DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
February 29, 2024

Administrator
The Emeralds At Grand Rapids LLC
2801 South Highway 169
Grand Rapids, MN 55744

RE: CCN: 245495
Cycle Start Date: January 11, 2024

Dear Administrator:

On February 26, 2024, the Minnesota Departments of Health and Public Safety, completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

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

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
January 19, 2024

Administrator
The Emeralds At Grand Rapids LLC
2801 South Highway 169
Grand Rapids, MN 55744

RE: CCN: 245495
Cycle Start Date: January 11, 2024

Dear Administrator:

On January 11, 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 a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E), 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:

Jen Bahr, RN, Unit Supervisor
Bemidji District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
705 5th Street NW, Suite A
Bemidji, Minnesota 56601-2933
Email: Jennifer.bahr@state.mn.us
Office: (218) 308-2104 Mobile: (218) 368-3683

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 April 11, 2024 (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 July 11, 2024 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

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

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

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

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

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245495	A. BUILDING _____ B. WING _____	C 01/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE EMERALDS AT GRAND RAPIDS LLC	2801 SOUTH HIGHWAY 169 GRAND RAPIDS, MN 55744

(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 1/7/24 to 1/11/24 , a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73 was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On 1/7/24 to 1/11/24, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was IN 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: H: 54959421C MN: 91900 H: 54958530C MN: 91702 H: 54958526C MN: 99264 H:54958527C MN: 98659 H:54958533C MN: 94242 H: 54958531C MN: 98544 H: 54958532C MN: 98115 The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance.	F 000		

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

Electronically Signed | 01/28/2024

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

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F 000	Continued From page 1 Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without	F 550		2/16/24

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F 550	Continued From page 2 interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure clothing (other than a hospital type gown) was offered or provided for 1 of 3 residents (R205) reviewed for dignity. In addition, the facility failed to ensure bathing was offered or provided for 1 of 3 residents (R5) reviewed for dignity. The facility also failed to ensure a Medicare notification of non-coverage for therapy was delivered in a private and dignified manor for 1 of 3 residents (R42) reviewed for resident rights. Findings include: R205: R205's admission Minimum Data Set (MDS) dated 1/9/24, identified R205 had moderate cognition, exhibited no rejection of care, and required assistance with ADL's including dressing, bed mobility, wheelchair locomotion and transfers. R205's diagnoses included right femur fracture and left tibia fracture. R205's care plan dated 1/4/24, identified a self-care deficit related to weakness. Interventions included assistance with ADL's including personal hygiene, dressing, and	F 550	Immediate Corrective Action: R205 is no longer a resident, R5 had a shower completed on 1/10 when issue was identified, MDS coordinator was educated on delivering notification of non-coverage for therapy in a private area. Corrective Action as it applies to others: All residents will be reviewed to ensure they have clothing other than a hospital gown, if they do not have clothing, it will be provided. Personal Property policy was reviewed and remains current. Clinical staff will be educated on Personal Property policy. All residents bath s will be audited to determine if they have been offered their bath per their bathing schedule. Activities of Daily Living Policy was reviewed and remains current. Clinical staff will be educated on Activities of Daily Living Policy. MDS coordinator was educated on	

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F 550	Continued From page 3 locomotion. R205's Personal Belongings Inventory dated 1/7/24 was blank and unsigned. There was no evidence if R205 had any clothing or had been offered, refused, or was provided any clothing upon admission. On 1/8/24 at 4:28 p.m., R205 was seated in a wheelchair in her room next to her bed. R205 was wearing a hospital type gown. On 1/8/24 at 4:42 p.m., nursing assistant (NA)-C stated R205 was admitted a few days ago and laundry only sent up one set of clothing. NA-C stated this usually happens until family can bring more clothes in, and R205's family had not come to the facility yet. On 1/9/24 at 2:47 p.m., R205 stated she didn't have any clothing and had been in a gown since admission. R205 reported she had talked to staff about it, but no one helped her and her family were unable to visit. R205 stated she was frustrated because she only had a gown to wear and felt as if she unable to leave her room due to not having regular clothing to wear. On 1/9/24 at 3:35 p.m., observed R205 seated in her wheelchair in the therapy room. R205 was wearing a hospital gown and had a blanket covering her lower extremities. On 1/9/24 at 4:08 p.m., registered nurse (RN)-A stated nurses complete the resident's admission assessments including the residents personal belongings list. Residents clothing is marked with their name by their family or staff upon arrival. If a resident does not have any clothing, they would	F 550	delivering notification of non-coverage for therapy in a private area. Confidentiality of information and personal privacy policy, and resident rights remains current. MDS coordinator will be educated on Confidentiality of information and personal privacy policy, and resident rights. Recurrence will be prevented by: Audits will be conducted weekly x3 weeks, and monthly x2 months on new admissions to ensure they have clothing. Audits will be conducted weekly x3 weeks, and monthly x2 months on baths to audit bath completion. Audits will be conducted weekly x3 weeks, and monthly x2 months on 5 notification of non-coverage for therapy, to determine if they were completed in a private area. Audits and findings will be reported to QAPI committee for further recommendations. Corrections will be monitored by: Director of Nursing or Designee	

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F 550	Continued From page 4 ask the residents family to bring some in, or look in the laundry for donated items. Upon arrival, R205 did not have any clothing. RN-A stated she was uncertain if R205 had any clothing since admission or if staff offered or attempted to find her clothing to wear. On 1/9/24 at 4:29 p.m., social services designee (SSD) stated if a resident was wearing only a gown, she would investigate why. If a new admission didn't have clothing upon arrival, staff should contact family or look in the laundry for donated/left over items. The SSD stated after reviewing R205's inventory list, it did not indicate if resident had any clothing upon arrival or since admission. On 1/9/24 at 4:56 p.m., the director of nursing (DON) stated if a resident didn't have clothing upon admission, staff would look in the laundry for donated items and/or contact the family to bring clothing in. It would also be discussed in the morning meeting and the staff would work as a team to find a solution. Staff would also enter a progress note in the resident's medical record. If there was not a progress note than it probably was not done. It is not dignified for a resident to be out of their room in only a gown unless it was their preference. The DON further stated she was unaware that R205 did not have any clothing and was wearing only a gown in and outside of her room, as well as not having any clothing since. R205's progress notes failed to identify offers or attempts to find clothing from R205's admission on 1/3/24, through 1/9/24. The facility Personal Property policy, revised 3/21, interpretation and implementation section	F 550		

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F 550	Continued From page 5	F 550		

included residents were encouraged to use personal belongings to maintain a homelike environment, and personal belongings and clothing were inventoried and documented upon admission and updated as necessary.

R5:

R5's quarterly Minimum Data Set (MDS) dated 12/29/23, identified R5 was cognitively intact and had not exhibited behaviors including rejection of care. R5's diagnoses included cerebral palsy and diabetes. R5 was dependent on staff assistance for ADL's including showering/bathing, personal hygiene and transfers.

R5's care plan dated 12/21/23, identified R5 had a self-care defect related to weakness, and goals included resident would accept assistance with self-cares, and would be bathed and groomed per resident preferences. Interventions included staff to assist R5 with bathing, dressing and grooming.

On 1/9/24 at 3:39 p.m., R5 stated she was scheduled for a shower twice weekly on Tuesday and Friday mornings. R5 had inquired about receiving her scheduled shower and reported staff told here there were not enough staff working at the time. R5 stated she had not received a shower in at least 10 days. R5 complained that she felt itchy, gross and her hair felt greasy. R5 stated it bothered her not to have her scheduled showers. R5's hair had been pulled back into a braid and observed to have dried white flakes at the base of the hair follicles. R5's hair looked shiny/wet like it hadn't been washed in several days.

On 1/10/24 at 8:39 a.m., R5 was seated in a

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F 550	Continued From page 6	F 550		

wheelchair in her room. R5's hair was pulled back into a braid and looked shiny/wet. R5 stated she had not received her scheduled shower yesterday.

On 1/10/24 at 9:09 a.m., nursing assistant (NA)-A stated she was working as a float and assisting residents with their daily showers. R5 needed assistance with activities of daily living (ADL's) including showering/bathing. NA-A stated R5 would not be getting a shore because the resident was not scheduled that day, staff had not reported to her that the resident needed a shower, and R5 was not on her shower list.

On 1/10/24 at 9:11 a.m., NA-B stated the unit bath book identified the bathing schedule with each resident assigned to a day, or days of the week and corresponding shift (i.e., "D" for days or "E" for evening). This identified R5 was scheduled for twice weekly baths on Tuesday and Friday day shift. NA-B stated when the bath is completed, the staff highlight the day and write "done" in the square. Staff also filled out skin assessment form to provide to the nurse.

R5's medical record, including skin assessments, progress notes, were reviewed. There was no evidence that R5 had been offered, refused, or provided any bathing episodes within the past several weeks.

On 1/10/24 at 1:12 p.m., the director of nursing (DON) stated if a resident declined a shower the nursing staff would make a notation on the skin inspection form and in the progress notes. Staff also discuss in the mornings who refused a shower and which residents needed a shower that day. The DON stated there were no skin

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F 550	Continued From page 7 assessments in F5's chart since 1/2/24 which would lead her to believe R5's last shower was on 1/2/24. Policies including resident refusal for bathing, activities of daily living, and documenting refusals were requested but not provided by the facility. R43: R43's significant change Minimum Data Set (MDS) dated 11/25/23, indicated R43 was cognitively intact, and diagnoses included diabetes, and end stage renal disease. R43's undated, care plan focus areas informed staff, R43 was at risk for alterations in behavior and mood related to the trauma of having a family member steal all their finances. The mood and behavior focus area implemented on 9/20/23, by registered nurse (RN)-A indicated past financial discussions had triggered R43's financial trauma and resulted in tearfulness and behaviors. Care planned interventions directed staff to consider past trauma and use trauma informed care when engaging in work with the resident, and to use a calm/understanding approach when finances were discussed. During an interview on 1/7/24 at 6:56 p.m., R43 stated she was in the large dining area for bingo and a staff came in and told them their therapy was ended. R43 did not feel privacy was provided and indicated they were so upset that they cried right there in the dining room in front of everyone. During a follow-up interview on 1/8/24 at 3:50 p.m., R43 indicated RN-A was the person that had told them their therapy had been canceled because insurance would not pay for it. R43	F 550		

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F 550	Continued From page 8 stated there were lots of people in the dining area for bingo that she did not know so it was very upsetting and embarrassing to have those residents hear their business and see them cry. It should have been done in private. During an interview on 1/9/24 at 2:50 p.m., the activities director stated they were not aware of a resident receiving information during group, and indicated the facility usually delivered things like mail or financial items to the resident in their room. During an interview on 1/9/24 at 2:57 p.m., the office manager stated they would not deliver a financial statement to a resident in a public area. They delivered statements to resident rooms for privacy. When R43 received their last statement in their room they said they were concerned about privacy because they had been given a notice about their therapy ending in the dining room. R43 expressed it was very humiliating and embarrassing to receive the notice in front of everyone in the dining room. During an interview on 1/9/24 at 3:07 p.m., activities aide (AA)-B stated they were in the dining room when R43 received their notice of therapy discontinuation. we were passing out snacks before bingo started in the dining room. RN-A, R43, and another resident were seated at a table. There were other residents around them for bingo. The interaction was about 5 to 7 minutes. R43 started to cry when RN-A gave them a paper notice that their therapy wasn't covered by insurance anymore. R43 had lots of financial things going on so social services was informed.	F 550		

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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 550	Continued From page 9 During an interview on 1/09/24 at 3:19 p.m., the director of nursing (DON) stated all Notice of Medicare Non-coverage (NOMNC) should be given in a private location. Based on R43's care plan and trauma related to finances, R43 should have received her NOMNC about therapy discontinuation in privacy. In addition, a second support person and follow-up assessment for trauma would have been appropriate for R43. During an interview on 1/11/24 at 9:51 a.m., RN-A confirmed they had delivered R43's NOMNC to R43 in the dining room. RN-A stated they usually delivered NOMNCs to the resident in their room, but when asked, R43 had said they could sit by the bird area in the dining room to talk. R43 started to cry when she received her notice about therapy no longer being covered. RN-A indicated in retrospect; it would have been better if R43 had received the NOMNC in privacy with a second staff along for resident support. The facility policy Confidentiality of Information and Personal Privacy dated 10/2017, indicated the facility would safeguard and protect resident personal privacy and confidentiality which included privacy related to resident medical treatments, visits, and personal and medical records. The facility policy Resident Rights dated 12/2016, indicated that residents had the right to privacy and confidentiality.	F 550		
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as	F 554		2/16/24

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	245495	A. BUILDING _____ B. WING _____	C 01/11/2024

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F 554	Continued From page 10 defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure self-administration of medications were assessed for safety and care planned accordingly to reduce the risk of an adverse event for 1 of 1 residents R31 reviewed for self-administration of medication. Findings include: R31's quarterly Minimum Data Set (MDS) dated 12/15/23, identified R31 had diagnoses of chronic respiratory failure (an absence of enough oxygen in the tissues to sustain bodily functions), dependence on respirator, right heart failure (chronic condition in which the heart doesn't pump blood as well as it should), morbid obesity, type 2 diabetes mellitus, hypertension and had a tracheostomy (an opening in the trachea [windpipe] from the outside to allow air and oxygen to reach the lungs). In addition, R31's MDS identified R31 was cognitively intact. R31's current physician order report undated, identified an order for miconazole nitrate powder 2% apply to itching or other topically as needed. Self-Administration of Medication Evaluation dated 3/14/23, identified R31 was not assessed for self-administration of topical medication/treatment. During an observation on 1/11/24 at 11:38 a.m., the miconazole powder medication was in R31's room. R31 stated the bottle was kept in his room	F 554	Immediate Corrective Action:¿¿¿ R31 had self-administration assessment completed for topical medications, and care plan updated in regards to self administration of medications. Corrective Action as it applies to others:¿¿ All residents will be audited to determine if a self-administration assessment is required, and one is completed if needed. Residents who self-administer medication will have care plan updated accordingly. Self-Administration of Medications policy was reviewed and remains current. Nurses and TMA's educated on Self-Administration of Medications policy. Recurrence will be prevented by:¿¿ Audits will be conducted weekly x3 weeks, and monthly x2 months on residents who self-administer medications to determine the self-administration policy is being followed by staff and residents, and resident care plan is up to date in regards to self-administration of medication. Audits and findings will be reported to QAPI committee for further recommendations.¿¿	

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F 554	Continued From page 11 and he self-administered the powder after taking a shower. During interview on 1/11/24 at 12:12 p.m., licensed practical nurse (LPN)-B stated R31 cannot self-administer any medications except for a nebulizer treatment staff set up for him. LPN-B further stated the director of nursing (DON) does self-administration of medication (SAM) assessments on residents and the results are flagged in the facility's electronic medical record (EMR). LPN-B further stated medications should not be in resident room if resident cannot self-administer medication. LPN-B entered R31's room and confirmed miconazole powder was on R31's room cart. LPN-B removed the miconazole powder from room and placed it in medication cart in hallway. During interview on 1/11/24 at 12:25 p.m., DON stated resident needs to have SAM assessment done in order to be able to self-administer medication. DON further stated she would discuss with medical doctor (MD) to see if it would be appropriate for a resident to self-administer medication. If deemed appropriate by MD, DON would do a SAM assessment. DON stated the SAM assessment was important to ensure proper use of medication and to prevent any adverse events. Self-Administration of Medications policy dated 12/2016, identified "Residents have the right to self-administer medications if the interdisciplinary team has determined that it is clinically appropriate and safe for the resident to do so." Policy further identified "the staff and practitioner will assess each resident's mental and physical abilities to determine whether self-administrating	F 554	Corrections will be monitored by:¿ Director of Nursing or Designee	

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F 554	Continued From page 12 medications is clinically appropriate". Policy also indicated "Staff shall identify and give to the Charge Nurse any medications found at the bedside that are not authorized for self-administration" and "Nursing staff will review the self-administered medication record on each nursing shift, and they will transfer pertinent information to the medication administration record (MAR)".	F 554		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure 1 of 1 resident (R23) had access to their call light. Findings include: R23's Minimum Data Set (MDS) dated 12/8/23, indicated R23 had severe cognitive impairment with the diagnoses of heart failure, end stage renal disease, and dementia. R23's care plan intervention dated 12/6/23, listed under fall risk, instructed staff to place call light within reach when in bed. During an observation on 1/7/24 at 2:51 p.m., R23 was in their room seated in a recliner. R23's call light was out of reach on the floor between	F 558	Immediate Corrective Action:¿¿¿ R23 Call light was put within reach after noted by surveyors. Corrective Action as it applies to others:¿¿ All residents could be affected by this deficient practice. Call light policy was reviewed and remains current. All Staff will be educated on Call Light policy and having resident call lights within reach.	2/16/24

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F 558	Continued From page 13 the night stand and bed. During an observation on 1/8/24 at 4:09 p.m., R23 was in bed. The call light was on top of R23's bed covers. During an observation on 1/9/24 at 8:06 a.m., R23 was in their room in a recliner. R23's call light was out of reach on the floor between R23's bed and nightstand. Licensed practical nurse (LPN)-A entered R23's room, placed a clothing cover up on R23 for breakfast, and then left the room without placing the call light within R23's reach. During an observation on 1/9/24 at 11:53 a.m., R23 was seated in a tilted wheelchair close to the room door. R23's call light was in the top nightstand drawer beside the head of the bed, several feet behind R23. During an interview on 1/9/24 at 12:05 p.m., LPN-A entered R23's room and confirmed R23's call light was not within reach. LPN-A took R23's call light and moved it to the chair R23 was seated in. LPN-A stated all residents should have their call light within reach when they are in their room. Even residents with significant cognitive impairment should have their call lights within reach, as they have moments where they are able to appropriately use their call light, . A soft touch or bell could be used as an alternative for a resident if that worked better for them. If R23's care plan idenitifies the call light being within reach when in bed, it should to be corrected to state the call light should be within reach at all times. During an interview on 1/9/24 at 4:47 p.m., the	F 558	Recurrence will be prevented by:¿¿ Audits will be conducted weekly x3 weeks, and monthly x2 months on 10 resident's call light's and if they are within reach. Audits and findings will be reported to QAPI committee for further recommendations.¿¿ Corrections will be monitored by:¿ Director of Nursing or Designee	

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F 558	Continued From page 14 director of nursing (DON) stated they expected staff to ensure the resident's call light was within reach of all residents before they left a resident room. The facility Call Light Policy dated 5/16/23, directed call cords, buttons or other communication devices must be placed where they are within reach of the resident.	F 558		
F 572 SS=E	Notice of Rights and Rules CFR(s): 483.10(g)(1)(16) §483.10(g) Information and Communication. §483.10(g)(1) The resident has the right to be informed of his or her rights and of all rules and regulations governing resident conduct and responsibilities during his or her stay in the facility. §483.10(g)(16) The facility must provide a notice of rights and services to the resident prior to or upon admission and during the resident's stay. (i) The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. (ii) The facility must also provide the resident with the State-developed notice of Medicaid rights and obligations, if any. (iii) Receipt of such information, and any amendments to it, must be acknowledged in writing; This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the resident Bill of Rights were provided in writing and ongoing for residents	F 572	Immediate Corrective Action:¿¿¿ R7, R15, R26, R43, and R50 have been	2/16/24

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F 572	Continued From page 15 of the facility for 5 of 5 residents (R7, R15, R26, R43, R50) interviewed during resident meeting. This deficient practice had the potential to affect all 54 residents residing in the facility. Findings include: R7 quarterly Minimum Data Set (MDS) dated 10/18/23, identified R7 had no cognitive impairment. R15 admission MDS dated 11/28/23, identified R15 had no cognitive impairment. R26 admission MDS dated 12/11/23, identified R26 had no cognitive impairment. R43 significant change MDS dated 11/25/23, identified R43 had no cognitive impairment. R50 significant change MDS dated 12/15/23, identified R50 was cognitively intact. On 1/9/24 at 10:02 am, R7, R15, R26, R43, and R50 stated they knew what the Residents' Bill of Rights was and on admit was told to read the rights but was not provided a copy. On 01/09/24 04:29 p.m., the social services designee (SDD) stated admission paperwork was completed online by the resident/resident representative and a staff member and included the Resident Bill of Rights. The SSD stated she or the resident/resident representative would read the words on the screen and then click through each page. The SSD would offer a printed or emailed and the resident/resident representative would sign indicating they accepted or declined the copy. They signed form was scanned into the	F 572	provided a written copy of the resident Bill of Rights. Corrective Action as it applies to others:¿¿ All residents have been provided a written copy of the resident Bill of Rights. Education provided to Social Services Director on providing residents a written copy of the Residents Bill of Rights, and the revised residents rights policy. Resident Rights policy has been reviewed, and revised. Recurrence will be prevented by:¿¿ Residents receiving the residents bill of rights will be audited on new admissions weekly x3 weeks, and monthly x2 months to ensure that all residents have received a written copy of the Resident Bill of Rights. Audits and findings will be reported to QAPI committee for further recommendations.¿¿ Corrections will be monitored by:¿ Social Services Director, or Designee	

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F 572	Continued From page 16 residents electronic medical record. The SSD stated she did not enter a notation in the residents electronic medical record indicating the printed copy had been accepted or declined. The facility Resident Rights policy revised 12/16, identified the resident rights were posted throughout the facility and a copy was provided to employees. The policy failed to identify the resident must be informed both orally and in writing in a language that the resident understood, of his/her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility.	F 572		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to correctly code Minimum Data Set (MDS) Section L. Oral/Dental Status to ensure dental issues were addressed in the plan of care for 1 of 1 resident (R12) reviewed for MDS accuracy. Findings include: R12's significant change MDS dated 11/15/23, identified R12 was cognitively intact with diagnoses of end stage renal disease and diabetes. R12's admission MDS dated 9/25/23, and significant change MDS dated 11/15/23, Section	F 641	Immediate Corrective Action:¿¿¿ MDS section L was corrected on 1/25/24, and care plan updated for R12. Corrective Action as it applies to others:¿¿ All resident MDS section L, and resident care plan's will be audited for accuracy, and corrected if inaccurate. Facility nurses who complete comprehensive assessments will be educated on completing them accurately, and care plan policy. Care Plan policy	2/16/24

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F 641	Continued From page 17 L. Oral /Dental Status both indicated R12 did not have any broken, cracked, or chipped teeth, dental pain, or other dental abnormalities. R12's undated, care plan did not include dental concerns or dental interventions related to R12's impaired dental status. The Teeth/Dentures section of R12's admission record dated 9/19/23, indicated R12 had their own teeth with no dentures or partials. The dental section did not identify broken teeth, any dental issues, nor was the unable to assess option selected to indicate R12's teeth were not assessed during admission. During an interview on 1/7/24 at 7:24 p.m., it was noted that R12 was missing several teeth in the front of his mouth. R12 stated they had multiple missing and broken teeth and indicated it hurt when they ate. R12 stated their teeth were like that when they arrived at the facility, and nobody had offered to help them get dental care. During an interview on 1/11/24 at 9:50 a.m., registered nurse (RN)-A stated R12's admission MDS dental section was completed based on data collected from R12's admission assessments. Data gets collected and synthesized into the MDS from multiple areas in the chart, medical history, staff input and at the morning meeting. R12's missing and broken teeth did not get entered into the MDS assessments because they were not identified/documented. During an interview on 1/9/24 at 3:27 p.m., the director of nursing (DON) reviewed R12's dental admission assessment and confirmed the assessment indicated R12 had their own teeth,	F 641	reviewed and still current. Recurrence will be prevented by:¿¿ 5 Residents will be audited weekly x3 weeks, and monthly x2 months to ensure that MDS section L, and resident care plan for dental care is accurate. Audits and findings will be reported to QAPI committee for further recommendations.¿ Corrections will be monitored by:¿ Director of Nursing or designee.	

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F 641	Continued From page 18 but didn't indicate how many or what condition R12's teeth were in. The DON explained resident teeth also get assessed with each comprehensive assessment so subsequent assessments should have identified R12's dental status and triggered the need for dental services.	F 641		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by:	F 657		2/16/24

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F 657	Continued From page 19 Based on observation, interview and document review, the facility failed to provide quarterly care conferences for 1 of 4 residents (R17) reviewed for care planning. Findings include: R17's quarterly Minimum Data Set (MDS) assessment dated 11/3/23, indicated R17 was cognitively intact. Diagnoses included depression, psychotic disorder, and schizophrenia. Review of R17's care conference forms and progress notes identified care conferences were held on 11/8/23, and 2/3/23. There was no other documentation of care conferences for R17. On 1/4/24 at 2:46 p.m., R17 stated there had not been a care conference in 2023, other than 11/23, and "possibly" a second one but she could not recall the date. During an interview on 1/9/24 at 11:26 a.m., licensed practical nurse (LPN)-A stated care conferences were held every quarter while the resident was in the facility. The care conference was needed to discuss the treatment plan for the resident and to ensure the resident's wishes were taken into account when updating the plan of care. During an interview on 1/9/24 at 11:34 a.m., the social services designee (SSD) stated that care conferences were held every 90 days and would be documented on the IDT Care Conference form. A progress note would also be made to show a care conference occurred. The SSD reviewed R17's medical record and stated there would have been two other care conferences	F 657	Immediate Corrective Action:¿¿¿ R17 had a quarterly care conference on 11/8/23, resident has a quarterly care conference scheduled for February 1st, 2024. Corrective Action as it applies to others:¿¿ All residents will be audited for quarterly care conference completion in the last 90 days. If there is a missing care conference, a care conference will be scheduled. Care Planning Policy was reviewed and remains current. Social Service Director will be educated on care planning policy, and care conference frequency. Recurrence will be prevented by:¿¿ 5 Residents will be audited weekly x3 weeks, and monthly x2 months to ensure that quarterly care conference has occurred. Audits and findings will be reported to QAPI committee for further recommendations.¿¿ Corrections will be monitored by:¿ Social Services Director, or Designee	

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F 657	Continued From page 20 between the one on 2/3/23, and the one on 11/3/23 but there was no documentation to indicate they were done, meaning the care conferences must not have occurred. During an interview on 1/11/24 at 11:00 a.m., the administrator stated an expectation that all care conferences would be done every 90 days, when the care plan updates were done. Facility policy Care Planning last revised 11/23, indicated a care plan would be done on admission, quarterly and with any significant change. The care plan would include input and wishes vocalized by the patient. The policy lacked any information related to care conferences.	F 657		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure routine bathing was offered or provided to promote good hygiene for 1 of 5 residents (R5) reviewed for activities of daily living (ADLs) and who was dependent on staff for their cares. Findings include: R5's quarterly Minimum Data Set (MDS) dated 12/29/23, identified R5 was cognitively intact, demonstrated no rejection of care behaviors, and required substantial assistance with ADL's	F 677	Immediate Corrective Action:¿¿¿ R5 had a shower completed on 1/10 when issue was identified. Corrective Action as it applies to others:¿¿ All residents bath's will be audited to determine if they have been offered their bath per their bathing schedule, and corrected if they have not.	2/16/24

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THE EMERALDS AT GRAND RAPIDS LLC	2801 SOUTH HIGHWAY 169 GRAND RAPIDS, MN 55744

(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 677	Continued From page 21 including showering/bathing, and transfers. R5's care plan, revision date 12/21/23, identified R5 would be dressed, groomed, and bathed per facility policy and would accept assistance with self cares. The plan identified R5 required assistance with personal hygiene, showering/bathing and transfers. However, the plan lacked any evidence for when or how (i.e., frequency, type) R5's bathing would be completed; nor did the plan outline any refusal of care behaviors. On 1/7/23 at 2:27 p.m., R5 stated she was scheduled for baths twice weekly on Tuesday and Friday. On 1/9/24 at 3:39 p.m., R5 stated her hair felt greasy, itchy and gross. Was supposed to have a shower twice weekly and it bothered her when she didn't get it. R5 stated she had asked but as of yet, had not received her scheduled morning shower and had not received a shower for at least 10 days. R5's hair had dried white flakes on the hair follicles at the base of the hair. R5's hair was pulled into a single braid, was shiny/wet and looked as if it hadn't been washed in several days. On 1/10/24 at 8:39 a.m., R5 was seated in her wheelchair in her room with her hair pulled back into a braid. R5's hair was shiny/wet looking. R5 stated she hadn't received her scheduled shower yesterday. On 1/10/24 at 9:09 a.m., nursing assistant (NA)-A stated when working as a float she helped transfer and shower the heavy lift residents. There was a binder with a list of names/days for	F 677	Activities of Daily Living Policy was reviewed and remains current. Nurses, TMA's, CNA's will be educated on Activities of Daily Living Policy as it relates to bath completion. Recurrence will be prevented by:¿¿ Audits will be conducted weekly x3 weeks, and monthly x2 months on baths to audit bath completion. Audits and findings will be reported to QAPI committee for further recommendations.¿¿ Corrections will be monitored by:¿ Director of Nursing or Designee	

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F 677	Continued From page 22 showers for the day and staff would also communicate who needed a shower. NA-A stated R5 needed assistance with ADL's including personal cares and bathing but was uncertain when R5 was scheduled for a shower. NA-A stated R5 was not on her shower list and she was not told that R5 needed a shower that day. On 1/10/24 at 9:11 a.m., NA-B stated the resident bath book identified residents, when and the frequency of showers/baths per week. If the resident needed a bath it would be documented as "D" for days or "E" for evenings in their date/name column. When the staff completed the residents bath they would highlight the date and write "done" in the square. The staff also completed a bath sheet to give to the nurse. NA-B stated the bath sheet was a form to communicate to the nurses when the residents bath was completed. The facility Wing 3 - bath aide baths list, undated, identified a bathing schedule with each resident assigned to days of the week and corresponding shift (i.e. day or evening). The list identified R5 was scheduled for twice weekly baths on Tuesday and Friday day shift. R5's POC (Point of Care) Response History, undated, outlined a series of questions which could be answered via electronic charting to demonstrate bathing completed for R5. The report included a look-back period of 30 days (i.e., 12/12/23 to 1/9/24), however, there was no evidence R5 had bathing offered, or completed, from 1/3/24 through 1/9/24, and all data fields were answered, "Not Applicable." R5's medical record, including progress notes,	F 677		

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F 677	Continued From page 23 were reviewed. There was no evidence R5 had been offered, refused, or provided any bathing episodes within the past several weeks. On 1/10/24 at 12:45 p.m., licensed practical nurse (LPN)-B stated the nurses are verbally notified after the NA's complete a shower/bath and are also provided the resident bath sheet. The bath sheet is an indicator that the residents needed a skin assessment. The nurse entered the information into the computer and sent the worksheet for scanning into the computer. LPN-B stated R5 is scheduled for baths on Tuesday's and Friday's but unfortunately did not work this past Tuesday and was uncertain if R5 received her shower. On 1/10/24 at 1:12 p.m., the director of nursing (DON) stated staff were to document on the skin inspection assessment and write a progress note if a resident declined their shower/bath. In the mornings, staff also discussed who refused and/or who needed a shower. The DON stated there was no documented skin inspection assessments for R5 since 1/2/24 which would lead her to believe R5 had not had a shower since 1/2/24. The facility policies including bathing/shower ad ADL's were requested and not received.	F 677		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure	F 684		2/16/24

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F 684	Continued From page 24 that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to appropriately position 1 of 3 residents (R24) reviewed for pressure ulcers. Findings include: R24's quarterly Minimum Data Set (MDS) dated 12/1/23, identified R24 had diagnoses that included enterocolitis due to Clostridium difficile (C. diff), quadriplegia (severe form of paralysis that affects all four limbs and the torso), acute respiratory failure with hypoxia (an absence of enough oxygen in the tissues to sustain bodily functions), chronic heart failure (condition in which the heart doesn't pump blood as well as it should), Methicillin resistant Staphylococcus aureus (MRSA) infection, and had a colostomy (opening in the large intestine to facilitate removal of feces from the body). R24's MDS further identified he was cognitively intact, required extensive assistance with activities of daily living (ADLs), and was at risk for pressure ulcers. R24's current physician order report undated, did not include the use of any adaptive equipment to ensure R24's legs remained in his wheelchair. R24's care plan dated 12/6/23, identified staff needed to monitor R24's skin integrity daily during cares and weekly skin inspections done by nurse. R24's care plan further identified the use of a pressure redistribution mattress and a pressure	F 684	Immediate Corrective Action: R24 has therapy order to assess resident feet for falling off wheelchair. Corrective Action as it applies to others: All residents will be audited for appropriate positioning to identify residents at risk for not being positioned properly. Residents identified at risk will be referred to therapy for appropriate positioning and devices. Safe Resident Handling Program and Skin Assessment & Wound Management Program reviewed and remains current. Nurses, TMA's, NAR's and therapy will be educated in regard to proper positioning of residents. Recurrence will be prevented by: Audits will be conducted weekly x3 weeks, and monthly x2 months on proper positioning and positioning devices. Audits and findings will be reported to QAPI committee for further recommendations. Corrections will be monitored by: Director of Nursing or Designee	

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F 684	Continued From page 25 reduction cushion to R24's wheelchair. R24's care plan did not identify the use of gait belt for positioning of lower extremities. During continuous observation on 1/9/24, from 1:14 p.m. to 4:12 p.m., the following was observed: -at 1:14 p.m., R24 was in his room, sitting in wheelchair and watching television (TV). R24 had a gait belt around his legs below his knees. -at 1:34 p.m., R24 was in his room, sitting in wheelchair. R24 continued to watch TV. R24 had a gait belt around his legs below his knees. -at 1:45 p.m., R24 continued to be in his room. R24 was sitting in wheelchair watching TV. R24 had a gait belt around his legs below his knees. -at 1:57 p.m., R24 went to community bathroom to shave with electric razor. R24 was in his wheelchair and had a gait belt around his legs below his knees. -at 2:15 p.m., R24 finished shaving and went back to his room. R24 was sitting in wheelchair and watching TV. R24 had a gait belt around his legs below his knees. -at 2:40 p.m., R24 was in his room, sitting in his wheelchair. R24 had a gait belt around his legs below his knees. -at 2:53 p.m., R24 was in his room sitting in wheelchair. R24 had a gait belt around his legs below his knees. -at 3:07 p.m., R24 was in his room, sitting in	F 684		

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F 684	Continued From page 26 wheelchair, and watching TV. R24 had a gait belt around his legs below his knees. -at 3:35 p.m., R24 was in his room sitting in wheelchair. R24 watching TV. R24 had a gait belt around his legs below his knees. -at 3:55 p.m., R24 was in his room, sitting in wheelchair. R24 continued to watch TV. R24 had a gait belt around his legs below his knees. -at 4:12 p.m., licensed practical nurse (LPN)-A was asked to check on R24's skin. LPN-A entered R24's room. R24 stated the gait belt was his idea to keep his legs from falling to the side and off of the wheelchair. R24 further reported the gait belt had been used this way for three days. LPN-A removed the gait belt and examined R24's skin. LPN-A noted there were visible indentations but no redness and no open areas on R24's legs. LPN-A confirmed "staff should be checking the area for redness every two hours." LPN-A further explained R24 had "fragile skin that just doesn't heal." During an interview on 1/10/24 at 10:21 a.m., occupational therapist (OT)-E stated he was not aware of the gait belt being used for positioning on R24's legs. OT-E confirmed gait belt was appropriate for transfers, but not appropriate to use to keep R24's legs on wheelchair. OT-E confirmed the gait belt should not be used in this way and there were no orders for the gait belt to be used for positioning R24's legs. OT-E further confirmed this was a positioning concern and use of the gait belt on R24's legs could start a new problem with skin breakdown. OT-E would expect nursing staff to tell OT there was a positioning concern for R24 and would expect nursing staff to	F 684		

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F 684	Continued From page 27 request a re-evaluation. During an interview on 1/11/24 at 8:24 a.m., director of nursing (DON) confirmed a gait belt should not be used for positioning R24's legs. DON stated R24 should have received education about risks and benefits of using a gait belt for his legs. DON further stated expectation for staff to report R24's request to use gait belt on his legs to the charge nurse and to the DON. DON confirmed the risk of adverse event to R24's use of the gait belt as it could cause circulation problems and/or cause more skin breakdown. Safe Resident Handling Program policy dated 3/2020, indicated "All resident care will be provided in a safe, appropriate, and timely manner in accordance with the individual resident's care plan." Skin Assessment & Wound Management policy dated 11/17/2023, indicated "Staff will perform routine skin inspections (with daily care). Nurses are to be notified if skin changes are identified. A weekly skin inspection will be completed by licensed staff."	F 684		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced	F 689		2/16/24

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F 689	Continued From page 28 by: Based on observation, interview and document review, the facility failed to follow care plan interventions for 1 of 2 residents (R33) reviewed for smoking. Findings include: R33's quarterly Minimum Data Set (MDS) dated 12/28/23, identified R33's diagnoses included spastic quadriplegic cerebral palsy (condition that affects movement and posture), dysphagia (condition with difficulty in swallowing food or liquid), emphysema (lung disease which results in shortness of breath), abnormal involuntary movements, and speech disturbances. In addition, R33's MDS identified him as cognitively intact and required total staff assistance for all activities of daily living (ADLs). R33's care plan dated 10/18/23, identified R33 was at risk for accidents related to safe smoking and required extensive staff assistance to smoke. R33's interventions included: -wearing a smoking apron -staff directed to assist resident by placing cigarette in resident's mouth using an extension holder -staff to light cigarette -staff to supervise resident smoking -staff to safely dispose of cigarette when resident was finished smoking R33's smoking assessment dated 12/27/23, included directions to staff to assist resident smoking by placing a smoking apron on resident, and to hold cigarette with an extension holder and light cigarette. Staff to remain with resident to supervise smoking. Staff to ash cigarette and	F 689	Immediate Corrective Action:¿¿¿ Nurses, TMA's, CNA's, and Therapeutic Recreation staff members educated on Resident Smoking Policy, and R33 Care plan for smoking. Corrective Action as it applies to others:¿¿ Current residents that smoke will have care plan reviewed for smoking interventions, and will audit current smokers to determine if staff members are following policy. Resident Smoking Policy, and EGR Smoking policy were reviewed and remain current. Nurses, TMA's, CNA's, and Therapeutic Recreation staff members will be educated on Resident Smoking Policy, and EGR Smoking Policy in regards to following care plan for smoking residents. Recurrence will be prevented by:¿¿ Audits will be conducted weekly x3 weeks, and monthly x2 months on 5 smokers to ensure smoking care plan is followed. Audits and findings will be reported to QAPI committee for further recommendations.¿¿ Corrections will be monitored by:¿ Director of Nursing or Designee	

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F 689	Continued From page 29 dispose of the cigarette safely when resident was finished smoking. On 1/07/24 at 7:15 p.m., an unidentified staff brought R33 outside to smoke. R33 was dressed in regular clothing. R33 had a blanket covering his body but was not covered with a smoking apron. Unidentified staff placed a cigarette in R33's mouth, no smoking extender was used. Unidentified staff lit the cigarette. Unidentified staff remained outside with R33 for the entire time. R33 finished cigarette and unidentified staff disposed of cigarette. On 1/10/24 at 10:01 a.m., R33 was outside smoking with activities aide (AA)-B. AA-B placed smoking apron on R33 over his blanket once outside. R33 dressed in sweatshirt with arms under smoking apron. AA-B put cigarette directly R33's mouth, and lit cigarette for him. AA-B ashed cigarette for resident. AA-B disposed of cigarette when R33 was finished smoking. During interview on 1/10/24 at 10:10 a.m., AA-B stated that smoking apron was kept in R33's wheelchair or in resident's backpack. Smoking apron was tucked under right armrest of chair and was supposed to be worn every time for safety. AA-B explained reason for smoking apron, R33 can't control his arms so if the cigarette fell it would be dangerous. During interview on 1/10/24 at 2:38 p.m., director of nursing (DON) stated that care plan for R33 instructed staff to put smoking apron on resident. DON further stated her expectation was for staff follow care plan, and for R33 to have smoking apron on all the time when smoking as it was a safety hazard. Smoking apron was used to	F 689		

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F 689	Continued From page 30 prevent burns on resident. Resident Smoking Policy dated 10/2022, identified the following, "All residents who smoke will be evaluated for the need of adaptive equipment." Policy further stated, "Residents requiring supervision will receive assistance with smoking, in accordance with facility and resident specific practices as identified on the individual resident care plans." Resident Smoking Agreement undated, identified, "Residents must follow the guidelines outlined in smoking assessment to ensure smoking safety. Interventions could include, but are not limited to the following: Smoking Smock, Assistive cigarette holder, Staff Supervision, Cigarettes locked at nurses' station."	F 689		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure tracheostomy cares were followed for 1 of 1 resident (R31) reviewed for tracheostomy (an opening in the trachea [windpipe] from the outside to allow air and oxygen to reach the lungs) care. In addition,	F 695	Immediate Corrective Action:¿¿¿ R31 had trach cares completed, and tubing changed. Corrective Action as it applies to	2/16/24

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F 695	Continued From page 31 the facility failed to ensure oxygen use parameters were followed and oxygen tubing was changed in a timely manner for 1 of 2 residents (R31) reviewed for respiratory care. Findings include: R31's quarterly Minimum Data Set (MDS) dated 12/15/23, identified R31 had diagnoses which included chronic respiratory failure with hypoxia (an absence of enough oxygen in the tissues to sustain bodily functions), dependence on respirator (ventilator) status, diabetes mellitus, and anxiety. R31's MDS also identified he was cognitively intact and he received oxygen therapy, suctioning, tracheostomy care, and non-invasive mechanical ventilator. R31's care plan dated 12/56/23, identified R31 had a tracheostomy with a goal of having no signs or symptoms of infection. Interventions included: -resident exhibits new behaviors with q-tips and trach cleaning supplies, resident had history of putting trach cleaning supplies in and around trach and stoma -monitor/document level of consciousness, mental status, and lethargy as needed -monitor/document respiratory rate, depth and quality. Check and document every shift as ordered -provide good oral care daily and as needed -suction as needed -ensure that trach ties are secured at all times R31's Order Listing Report identified the following:	F 695	others:¿¿ Residents with tracheostomy will be audited for tracheostomy care completion, and tubing replacement date. Tracheostomy Care, and Oxygen Administration policy reviewed and remains current. Nurses will be educated on Tracheostomy Care policy, and Oxygen Administration policy in regards to completed cares, and oxygen tubing replacement. Date of Compliance:¿ 2/16/24 Recurrence will be prevented by:¿¿ Audits will be conducted weekly x3 weeks, and monthly x2 months, on residents receiving tracheostomy care for care completion, and tubing changes. Audits and findings will be reported to QAPI committee for further recommendations.¿¿ Corrections will be monitored by:¿ Director of Nursing or Designee	

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F 695	Continued From page 32 3/26/23, change oxygen tubing weekly, mark with the date, wipe down concentrator, wash filter with soap and water, pat dry 3/14/21, change nebulizer kits and wipe off machine weekly 3/15/21, nurse to brush teeth twice daily 3/19/21, oxygen at five liter per minute via tracheostomy dome every shift 4/10/21, suction every morning during trach cares, document any refusals 3/14/21, change blue corrugated tubing trach mask/venturi tubing, and clean humidifier every week 3/9/21, cleanse trach site with normal saline, pat dry; apply split trach gauze twice daily every day and evening shift 3/16/21, Trilogy (non-invasive ventilator) one time daily, document any refusals in progress note. Re-approach if not ready to go to sleep yet. Place earlier if falling asleep. R31's documentation from the electronic medication and treatment record for January 2024: -oxygen tubing change, missing documention on 1/7/24 -suction every morning during trach cares, missing documentation on 1/6/24, 1/7/24, 1/8/24, 1/9/24 -change blue corrugated tubing, trach mask/venturi and tubing, and clean humidifier,	F 695		

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F 695	Continued From page 33 missing documentation on 1/7/24 -Trilogy one time daily, document any refusals, missing documentation on 1/1/24, 1/2/24 -oral care nurse to brush teeth twice daily missing missing documention on 1/1/24 evening, 1/8/24 morning and evening -tracheostomy care missing documention on evening 1/1/24, morning and evening on 1/8/24 -oxygen at five liters per minute every shift missing documentation on evenings and nights on 1/1/24, days on 1/3/24, and 1/6/23, days and evenings on 1/8/24, days on 1/8/24 R31's documentation from the electronic medication and treatment record for December 2023: -oxygen tubing change, missing documention on 12/3/23, 12/10/23, 12/17/23, 12/24/23 -change nebulizer kits and wipe off machine weekly, missing documention on 12/3/23, 12/17/23, 12/24/23 -suction every morning during trach cares, missing documentation on 12/2/23, 12/3/23, 12/13/23, 12/15/23, 12/17/23, 12/19/23, 12/24/23 -change blue corrugated tubing, trach mask/venturi and tubing, and clean humidifier, missing documentation on 12/3/23, 12/17/23, 12/31/23 -Trilogy one time daily, document any refusals, missing documentation on 12/1/23, 12/2/23, 12/9/23, 12/17/23, -oral care nurse to brush teeth twice daily missing missing documention on 12/1/23 evening, 12/2/23 morning, 12/3/23 morning and evening, 12/9/23 evening, 12/10/23 evening, 12/11/23 evening, 12/13/23 morning, 12/17/23 morning and evening, 12/28/23 evening, 12/30/23 evening, 12/31/23 evening	F 695		

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F 695	Continued From page 34 -tracheostomy care, missing documention on 12/1/23 evening, 12/2/23 morning, 12/3/23 morning and evening, 12/9/23 evening, 12/10/23 evening, 12/11/23 evening, 12/13/23 morning, 12/15/23 morning, 12/16/23 morning, 12/17/23 morning and evening, 12/28/23 evening, 12/29/23 morning, 12/30/23 morning, 12/31/23 morning and evening -oxygen at five liters per minute every shift, missing documentation on 12/1/23 evening and nights, 12/2/23 days, 12/3/23 days and evenings, 12/9/23 evenings, 12/10/23 evenings, 12/11/23 evenings, 12/12/23 days, 12/13/23 days, 12/15/23 days, 12/16/23 days and nights, 12/17/23 days and evenings, 12/19/23 days, 12/24/23 days, 12/30/23 days and evenings, 12/31/23 days, evenings, and nights R31's progress notes were reviewed from 12/1/23-1/10/24, and revealed the following: 1/10/24 at 2:32 p.m., refused multiple attempts for trach care 12/28/23 at 6:24 a.m., refused suctioning 12/14/23 at 8:30 a.m., refused suctioning During an interview on 1/8/23 at 9:37 a.m., R31 stated staff completed trach care maybe weekly, suctioned him rarely, and oxygen tubing had been changed the day before but before that stated it had been weeks. R31's Trilogy machine humidifier was dated 11/5/23, he stated he used it maybe one to two times a week. During an interview on 1/10/24 at 12:44 p.m., R31 stated he had not had any trach cares completed that day and none the day before. R31 stated he had not been asked if/when he wanted his trach cares completed.	F 695		

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F 695	Continued From page 35 During an interview on 1/10/24 at 2:15 p.m., the director of nursing (DON) stated she would expect trach cares to be completed as ordered and documented in the medical record. The DON stated she would expect tubing changes, equipment maintenance to be completed as ordered to prevent infection which was a particular concern when a resident had a tracheostomy. The DON verified the Trilogy humidifier was dated 11/5/23. The DON reviewed R31's medication and treatment record and verified there was missing documentation for trach care, suctioning, oral care, and tubing changes. During an interview on 1/10/23 at 2:34 p.m., licsensed practical nurse (LPN)-B stated R31 often refused care and stated he had refused trach cares that day and then documented the refusal in the record. During an interview on 1/10/24 at 2:45 p.m., R31 stated he had not been offered trach cares and LPN-B usually did not do any trach cares or offer to complete them. Oxygen Administration dated 10/2010, did not address the frequency of tubing changes. Tracheostomy Care dated 3/18/21, identified trach care should be performed as ordered by the provider.	F 695		
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who	F 698		2/16/24

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F 698	Continued From page 36 require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure dialysis assessments and treatments were completed as ordered and documented per policy for 2 of 2 residents (R43 and R12) reviewed for dialysis care. Findings include: R43: R43's significant change Minimum Data Set (MDS) dated 11/25/23, indicated R43 was cognitively intact, and diagnoses included diabetes and end stage renal disease. R43 currently received dialysis. R43's care plan dated 1/11/24, informed staff R43 was at risk for complications related to dialysis and the interventions instructed staff to call 911 for uncontrolled bleeding, and provide treatment and dressing per protocol. R43's Order Summary dated 1/11/24, included the following orders: modified renal diet, check blood glucose before meals, complete dialysis communication Tuesday, Wednesday, and Saturday (Tue-Thu-Sat), dialysis Tue-Thu-Sat remember to send a snack, daily weight, dialysis vital signs one time a day after dialysis, and monitor dialysis site for bleeding. R43's Treatment Administration Record (TAR)	F 698	Immediate Corrective Action:¿¿¿ Hemodialysis policy was reviewed and remains current. Nurse's will be educated on Hemodialysis policy, and completing vital signs, and assessment of access site, and dialysis communication tool. Corrective Action as it applies to others:¿¿ All residents receiving dialysis will be audited to determine if vital signs, assessment of access site, and dialysis communication tool are being completed. Hemodialysis policy was reviewed and remains current. Nurse's will be educated on Hemodialysis policy, and completing vital signs, and assessment of access site, and dialysis communication tool. Recurrence will be prevented by:¿¿ Audits will be conducted weekly x3 weeks, and monthly x2 months for residents receiving dialysis care to audit vital signs, assessment of access site, and dialysis communication tool completion. Audits and findings will be reported to QAPI committee for further recommendations.¿¿	

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F 698	Continued From page 37 Summary documents for the following months identified the provider ordered assessments were not completed or documented in the electronic record: October 2023: -2 sets of post dialysis vital signs were not documented. -3 shifts did not document R43's site had been monitored for bleeding. November 2023: -5 daily weights were not documented. -2 sets of post dialysis vital signs were not documented. -16 shifts did not document R43's site had been monitored for bleeding. December 2023: -13 daily weights were not documented. -4 sets of post dialysis vital signs were not documented. -12 shifts did not document R43's site had been monitored for bleeding. January between the dates of 1/1/2024 and 1/10/2024: -5 daily weights were not documented. -1 set of post dialysis vital signs were not documented. -3 shifts did not document R43's site had been monitored for bleeding. During an interview on 1/7/24 at 7:01 p.m., R43 stated they had dialysis on Tuesday, Thursday, and Saturday and nobody at the facility would ever take their blood pressure before or after dialysis, or looked at their access.	F 698	Corrections will be monitored by:¿ Director of Nursing or Designee	

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F 698	Continued From page 38 During an interview on 1/8/24 at 3:54 p.m., R43 stated they left for dialysis at 5:30 a.m. on dialysis days. They had breakfast before they left and when they got back, they would go to their room and have lunch and rest. R43 stated the nurses did not look at their access site when they got back from dialysis. During a follow up interview on 1/10/24 at 8:46 a.m., R43 stated yesterday they got back from dialysis early because their blood pressure went so low the dialysis nurses stopped their run. R43 reported when they got back to the facility yesterday, nobody checked their access dressing or blood pressure, but they thought that was probably because the dialysis facility nurses took care of everything. R43 stated they didn't get a snack sent with them to dialysis, but that was okay because they could get a protein cookie at dialysis. R12: R12's significant change Minimum Data Set (MDS) dated 11/15/23, identified R12 was cognitively intact with diagnoses of end stage renal disease and diabetes. R12 currently received dialysis. R12's care plan dated 1/10/24, informed staff R12 was at risk for complications related to dialysis and the interventions instructed staff to call 911 for uncontrolled bleeding, follow treatment and dressing protocol, and follow fluid restriction. R12's Order Summary dated 1/11/24, identified the following: blood glucose before meals and at bedtime, complete dialysis communication form and send with resident to dialysis every	F 698		

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F 698	Continued From page 39 Tue-Thu-Sat, dialysis Tue-Thu-Sat - remember to send a snack, daily weight, monitor fistula for bruit and thrill every shift, vital signs in the evening after dialysis, monitor dialysis site for bleeding, and fluid restriction. R12's treatment Administration Record Summary documents for the following months identified the following provider ordered assessments were not completed or documented in the electronic record: October 2023: -4 sets of post dialysis vital signs were not documented. -1 daily weight was not documented. -3 shifts did not document R12's site had been monitored for bleeding. -9 shifts did not document an assessment of R12's fistula for bruit and thrill. November 2023: -3 daily weights were not documented. -6 sets of post dialysis vital signs were not documented. -23 shifts did not document an assessment of R12's fistula for bruit and thrill. -16 shifts did not document R12's site had been monitored for bleeding. December 2023: -17 daily weights were not documented. -5 sets of post dialysis vital signs were not documented. -9 shifts did not document R12's site had been monitored for bleeding. -21 shifts did not document an assessment of R12's fistula for bruit and thrill.	F 698		

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F 698	Continued From page 40 January, between 1/1/2024, and 1/10/2024: -5 daily weights were not documented. -1 set of post dialysis vital signs were not documented. -1 shift did not document R12's site had been monitored for bleeding. -4 shifts did not document an assessment of R12's fistula for bruit and thrill. R12's Dialysis Communication Tool dated 12/2/23, had documented vital signs in the facility completed portion of the form that were identical to the post dialysis vitals signs documented in R12's TAR in the medical record. The 1/2/24, facility post dialysis vitals signs documented in R12's TAR were identical to the pre-dialysis vital signs documented in the dialysis team section of the Dialysis Communication Tool dated 1/2/24. During an interview on 1/7/24 at 7:25 p.m., R12 stated nobody at the facility looked at their dialysis access site. During a follow-up interview on 1/10/24 at 8:51a.m., R12 stated nobody had checked their dialysis site after they returned from dialysis yesterday. "They don't do that here." During an interview on 1/11/24 at 9:15 a.m., licensed practical nurse (LPN)-B stated as part of their routine, they checked R43's site for bleeding and R12's site for bleeding and thrill at the same time they completed pre-lunch blood sugars. LPN-B stated nurses used the vital signs from the dialysis communication tool to document post dialysis vital signs in the TAR, but if a resident was off, then nurses would do a set of vital signs and document them in the TAR.	F 698		

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F 698	Continued From page 41 During an interview on 1/11/24 at 10:16 a.m., LPN-A stated when a resident returns from dialysis their access site should be assessed and a set of vital signs including a blood pressure should be done and documented. The assessment needed to be done to make sure the resident was stable post dialysis. During an interview on 1/11/24 at 11:46 a.m., the director of nursing DON stated it was an expectation for residents to be assessed when they returned from dialysis. Both vital signs and an assessment of the access site should be completed to ensure the resident was not having post dialysis complications. Dialysis orders need to be followed. The facility policy Hemodialysis dated 11/22/19, included the following: If run information is not received with the resident upon return, staff will call the dialysis unit and obtain run information. "Documentation requirements should include, but is not limited to, pre and post dialysis assessment/observation, daily check of the access site, evaluation for infection, and fluid intake amounts for each shift, fluid restriction in place." Dialysis Communication Tools were requested for both R43 and R12. Only three were received for R43 and four for R12.	F 698		
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.	F 756		2/16/24

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F 756	Continued From page 42 §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 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 the consultant pharmacist recommendations were addressed for 1 of 5 residents (R31) reviewed for unnecessary	F 756	Immediate Corrective Action:¿¿¿ R31 Pharmacy Recommendation was addressed by physician.	

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F 756	Continued From page 43 medications. Findings include: R31's quarterly Minimum Data Set (MDS) dated 12/15/23, indicated R31's diagnoses included type 2 diabetes mellitus, anxiety disorder, morbid obesity. R31 had intact cognition, independent with most activities of daily living (ADLs) needed assistance with toileting hygiene. R31's care plan dated 12/7/23, directed staff to "monitor for skin breakdown for signs/symptoms of infection. Report signs/symptoms to medical doctor (MD)." Care plan further directed staff to "document on skin condition and keep MD informed of changes." R31's Order Listing Report identified the following: 10/25/23, miconazole nitrate powder 2% (medication for itching) apply to itching or other topically as needed for stasis dermatitis (condition of skin changes due to insufficient blood return). A Consultant Pharmacist Communication to the provider dated 9/7/23, requested frequency on medication order for miconazole nitrate powder 2%. R31's medical record did not have documentation of a response from provider. On 1/11/24 at 08:20 a.m., the director of nursing (DON) stated 30 days was a reasonable timeframe to receive a response from the provider regarding consultant pharmacist communication. DON stated she would expect staff to follow up with provider regarding on how often a medication should be used.	F 756	Corrective Action as it applies to others:¿¿ Outstanding pharmacy recommendations will be audited, and providers reached out to if more than 30 days without a response. Medication Regimen Review policy was reviewed and remains current. Director of Nursing will be educated on Medication Regimen Review policy and follow-up for Pharmacy Recommendation if not received back in 30 days. Recurrence will be prevented by:¿¿ Audits will be conducted weekly x3 weeks, and monthly x2 months on pharmacy recommendations and provider response. If there is no response from providers after 30 days, facility will follow up with provider. Audits and findings will be reported to QAPI committee for further recommendations.¿Audits and findings will be reported to QAPI committee for further recommendations.¿¿ Corrections will be monitored by:¿ Director of Nursing or Designee	

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F 756	Continued From page 44 On 1/11/24 at 11:00 a.m., consulting pharmacist (CP)-D stated she would expect a response from provider within 30 days. CP-D would then follow up at 60 days if there was no response from provider. CP-D verified due to lack of provider response the medication order for R31's miconazole nitrate powder 2% was not an acceptable order. CP-D verified the frequency of medication was important to have to prevent misuse of medication and to ensure proper medication administration. Medication Regimen Reviews (MRR) policy dated 5/2019, identified "The goal of the MRR is to promote positive outcomes while minimizing adverse consequences and potential risks associated with medication." Policy further identified "The MRR involves a thorough review of the resident's medical record to prevent, identify, report and resolve medication related problems, medication errors and other irregularities, for example: ... incorrect medications, administration times or dosage forms; or other medication errors, including those related to documentation."	F 756		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals	F 761		2/16/24

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F 761	Continued From page 45 §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure medications were dated when opened in 3 of 3 med carts reviewed for medication storage. This had the opportunity to affect five residents (R51, R46, R14, R35, R6). Findings include: During an observation on 1/11/24 at 11:10a.m., of the wing 100 medication cart revealed R51's Timolol eye drops were opened without being labeled with the date opened. During an observation on 1/11/23 at 11:18 a.m., of the wing 300 medication cart revealed R46's Derm Otic Oil (ear drops) were opened without being labeled with the date opened. R14's inhaler was opened without being labeled with the date it was opened. During an observation on 1/11/24 at 11:27a.m., of the wing 200 medication cart revealed R35's	F 761	Immediate Corrective Action:¿¿¿ R51, R46, R14, R35, and R6 open medications have been replaced, and dated. Corrective Action as it applies to others:¿¿ Med carts will be audited to ensure open medications have been dated. Storage of Medication policy was reviewed and remains current. Nurse's and TMA's will be educated on Storage of Medication policy and dating medications that are opened. Recurrence will be prevented by:¿¿ Audits will be conducted weekly x3 weeks,	

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F 761	Continued From page 46 Incruse Ellipta inhaler and R6's Refresh eye drops were labeled without being labeled with the date they were opened. During an interview on 1/11/24 at 11:32 a.m., the director of nursing (DON) stated medications should be labeled with the date they were opened to ensure the medication is safe and effective for the residents. A facility document Storage of Medications policy dated 11/2020, directed the facility strores all drugs and biological's in a safe, secure, and orderly manner. Drugs containers that have missing, incomplete, improper, or incorrect labels are returned to the pharmacy for proper labeling before storing.	F 761	and monthly x2 months on medication carts to identify opened medications have been dated. Audits and findings will be reported to QAPI committee for further recommendations.¿¿ Corrections will be monitored by:¿ Director of Nursing or Designee	
F 790 SS=D	Routine/Emergency Dental Srvcs in SNFs CFR(s): 483.55(a)(1)-(5) §483.55 Dental services. The facility must assist residents in obtaining routine and 24-hour emergency dental care. §483.55(a) Skilled Nursing Facilities A facility- §483.55(a)(1) Must provide or obtain from an outside resource, in accordance with with §483.70(g) of this part, routine and emergency dental services to meet the needs of each resident; §483.55(a)(2) May charge a Medicare resident an additional amount for routine and emergency dental services; §483.55(a)(3) Must have a policy identifying those	F 790		2/16/24

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F 790	Continued From page 47 circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; §483.55(a)(4) Must if necessary or if requested, assist the resident; (i) In making appointments; and (ii) By arranging for transportation to and from the dental services location; and §483.55(a)(5) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay. This REQUIREMENT is not met as evidenced by: Based on interview, observation, and document review, the facility failed to coordinate necessary dental services for 1 of 1 resident (R12) reviewed for dental services. Findings include: R12's significant change Minimum Data Set (MDS) dated 11/15/23, identified R12 was cognitively intact with diagnoses of end stage renal disease and diabetes. Section GG0130. Self-Care letter I. indicated R12 required assistance to perform oral hygiene. R12's admission MDS dated 9/25/23, and significant change MDS dated 11/15/23, Section L. Oral /Dental Status both indicated R12 did not	F 790	Immediate Corrective Action:¿¿¿ Dental services have been coordinated for R12. Corrective Action as it applies to others:¿¿ All residents will be audited to identify if dental services have been offered to residents. If they have not services will be offered. Dental Services policy was reviewed and remains current. Nursing management team, and Health Information Management will be educated on offering	

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F 790	Continued From page 48 have any broken, cracked, or chipped teeth, dental pain, or other dental abnormalities. R12's undated, care plan focus areas identified potential for altered nutrition and self-care deficit related to weakness, but did not include dental concerns or dental interventions related to R12's impaired dental status. During an interview on 1/7/24 at 7:24 p.m., it was noted that R12 was missing several teeth in the front of his mouth. R12 stated they had multiple missing and broken teeth and indicated it hurt when they ate. R12 stated their teeth were like that when they arrived at the facility, and nobody had offered to help them get dental care. During an interview on 1/11/24 at 9:50 a.m., registered nurse (RN)-A stated R12's admission MDS dental section was completed based on data collected from R12's admission assessments. During an interview on 1/9/24 at 3:27p.m., the director of nursing (DON) reviewed R12's dental admission assessment and confirmed the assessment indicated R12 had their own teeth, but didn't indicate how many or what condition R12's teeth were in. The DON confirmed if R12's dental assessment had identified R12's broken teeth, R12 would have been offered dental services at admission. The DON explained resident teeth also get assessed with each comprehensive assessment so subsequent assessments should have identified R12's dental status and triggered the need for dental services. Based on the condition of R12 's teeth, R12 should have been offered dental services.	F 790	dental services to residents, and dental services policy. Recurrence will be prevented by:¿¿ Audits will be conducted weekly x3 weeks, and monthly x2 months on new admissions to determine if dental services have been offered and coordinated for residents. Audits and findings will be reported to QAPI committee for further recommendations.¿¿ Corrections will be monitored by:¿ Director of Nursing or Designee	

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F 790	Continued From page 49 Facility Policy Dental Services dated 12/2016, identified routine and emergency dental services would be available and provided to residents in accordance with resident assessment and plan of care.	F 790		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;	F 880		2/16/24

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F 880	Continued From page 50 (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §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 proper hand hygiene and glove use practices were maintained for 1 of 3 residents (R24) observed during wound	F 880	Immediate Corrective Action:¿¿¿ R24, is no longer a resident at the facility.	

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F 880	Continued From page 51 care. Findings include: R24's quarterly Minimum Data Set (MDS) dated 12/1/23, identified R24's diagnoses included enterocolitis due to clostridium difficile (inflammation of the colon caused by bacteria Clostridium difficile, it can cause severe damage to the colon and can even be fatal), depression, colostomy status (an opening from the colon or large intestine through the abdomen), and quadriplegia (paralysis that affects all a person's limbs and body from the neck down). In addition, R24's MDS identified R24 was cognitively intact and required assistance with activities of daily living. R24's MDS further identified he was at risk for pressure ulcers and had one stage two, three stage four, and one unstageable pressure ulcer(s). R24's care plan dated 12/19/23, identified R24 had a current infection extended-spectrum beta-lactamase, an enzyme which is resistant to most beta-lactam antibiotics (ESBL) and pseudomonas (a type of germ that can cause infections in humans) ischial wound. Interventions included wound care as ordered, isolation precautions per protocol. R24's care plan dated 11/30/23, identified R24 had an alteration in skin integrity (right ankle, left ankle, left plantar foot, left great toe, right lateral foot, right ischium, and left Achilles). Interventions included to monitor skin daily during cares, weekly skin inspection by nurse weekly, treatment to open areas per orders, monitor for signs and symptoms of infection and report any infections to provider. R24's Order Summary Report identified the	F 880	Corrective Action as it applies to others:¿¿ This deficient practice has the potential to affect all residents Handwashing/Hand Hygiene policy was reviewed and remains current. All staff will be educated on hand washing and hand hygiene policy. Recurrence will be prevented by:¿¿ Audits will be conducted weekly x3 weeks, and monthly x2 months on 5 residents receiving wound care to audit hand hygiene. Audits and findings will be reported to QAPI committee for further recommendations.¿¿ Corrections will be monitored by:¿ Director of Nursing or Designee	

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F 880	Continued From page 52 following orders: -1/5/23, Wound care right foot. Remove current dressing, cleanse with saline and gauze, moisten 2 x 2 gauze with Dakin's 0.125 % solution (mildly effective antiseptic) , open up 2 x 2 gauze, using sterile q-tip gently pack into wound making sure whole wound base is covered, secure with Kerlix (bandage roll with fast-wicking action, superior aeration, and excellent absorbency) and tape, change two times daily. Elevate foot a much as possible. -10/9/23, Wear Prevalon boots (a cushioned bottom that floats the heel off the surface of the mattress, helping to reduce pressure) at all times. -11/21/23, Wound care ischial (also known as sit bone) wound. Cleanse with wound cleanser, 25% dakins 1/2-inch gauze packing, secure with ABD and tape, change daily and as needed. -11/21/23, Wound care left lateral foot. Remove old dressing, paint area of eschar (dead tissue that eventually slough off healthy skin after an injury) with betadine (antiseptic used for skin disinfection), cushion with abdominal gauze pad (ABD), secure in place with Kerlix roll gauze, change two times a day. -1/8/24, Wound care right lateral foot. Cleanse with wound cleanser, apply bordered foam dressing. change every three days and as needed. During a continuous observation on 1/9/24 the following was observed: -at 10:35 a.m., licensed practical nurse (LPN)-B	F 880		

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F 880	Continued From page 53 gowned and gloved outside of R24's room. LPN-B gathered supplies in R24's room, wearing gloves LPN-B removed the dressings from R24's right lateral foot and ankle by spraying wound cleaner to loosen the dressings. LPN-B wearing the same gloves cleansed R24's right lateral wound and wound on ankle, with same gloves LPN-B painted betadine on both wounds, then placed a betadine soaked 2 x 2 in the right lateral wound. LPN-B then removed the top pair of gloves (she stated she had put on two pairs of gloves prior to starting). LPN-B then removed one of the gloves stating it had a hole in it and put on a new glove. No hand hygiene was performed. LPN-B then placed a 4 x 4 gauze, an ABD, on the wound and wrapped the ankle in gauze. LPN-B initialed, dated, and timed the dressing on the tape. -at 10:42 a.m., LPN-B wearing the same gloves, removed the dressing on the left ankle and left lateral wound using wound cleanser. LPN-B removed her gloves, no hand hygiene was performed and put on a new pair of gloves. LPN-B then cleansed the ankle wound using wound cleanser. LPN-B placed a Mepilex (absorbent foam) dressing to the ankle wound. LPN-B then cleansed the left lateral wound, painted the wound with betadine, placed a 4 x 4 gauze, an ABD, and wrapped the foot in Kerlix and initialed, dated and timed the dressing. -at 10:49 a.m., LPN-B still wearing the same gloves placed her pen on her name badge under her isolation gown, then removed her gloves. No hand hygiene was performed. LPN-B then put R24's heel boots on both feet. -at 10:50 a.m. LPN-B not wearing gloves	F 880		

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F 880	Continued From page 54 flattened R24's bed put on gloves, no hand hygiene, and assisted R24 to roll to his side, LPN-B removed the Mepilex from his sacrum, cleaned the wound with wound cleanser, removed her gloves, no hand hygiene and placed a Mepilex dressing. LPN-B put on a pair of gloves. -at 10:54 LPN-B removed the dressing from R24's coccyx, removed her gloves, cleansed the wound, no hand hygiene, put on new gloves, placed a Dakin's soaked 2 x 2 gauze dressing, and placed a Mepilex over it. -at 10:58 a.m. LPN-B wearing the same gloves removed R24's supra pubic (SP [a hollow flexible tube that is used to drain urine from the bladder]) dressing, cleansed area with wound cleanser, dried area with gauze, and placed two split gauze dressings around the SP tube and taped the dressing. -at 11:01 a.m. LPN-B gathered garbage, removed her gloves then her gown and picked up her scissors and exited the room. During an interview on 1/9/23 at 11:05 a.m., LPN-B verified she did not change her gloves each time she moved from a dirty area to a clean area. LPN-B verified she did not perform hand hygiene at any time when removing gloves and before putting on a new pair. LPN-B verified she placed her pen on her name badge while in R24's room. LPN-B stated she cleaned her pen later and cleaned the scissors after exiting R24's room. During an interview on 1/10/24 at 2:36 p.m., the director of nursing (DON) stated it was an	F 880		

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F 880	Continued From page 55 expectation staff would wear gloves during wound care and change them each time they moved from a dirty area to a clean area. The DON further stated staff were expected to perform hand hygiene with each glove change. The DON stated it was not an acceptable practice to double glove and consider the pair underneath to be clean. The DON stated equipment, pens, scissors should remain in an isolation room. The DON stated all these steps were important to follow to prevent infection(s) from spreading. The policy Handwashing/Hand Hygiene dated 8/2019, directed staff to follow the handwashing/hand hygiene procedures to help prevent the spread of infection to other personnel, residents, and visitors. The policy directed staff to use an alcohol-based hand rub containing at least 62% alcohol; or, alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations: -before handling clean or soiled dressings, gauze pads, etc. -before moving from a contaminated body site to a clean body site during resident care -after contact with blood or bodily fluids -after handling used dressings, contaminated equipment -after removing gloves	F 880		
F 883 SS=E	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization,	F 883		2/16/24

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F 883	Continued From page 56 each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the	F 883		

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F 883	Continued From page 57 following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to have a process to assess, offer and provide the most recent Centers for Disease Control (CDC) education regarding the potential risks and benefits of the pneumococcal vaccine for 4 of 5 residents (R7, R13, R14, R24) reviewed for immunizations. This had the potential to affect all residents who were eligible for the pneumococcal booster. Findings include: R7's quarterly Minimum Data Set (MDS) dated 10/18/23, identified R7 was 80 years old and had diagnoses of type 2 diabetes mellitus and heart failure. R7's immunization record undated, identified R7 received the pneumococcal polysaccharide vaccine (PPSV23) on 6/10/14, and received the pneumococcal conjugated vaccine (PCV-13) on 11/22/16. R7's medical record did not include evidence R7 or R7's representative received education regarding pneumococcal vaccine booster and there was no indication R7 was offered the pneumococcal vaccine per CDC guidance.	F 883	Immediate Corrective Action:¿¿¿ R7, R13, R14, R24 have been offered pneumococcal vaccine and provided the most recent Centers for Disease Control (CDC) education regarding the potential risks and benefits of the pneumococcal vaccine. Corrective Action as it applies to others:¿¿ All residents will be audited to determine if they have been offered pneumococcal vaccine if they qualify, and provided the most recent Centers for Disease Control (CDC) education regarding the potential risks and benefits of the pneumococcal vaccine. Pneumococcal Policy reviewed and remains current. Nurses will be educated on Pneumococcal Policy. Recurrence will be prevented by:¿¿ Audits will be conducted Monthly x3 months to determine if residents have	

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	245495	A. BUILDING _____ B. WING _____	C 01/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE EMERALDS AT GRAND RAPIDS LLC	2801 SOUTH HIGHWAY 169 GRAND RAPIDS, MN 55744

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F 883	Continued From page 58 R13's admission MDS dated 11/28/23, identified R13 was 86 years old and had diagnoses of dislocated left shoulder, type 2 diabetes mellitus, and thyroid disorder. R13's immunization record undated, identified R13 received the PPSV23 on 11/8/91, 3/26/01, and 6/10/14. R13's medical record did not include evidence R13 or R13's representative received education regarding pneumococcal vaccine booster and there was no indication R13 was offered the pneumococcal vaccine per CDC guidance. R14's quarterly MDS dated 12/14/23, identified R14 was 58 years old and had diagnoses of non-ST elevation (NSTEMI) myocardial infarction (heart attack), end stage renal disease, and type 2 diabetes mellitus. R14's immunization record undated, identified R14 received the PPSV23 on 2/20/12 and 4/12/18. R14's medical record did not include evidence R14 or R14's representative received education regarding pneumococcal vaccine booster and there was no indication R14 was offered the pneumococcal vaccine per CDC guidance. R24's quarterly MDS dated 12/1/23, identified R24 was 62 years old and had diagnoses of enterocolitis due to Clostridium difficile (C. diff), quadriplegia, supraventricular tachycardia, and heart failure. R24's immunization record undated, identified R24 received the PPSV23 on 2/21/18. R24's medical record did not include evidence R24 or R24's representative received education	F 883	been offered pneumococcal vaccine if they qualify, and provided the most recent Centers for Disease Control (CDC) education regarding the potential risks and benefits of the pneumococcal vaccine. Audits and findings will be reported to QAPI committee for further recommendations.¿¿ Corrections will be monitored by:¿ Director of Nursing or Designee	

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F 883	Continued From page 59 regarding pneumococcal vaccine booster and there was no indication R24 was offered the pneumococcal vaccine per CDC guidance. During an interview on 1/10/24, at 1:47 p.m., director of nursing (DON) stated they were not familiar with updated guidelines regarding pneumococcal vaccinations. DON further stated at this time the facility had not given any education regarding the updated pneumococcal guidelines and had not offered any resident pneumococcal vaccinations. Pneumococcal Policy dated 4/6/22, identified purpose is "to follow recommendations of the Advisory Committee on Immunizations Practices (ACIP), Centers for Disease Control (CDC), and/or the state Department of Health for prevention of Pneumococcal disease by identifying those residents at risk for Pneumococcal disease and offering Pneumococcal vaccination."	F 883		
F 908 SS=E	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 preventative maintenance and weight calibration was conducted on three scales. This had the opportunity to affect 29 residents at the facility who are routinely weighed with these scales. Findings include:	F 908	Immediate Corrective Action:¿¿¿ Preventative maintenance and weight calibration was conducted on facility scales. Corrective Action as it applies to others:¿¿	2/16/24

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F 908	Continued From page 60 On 1/9/24 at 3:20 p.m., the director of maintenance (DOM) stated there was no scheduled preventative maintenance or scheduled weight calibration for the three wheelchair scales in the facility. The DOM stated there were no records of weight calibration conducted on the scales. The DOM stated the importance of accurate weights was residents' care and well-being. On 1/10/24 at 9:41 a.m., licensed practical nurse (LPN)-A stated the maintenance department conducts preventative maintenance on the wheelchair scales on a regular basis. On 1/10/24 at 11:35 a.m., a Detecto scale technical support representative stated preventative maintenance and weight calibration should be conducted according to the Detecto preventative maintenance list and owner 's manual. Document review of Detecto scale preventative maintenance list directed to maintain scale accuracy for all clinical scales, we recommend a minimum 6-month calibration cycle. On 1/10/24 at 11:58 a.m., a Brecknell scale technical support representative calibration of the scale was recommended annually. On 1/10/24 at 12:02 p.m., a Scale Tronix (Baxter) technical support representative stated weight calibration was recommended annually. Document review of Scale Tronix scale user manual directed to routinely perform the following preventive maintenance to keep your scale in working order:	F 908	This deficient practice has the potential to affect all residents. Preventative maintenance policy was reviewed and remains current. Maintenance Director, and Maintenance Assistants educated on preventive maintenance policy, and scale calibration has been added as a quarterly task in Tels. Recurrence will be prevented by:¿¿ Scale calibration will be audited quarterly x3 quarters to determine if scale weight calibration has been completed. Audits and findings will be reported to QAPI committee for further recommendations.¿¿ Corrections will be monitored by:¿ Director of Maintenance or Designee	

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F 908	Continued From page 61 1. Check the calibration annually 2. Inspect the scale for cracks or loose mounting hardware. Replace or repair as necessary. 3. Visually inspect the scale enclosure for damage or loose or missing hardware. 4. Replace or repair as necessary. 5. if equipped, inspect the AC line cord for abrasions or other signs of wear. On 1/10/24 at 12:29 p.m., the director of nursing (DON) stated scales should be calibrated to ensure accuracy of residents' weights. The DON stated the frequency of calibration should be determined by the owner's manual of the scale. The DON stated accurate weights were important to evaluate residents' well-being and some residents' medication dosage was determined by their weight. On 1/10/24 at 1/10/24, at 3:32 p.m., the administrator stated she would expect preventative maintenance to be performed on the wheelchair scales. Maintenance Service policy dated 2009, identified maintenance services shall be provided to all areas of the building, grounds, and equipment. The maintenance department is responsible for maintaining the buildings, grounds, and equipment in a safe and operable manner at all times. The maintenance director is responsible for developing and maintaining a schedule of maintenance service to assure that the buildings, grounds, and equipment are maintained in a safe and operable manner. A copy of the maintenance schedule shall be shared be provided to each department director so that appropriate scheduling can be made without interruption of services to residents. Maintenance personnel	F 908		

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F 908	Continued From page 62 shall follow the manufacturer's recommended maintenance schedule. Records shall be maintained in the Maintenance Director's office. Maintenance personnel shall follow established safety regulations to ensure the safety and well-being of all concerned. Preventative maintenance logs were requested for wheelchair scales but were not provided.	F 908		

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	245495	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**01/08/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 01/08/2024. At the time of this survey, The Estates At Grand Rapids 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	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		01/28/2024

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

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K 000	Continued From page 1 IS NOT REQUIRED. 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. The Emeralds At Grand Rapids is a 1-story building with a partial basement and was constructed at 4 different times. The original building was constructed in 1963, is 1 story with a partial basement, and was determined to be of Type II(111) construction. In 1968 a one story addition, without a basement, was constructed south and west of the original building, and was	K 000		

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K 000	Continued From page 2 determined to be of Type II (111) construction. In 1980 a one story addition was constructed to the north of the original building, was determined to be a type V (111) construction, and is separated with a 2-hour fire barrier. This building is no longer used by residents and is staff only. In 2001 two other one story additions were built, one north of the west wing (a chapel) and one south of the west wing (special cares unit) which were determined to be Type II (111) construction and separated with 2-hour fire barriers. The building is divided into 8 smoke compartments by 30-minute and 2-hour fire barriers. The facility is fully sprinkler protected and has a fire alarm system with smoke detection in the corridor system and in all sleeping rooms that is monitored for automatic fire department notification. The facility has a capacity of 95 beds and had a census of 59 at the time of the survey. The requirements at 42 CFR, Subpart 483.70(a), are NOT MET as evidenced by:	K 000		
K 223 SS=E	Doors with Self-Closing Devices CFR(s): NFPA 101 Doors with Self-Closing Devices Doors in an exit passageway, stairway enclosure, or horizontal exit, smoke barrier, or hazardous area enclosure are self-closing and kept in the closed position, unless held open by a release device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke compartment or entire facility upon activation of: * Required manual fire alarm system; and	K 223		2/16/24

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K 223	Continued From page 3 * Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and * Automatic sprinkler system, if installed; and * Loss of power. 18.2.2.2.7, 18.2.2.2.8, 19.2.2.2.7, 19.2.2.2.8 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to install self-closing device per NFPA 101 (2012 edition), Life Safety Code, section 19.3.2.1.3 and 19.3.2.1.5. These deficient findings could have a patterned impact on the residents within the facility. Findings include: 1) On 01/08/2024 between 09:00am and 12:00pm, it was revealed by observation that smoke barrier patient room doors on the 400 Wing that have been converted to storage rooms require self-closing devices. 2) On 01/08/2024 between 09:00am and 12:00pm, it was revealed by observation that the smoke barrier door in the laundry requires a self-closing device. An interview with the Director of Maintenance and Regional Maintenance Director verified these deficient findings at the time of discovery.	K 223	Immediate Corrective Action: Patient rooms on the 400 wing that have been converted to storage rooms, and the smoke barrier door in the laundry area have an self-closing device installed on doors. Corrective Action as it applies to others: Education will be provided to the Maintenance director and maintenance assistants to install self-closing device per NFPA 101 (2012 edition), Life Safety Code, section 19.3.2.1.3 and 19.3.2.1.5. Recurrence will be prevented by: Audits will be conducted to ensure rooms that need a self-closing device per NFPA 101 (2012 edition), Life Safety Code, section 19.3.2.1.3 and 19.3.2.1.5. have them. Audits will be completed weekly for 3 weeks, and then monthly for 2 months. Audits and findings will be reported to QAPI committee for further recommendations.¿	

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K 223	Continued From page 4	K 223	Corrections will be monitored by: Maintenance Director or Designee	
K 372 SS=D	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain their smoke barrier per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.7.1, 19.3.7.3, 8.5.2.2, and 8.5.6.5. These deficient findings could have an isolated impact on the residents within the facility. Findings include: On 01/08/2024 between 9:00am and 12:00pm, it was revealed by observation that there was a penetration running from one smoke compartment to another above doors leading to the 400 wing. An interview with the Director of Maintenance and Regional Maintenance Director verified these deficient findings at the time of discovery.	K 372	Immediate Corrective Action: The penetration running from one smoke compartment to another above doors leading to the 400 wing has been sealed. Corrective Action as it applies to others: Education will be provided to the Maintenance director and maintenance assistants on maintaining smoke barriers per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.7.1, 19.3.7.3, 8.5.2.2, and 8.5.6.5 Smoke barriers will be audited to identify any other penatrations.	2/16/24

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	245495	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**01/08/2024**

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K 372	Continued From page 5	K 372	Recurrence will be prevented by: Audits will be conducted to ensure smoke barriers are maintained per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.7.1, 19.3.7.3, 8.5.2.2, and 8.5.6.5 Audits will be completed monthly for 3 months. Audits and findings will be reported to QAPI committee for further recommendations.¿ Corrections will be monitored by:	
K 374 SS=D	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to install self-closing device per NFPA 101 (2012 edition), Life Safety Code, section 8.5.4.1 and 8.5.4.4. These deficient findings could have an isolated impact on the residents within the	K 374	Immediate Corrective Action: Smoke barrier doors leading to wing 3 have been adjusted, and close per NFPA 101 (2012 edition), Life Safety Code, section	2/16/24

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K 374	Continued From page 6 facility. Findings include: On 01/08/2024 between 9:00am and 12:00pm, it was revealed by observation that smoke barrier doors leading to Wing 3, did not completely close when tested. An interview with the Director of Maintenance and Regional Maintenance Director verified these deficient findings at the time of discovery.	K 374	8.5.4.1 and 8.5.4.4 Corrective Action as it applies to others: Education will be provided to the Maintenance director and maintenance assistants on installing of self closing device per NFPA 101 (2012 edition), Life Safety Code, section 8.5.4.1 and 8.5.4.4. All smoke barrier doors will be audited to ensure they close per NFPA 101 (2012 edition), Life Safety Code, section 8.5.4.1 and 8.5.4.4 Recurrence will be prevented by: Audits will be conducted to ensure doors that need a self closing device per NFPA 101 (2012 edition), Life Safety Code, section 8.5.4.1 and 8.5.4.4. close properly. Audits will be completed weekly for 3 weeks, and then monthly for 2 months. Audits and findings will be reported to QAPI committee for further recommendations.¿ Corrections will be monitored by: Maintenance Director or Designee	