managers followed up on the recommendations and returned the pharmacist form to the DON after completion. LPN-B confirmed R1's trazodone did not have an end date and did not have side effect monitoring in place for psychotropic medication. When interviewed on 12/16/24 at 11:01 a.m., the DON stated they printed out the pharmacist recommendation forms and made copies in	21530		

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21530	Continued From page 64 green. DON gave the original copy to the doctors and nurses to address and placed the green copy in a binder, so they knew the recommendation still needed to be followed up on. DON stated if providers do not follow up on pharmacy recommendations within one month, they asked the provider again. DON received emails and followed up immediately on anything "dire". When interviewed on 12/16/24 at 11:11 a.m., the consulting pharmacist (CP) expected pharmacist recommendations to be followed up on within 30 days or by the next visit. CP gave recommendations again when not completed, but the timing on when to give the second reminder depended on what the initial recommendation was, since the providers liked to see the residents before acting or not on some recommendations. CP confirmed the facility had not placed in an end date for R1's trazodone and would have expected them to complete after the recommendation in November of 2024, since they needed to know why trazodone was administered and needed to re-evaluate the use per regulations. CP also confirmed R1 did not have side effect monitoring for psychotropic medication in place as was recommended previously. Per facility policy titled Medication Reconciliation last revised 10/24/22, the facility reconciled medication throughout a resident's stay to ensure the resident was free of any significant medication errors. The policy indicated the monthly process was the provide the consultant pharmacist access to all medication areas and records for completion of pharmacy services activities. Furthermore, the policy directed staff to respond to any medication irregularities reported by the pharmacist within relevant time frames.	21530		

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21530	Continued From page 65 SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures for pharmacy reviews and irregularities. The director of nursing or designee could develop a system to educate staff and develop a monitoring system to ensure pharmacy reviews are timely and irregularities are being acted upon. The quality assurance committee could monitor these measures to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) days	21530		
21555	MN Rule 4658.1325 Subp. 2 Administrationof Medications Staff designated Subp. 2. Staff designated to administer medications. A nurse or unlicensed nursing personnel, as described in part 4658.1360, must be designated as responsible for the administration of medications during each work period. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure prescription topical medications were applied and documented in accordance with professional standards of practice for 1 of 2 residents (R26) observed during morning activities of daily living (ADL) cares. Findings include:	21555	Corrected	1/27/25

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21555	Continued From page 66 R26's quarterly Minimum Data Set (MDS) dated 9/26/24, indicated severely impaired cognition and substantial to moderate staff assistance with personal and toileting hygiene cares. The MDS identified diagnoses of muscle weakness, depression, and high blood pressure. R26's undated and unsigned order summary was reviewed 12/11/24, and reflected the following active physician orders: - "Nystatin external powder 100000 unit/gm (gram) (Nystatin (Topical)) Apply to skin folds topically as needed for rash under breasts," dated 9/9/24. - "Nystatin powder (Nystatin (Bulk)) Apply to groin topically every 12 hours as needed for groin," dated 10/8/24 A request for R26's most recently signed order summary was requested but not received. R26's medication administration record (MAR) dated 10/2024, lacked documentation of as needed (PRN) Nystatin powder administration for "rash under breasts," as well as "groin". R26's MAR dated 11/2024, lacked documentation of as needed (PRN) Nystatin powder administration for "rash under breasts," as well as "groin". R26's MAR dated 12/2024, lacked documentation of as needed (PRN) Nystatin powder administration for "rash under breasts," as well as "groin". R26's treatment administration record (TAR) dated 10/2024, indicated an order for, "weekly skin review every evening shift every Fri [sic,	21555		

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21555	Continued From page 67 Friday] if new area is identified follow protocol ...". This order was marked as completed on 10/3/24, 10/11/24, 10/18/24, and 10/25/24. R26's TAR dated 11/2024, indicated an order for, "weekly skin review every evening shift every Fri [sic, Friday] if new area is identified follow protocol ...". This order was marked as completed on 11/1/24, 11/8/24, 11/15/24, 11/22/24, and 11/29/24. R26's TAR dated 12/2024, indicated an order for, "weekly skin review every evening shift every Fri [sic, Friday] if new area is identified follow protocol ...". This order was marked as completed on 12/6/24. R26's care plan dated 9/9/24, identified her self-care deficit and guided staff to provide assistance with personal hygiene and bathing cares. Additionally, the care plan identified a risk for skin integrity concerns and indicated a head-to-toe assessment would be performed by a licensed nurse. During observation on 12/11/24 at 7:34 a.m., nursing assistant (NA)-D performed morning cares with R26. NA-D washed under R26's underarms and breasts and patted the areas dry with a clean hand towel. NA-D stated R26 had dry skin and "every morning" NA-D applied lotion and the "doctor ordered this powder" for under R26's arms and breasts. NA-D showed the surveyor a bottle with a prescription label affixed to it that read, "Kaylesta (Nystatin) powder". NA-D stated "they gave me this to put on" for the dry skin and NA-D applied the powder from the bottle under R26's arms and breasts. NA-D further explained R26 had issues with her skin intermittently because "she's a large woman with a lot of skin	21555		

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21555	Continued From page 68 there." NA-D stated NAs monitored the skin and would report when the areas were improving or worsening to the nurses as well if NAs used the powder on R26. Per interview on 12/13/24 at 9:46 a.m., licensed practical nurse (LPN)-D expected prescription medications, including topical powders like Nystatin, be applied by nurses because nurses were responsible for the "assessment piece" and to determine if a resident had reactions to the medication. Per interview on 12/13/24 at 9:53 a.m. with LPN-C, prescription topical medications, like Nystatin powder, should be kept in the locked medication cart and should be applied by a nurse unless a resident had been assessed to safely administer their own medications and had the order in place. LPN-C reviewed R26's MAR and confirmed there were no documented administrations of Nystatin powder on 12/11/24, or for the MAR dated 12/2024. LPN-C was unaware of any skin concerns for R26. LPN-C was unable to locate a skin assessment for R26 identifying any current skin concerns for R26. LPN-C stated a NA applying a prescription topical powder without a nurse's knowledge and keeping it at bedside "sounds like an educational piece." LPN-C verified the prescription bottle of Nystatin powder in R26's room before locking the bottle in the medication cart. Per interview on 12/16/24 at 12:01 p.m., with director of nursing (DON), only the nurse should apply medications that are prescribed unless a resident had been assessed to administer them safely themselves and had an order to do so. The DON stated this was important because nurses needed to follow the rights of medication	21555		

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21555	Continued From page 69 administration. The DON stated prescription medications, including topical powders like Nystatin, should be kept in the nurse's cart. Per facility policy titled Medication Administration dated 1/2024, medications were expected to be administered in accordance with manufacturer's specifications, good nursing principles and practices and only by persons legally authorized to do so. Personnel authorized to administer medications do so only after they have familiarized themselves with the medication. The policy directed staff to have medications prepared only by licensed nursing, medical, pharmacy or other personnel authorized by state regulations to prepare medications. Further, the policy directed the individual who administered the medication to record the administration on the resident's MAR immediately following the medication being given and if administer a PRN (as needed) medication, the individual administering the medication should also document the date and time, dose, route of administration, complaints or symptoms for which the medication was given, results achieved from giving the dose and the time the results were noted, and a signature or initials of person recording the administration and/or of the person recording effects. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures for ensuring physician or prescriber orders are administered as ordered in accordance with State law. The DON or designee could develop a system to educate staff and develop a auditing system to ensure medications are administered either by a licensed nurse or, if permitted by State law, under the supervision of a licensed nurse.	21555		

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21555	Continued From page 70 The quality assurance committee could monitor these audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) days	21555		
21665	MN Rule 4658.1400 Physical Environment A nursing home must provide a safe, clean, functional, comfortable, and homelike physical environment, allowing the resident to use personal belongings to the extent possible. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure structural issues and items in disrepair throughout the facility were addressed to help promote a functional, sanitary, and safe environment. Additionally, the facility failed to ensure an ice and water dispensing machine in the second floor TCU and LTC (transitional care unit and long-term care) dining room was clean and free of excess mineral build up and properly functioning. This had the potential to affect all 37 residents residing in, visitors, and staff working in the facility. Findings include: A resident council meeting was held on 12/10/24 at 10:00 a.m., and residents in attendance reported the condition of the facility was "a shithole". The residents stated they were aware there was no maintenance in the building to fix the "multiple problems" in resident rooms, dining rooms, hallways, and the holes in the walls.	21665	Corrected	1/27/25

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21665	Continued From page 71 MAIN KITCHEN During observation on 12/11/24 at 11:37 a.m., the wall across from the main kitchen refrigerator had multiple blackish-brownish colored speckles. The area under the three-compartment sink had multiple crumbs on the floor and the wall below the sanitizer end of the three-compartment sink had brownish colored speckles. The wall next to an oven-like compartment used keep food at holding temperature had streaks of tannish colored substance down the wall. When interviewed on 12/13/24 at 10:01 a.m., a.m., dietary manager (DM) stated staff have daily cleaning assignments. Account manager (AM - serving as director of culinary services) and DM verified the wall across from the refrigerator with the blackish-brownish colored speckles, and DM stated black colored serving carts must bump against the wall. The speckles on the wall were throughout an area of approximately five feet across and two feet vertical. MEMORY CARE DINING AREA When interviewed on 12/10/24 at 8:37 a.m., family member (FM)-A stated the memory care dining area had missing appliances, cabinet pieces missing, and other mismatched items. FM-A stated the dining area did not feel like a "home", and the whole interior of the building appeared "tired". During observation and interview on 12/11/24 at 9:03 a.m., the memory care dining area had orange-yellow-colored splotches about the size of	21665		

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21665	Continued From page 72 a quarter at the entrance to the right on the wall. About six air vents lined the wall near the ceiling on both sides of the dining room and had grayish-blackish colored fuzzy substance speckled throughout various areas of each vent. One vent near one corner of the dining room had brownish-black speckled color particles and streaks extending on the wall from each of the four corners of the vent. The valance which hung above the window next to the vent was darker colored by brownish-black speckles. The other corner of the dining area had another valance above a window and had thick, grayish colored particles covering the side of the valance closest to a vent. There was a sink on top of a brown cabinet. One side of the cabinet had a missing brown area about one and a quarter foot by one inch and a circular area of cabinet missing the outer brown area about one inch by one and half inches and two other similar missing areas. Two sides of a blue wall had various white scuff marks, with one spot eight inches by one inch and others were similar in size or less. A spot of cabinetry near the refrigerator was missing and a yellowish tan area with areas of white plaster shown on the wall about three feet down and two feet across. A spot of the cabinetry liner was missing. Other various parts of the walls had faint tannish color streaks down them. When interviewed on 12/11/24 at 9:32 a.m., nursing assistant (NA)-G stated the area missing in between cabinets near the refrigerator used to be an oven and had been so for a year or more. NA-G confirmed the condition of the wall where the oven used to be and stated they would not want their home looking that way. NA-G confirmed the other memory care area dining observations and stated they focused attention to the residents so had not noticed the dining room	21665		

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21665	Continued From page 73 appearance but would not want their home to have the appearance of the dining room. During environmental tour on 12/13/24 at 1:17 p.m. with the administrator and housekeeping director (HD), the administrator stated there was a stove which was removed from the memory care dining area and had been that way a couple months or more. The administrator verified the area needed repainting or to be blocked. Administrator and HD verified the other conditions of the memory care dining area, and the administrator stated the scuffs on the wall were most likely from food carts or wheelchairs. The administrator stated the dining room was not "horrible" but needed a "make-over". Upon review of the main kitchen on the first floor, the administrator and HD confirmed the wall looked like it had splatter, grime, or evidence of rubbing from a caret, and stated the wall needed to be wiped down. When interview on 12/13/24 at 2:56 p.m., licensed practical nurse (LPN)-B stated they have seen the HD steam clean the valances before. LPN-B stated the memory care residents were calm and conversed as able in the dining area so in that sense was homelike, but family members and staff had concerns about the appearance of the dining area for at least two years. LPN-B stated housekeeping cleaned in the dining room after meals but not much of other actions were taken to fix the appearance of the dining area. ICE MACHINE During interview on 12/10/24 at 1:37 p.m., family member (FM)-C reported getting water and ice from the machine behind the steamtable in the	21665		

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21665	Continued From page 74 second-floor dining room independently without staff assistance. FM-C stated the machine was malfunctioning and stated, "the ice machine needs maintenance, it sprays everywhere, and it goes everywhere." During observation on 12/11/24 at 12:11 p.m., dietary aide (DA)-A raised one water pitcher, which was already nearly full, to the water dispenser in the second-floor TCU and LTC dining area and held the pitcher so the mouth of the pitcher almost touched the water dispenser. After a second, DA-A stopped and moved the pitcher to the ice machine to add ice which raised the water line to fill the rest of the pitcher. DA-A used the ice machine to fill up two more water pitchers in this manner. White sediment was around the ice spout, on the grate, and speckled on the back splash. When interviewed on 12/13/24 at 10:08 a.m., DM stated staff tried to wipe down the ice and water dispensing machine as much as possible to keep clean. The machine had preventative maintenance, but the facility needed a new maintenance director. DM stated the facility had hard water and the grate and other areas of the ice machine needed to be broken down for a deep cleaning. DM attempted to fill a cup with water, and the water dispenser spurted water in different directions and filled the cup when the cup was held closer to the spout. DM stated the nozzle needed to be cleaned or placed correctly, so one stream of water could fill the cup. During interview on 12/13/24 at 10:31 a.m., housekeeper (H)-A stated they had a checklist for cleaning rooms but not the dining areas and they did not wipe down ice machine.	21665		

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21665	Continued From page 75 The Work History Report created 12/12/24 with due date timeframe of 1/24 to 10/24, indicated the ice machine and/or ice bins task was completed on 8/26/24 and included check filter, clean coils, sanitize interior, delime as necessary. The same task was marked as completed on 3/8/24. The report lacked indication the exterior surfaces were cleaned. Per interview on 12/12/24 at 2:11 p.m. with the administrator, the facility was without a maintenance director since 9/2024. The administrator stated, "I hear about things, and I just go fix them," and was unsure "how comprehensive" the maintenance reports were. The administrator explained the facility received help from a corporate maintenance person "every two weeks". The Physical Environment: Electrical Equipment Policy dated 6/16/22, indicated the maintenance director shall maintain schedules for routine inspection and maintenance of all mechanical, electrical, and patient care equipment. The policy indicated essential equipment shall be repaired or replaced as soon as practicable. The facility assessment last reviewed 8/8/24, indicated the process to ensure adequate supply, appropriate maintenance of or replacement of building and/or other physical structures and equipment was the TELS maintenance program and activities. The assessment identified the administrator was responsible for reviewing the TELS program and activity "daily, weekly, and monthly for preventative maintenance, Life Safety monitoring, and reporting along with daily work-order tracking." The assessment identified examples, including, "bathroom safety bars, sinks for residents and for staff, lifts, lift slings, room	21665		

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21665	Continued From page 76 and common space furniture, steam table, waste management, sliding doors, nurse call system, and emergency power". Per facility policy titled Resident Rights last revised 7/2022, residents would be treated with respect and dignity and care for each resident would be given in a manner and in an environment that promotes maintenance or enhancement of his/her quality of life. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could educate staff regarding the importance of a safe, clean, functional and homelike environment. The DON or designee, could coordinate with maintenance and housekeeping staff to conduct periodic audits of areas residents frequent to ensure a safe, clean, functional and homelike environment is maintained to the extent possible. Time Period for Correction: Twenty-one (21) days.	21665		
21685	MN Rule 4658.1415 Subp. 2 Plant Housekeeping, Operation, & Maintenance Subp. 2. Physical plant. The physical plant, including walls, floors, ceilings, all furnishings, systems, and equipment must be kept in a continuous state of good repair and operation with regard to the health, comfort, safety, and well-being of the residents according to a written routine maintenance and repair program. This MN Requirement is not met as evidenced by:	21685		1/27/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00872	A. BUILDING: _____ B. WING _____	C 12/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOPKINS HEALTH SERVICES	725 SECOND AVENUE SOUTH HOPKINS, MN 55343

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21685	Continued From page 77 Based on observation, interview, and document review, the facility failed to ensure a bed remote control was monitored and kept in safe condition for 1 of 1 resident (R16) reviewed for bed controls. Findings include: R16's quarterly Minimum Data Set (MDS) dated 9/20/24, indicated R16 had severely impaired cognition and diagnoses of heart failure, diabetes mellitus, depression, and dementia. R16 had no impairment to upper and lower extremity and was independent with mobility, such as rolling left and right, sit to lying, and lying to sitting on side of bed and required more assistance with transfers and dressing. During observation and interview on 12/9/24 at 2:42 p.m., R16 laid in bed with the bed controller within reach. The bed controller cord had a black covering which had a half inch or less gap between the controller with the buttons and insulated wires were visible and not frayed. R16 stated they used their bed controller independently. When interviewed on 12/13/24 at 2:12 p.m., nursing assistant (NA)-G stated R16 required extensive assistance for most ADLs but was able to turn herself side to side in bed and used the bed controller independently. NA-G did not notice wires on R16's bed controller but would report to nursing and maintenance if observed. NA-G stated the facility had a TELS (a building management platform) system to report concerns to maintenance. When interviewed on 12/13/24 at 2:16 p.m., licensed practical nurse (LPN)-I stated they had	21685	Corrected	

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	00872	A. BUILDING: _____ B. WING _____	C 12/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOPKINS HEALTH SERVICES	725 SECOND AVENUE SOUTH HOPKINS, MN 55343

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21685	Continued From page 78 not heard about any bed controller concerns recently but would report to maintenance or director of nursing if such a concern occurred. LPN-I stated electrical concerns caused risk of shock and at times have needed to disconnect residents' bed and move them to another room to ensure safety. When interviewed on 12/13/24 at 2:18 p.m., LPN-B expected staff to place a maintenance request in TELS if they saw exposed wires to protect resident safety. LPN-B observed R16's bed controller and ensured it worked. LPN-B stated there were exposed wires but were not frayed so would let the administrator know the controller needed to be replaced. The TELS Work Orders dated 3/1/24 to 12/12/24, did not indicate R16's bed controller needed repair. When interviewed on 12/16/24 at 10:02 a.m., the administrator stated they saw the bed controller and replaced it. Administrator expected staff to enter a TELS request if a bed controller needed replacement. The Work History Report dated January to October 2024, indicated "Bed-Electric audits were completed 8/10/24 and described as "not good". The report described the beds as "shortage of good beds" on 8/17/24, "very short" on 8/24/24, "short on good beds" on 8/31/24, "beds are poor condition, and we are low" on 9/7/24. The task was indicated as "skipped" with description "no maintenance director at this time on 9/14/24. The "Perform Bed Inventory Check" for "Beds-Electric" indicated "no action recorded" on 9/21/24 and 9/28/24. Bed safety audits were completed on 9/30/24. The task did not record	21685		

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	00872	A. BUILDING: _____ B. WING _____	C 12/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOPKINS HEALTH SERVICES	725 SECOND AVENUE SOUTH HOPKINS, MN 55343

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21685	Continued From page 79 any action on 10/5/24. The task indicated "no maintenance director at this time" and action "skipped" on 10/12/24. The task did not record any action on 10/19/24 and 10/26/24. The Physical Environment: Electrical Equipment Policy dated 6/16/22, indicated the maintenance director would maintain schedules for routine inspection and maintenance of all machinal, electrical, and patient care equipment. The policy directed inspection, testing, and maintenance of electrical equipment to be tracked in the TELs building management platform. SUGGESTED METHOD OF CORRECTION: The administrator, maintenance supervisor, or designee could ensure a preventative maintenance program was developed to accurately reflect ongoing preventative maintenance scheduled or needed in the facility on a routine basis. The facility could create policies and procedures, educate staff on these changes and perform environmental rounds/audits periodically to ensure preventative maintenance is adequately completed. The facility could report those findings to the quality assurance performance improvement (QAPI) committee for further recommendations to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21685		
21695	MN Rule 4658.1415 Subp. 4 Plant Housekeeping, Operation, & Maintenance Subp. 4. Housekeeping. A nursing home must provide housekeeping and maintenance services	21695		1/27/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00872	A. BUILDING: _____ B. WING _____	C 12/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOPKINS HEALTH SERVICES	725 SECOND AVENUE SOUTH HOPKINS, MN 55343

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21695	Continued From page 80 necessary to maintain a clean, orderly, and comfortable interior, including walls, floors, ceilings, registers, fixtures, equipment, lighting, and furnishings. This MN Requirement is not met as evidenced by: Based on observation, interview, and documentation review, the facility failed to ensure a safe, clean, comfortable homelike environment when the facility failed to address maintenance issues identified in the dining areas, resident rooms, and throughout the building for 2 of 8 residents (R30, R36) reviewed for homelike environment. Findings include: R30's admission record printed 12/16/24, indicated he admitted to the facility on 9/30/22. A complaint/incident investigation reported by R30 and dated 9/16/24, was reviewed and indicated "the facility itself is very unsanitary." The report included, "one part of the walls at the facility is currently missing," and staff did not appear "to be doing anything to fix this." A complaint/incident investigation reported by R30 and dated 10/8/24, was reviewed and indicated the facility had environmental issues but lacked specificity on where the alleged "mold" was. A complaint/incident investigation reported by R30 and dated 11/27/24, was reviewed and identified a "fire hazard and electrical hazard" in the facility.	21695	Corrected 1/27/	

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	00872	A. BUILDING: _____ B. WING _____	C 12/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOPKINS HEALTH SERVICES	725 SECOND AVENUE SOUTH HOPKINS, MN 55343

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21695	Continued From page 81 A TELS closed work orders report printed 12/13/24 for the dates of 3/1/24 - 12/12/24 identified the following closed work orders: - "the dining room baseboard trims fell off" in the dining, created 4/8/24, completed 4/9/24. - "walls behind bed are scratched/gauged (needs repair-puttying)" for R30's room, created 8/22/24, completed 9/4/24. - "LTC [sic, long-term care] dining room" in second floor dining, created 2/16/24, completed 3/11/24. Per observation on 12/9/24 at 2:18 p.m. of the second-floor dining room, the following environmental concerns were identified: - the corner of the wall near the dining room entrance had gouge marks with large parts of the wall missing as well as a loose baseboard. - across from the wall with the gouge marks and missing wall, there was a wall with baseboards missing. - at the serving line in front of the steam table, there was another missing baseboard. - multiple ceiling tiles with large tan-to-light brown stains that covered approximately half of the ceiling tile's surface area. - the wall on the opposite side of the room's doorway had a long, dark black and gray scuff mark that ran along the side of the wall. - throughout the dining room, multiple baseboards had black and green taped areas. - the first window across from the steamtable and serving line had brown blinds and had thick white, web-like material on the blinds and above them onto the wall. - the second window's bottom ledge showed dried white chips and dark brown flecks coming off the ledge of the wall. On one spot of the window	21695		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOPKINS HEALTH SERVICES	725 SECOND AVENUE SOUTH HOPKINS, MN 55343

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21695	Continued From page 82 ledge, there was an area approximately 8-inches across and 2-inches down, that had long dried white and brown chips and was nearly coming off the wall entirely. - white, web-like material was in the corner of dining room by the two windows, as well as dried white chips flaked off the walls. - the baseboard and tile on the floor across from window in the back of the dining room was warped. - the ice and water machine behind the steam table had thick white buildup around the ice dispenser, and dried white buildup in the drain area and gates. Per interview on 12/9/24 at 2:46 p.m. with dietary aide (DA)-A, the areas noted during the second-floor dining room observation had been present for the duration of DA-A's employment. DA-A reported working in the facility for two weeks. During dining observation on 12/9/24 at 5:54 p.m., R30 was eating supper in the dining room with two other unidentified residents. During observation on 12/10/24 at 3:34 p.m., the baseboard on the wall outside the door of the second-floor dining room was falling off the wall. There were dried white chips flaking off the wall underneath where the baseboard once was. The baseboard was attached only at the corner of the wall and the rest of the slab of baseboard rested on the floor. It spanned the entire wall length, which was approximately 6-feet in length. During observation on 12/11/24 at 11:09 a.m., the dining room and baseboard outside the dining room remained unchanged.	21695		

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21695	Continued From page 83 During observation and interview on 12/9/24 at 5:58 p.m., R30 confirmed filing the complaint/incident investigation reports and stated he reported these grievances in resident council. He pointed to the wall behind his bed and nightstand and observed were 9 scuff marks and an electrical outlet that was coming out/detached from the wall. R30 ate his meals in the second-floor dining room and confirmed the various scuff marks, gouges in the walls, black marks, and baseboards falling off. He stated the dining room had "been like that since I've been here." R30 said the overall condition of his room and the dining room made him "think the building isn't healthy and safe." Per interview on 12/10/24 at 1:37 p.m. with family member (FM)-C, the facility's maintenance department was "really lacking" and the facility only repaired something when it was broken. FM-C reported a privacy curtain was falling off the tracks in a resident room and stated it was reported before, but the facility had not done anything to repair it. Additionally, FM-C reported "I've seen mold around the dining room area." FM-C did not believe the second-floor dining room, R3's room, or the facility itself felt homelike. Per interview on 12/11/24 at 7:24 a.m. with housekeeper (H)-B, any staff were able to enter a maintenance request through the facility's TELS system if they identified a concern. Per interview on 12/11/24 at 7:31 a.m., nursing assistant (NA)-D confirmed the dining room was something staff had been working on. NA-D stated the administrator made daily rounds in the morning to assess the facility "for things that might be wrong."	21695		

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	00872	A. BUILDING: _____ B. WING _____	C 12/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOPKINS HEALTH SERVICES	725 SECOND AVENUE SOUTH HOPKINS, MN 55343

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21695	Continued From page 84 During interview on 12/13/24 at 10:03 a.m., licensed practical nurse (LPN)-C confirmed staff reported their environmental concerns and submitted TELS requests for the second-floor dining room and staff did not do anything about them. LPN-C was unable to recall how long ago the requests were made, however, stated they were submitted when the previous maintenance director was still in the facility, in September, "and now, we do not have a maintenance person at all, so you can imagine how that works." During interview on 12/13/24 at 10:31 a.m., housekeeper (H)-A stated they had a checklist for cleaning rooms but not the dining areas and did not wipe down ice machines, walls, or windows. During interview and environmental tour on 12/13/24 at 1:19 p.m., the administrator and housekeeping director (HD), verified the second-floor dining room needed improvement. The administrator stated the dining room "needs a good look" and was "a project" for the facility. The environmental tour continued, and the administrator verified the gouges in the wall behind R18's head of bed and stated staff "have been running the bed into that." In R30's room, the administrator stated the "whole wall needs to be looked at" and verified being aware of the scuff marks and headboard. The administrator confirmed the electrical outlet was detached/coming out of the wall and stated it was discussed during the LifeSafety survey. R36 R36 ' s Minimum Data Set (MDS) dated 11/14/24, indicated intact cognitive function, and included	21695		

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21695	Continued From page 85 diagnosis of mechanical complication of internal fixation device of right humerus (surgery to repair a right broken shoulder). The MDS indicated R36 was ambulatory with use of rolling walker with seat. The record review on 12/13/24 at 2:24 p.m., on 11/8/24 a deep clean of room check off sheet completed. It did not state unstable cabinetry. During an observation and interview of R36's room on 12/9/24 at 3:35 p.m., R36 stated there was no heat vent in the bathroom and they needed to leave bathroom door open for heat. Four bath blankets were rolled up on the windowsill next to the glass. R36 stated they were there to prevent cold air from entering the room. The wall adjacent from window had 2 large gouges out of it, approximately 4 inches wide, 24 inches long and two inches deep, it had unpainted patchwork around the area. A privacy curtain hung with missing hooks and unable to fully close. The dull blue/gray curtain was covered in brown splotchy areas of unknown substance ranging in size from 1 inch by 1 inch to 4 inches by 3 inches. The floor to ceiling cabinetry was not securely affixed to the wall. It was very unstable, wiggled and moved with any activity. R36 stated they did not consider it a homelike environment, that the place is falling down, and no one cares. During an interview on 12/12/24 at 9:51 a.m., licensed practical nurse (LPN)-D stated the process for a concern in a resident ' s room was to discuss concern(s) with administrator. There was not a maintenance department in the facility. LPN-D observed the cabinetry and confirmed there was a safety concern and reported that to administrator.	21695		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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21695	Continued From page 86 During an interview on 12/12/24 at 2:49 p.m., registered nurse (RN)-A stated any concern with a resident ' s room was brought to the administrator. RN-A stated that safety of the residents was the number one concern, and verbalized the cabinetry would be shown to the management. During an interview on 12/13/24 at 11:48 a.m., administrator discussed the maintenance policy and procedure of rooms and facility. He verified there was not a maintenance department in the facility. A corporate maintenance person came to facility once a month. The facility policy on Safe and Homelike Environment Policy dated 6/16/22 stated Policy: In accordance with residents' rights, the facility will provide a safe and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. SUGGESTED METHODS OF CORRECTION: The director of environmental services or designee could develop, review, and /or revise policies and procedures to ensure all areas of the facility are maintained in a clean and sanitary manner. The admistration could ensure that the walls, cabintry and heat are in good repair. The director of environmental services or designee could educate all appropriate staff. The director of environmental services or designee could develop monitoring systems to ensure ongoing compliance and report those results to the quality assurance committee for further	21695		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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HOPKINS HEALTH SERVICES	725 SECOND AVENUE SOUTH HOPKINS, MN 55343

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21695	Continued From page 87 recommendations. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21695		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245293	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**12/10/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOPKINS HEALTH SERVICES	**725 SECOND AVENUE SOUTH** **HOPKINS, MN 55343**

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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 12/10/2024. At the time of this survey, Hopkins Health Services 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		01/13/2025

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
	245293	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**12/10/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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. Hopkins Health Services original building is a 2-story building without a basement that was built in 1958 and was determined to be of Type II(222) construction. The 1st addition is 2-stories without a basement that was built in 1960 and determined to be of Type II(222) construction. The 2nd addition is 2-stories without a basement that was built in 1965 and determined to be of Type II(222) construction. The 3rd addition is 2-stories without a basement that was built in 1989 and was determined to be of Type II(222)	K 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245293	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**12/10/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOPKINS HEALTH SERVICES	**725 SECOND AVENUE SOUTH** **HOPKINS, MN 55343**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 2 construction. The 4th addition is 2-stories without a basement that was built in 1993 and was determined to be of Type II(222) construction. This facility is fully protected throughout by an automatic fire sprinkler system and has a fire alarm system with smoke detection in the corridors and spaces open to corridors which is monitored for automatic fire department notification. The facility has a capacity of 118 beds and had a census of 37 at the time of the survey.	K 000		
K 211 SS=E	The requirements at 42 CFR, Subpart 483.70(a), are NOT MET as evidenced by: Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain emergency egress doors and corridors per NFPA 101 (2012 edition), Life Safety Code, sections 19.2.1, 19.2.2.2.1, 19.2.3.4, 7.1.10.1 and 7.2.1.4.5.1. These deficient findings could have a patterned impact on the residents within the facility.	K 211	The Executive Director with the Housekeeping Director cleared the egress corridor near resident room 165-175 by removing three beds which were stored in the corridor and located them in appropriate resident room settings. Until a Maintenance Director is hired the Administrator and Housekeeping Director	12/13/24

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K 211	Continued From page 3 Findings include: 1. On 12/10/2024 between 09:30 AM and 01:00 PM, it was revealed by observation that three beds were being stored in the egress corridor near resident rooms 165-175. 2. On 12/10/2024 at 12:27 PM, it was revealed by observation that the emergency exit door out of the 2 east corridor by the roof was difficult to open. 3. On 12/10/2024 at 12:34 PM, it was revealed by observation that the door handle on the exit door near resident room 263 did not fully release the latch causing the door to get stuck when attempting to open. An interview with the Executive Director verified these deficient findings at the time of discovery.	K 211	will be responsible for maintaining clear egress corridors in compliance with the NFPA 101 Life Safety Code. The Emergency exit door out of the 2 East corridor was adjusted by a Maintenance Director to function properly and open without difficulty. A Maintenance Director fixed the door near resident room 263 so the latch will fully release, allowing the door to open and close without difficulty. Maintaining a clear path for egress is part of the facility□s preventative maintenance program. Until a Maintenance Director is hired the Administrator and Housekeeping Director or designee will be responsible for monitoring all egress corridors and egress doors for proper functioning in compliance with the NFPA 101 Life Safety Code.	
K 293 SS=E	Exit Signage CFR(s): NFPA 101 Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) This REQUIREMENT is not met as evidenced by: Based on observation, and staff interview, the	K 293	A Maintenance Director inspected exit	1/16/25

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K 293	Continued From page 4 facility failed to maintain exit signs per NFPA 101 (2012 edition), Life Safety Code, sections 19.2.10.1, 7.10.5.1, and 7.10.5.2.1. These deficient findings could have a patterned impact on the residents within the facility. Findings include: 1. On 12/10/2024 at 12:19 PM, it was revealed by observation that the exit sign near room 207 was not illuminated. 2. On 12/10/2024 at 12:36 PM, it was revealed by observation that the exit sign above the smoke barrier doors near the 2 east dining room/ nurses station was not illuminated. An interview with the Executive Director verified these deficient findings at the time of discovery.	K 293	signs for proper illumination. Exit light bulbs to be replaced in the exit sign near room 207 and the exit sign above the smoke barrier doors near the 2 East dining room/nurses station. Exit lights were inspected and no other issues were found. Exit sign inspection is part of the preventative maintenance program and until a Maintenance Director is hired the Administrator and Housekeeping Director or designee will be responsible for monitoring all exit signs for proper illumination in compliance with the NFPA 101 Life Safety Code.	
K 324 SS=D	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4.	K 324		1/2/25

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K 324	Continued From page 5 Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain kitchen doors per NFPA 101 (2012 edition), Life Safety Code, section 19.3.2.5.5. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 12/10/2024 at 12:02 PM, it was revealed by observation that the door to the kitchen/ dish room would not positively latch. An interview with the Executive Director verified this deficient finding at the time of discovery.	K 324	A Maintenance Director repaired the kitchen/dish room door to ensure that it will stay properly latched at all times. Similar areas were audited, and issues were repaired as needed. Checking doors for deigned operation is part of the preventative maintenance program and until a Maintenance Director is hired the Administrator and Housekeeping Director or designee will be responsible for monitoring all kitchen doors and others for compliance with the NFPA 101 Life Safety Code.	
K 345 SS=B	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72	K 345		1/16/25

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K 345	Continued From page 6 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to maintain the fire alarm system per NFPA 101 (2012 edition), Life Safety Code, section 9.6.1.5, and NFPA 70, (2011 edition), National Electrical Code, sections 760.24 and 760.53 (A) (1). This deficient finding could have a patterned impact on the residents within the facility. Findings include: On 12/10/2024 at 11:28 AM, it was revealed by observation that there was an open fire alarm junction box with the wires pulled out of it above the ceiling on the first floor to the left of the smoke barrier doors at the entrance to the corridor that contains resident rooms 120-128. An interview with the Executive Director verified this deficient finding at the time of discovery.	K 345	A Maintenance Director will repair the wiring into the junction box above the ceiling on the first floor to the left of the barrier doors at the entrance to the corridor that contains resident rooms 120-128. Maintaining the fire alarm system is part of the preventative maintenance program and until a Maintenance Director is hired the Administrator or designee will be responsible for monitoring the Fire Alarm System compliance with the NFPA 101 Life Safety Code.	
K 346 SS=C	Fire Alarm System - Out of Service CFR(s): NFPA 101 Fire Alarm - Out of Service Where required fire alarm system is out of services for more than 4 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.6 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to implement	K 346	On 1/6/2025 the Executive Director reviewed the facility Fire Alarm	1/6/25

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K 346	Continued From page 7 a fire alarm out-of-service policy per NFPA 101 (2012 edition), Life Safety Code, section 9.6.1.6. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 12/10/2024 between 09:30 AM and 01:00 PM, it was revealed by review of available documentation that the fire alarm out-of-service policy that the facility provided at the time of the survey did not state to call the Deputy State Fire Marshal in the event the fire alarm system went down. An interview with the Executive Director verified this deficient finding at the time of discovery.	K 346	Out-Of-Service policy and made revision to include contacting the Deputy State Fire Marshal (currently Greg Hubbard) at 651-769-7778 in the event of a fire alarm system failure. The Executive Director is responsible for ensuring that the facility is in compliance NFPA 101 section 9.6.1.6	
K 354 SS=C	Sprinkler System - Out of Service CFR(s): NFPA 101 Sprinkler System - Out of Service Where the sprinkler system is impaired, the extent and duration of the impairment has been determined, areas or buildings involved are inspected and risks are determined, recommendations are submitted to management or designated representative, and the fire department and other authorities having jurisdiction have been notified. Where the sprinkler system is out of service for more than 10 hours in a 24-hour period, the building or portion of the building affected are evacuated or an approved fire watch is provided until the sprinkler system has been returned to service. 18.3.5.1, 19.3.5.1, 9.7.5, 15.5.2 (NFPA 25) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation	K 354	On 1/4/2025 the Executive Director	1/6/25

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K 354	Continued From page 8 and staff interview, the facility failed to implement a fire sprinkler out-of-service policy per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.5.1 and 9.7.5, and NFPA 25 (2011 edition), Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, section 15.5.2. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 12/10/2024 between 09:30 AM and 01:00 PM, it was revealed by a review of available documentation that the fire sprinkler out-of-service policy that the facility provided at the time of the survey did not state to call the Deputy State Fire Marshal in the event the fire sprinkler system went down. An interview with the Executive Director verified this deficient finding at the time of discovery.	K 354	reviewed the facility Fire Sprinkler Out-Of-Service policy and made revision to include contacting the Deputy State Fire Marshal (currently Greg Hubbard) at 651-769-7778 in the event of a fire alarm system failure. The Executive Director is responsible for ensuring that the facility is in compliance NFPA 25 section 15.5.2	
K 362 SS=E	Corridors - Construction of Walls CFR(s): NFPA 101 Corridors - Construction of Walls 2012 EXISTING Corridors are separated from use areas by walls constructed with at least 1/2-hour fire resistance rating. In fully sprinklered smoke compartments, partitions are only required to resist the transfer of smoke. In nonsprinklered buildings, walls extend to the underside of the floor or roof deck above the ceiling. Corridor walls may terminate at the underside of ceilings where specifically permitted by Code. Fixed fire window assemblies in corridor walls are in accordance with Section 8.3, but in sprinklered	K 362		1/16/25

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K 362	Continued From page 9 compartments there are no restrictions in area or fire resistance of glass or frames. If the walls have a fire resistance rating, give the rating _____ if the walls terminate at the underside of the ceiling, give brief description in REMARKS, describing the ceiling throughout the floor area. 19.3.6.2, 19.3.6.2.7 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain corridor walls per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.6.2.1, 19.3.6.2.2, and 19.3.6.2.3. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 12/10/2024 at 12:06 PM, it was revealed by observation that the corridor walls and resident room walls in the wing that contains resident rooms 102-107 had the lower section of drywall removed due to a water leak. An interview with the Executive Director verified this deficient finding at the time of discovery.	K 362	The facility is respectfully requesting a temporary waiver on form CMS-2786R due to time restrictions for completion. Please see new Waiver Request attached to e-mail sent to Travis Z. Ahrens on 1/16/2025.	
K 363 SS=E	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist	K 363		1/16/25

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K 363	Continued From page 10 the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain corridor doors per NFPA 101 (2012 edition), Life Safety Code, section 19.3.6.3.5. These deficient findings could have a patterned impact on the residents within the facility. Findings include:	K 363	A Maintenance Director will repair the doors that failed to positively latch. Specifically, the doors to resident room 206, 220 and the door to the East dining room on the 2nd floor. Proper operation of facility doors is part of the preventative maintenance program	

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K 363	Continued From page 11 1. On 12/10/2024 at 12:18 PM, it was revealed by observation that the door to resident room 206 did not positively latch. 2. On 12/10/2024 at 12:22 PM, it was revealed by observation that the door to resident room 220 did not positively latch. 3. On 12/10/2024 at 12:24 PM, it was revealed by observation that the door to the east dining room on the second floor did not positively latch. An interview with the Executive Director verified these deficient findings at the time of discovery.	K 363	and until a Maintenance Director is hired the Administrator or designee will be responsible for monitoring all doors to ensure that they properly latch in compliance with the NFPA 101 Life Safety Code.	
K 712 SS=F	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to conduct fire drills per NFPA 101 (2012 edition), Life Safety Code sections 19.7.1.4, 19.7.1.6, 4.7.4, and 4.6.1.1. This deficient finding could have a widespread impact on the residents within the	K 712	The Executive Director and the Maintenance Director are responsible for ensuring that fire drills are conducted on a quarterly basis for each shift. An annual schedule for monthly fire drills has been established as of January 1, 2025. Drills	1/10/25

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K 712	Continued From page 12 facility. Findings include: 1. On 12/10/2024 between 09:30 AM and 01:00 PM, it was revealed by a review of available documentation at the time of the survey the facility could not provide documentation showing that they conducted a fire drill during the first shift during the first quarter of 2024. 2. On 12/10/2024 between 09:30 AM and 01:00 PM, it was revealed by a review of available documentation that the facility did not vary the times that the third shift fire drills were being conducted. An interview with the Executive Director verified this deficient finding at the time of discovery.	K 712	will be conducted once per shift per quarter. Drills will not be conducted on one shift that are within 1 hour of any other in in a rolling year. The Facility will be in compliance as of the first quarter ending March 31, 2025. Ongoing compliance and documentation will be audited by the Executive Director and will be presented to the quarterly QAPI committee by the Director of Maintenance or designee.	
K 761 SS=F	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This REQUIREMENT is not met as evidenced	K 761		1/16/25

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K 761	Continued From page 13 by: Based on a review of available documentation and staff interview, the facility failed to inspect fire doors per NFPA 101 (2012 edition), Life Safety Code section 8.3.3.1, and NFPA 80 (2010 edition), Standard for Fire Doors and Other Opening Protectives, section 5.2.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 12/10/2024 between 09:30 AM and 01:00 PM, it was revealed by a review of available documentation at the time of the survey the facility could not provide documentation showing that the fire doors have been inspected within the last year. An interview with the Executive Director verified this deficient finding at the time of discovery.	K 761	Annual fire door inspections will be conducted by a Maintenance Director and the results will be filed. The annual fire/smoke door inspection is part of the facility's preventative maintenance program, and the maintenance director will be responsible for future compliance.	
K 901 SS=F	Fundamentals - Building System Categories CFR(s): NFPA 101 Fundamentals - Building System Categories Building systems are designed to meet Category 1 through 4 requirements as detailed in NFPA 99. Categories are determined by a formal and documented risk assessment procedure performed by qualified personnel. Chapter 4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation	K 901	The facility was able to locate the facility	1/13/25

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	245293	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**12/10/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOPKINS HEALTH SERVICES	**725 SECOND AVENUE SOUTH** **HOPKINS, MN 55343**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 901	Continued From page 14 and staff interview, the facility failed to provide a Risk Assessment per NFPA 99 (2012 edition), Health Care Facilities Code, section 4.2. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 12/10/2024 between 09:30 AM and 01:00 PM, it was revealed by a review of available documentation at the time of the survey the facility could not provide documentation showing a risk assessment of the facility has been completed using chapters 5 through 11 of NFPA 99 (2012 edition), Health Care Facilities Code. An interview with the Executive Director verified this deficient findings at the time of discovery.	K 901	risk assessment in the Emergency Operations Manual. The work sheet (appendix a) was previously completed to reflect the facility□s top 3 risks. The Executive Director will be responsible for future assessments, reviews, and updates.	
K 912 SS=D	Electrical Systems - Receptacles CFR(s): NFPA 101 Electrical Systems - Receptacles Power receptacles have at least one, separate, highly dependable grounding pole capable of maintaining low-contact resistance with its mating plug. In pediatric locations, receptacles in patient rooms, bathrooms, play rooms, and activity rooms, other than nurseries, are listed tamper-resistant or employ a listed cover. If used in patient care room, ground-fault circuit interrupters (GFCI) are listed. 6.3.2.2.6.2 (F), 6.3.2.2.4.2 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to maintain electrical outlets per NFPA 99 Standards for Health Care Facilities 2012 edition, section	K 912	A Maintenance Director will secure the electrical receptacle into the back box behind the TV stand in resident room 255. An audit of similar areas will be completed	1/16/25

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	245293	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**12/10/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOPKINS HEALTH SERVICES	**725 SECOND AVENUE SOUTH** **HOPKINS, MN 55343**

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K 912	Continued From page 15 6.3.2.1, and NFPA 70, (2011 edition), National Electrical Code, sections 406.5 and 406.6. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 12/10/2024 at 09:37 AM, it was revealed by observation that the electrical receptacle behind the TV stand in resident room 255 was not secured into the back box and was coming out of the wall. An interview with the Executive Director verified this deficient finding at the time of discovery.	K 912	and any issues found will be repaired. Secured electrical receptacles is a part of the facility's preventative maintenance program and the maintenance director or designee will ensure future compliance.	
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in	K 918		1/16/25

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	245293	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**12/10/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOPKINS HEALTH SERVICES	**725 SECOND AVENUE SOUTH** **HOPKINS, MN 55343**

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K 918	Continued From page 16 accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to maintain generators per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.4.4.1.1.3, and NFPA 110 (2010 edition), Standard for Emergency and Standby Power Systems, sections 8.4.1, 8.4.2, and 8.4.2.3. These deficient findings could have a widespread impact on the residents within the facility. Findings include: 1. On 12/10/2024 between 09:30 AM and 01:00 PM, it was revealed by a review of available documentation at the time of the survey the facility could not provide documentation showing a monthly emergency generator test was completed during the month of November. 2. On 12/10/2024 between 09:30 AM and 01:00 PM, it was revealed by a review of available documentation at the time of the survey the facility could not provide documentation showing	K 918	A Maintenance Director, Executive Director or designee will ensure that generator inspections are completed on a weekly and monthly basis. These inspections are scheduled in the facility□s maintenance repair and preventative maintenance program. The Executive Director has been trained and is responsible for auditing these inspections in an ongoing fashion to verify compliance.	

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K 918	Continued From page 17 that any weekly emergency generator inspections have been completed since September 21, 2024. An interview with the Executive Director verified these deficient findings at the time of discovery.	K 918		
K 930 SS=D	Gas Equipment - Liguid Oxygen Equipment CFR(s): NFPA 101 Gas Equipment - Liquid Oxygen Equipment The storage and use of liquid oxygen in base reservoir containers and portable containers comply with sections 11.7.2 through 11.7.4 (NFPA 99). 11.7 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to safely store liquid oxygen per NFPA 99 (2012 edition), Health Care Facilities Code, section 11.7.4. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 12/10/2024 at 12:32 PM, it was revealed by observation that in resident room 254 there were two liquid oxygen containers, one was being used and the other was being stored in the room. An interview with the Executive Director verified this deficient finding at the time of discovery.	K 930	The stored oxygen tank was removed from the resident room and stored in compliance with NFPA 99 Sections 11.7.2-11.7.4 Unit Staff provided education on proper storage and use of liquid oxygen. Oxygen storage compliance is part of the center□s preventative maintenance program and the ED and DON or designee will monitor future compliance.	1/10/25

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
February 21, 2025

Administrator
Hopkins Health Services
725 Second Avenue South
Hopkins, MN 55343

RE: CCN: 245293
Cycle Start Date: December 16, 2024

Dear Administrator:

On February 20, 2025, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Correction of the Life Safety Code deficiency cited under K362 - Corridors - construction of walls at the time of the December 16, 2024, standard survey has not yet been verified. Your plan of correction for this deficiency including your request for a temporary waiver with a date of completion of April 30, 2025, has been forwarded to the Region V Office of the Centers for Medicare and Medicaid Services (CMS) for their review and determination. Failure to come into substantial compliance with this deficiency by the date indicated in your plan of correction may result in the imposition of enforcement remedies.

Feel free to contact me if you have questions.

Sincerely,

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

February 21, 2025

Administrator
Hopkins Health Services
725 Second Avenue South
Hopkins, MN 55343

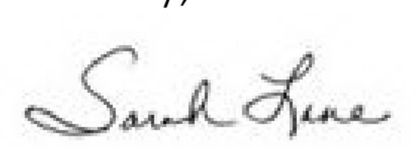
Re: Reinspection Results
Event ID: DVSD12

Dear Administrator:

On February 20, 2025 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 December 16, 2024. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,



Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
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