DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
November 8, 2023

Administrator
Cerenity Marian Of St Paul LLC
200 Earl Street
Saint Paul, MN 55106

RE: CCN: 245365
Cycle Start Date: September 21, 2023

Dear Administrator:

On November 7, 2023, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
October 4, 2023

Administrator
Cerenity Marian Of St Paul LLC
200 Earl Street
Saint Paul, MN 55106

RE: CCN: 245365
Cycle Start Date: September 21, 2023

Dear Administrator:

On September 21, 2023, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Renee McClellan, Unit Supervisor
Metro A District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: renee.mcclellan@state.mn.us
Office: 651-201-4391 Mobile: 651-328-9282

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

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

If substantial compliance with the regulations is not verified by December 21, 2023 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by March 21, 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,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245365	A. BUILDING _____ B. WING _____	C 09/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CERENITY MARIAN OF ST PAUL LLC	200 EARL STREET SAINT PAUL, MN 55106

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments On 9/18/23 through 9/21/23, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) was conducted during a standard recertification survey. The facility was not 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		
E 004 SS=F	Develop EP Plan, Review and Update Annually CFR(s): 483.73(a) §403.748(a), §416.54(a), §418.113(a), §441.184(a), §460.84(a), §482.15(a), §483.73(a), §483.475(a), §484.102(a), §485.68(a), §485.542(a), §485.625(a), §485.727(a), §485.920(a), §486.360(a), §491.12(a), §494.62(a). The [facility] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section. The emergency preparedness program must include, but not be limited to, the following elements: (a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be [reviewed], and updated at least every 2 years. The plan must do all of the following: * [For hospitals at §482.15 and CAHs at	E 004		10/27/23

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

Electronically Signed | 10/13/2023

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

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E 004	Continued From page 1 §485.625(a):] Emergency Plan. The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. * [For LTC Facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. * [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least every 2 years. . This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure their emergency operations plan (EOP) was reviewed and updated annually in accordance with the requirements of CFR 483.73. This had the potential to affect all 72 residents who reside in the facility. Findings include: The facility's EOP dated 2017, indicated the last review of the program was 2019. Furthermore, the EOP directed the facility will review and update the EOP annually. The facility will review and update as necessary the EOP policies and procedures annually	E 004	The facility's Emergency Operations Plan (EOP) has been compressively reviewed and updated effective October 2023. The facility's EOP plan will be reviewed, and updated as needed annually, in October of subsequent years. A calendar reminder is on the Executive Director's calendar for October of 2024. The EOP review will be done in conjunction with the Facility Assessment and Quality Plan schedule. EOP updates will be brought forth to future QA meetings, when applicable, for review.	

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E 004	Continued From page 2 Evidence of the facility's review of the of the EOP's policies and procedures within the past year was requested however was not received. When interviewed on 9/21/23 at 3:45 p.m., the administrator verified the EOP had not been reviewed in the past year. The Administrator further stated there was work being done at the corporate level to revise the entire program.	E 004		
E 013 SS=F	Development of EP Policies and Procedures CFR(s): 483.73(b) §403.748(b), §416.54(b), §418.113(b), §441.184(b), §460.84(b), §482.15(b), §483.73(b), §483.475(b), §484.102(b), §485.68(b), §485.542(b), §485.625(b), §485.727(b), §485.920(b), §486.360(b), §491.12(b), §494.62(b). (b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years. *[For LTC facilities at §483.73(b):] Policies and procedures. The LTC facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually.	E 013		10/27/23

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E 013	Continued From page 3 *Additional Requirements for PACE and ESRD Facilities: *[For PACE at §460.84(b):] Policies and procedures. The PACE organization must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must address management of medical and nonmedical emergencies, including, but not limited to: Fire; equipment, power, or water failure; care-related emergencies; and natural disasters likely to threaten the health or safety of the participants, staff, or the public. The policies and procedures must be reviewed and updated at least every 2 years. *[For ESRD Facilities at §494.62(b):] Policies and procedures. The dialysis facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years. These emergencies include, but are not limited to, fire, equipment or power failures, care-related emergencies, water supply interruption, and natural disasters likely to occur in the facility's geographic area. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to review policies and procedures for hazards deemed significant based on an	E 013	The facility's all-hazard risk assessment was updated in October 2023. The facility's all-hazard risk assessment	

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E 013	Continued From page 4 all-hazards risk assessment as part of their emergency operations plan (EOP) on an annual basis in accordance with the requirements of CFR 483.73(a)(1)(2). This had the potential to affect all 72 residents who reside in the facility. The facility's EOP dated 2017, indicated the last review of the program was 2019. Furthermore, the EOP directed the facility will review and update the EOP will be reviewed if necessary and updated annually. Evidence of the facility's review of the of the EOP's policies and procedures within the past year was requested however was not received. When interviewed on 9/21/23 at 3:45 p.m., the administrator verified the EOP's policies and procedures had not been reviewed in the past year. The administrator further stated there was work being done at the corporate level to revise the entire program.	E 013	will be reviewed, and updated as needed, annually in October of subsequent years. A calendar reminder is on the Executive Director's calendar for 2024. The EOP all-hazard review will be done in conjunction with the Facility Assessment and Quality Plan schedule. All-hazard updates will be brought forth to future QA meetings, when applicable, for review.	
E 029 SS=F	Development of Communication Plan CFR(s): 483.73(c) §403.748(c), §416.54(c), §418.113(c), §441.184(c), §460.84(c), §482.15(c), §483.73(c), §483.475(c), §484.102(c), §485.68(c), §485.542(c), §485.625(c), §485.727(c), §485.920(c), §486.360(c), §491.12(c), §494.62(c). (c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities].	E 029		10/27/23

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E 029	Continued From page 5 This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to review the communication plan as part of their emergency operations plan (EOP) on an annual basis in accordance with the requirements of 42 CFR 483.73(a)(1)(2). This had the potential to affect all 72 residents who reside in the facility. The facility's EOP dated 2017, indicated the last review of the program was 2019. Furthermore, the EOP directed the facility will review and update the EOP will be reviewed if necessary and updated annually. Evidence of the facility's review of the of the EOP's communication plan within the past year was requested however was not received. When interviewed on 9/21/23 at 3:45 p.m., the administrator verified the EOP's communication plan had not been reviewed in the past year. The administrator further stated there was work being done at the corporate level to revise the entire program.	E 029	The facility's communication plan was updated in October 2023. The facility's communication plan will be updated, as needed and annually, in October of subsequent years. A calendar reminder is on the Executive Director's calendar for 2024. The EOP communication plan will be reviewed in conjunction with the Facility Assessment and Quality Plan schedule. Communication plan updates will be brought forth to future QA meetings, when applicable, for review.	
F 000	INITIAL COMMENTS On 9/18/23 through 9/21/23, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was not in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed with no deficiencies cited: H53655549C (MN95546); H53655550C (MN95385); and H53655547C	F 000		

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F 000	Continued From page 6 (MN96780). The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F 000		
F 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 the call light was within reach for 1 of 1 resident (R22) reviewed for call light accessibility. Findings include: R22's quarterly Minimum Data Set (MDS) dated 9/8/23, indicated R22 had moderate cognitive impairment, required extensive assistance with transfers, toileting, and personal hygiene. R22's diagnoses included Alzheimer's, cancer, diabetes, and depression.	F 558	This plan of correction constitutes the facility's credible allegation of compliance. Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truths or facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed in accordance with federal and state law requirements. Resident #22’s call light was placed within	10/27/23

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F 558	Continued From page 7 R22's care plan (CP) dated 9/8/23, indicated R22 was at risk for falling due to increased weakness, cognitive impairments, and other diagnoses. The CP instructed staff to keep resident in a safe area or bed after meals and to ensure call light was in reach. R22's falls risk assessment dated 9/8/23, indicated R22 was at risk for falls and had three or more falls in the previous three months. During observation and interview on 9/19/23 at 1:24 p.m., R22 was in her room sitting in a wheelchair with a tray table in front of her. R22's pressure pad type call light was approximately two feet away under her bed and wrapped around her walker. R22 stated she could not reach the call light to activate it if she needed assistance. During interview on 9/19/23 at 1:41 p.m., activites personnel (A)-A confirmed R22's call light was on the floor wrapped around walker and under her bed. A-A stated R22 would not be able to reach it if she wanted to use it. During interview on 9/19/23 at 1:59 p.m., nursing assistant (NA)-A stated R22 was a falls risk and was capable of pressing her call light if she needed something. During interview on 9/19/23 at 2:04 p.m., registered nurse (RN)-A stated R22 was a falls risk and one of the falls prevention interventions was to have her call light within reach. During interview on 9/19/23 at 2:48 p.m., licensed practical nurse (LPN)-B stated R22 could use the call light and it should be within reach when she	F 558	reach on 9/19/23. All resident's call lights were verified to be in reach on 9/19/23. Staff were educated on the importance of call light placement immediately when the issue was discovered. Additionally, call light audits were completed during survey. All staff were re-educated on the importance of call light placement beginning 10/09/2023 and will continue until all staff receive are re-educated. Assigned leadership staff will complete audits on 4 rooms on each floor (total of 12 rooms) 3X's per week for 4 weeks, 3 rooms on each floor (9 rooms) for 4 weeks, and then 2 room on each floor (6 rooms) for 4 weeks. Issues identified will be followed up on appropriately. The Director of Nursing is responsible for ensuring call lights are within reach for residents. Audit results will be referred to the facility's Quality Meeting for review and to determine the need to ongoing audits.	

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F 558	Continued From page 8 was in her room. During interview on 9/19/23 at 2:53 p.m., LPN-A stated expectation was all call lights should be within reach so a resident could use it when needed. During interview on 9/20/23 at 2:53 p.m., director of nursing (DON) stated expectation was staff should ensure call lights were within reach and working. A policy on call lights was requested but not received.	F 558		
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the	F 561		10/27/23

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F 561	Continued From page 9 facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide baths for 1 of 1 resident (R23), reviewed for bath preferences. Findings include: R23's admission Minimum Data Set (MDS) dated 8/3/23, indicated R23 had moderate cognitive impairment, with daily preference for bath, very important to choose between a tub bath, shower, bed bath and sponge bath. R23 required limited assist with personal hygiene and physical transfers for bathing. R23's activities of daily living care plan, edited 8/29/23, did not mention of R23's bath preference. . R23's face sheet undated, included diagnosis of parkinson disease and injury of nerve root of lumbar spine. R23's progress notes from admission on 7/28/23 through 9/18/23, had no documentation of R23 refusing baths or showers. R23's general order dated 8/25/23, indicated bath documentation: body audit to be completed on shift of scheduled shower. If refuses bath/shower, body audit still needs to be completed with any	F 561	Resident #23 discharged on 10/5. All residents will receive personal bathing (shower/tub/bed bath) per their preference on a weekly basis. Skin checks will be documented per facility policy. All residents in the facility were re-assessed for their bathing preferences; results were communicated to nursing. Wellness was educated on our new communication system for bathing preferences beginning 10/9/2023 and will continue until completed. Nursing staff were re-educated on providing baths in accordance with facility policy/careplan beginning on 10/17/2023 and will continue until completed. Wellness staff will review with Resident Council their right to choose bathing preferences at the next 3 scheduled resident council meetings. The DON, or designee, will audit 3 wellness preference assessments per week to ensure preferences are communicated to nursing. The DON, or designee, will also audit 4 residents from each floor to ensure their baths were given and skin checks were documented. These audits will be done for a period of 12 weeks. Audit results will be referred to the facility's Quality Meeting for review and to	

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F 561	Continued From page 10 skin impairments and faxed into Matrix. Bath frequency once a day on Monday. R23's bath documentation since admission on 7/28/23, showed R23 only had the following four skin bath audits completed: -08/6/23-shower checked for a pm shift bath with skin checks completed -8/20/23-shower checked for pm shift bath with skin checks completed -8/28/23 -bed bath checked for am bath, with skin checks completed -9/4/23- no bath method indicated with skin checks completed. R23 only had four total documentation of skin bath audit that included two showers, one bed bath and no bath method documented on 9/4/23. During interview on 9/18/23 at 4:33 p.m., R23 explained she had often requested to get baths, however the facility continued to only gave her showers. R23 further stated baths were her preference but was unsure if the facility had a tub to provide her baths and also explained her bath days are not stable and often changed from week to week to different days. During interview on 9/20/23 at 11:02 a.m., nurse manager, licensed practical nurse (LPN)-C stated was unaware resident preferred a bath instead of a shower. LPN-C stated if R23 had informed LPN-C, R23's care plan would have been updated to reflect bath preference. LPN-C stated would have to check in with activities to determine if R23 had mentioned to them her bath preferences. During interview on 9/21/23 at 11:02 a.m.,	F 561	determine the need to ongoing audits.	

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F 561	Continued From page 11 interview with assistant wellness director (AWD)-B stated R23 had an assessment done on 7/28/23, and had mentioned she preferred a bath since did not like to sit and possibly slip, if she took a shower. AWD-B stated, when activities completed their assessments, they were entered into Matrix charting system so other departments could access. AWD-B further mentioned activities did not communicate with nursing the resident's preferences and that nursing had to find their assessment placed into Matrix then make any necessary changes to care plans. During interview on 9/21/23 at 12:25 p.m., nurse manager, LPN-C stated, R23 had only had the four showers since admission on 7/28/23, and verified it in Matrix. LPN-C also stated there was no documentation of R23 refusing showers since her admission. LPN-C did not know R23's bath preference was bath instead of showers, and did not update the care plan or nursing assistant care sheets. LPN-C stated the facility would have to look into the process of communicating between departments. During interview on 9/21/23 at 2:50 p.m., director of nursing (DON) stated there was no documentation R23 had refused showers or baths and had become aware R23 had only received four showers since admission into facility. The expectation was resident's preferences should be addressed and documented in resident's electronic records and scheduled showers should be completed with refusals documented. A bathing policy was requested and was not received.	F 561		

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F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure a resident's	F 583	Resident #17's audio monitoring device was removed from his room.	10/27/23

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F 583	Continued From page 13 right to privacy was maintained for 1 of 1 resident (R17) who had an audio monitoring unit turned on in his room 24 hours a day. Findings include: R17's significant change Minimum Data Set (MDS) dated 9/9/23, indicated R17 was cognitively intact, required extensive assistance with bed mobility, transfers, and most activities of daily living (ADLs). R17's diagnoses included history of stroke, diabetes, anxiety, and depression. R17's care plan (CP) undated, indicated R17 was at risk for falls and had an intervention initiated 6/10/22, for an audio monitor in room to anticipate him getting out of bed unattended. The CP indicated another falls intervention initiated 10/20/22, for staff to remind R17 to use the call light and wait for assistance. R17's physician order dated 6/10/22, instructed staff to make sure the audio monitor was in working order, turned on at the nurses station, and in the room every shift. R17's admission agreement signed 2/22/22, indicated consent for facility to photograph, record, and video for the purpose of marketing but lacked evidence of consent for use of an audio device for continuous audio monitoring. R17's falls event note dated 6/15/22, indicated R17 had a fall on 6/10/23 at 1:45 a.m., with interventions initiated to include an audio monitor placed in room to alert staff of attempts to get up independently.	F 583	All like residents reviewed for use of audio monitor use. IDT agreed to remove audio monitor use on 9/29/23 for all other residents using monitor. All audio monitors were removed the building. Staff were educated on audio monitoring, how it relates to privacy and alternative interventions beginning on 10/9/2023 and will continue until all staff are educated. The Administrator is responsible for ensuring audio monitors are not used in the facility.	

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F 583	Continued From page 14 R17's progress note dated 9/29/22, at 10:20 a.m., indicated an IDT note (interdisciplinary team), "Resident continues to self-transfer and fall. Residents cognition and weakness result in the falls. Bed was moved against the wall so he can get out of the bed on the right and prevent injury from the falls." R17's progress note dated 8/10/23 at 10:40 p.m., indicated R17 was found on the floor inside the bathroom and the audio monitor was on and in place, but the writer did not hear R17 self-transferring. During observation and interview on 09/18/23 at 1:10 p.m., R17 was sitting in wheelchair in room watching TV. An audio monitor was on the nightstand just below the TV and turned on. R17 could not explain what the device was and did not know how long it had been there. During interview on 9/19/23 at 2:08 p.m., registered nurse (RN)-A stated R17 was a falls risk and required assistance with toileting. RN-A stated R17 could use his call light to request assistance. During interview on 9/20/23 at 2:07 p.m., licensed practical nurse (LPN)-A stated R17 was a falls risk and had an audio monitor in his room so staff could hear him get up at night. LPN-A was not aware of any consent for audio monitoring and it had been in his room for quite a while. During observation on 9/21/23 at 9:18 a.m., an audio monitor in nurses station labeled with R17's name and room number was producing very clear audio of sounds from R17's room.	F 583		

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F 583	Continued From page 15 During follow up interview on 9/21/23 at 10:44 a.m., LPN-A could not recall when the audio monitor was first placed in R17's room but thought there was a consent signed upon admission. LPN-A stated R17 would not be able to have a private conversation with the audio monitor on and was not sure if he knows how to turn it off. LPN-A further stated R17 had multiple falls since the audio monitor was installed and it was not working to reduce falls as originally intended and probably should be discontinued. During interview on 9/21/23 at 11:33 a.m., social services director (SSD) stated R17 was his own person and could not recall any conversation or consent for the audio monitor. SSD stated the audio monitor would prevent R17 from having a private conversation and violated his privacy rights. During interview on 9/21/23 at 12:37 p.m., director of nursing (DON) stated there should have been a conversation regarding audio monitoring and should be regularly assessed to determine if it's still appropriate. Facility policy Resident Rights and Notification of Resident Rights dated 11/28/17, indicated the facility acts to protect and ensure the rights of residents to include communication privacy.	F 583		
F 604 SS=E	Right to be Free from Physical Restraints CFR(s): 483.10(e)(1), 483.12(a)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any	F 604		10/27/23

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F 604	Continued From page 16 physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(2) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure a resident (R17) was free from physical restraints when he had a wanderguard on his wheelchair and assessed as low risk for elopement. This had the potential to affect all 13 residents with a wanderguard residing in the facility. Findings include: R17's significant change Minimum Data Set (MDS) dated 9/9/23, indicated R17 was	F 604	Resident #17 had a new elopement assessment completed and cognitive testing completed. Resident #17's wanderguard has been removed and the careplan updated. All residents with wander guards in place have been reassessed for appropriate use, elopement assessments completed and care plans updated as appropriate. The inter-disciplinary team were re-educated on the use of wanderguards, the potential for restraint, the need for	

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F 604	Continued From page 17 cognitively intact, required extensive assistance with transfers, supervision and one-person assistance with mobility and did not display wandering behavior. R17's MDS further indicated a wanderguard alarm restraint was used daily. R17's diagnoses included history of stroke, diabetes, anxiety, and depression. R17's care plan (CP) last reviewed/revised 9/5/23, indicated R17 was at risk for elopement with an intervention dated 3/3/22, "A wandergurd [sic] has been added to residents WC [wheelchair]." R17's elopement risk assessment dated 9/8/23, indicated R17 was at low risk for elopement. R17's progress note (PN) dated 5/16/23 at 3:16 p.m., indicated R17 had a wanderguard related to past elopement attempts. R17's PN's dated 2/1/23 through 9/21/23, lacked any further evidence of actual elopement attempts. In addition, the PN lacked any evidence regarding alcohol, liquor or R17's recovering alcohol addiction. During observation and interview on 9/18/23 at 12:52 p.m., R17 was in his room in WC watching TV. A wanderguard was attached to the bottom of his WC. R17 stated disappointment he was not allowed to leave the building, go shopping, or even go outside to the facility grounds. During observation and interview on 9/19/23 at 1:14 p.m., R17 was in room sitting in WC watching TV. The wanderguard was attached to the bottom of the WC. R17 was able to self-propel in WC. R17 stated he wanted to go to	F 604	assessment, appropriate use and alternative interventions beginning on 10/17/2023. Education will continue until completed. The IDT team will review residents annually, with a significant change of condition, and with new placement of a wanderguard to ensure appropriate usage. Audit results will be provided to QA to analyze and determine ongoing frequency and duration.	

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F 604	Continued From page 18 Target to purchase a shaver and could arrange a ride with Metro Mobility to get there and back. During observation on 9/19/23 at 1:55 p.m., R17 wheeled self to licensed practical nurse (LPN)-A's office and asked if she would assist him downstairs tomorrow (9/20/23) if he made arrangements with Metro Mobility to go shopping. LPN-A responded she would talk to social service director (SSD). During interview on 9/19/23 at 2:08 p.m., registered nurse (RN)-A stated R17 was not at risk for elopement and his elopement risk was assessed regularly. During interview on 9/20/23 at 9:00 a.m., R17 stated he was not able to go out shopping per SSD. During interview on 9/20/23 at 2:07 p.m., LPN-A stated a person would be considered at risk for elopement if they made statements regarding wanting to leave the facility. LPN-A further stated R17 had previously attempted to leave and his safety awareness was gone. During interview on 9/21/23 at 11:33 a.m., SSD stated R17 was his own person and could make his own decisions regarding advanced directives. SSD could not recall the last time R17 attempted to elope. SSD stated R17 wanted to go to Target last winter, but he only wore shorts and SSD did not think he had proper insight into environmental factors. SSD further stated R17 probably wanted to buy liquor and was always trying to find a liquor store due to being a recovering addict. During interview on 9/21/23 at 12:37 p.m.,	F 604		

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F 604	Continued From page 19 director of nursing (DON) stated expectation was for elopement assessments be completed quarterly and as needed and the result of the assessment would drive the need for a wanderguard. DON further stated if a resident was their own person, they had the right to make their own decisions, even if they were poor decisions. Facility policy Wandering and/or Active Elopement dated 9/11/19, indicated wandering and/or elopement attempts should be documented in the resident's medical record. A facility policy on restraints was requested and not provided.	F 604		
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 interview and document review, the facility failed to accurately code the Minimum Data Set (MDS) for 1 of 2 residents (R43) in the sample who were reviewed for pressure ulcers. Findings include: The Centers for Medicare and Medicaid (CMS) Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, dated 10/2018, outlined an overview which included, "The purpose of this manual is to offer clear guidance about how to use the [RAI] correctly and effectively to help provide appropriate care ... The	F 641	R43's MDS was modified on 9/20/23 to reflect that they did not have a pressure injury present. All residents that were coded for pressure areas in the past quarter reviewed to ensure coding accuracy of pressure areas was completed on 10/10/2023. Education completed with MDS Coordinator on accuracy of documenting pressure on 10/12/2023. The DON, or designee, will audit submitted MDSs for pressure area coding accuracy weekly x1 month then monthly x2 months.	10/27/23

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F 641	Continued From page 20 RAI helps nursing home staff in gathering definitive information on a resident's strengths and needs, which must be addressed in an individualized care plan." The manual then outlined each MDS section with corresponding instructions and directions. This included Section M-Skin Conditions, report based on highest stage of existing ulcer(s) at its worst; do not reverse stage. This section included: M0150. risk of pressure ulcers, M0210. unhealed pressure ulcers, and M0300. current number of unhealed pressure ulcers at each stage. R43's quarterly MDS dated 6/29/23, identified R43 was cognitively intact, and had diagnosis which included anxiety disorder, respiratory failure, congestive heart failure, lymphedema, bladder incontinence and urge bowel incontinence . Identified R43 required extensive assist with bed mobility, transfers, toileting, dressing and personal hygiene, indicated R43 was coded for a stage 3 pressure ulcer (full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon, or muscle is not exposed.) The assessment reference date (ARD) was identified as ending 6/29/23. R43's plan of care dated 7/11/23, indicated R43 was at risk for pressure ulcers r/t (related to) increased weakness, lymphedema, diuretic use, functional bladder incontinence, urge bowel incontinence, use of compression stockings, impaired mobility, and CHF (congestive heart failure) Review of R43's medical record indicated wound doctor weekly notes starting 5/17/23 through 7/26/23, indicating R43 had a "Non Pressure related area to buttocks due to MASD" (moisture	F 641	Audit results will be referred to the facility's Quality Meeting for review and to determine the need to ongoing audits.	

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F 641	Continued From page 21 associated skin damage). During an interview on 09/20/23, at 11:22 AM, registered nurse (RN)-B reviewed R43's progress notes and wound physician notes, and quarterly MDS dated 6/29/23, and verified R43 did not have a pressure ulcer, and the MDS would be corrected.	F 641		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on interview, observation, and document review, the facility failed to follow physician orders for 1 of 1 resident (R67) reviewed for weights monitoring who had congestive heart failure (CHF) with edema and also failed to develop a care plan for R67's edema. The facility further failed to complete an abnormal involuntary movement assessment (AIMS) for 1 of 1 resident (R67) who was taking antipsychotic medications. Findings Include: Weight monitoring R67's 5 day prospective payment system assessment Minimum Data Set (MDS) dated	F 684	R67 has discharged from facility. Chart review will be presented to QA committee for process improvement opportunities. All residents with CHF had their care plans reviewed to address edema. All residents with CHF were reviewed to ensure weight monitoring is followed per MD orders. All residents receiving antipsychotic medications were reviewed to ensure AIMs assessment was completed in the past 6 months. Licensed nursing staff were re-educated in following prescribed MD orders and to notify MD if unable to obtain and follow prescribed weight orders. Education began on 10/17/2023 and will continue	10/27/23

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F 684	Continued From page 22 8/30/23, indicated R67 was cognitively intact, received diuretics, and needed extensive assist of one staff for transfers, toileting and personal hygiene. R67's face sheet undated, indicated diagnosis that included Chronic diastolic (congestive) heart failure (stiff left heart ventricle. When your left heart ventricle is stiff, it doesn't relax properly between heartbeats. Diastolic heart failure can lead to decreased blood flow and other complications), restless leg syndrome, non-pressure chronic ulcer of unspecified part of right lower leg limited to breakdown of skin. R67's physician orders 8/25/23, included bumetanide tablet 2 milligrams (mg), take twice daily for chronic diastolic congestive heart failure. R67's skin care plan initiated 8/30/23, indicated R67 had skin impairments currently related to open wounds on admit, had CHF, and type II diabetes. R67's care plan lacked reference to edema. The care plan further lacked documentation of goals and interventions for edema. R67's Physician orders dated 8/30/23, indicated daily weight with an average of 145 pounds (lbs). Call for weight gain of 3lbs or more in 24 hours or 5 lbs in 1 week. R67's weight documentation from 8/28/23 through 9/21/23: -8/28/2023 at 2:30 a.m., weight: 150 lbs -8/29/2023 at 9:55 a.m., weight: 145.6 lbs -9/2/2023 at 10:52 a.m., weight: 146.8 lbs -9/3/2023 at 9:42 a.m., weight: 147.6 lbs	F 684	until all licensed staff are re-educated. Additionally, all licensed nursing staff were re-educated on completing AIMs assessment on all residents receiving antipsychotic medications per policy. Nursing staff were re-educated to include edema care plans on residents with CHF with edema on 10/17/2023 . The DON or designee will audit 3 residents with CHF dx per unit weekly x3 months to ensure edema is care planned. The DON or designee will audit 3 residents per unit/week for 3 months with MD prescribed weight orders to ensure MD orders are being followed. Residents receiving antipsychotic medications will be reviewed at the weekly IDT meet to ensure AIMS policy is being followed. Audit results will be referred to the facility's Quality Meeting for review and to determine the need to ongoing audits.	

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F 684	Continued From page 23 -9/4/2023 at 1:13 p.m., weight: 144.6 lbs -9/5/2023 at 10:29 a.m., weight: 144.4 lbs -9/15/2023 at 12:18 p.m., weight: 149.2 lbs -9/17/2023 at 10:46 a.m., weight: 150.2 lbs -9/18/2023 at 10:20 a.m., weight: 152.2 lbs -9/19/2023 at 10:38 a.m., weight: 151.8 lbs -9/20/2023 at 10:24 a.m., weight: 150.4 lbs -9/21/2023 at 9:20 a.m., weight: 154.4 pounds (lbs) R67's weights were missed from 9/6/23 through 9/15/23 , ten days of missed weights, although R67 had an order for daily weights; R67 weights were also missed 9/16/23. There were no progress notes indicating physician was notified, or orders to hold weight monitoring during that period. During observations on 9/21/23 at 9:33 a.m., R67 was sitting up in bed, with feet on floor, at least three to four plus edema noted to bilateral legs. During interview on 9/21/23 at 11:41 a.m., nurse manager, licensed practical nurse (LPN)-C stated upon review of R67's care plan, there was no care plan specific to R67's edema and one should have been completed. LPN-C also stated resident had clostridioides difficile (c-diff) (a germ (bacterium) that causes diarrhea and colitis (an inflammation of the colon) , during the period of missed weights from 9/6/23 through 9/15/23, but there was no documentation the physician had been notified to request weights to be placed on hold during R67"s c-diff infection. During interview on 9/21/23 at 2:50 p.m., director of nursing (DON) stated, it was the expection that staff would follow doctor's orders to complete daily weights for a resident with CHF, and doctors	F 684		

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F 684	Continued From page 24 orders should have been requested so daily weights could be placed on hold while R67 was on c-diff precautions. DON further stated R67 should have a care plan for edema with interventions in place. Facility Comprehensive Assessments and Care Planning policy dated 2017, indicated person-centered care plan interventions will be implemented by qualified personnel. Interventions may be communicated through the electronic health record, resident profile, assignment sheets, and/or verbal communication. AIMS Assessment R67's 5 day prospective payment system assessment Minimum Data Set (MDS) dated 8/30/23, indicated R67 was cognitively intact. R67 had received antianxiety medications, had not received antipsychotic medication during the look back period and had diagnosis that included antianxiety disorder. R67's skin care plan initiated 8/30/23, indicated R67 received psychotropic medications: ativan, fluoxetine, remeron, trazodone and trintellix. Interventions included monitor target behavior with goal that R67 would not experience adverse reactions through the review date. R67's face sheet undated, indicated diagnosis that included major depressive disorder(recurrent, moderate)(when an individual has a persistently low or depressed mood, decreased interest in pleasurable activities, feelings of guilt or worthlessness, lack of energy, poor concentration, appetite changes, psychomotor retardation or agitation, sleep	F 684		

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F 684	Continued From page 25 disturbances, or suicidal thoughts.), generalized anxiety disorder, and essential tremors. R67's physician orders dated 8/24/23, included fluoxetine capsule 20 mg once a day; lorazepam 0.5 mg twice a day; remeron 30 mg at bedtime; trazodone 100 mg take 200 mg at bedtime; trintellix 10 mg once a day. R67's medical record lacked documentation of abnormal involuntary movement (AIMS) monitoring and also lacked the AIMS assessment. During interview 9/21/23 at 11:41 a.m., nurse manager, licensed practical nurse (LPN)-C verified R67 did not have an AIMS assessment completed. LPN-C also stated the nurses completed the AIMS assessment however, had checked R67's medical record and could not find a completed AIMS assessment or monitoring of abnormal involuntary movements in R67's record. During interview on 9/21/23 at 2:50 p.m., DON stated AIMS assessments should be completed on residents receiving antipsychotic medications. No AIMS assessments policy were provided.	F 684		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain.	F 690		10/27/23

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F 690	Continued From page 26 §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to comprehensively assess 1 of 1 resident (R33) for urinary incontinence and determine if a toileting schedule/program was beneficial to improve, maintain, or reduce the risk of worsening bladder function. Furthermore, the facility failed to ensure adequate catheter care was provided for 1 of 1 resident (R69), with an indwelling catheter with noted bleeding at catheter insertion site.	F 690	R33 was comprehensively re-assessed for urinary incontinence to determine if toileting schedule/program is beneficial to improve/maintain/reduce risk of worsening bladder functioning. R69 has discharged from the facility. All incontinent residents were reviewed to ensure assessments include review of toileting schedule/program and implement if determined it would be beneficial to	

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F 690	Continued From page 27 Findings include: R33's quarterly Minimum Data Set (MDS) dated 9/1/23, indicated R33 was cognitively intact, had no refusals of care and was frequently incontinent. Furthermore, R33's MDS indicated R33 had diagnoses of schizophrenia (mental health disorder where reality may be distorted) and benign prostrate hyperplasia (enlarged prostrate that can cause increased frequency of urination, BPH). R33's Bladder Care Area Assessment (CAA) dated 12/22/22, indicated R33 was at risk for bladder incontinence related to diuretic use, antipsychotic medication use, and obesity. R33's bladder assessment dated 1/25/23-1/27/23, indicated R33 was occasionally incontinent and identified risk factors for incontinence as impaired mobility, kidney stones, and antipsychotic medication use. R33's bladder assessment lacked identification of any signs or symptoms of incontinence, any potentially reversible causes of incontinence, any identified symptoms of incontinence, or identification of the kind of incontinence R33 experienced. R33's quarterly assessment review dated 6/2/23 at 12:55 p.m., indicated there was no change from the clinical documentation reviewed from 1/2023. R33's assessment review indicated R33 was to be placed in a brief and offered reminders for assistance to toilet. R33 had been unsuccessful using urinal on own and causing a safety hazard with urine on the floor in large amounts and should be offered a toileting schedule at bedtime and overnight. Furthermore,	F 690	improve/maintain/reduce risk of worsening bladder functioning. All residents with catheters are provided care consistent with standards of practice. Nursing staff were re-educated on catheter care and toileting plans. Education began on 10/17/2023 and will continue until all staff are re-educated. The DON or designee will audit 3 resident charts per unit per week x3 months to ensure assessments include if it would be beneficial to improve/maintain/reduce risk of worsening bladder functioning on incontinent residents The DON or designee will audit catheter care on 1 resident per unit per week x3 months to ensure proper placement of securement device and no pulling/tugging occurs during care. Results will be provided to QA to analyze and determine ongoing frequency and duration.	

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F 690	Continued From page 28 resident required further education on using the toilet rather than bed wetting and laying in wet clothing. R33's quarterly assessment review dated 9/1/23 at 2:07 p.m., indicated there was no change from the clinical documentation reviewed from 1/2023. R33's assessment review indicated R33 was to be placed in brief and offered reminders for assistance to toilet. R33 had been unsuccessful using urinal on own and causing a safety hazard with urine on the floor in large amounts and should be offered a toileting schedule at bedtime and overnight. Furthermore, resident required further education on using the toilet rather than bed wetting and laying in wet clothing. R33's care plan revised 9/1/23, indicated R33 had bladder incontinence related to weakness, poor eyesight, obesity, noncompliance, and lack of coordination. The care plan further instructed R33 to be placed in brief and offered reminders for assistance to toilet. R33 had been unsuccessful using urinal on own and causing a safety hazard with urine on the floor in large amounts and should be offered a toileting schedule at bedtime and overnight. Furthermore, resident required further education on using the toilet rather than bed wetting and laying in wet clothing. Interventions included to apply moisture barrier to skin after incontinent episodes, approach while awake and offer assistance to the toilet or with incontinent cares, encourage incontinent products as needed, have urinal within reach and offer assistance every 2.5-3 hours while awake, provide assistance for toileting every 2.5-3 hours when awake, keep call light in reach and remind resident to use.	F 690		

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R33's nursing assistant (NA) point of care document for 9/2023, indicated R33 refused incontinent cares once and had both incontinent and continent episodes documented.

When observed on 9/18/23 at 12:08 p.m., R33 was not in his room, however the room had a strong urine smell. An empty urinal was on R33's bedside table.

When observed on 9/18/23 at 5:07 p.m., R33 self-propelled from the dining area to his room. R33's room had a strong urine smell. When requested to speak with R33, [R33] stated "after I use the bathroom". R33 then proceeded to use the bathroom.

When observed on 9/19/23 at 7:56 a.m., there was a strong, pungent urine smell on the hallway leading to R33's room. R33's door was open and R33 was observed to be sleeping in bed wearing sweatpants. R33's sweatpants were visibly wet with urine.

When observed on 9/19/23 at 1:45 p.m., R33 was participating in an activity in the dining area. R33 had no signs of wet pants or incontinence. At 2:31 p.m., R33 left the activity and wheeled back to his room and entered the bathroom. At 2:36 p.m., R33 exited his room and returned to the group activity.

When observed on 9/20/23 at 6:37 a.m., R33's door was open and R33 was sleeping. The hallway surrounding R33's room had a strong urine smell. At 7:25 a.m., R33's call light went on and licensed practical nurse (LPN)-A entered the room at 7:28 a.m. LPN-A turned off the light and let R33 know the NA would be in shortly. At 7:30

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F 690	Continued From page 30 p.m., NA-D entered R33's room to assist with morning cares. R33's room had a strong foul smell of urine. NA-D assisted the resident to sit up in bed. R33's pants were soaked down to his knees. R33 used the walker to walk into the bathroom. Once in the bathroom, NA-D assisted R33 to pull down the urine-soaked pants and saturated brief. NA-D then gave some privacy for R33 to void and went to remove the saturated bed linen from R33's bed and placed in a bag. R33 had a plastic sheet that was ripped and wet that was left on the bed. After assisting R33 with cleaning and dressing, NA-D left the room to obtain a toothbrush for R33. At this point, R33 stood and turned towards the toilet and voided. NA-D returned and then set up R33 for oral cares. When interviewed on 9/18/23 at 5:16 p.m., R33 stated he was able to use the bathroom by himself and staff "helped when they can". R33 stated he could wheel to the toilet and stand to void. R33 further stated the urinal was only used when R33's roommate was in the bathroom, otherwise R33 used the toilet. A follow up interview on 9/20/23 at 7:53 a.m., R33 stated staff used to come and wake him up two or three times overnight to use the bathroom or help get cleaned up, but that no longer happened. R33 further stated it would be nice if they did but now "I just get cleaned up in the morning". When interviewed on 9/20/23 at 7:58 a.m., NA-D stated R33 was continent during the day but was not sure why he was incontinent at night. NA-D further stated R33 was "soaked like that" every morning and mostly used the bathroom during the day. NA-D stated R33 used the call light for help	F 690		

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sometimes, but mostly just went on his own. NA-D further stated night shift never reported why R33 was incontinent at night and never asked about it.

When interviewed on 9/20/23 at 8:32 a.m., NA-E stated R33 was incontinent sometimes but was mostly continent. NA-E stated R33 usually went to the bathroom by himself. NA-E further stated R33 was incontinent at times when R33 drank a lot of fluids but was normally able to tell when he had to urinate.

When interviewed on 9/20/23 at 9:04 a.m., registered nurse (RN)-A stated R33 was continent during the day and only had a few episodes of incontinence. RN-A further stated R33 was usually soaked when getting up in the morning and wasn't sure why R33 had increased incontinence at night. Furthermore, RN-A verified R33 was not on a toileting program and had no changes in how frequently R33 was incontinent.

When interviewed on 9/20/23 at 10:40 p.m., NA-F stated on nights resident rounds were completed twice a shift at midnight and again at 4:00 a.m. NA-F further stated during rounds, if resident had been incontinent, they were woken up to be cleaned up and changed. If residents did refuse, the nurse was informed, and the refusal documented. NA-F verified R33 was checked on during both rounds. R33 was always incontinent and never got up to use the bathroom on his own and always wore a brief. Furthermore, NA-F stated R33 sometimes refused, but with prompting, always got out of bed and to the bathroom to get cleaned up.

When interviewed on 9/20/23 at 1:32 p.m., LPN-A

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F 690	Continued From page 32 stated bladder assessments were completed annually, upon admission or with any significant change MDS assessment. Continence was determined by staff documentation during the look back period. Each quarter, the most recent bladder assessment was reviewed and if the bladder status was the same, no changes to the care plan were required. When the quarterly review was completed, care plan interventions were also reviewed to ensure appropriateness. LPN-A verified R33's bladder assessment from 1/2023 lacked some information, however staff documentation always showed R33 was both continent and incontinent. R33 used the bathroom a lot on his own during the day but still required assistance with incontinent cares. LPN-A stated there had been a time or two when R33 was noted to have incontinence during the day and verified R33 was not on a toileting plan or schedule. LPN- A stated they were not aware of any voiding patterns or patterns of when R33 was incontinent. LPN-A stated there had not been any changes to R33's incontinent status and was not aware of any increased incontinence at night with the last assessment review. Furthermore, when completing the bladder assessments and reivew, R33 had not been asked about incontinece as R33 may have some barriers in understnding due to his mental health diagnoses. However, LPN-A stated R33 had increased trust of staff and his environment and has come a long way in adjusting to the facility. LPN-A verified R33's care plan lacked interventions related to nighttime incontinence or waking R33 to offer toileting. When interviewed on 9/21/23 at 10:13 a.m., the director of nursing (DON) expected staff to complete a thorough bladder assessment that	F 690		

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F 690	Continued From page 33 included a review of their continence status, any patterns, barriers or other reasons for incontinence. DON further stated resident input to incontinece was also needed for a thourough assessment. Furthermore, the DON acknowledged a comprehensive bladder assessment was necessary to develop interventions to help ensure their toileting needs and goals are met. A facility policy on bladder assessments was requested however was not received. R69's admission Minimum Data Set (MDS), dated 8/13/23, indicated R69 had moderate cognitive impairment, required supervision with toileting, and had an indwelling catheter. R69's face sheet printed 9/23/23, diagnosis included acute cystitis with hematuria, type 2 diabetes mellitus with diabetic chronic kidney, retention of urine unspecified. R69's physician orders dated 8/7/23, indicated catheter output three times a day. R69's indwelling urinary catheter care plan updated 8/8/23, related to retention of urine, had a goal that included resident was to have catheter care managed appropriately as evidenced by not exhibiting signs of infection or urethral trauma. Interventions included avoid lying on top of tubing, avoid obstructions in the drainage, change catheter per md order, encourage usage of catheter strap. Assure enough slack is left in the catheter between the meatus and strap, keep catheter system closed as much as possible.	F 690		

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F 690	Continued From page 34 Observe urine drainage; observe for signs and symptoms of urinary tract infection; blood in urine, low back flank pain. Record the amount, type color, odor per facility policy. Update as needed. Observe for leakage. Provide needed assistance for catheter care. R69's bladder assessment dated 8/10/23, indicated indwelling catheter for urinary obstruction, benign prostate hypertrophy and decreased manual dexterity. R69's bladder care plan updated 8/31/23, indicated enhanced barrier precautions related to presence of indwelling foley catheter, with goal that included will not develop signs or symptoms of acute infection. Interventions included monitor for signs and symptoms of infections; staff to apply gloves and gown prior to facility identified high contact care activities. During observations on 9/20/23 at 9:30 a.m., nursing assistant (NA)-D provided morning cares for R69. NA-D brought in supplies including a trash bag, depends and a gown. R69 was on hospice, and unresponsive to communication and touch. NA-D washed R69's face and upper body and dried upper body with dry towel. NA-D then began to provide peri care to R69 washing groin area. NA-D did not clean catheter, which had dried blood and was bleeding since there was not enough slack between the catheter and the stat lock on R69's left upper thigh. R69's catheter had a leg strap in place. NA-D adjusted foley catheter removing from stat lock on R68's left upper thigh. As NA-D turned R69 away, towards the window, the catheter tubing was also clipped to the bed with a blue clip to mattress. The catheter tubing at insertion site was noted pulling during turning,	F 690		

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F 690	Continued From page 35 and began to pull even more, causing even more bleeding from catheter insertion site. Surveyor informed NA-D that catheter was pulling and should undo the clip to mattress for more slack. NA-D removed the clipping on the mattress to give more slack to prevent further pulling and bleeding from catheter insertion site. During interview on 9/20/23 at 10:12 a.m., nurse manager, licensed practical nurse (LPN)- C stated nursing assistants were expected to clean the catheter around insertion site and outward during peri cares. It was the expectation if a catheter was bleeding the nurse would be notified. During interview on 9/20/23 at 1:15 pm LPN-D stated had not been notified by NA-D that R69 had bleeding from catheter insertion site. LPN-D also stated R69 had been admitted with a foley catheter and when catheter was pulled a lot, he would often bleed from catheter. During interview on 9/20/23 at 1:33 p.m., NA-D stated should have cleaned the catheter insertion site during peri cares, especially with dried blood and active bleeding from catheter insertion site. NA- D also stated did not inform the nurse that R69 had had some bleeding due to catheter pulling from tubing not being slack enough with the stat lock a bit too far and pulling on the catheter. The facility Prevention of Catheter-Associated Urinary Tract dated 2017, indicated when a resident is admitted to the facility with a catheter in place, a thorough physical assessment, as well as history review will be completed. Secure catheter to avoid pulling and trauma to the	F 690		

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F 690	Continued From page 36 bladder and urethra.	F 690		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure insulin pens and an inhaler stored in the medication cart were labeled with an expiration date for 3 residents (R1, R3, R12). In addition, the facility failed to ensure an insulin pen stored in the medication cart was labeled with a legible resident name or	F 761	R1, R3 and R 12's medications were corrected with expiration dates on 9/20/23. Additionally, all med carts were reviewed to ensure insulin was labeled with resident name and expiration dates. All residents' insulin pens were audited to ensure expiration dates and proper labels.	10/27/23

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F 761	Continued From page 37 an expiration date for 1 unidentified resident. Findings include: R1's quarterly Minimum Data Set (MDS) dated 7/7/23, indicated R1 had moderate cognitive impairment, required extensive assistance with most activities of daily living (ADL) and had diagnosis of diabetes mellitus. R1's physician order dated 4/19/23, indicated Novolog Flexpen U-100 Insulin pen; 100 unit/mL (3mL). Administer subcutaneous (SQ) per sliding scale three times a day. R1's medication administration record (MAR) dated 8/1/23 through 8/31/23, indicated R1 received 34 units of insulin. R1's MAR dated 9/1/23 through 9/19/23, indicated R1 received 34 units of insulin. R3's admission MDS dated 6/29/23, indicated R3 had moderate cognitive impairment, required extensive assistance with most ADLs, and had diagnosis of chronic obstructive pulmonary disease (COPD). R3's physician order dated 6/23/23, indicated Arnuity Ellipta (fluticasone furoate) blister with device: 100 mcg/actuation; inhale 1 puff daily. R3's MAR dated 8/1/23 through 8/31/23 indicated R3 received Arnuity 31 times. R3's MAR dated 9/1/23 through 9/21/23 R3 received Arnuity 20 times in September through 9/20/21. R12's quarterly MDS dated 8/11/23, indicated R12 was cognitively intact, required extensive assistance with most ADLs, and had diagnosis of	F 761	All medication/treatments were visualized for expiration dates and proper labels are on all medications. All nurses/TMAs were educated on adding expiration dates and ensuring all medications are labeled properly. Education began on 10/17/2023 and will continue until all nurses and TMAs are re-educated. The DON or designee will audit 1 medication cart per unit per week x3 months for expiration dates and proper labels. Results will be provided to QA to analyze and determine ongoing frequency and duration.	

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F 761	Continued From page 38 diabetes mellitus. R12's physician order dated 3/31/23, indicated Novolog Flexpen U-100 Insulin pen; 100 unit/mL (3mL). Administer SQ 4 units two times a day when blood glucose over 150. R12's MAR dated 8/1/23 through 8/31/23 indicated R12 received 192 units in August. R12's MAR dated 9/1/23 through 9/21/23, indicated R12 received 112 units on insulin in September through 9/20/21. During observation and interview on 9/20/23 at 11:33 a.m., registered nurse (RN)-A removed and reviewed the insulin pen for R1. The insulin pen had a sticker indicating "open date"; however, the sticker was blank and lacked evidence when it was opened. RN-A stated not knowing when the pen was opened and that it should have been dated. RN-A further stated believed the pens were good for 28 days after opening. During observation and interview on 9/20/23 at 12:01 p.m., RN-A removed and reviewed the insulin pen for R12. The insulin pen had a sticker indicated "open date" however, the sticker was blank and lacked evidence when it was opened. RN-A stated not knowing when the pen was opened and that it should have been dated. Licensed practical nurse (LPN)-A assisted with medication cart review and stated all insulin was stored in the refrigerator until opened and once opened was good for 28 days. LPN-A stated the insulin pens should be dated when opened. A third insulin pen was removed which had a sticker "open date"; however, the sticker was blank and lacked evidence when it was opened. The resident label on this pen has black smudges on	F 761		

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F 761	Continued From page 39	F 761		

it which made the resident name illegible. RN-A confirmed all three insulin pens had been used, but could not state who the third pen had been used on.

During observation and interview on 9/20/23 at 1:48 p.m., trained medication aide (TMA)-A removed an Arnuity inhaler from a medication storage cart. The inhaler had a sticker indicating "open date"; however, it was blank and lacked evidence when it was opened. TMA-A stated it had been used and did not know when it was opened. TMA-A stated it should have been dated when opened but was not sure how long it was good for after opening.

During interview on 9/20/23 at 2:52 p.m., director of nursing (DON) stated expectation was for medication such as insulin and inhaler be dated when opened and that insulin was typically good for 28 days after opening.

During interview on 9/21/23 at 8:20 a.m., consultant pharmacist (CP) stated the Novolog Flexpen insulin pens should be dated when removed from refrigerator and opened and they were good for 28 days. After 28 days the efficacy decreased. CP further stated Arnuity inhalers were good for six weeks (42 days) after opening and should be dated when opened. CP stated there was a slight decrease in dose after the 6 weeks.

Facility policy Medication Storage dated 11/2018, indicated medications and biologicals should be stored properly following manufacturer's or supplier's recommendations. The policy further indicated when the original seal of a manufacture's container was initially broken, it

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F 761	Continued From page 40 was recommended that a nurse write the date opened on the medication container.	F 761		
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; (ii) When and to whom possible incidents of communicable disease or infections should be reported;	F 880		10/27/23

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F 880	Continued From page 41 (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 hand hygiene was completed for 1 of 1 resident (R33) observed for incontinent cares. Furthermore, the facility failed to ensure hand hygiene was completed during catheter cares and catheter cares were provided to minimize risk of infection for 1of 1	F 880	R69 has discharged from the facility. Resident #33 is provided care in accordance with infection control standards; resident is not exhibiting any signs or symptoms of infection. All residents are provided incontinence and catheter care in accordance to	

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F 880	Continued From page 42 residents (R69) observed for indwelling catheters. Findings include: R33's quarterly Minimum Data Set (MDS) dated 9/1/23, indicated R33 was cognitively intact and was frequently incontinent. Furthermore, R33's MDS indicated R33 had diagnoses of schizophrenia (mental health disorder where reality may be distorted) and benign prostrate hyperplasia (enlarged prostrate that can cause increased frequency of urination, BPH). During an observation on 09/20/23 at 7:30 a.m., nursing assistant (NA)-D entered R33's room to assist with morning cares. R33 was in bed and pants and linens were observed to besaturated with urine. NA-D donned gloves and assisted R33 to sitting up. NA-D provided choices of clean clothing and then laid R33's clean clothing choices on R33's walker. Using the walker, R33 then walked into the bathroom and stood in front of the toilet. NA-D assisted R33 in pulling down the urine-soaked sweatpants and urine-soaked brief. R33 then sat down on the toilet. NA-D removed R33's urine-soaked sweatpants and brief and placed the brief in the garbage and the sweatpants in a bag on the floor. Without exchanging gloves or performing hand hygiene, NA-D then assisted R33 with removing his shirt. The shirt was then placed with the sweatpants in the dirty laundry bag. Without glove removal or hand hygiene, NA-D then adjusted R33's clean pants that were hanging on the walker as they were slipping off. NA-D provided privacy and exited R33's bathroom. Without glove exchange or hand hygiene, NA-D removed R33's bedspread from the bed and placed on a 4 wheeled walker with seat that was stored along	F 880	standards to minimize risk of infection. All nursing staff were re-educated on proper hand hygiene with incontinent care and catheter care. Education began on 10/17/2023 and will continue until all staff are re-educated. The DON or designee will audit 3 incontinent residents/week/ x 3 months for proper gloving and hand hygiene performed. The DON or designee will audit 1 resident catheter care per week per unit x3 months for proper gloving and hand hygiene performed. Results will be provided to QA to analyze and determine ongoing frequency and duration	

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F 880	Continued From page 43 the wall. NA-D then removed the remaining urine-soaked linens from the bed and placed in a plastic bag and set on the floor. Without glove exchange or hand hygiene, NA-C then obtained R33's shoes and socks before re-entering the bathroom. Without hand hygiene or glove exchange, NA-D turned on warm water and placed clean washcloths in the sink. NA-D handed a warm washcloth to R33 to wash his face. NA-D used another clean washcloth to wash under R33's arms. NA-D pulled R33's walker closer so R33 could stand and used three washcloths to provide incontinent cares, which included cleaning off some dried stool from R33's bottom. Without glove exchange or hand hygiene, NA-Dhelped R33 put on clean brief and clean pants, socks and shoes. NA-D handed R33 their clean shirt to put on before assisting R33 to standing position and assisted to pull up the clean brief and sweatpants. Without hand hygiene or glove exchange, NA-Dthen picked up R33's comb and combed R33's hair. R33 then walked out of the bathroom to his wheelchair. Without glove removal or hand hygiene, NA-D opened R33's bathroom cupboards moving items around searching for R33's toothbrush. Unable to find one, NA-D then removed the gloves and without performing hand hygiene, left R33's room to obtain a new one. R33 then wheeled himself into the bathroom, stood and voided in the toilet and sat back down in the wheelchair. NA-D returned with a new toothbrush, donned gloves and set R33 up to brush their teeth. NA-D then tied up the dirty linen bags and removed gloves. Without hand hygiene, NA-D left R33's room to place soiled bags in dirty utility room. R33 had left for breakfast. When interviewed on 9/20/23 at 7:58 a.m., NA-D	F 880		

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F 880	Continued From page 44 verified glove removal and hand hygiene was not completed between handling soiled items and clean items, after incontinent cares were provided, or before exiting R33's room. NA-D further stated the resident sink was not typically used for hand hygiene, but rather the one down near the dining area. When interviewed on 9/20/23 at 1:32 p.m., licensed practical nurse (LPN)-A stated staff were expected to remove gloves and perform hand hygiene upon entering and exiting a room, after handling any soiled items, and after moving from a dirty area to a clean area during cares. When interviewed on 9/21/23 at 10:15 a.m., the director of nursing (DON) expected staff to perform hand hygiene when moving from a soiled or contaminated area to a clean area during resident cares. Furthermore, proper hand hygiene was important to minimize risk of transferring bacteria around and to prevent infections. A facility policy titled Hand Hygiene dated 6/2017, directed staff to perform hand hygiene before and after direct resident contact, assisting with personal cares, before and after assisting a resident to the bathroom, after handling soiled linens, and after glove removal.	F 880		

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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 880	Continued From page 45 R69's admission Minimum Data Set (MDS) dated 8/13/23, indicated R69 had moderate cognitive impairment, required supervision with toileting, and had an indwelling catheter. R69's face sheet printed 9/23/23, diagnosis included acute cystitis with hematuria, type 2 diabetes mellitus with diabetic chronic kidney, retention of urine unspecified. R69's physician orders dated 8/7/23, indicated catheter output three times a day. R69 indwelling urinary catheter care plan updated 8/8/23, related to retention of urine, had a goal that included resident was to have catheter care managed appropriately as evidenced by not exhibiting signs of infection or urethral trauma. Interventions included avoid lying on top of tubing, avoid obstructions in the drainage, change catheter per md order, encourage usage of catheter strap. Assure enough slack is left in the catheter between the meatus and strap, keep catheter system close as much as possible. Observe urine drainage; observe for signs and symptoms of urinary tract infection, blood in urine, low back flank pain. Record the amount, type color, odor per facility policy. Update as needed. Observe for leakage. Provide needed assistance for catheter care. R69's bladder assessment dated 8/10/23, indicated indwelling catheter for urinary obstruction, benign prostate hypertrophy and decreased manual dexterity. R69's bladder care plan updated 8/31/23, indicated enhanced barrier precautions related to presence of indwelling foley catheter, with goal	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245365	A. BUILDING _____ B. WING _____	C 09/21/2023

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CERENITY MARIAN OF ST PAUL LLC	200 EARL STREET SAINT PAUL, MN 55106

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F 880	Continued From page 46 that included will not develop signs or symptoms of acute infection. Interventions included monitor for signs and symptoms of infections; staff to apply gloves and gown prior to facility identified high contact care activities. During observation on 9/19/23 at 10:09 a.m., R69's catheter bag was noted touching floor. The bed was in a low position. No privacy bag in place, to prevent catheter bag from touching the floor. During observation on 9/19/23 at 2:20 a.m., R69 was in bed asleep. R69's bed was in low position with catheter touching the floor. No privacy bag in place to prevent R69's catheter bag from touching the floor. During observations on 9/20/23 at 9:30 a.m., nursing assistant (NA)-D provided peri care for R69 and cleaned anterior peri area. NA-D then took the washcloth placed it on top of the pink basin filled with water and on top of the bedside table. NA-D rinsed washcloth in water and used the same washcloth to remove blood off R69's left leg which had blood from catheter insertion site, although did not clean the catheter insertion site. NA-D then turned R69 away towards the wall, to provide perianal care. R69 did not have a bowel movement. After providing perianal care, NA-D did not change gloves and took a dry towel from on top of a plastic bag on floor and dried R69's perianal area, back, and legs. NA-D then went and applied barrier cream to R69's perianal area and then changed gloves and fastened depends. No hand sanitizing or hand washing observed between glove changes at this point. During interview on 9/20/23 at 10:12 a.m., nurse	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245365	A. BUILDING _____ B. WING _____	C 09/21/2023

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CERENITY MARIAN OF ST PAUL LLC	200 EARL STREET SAINT PAUL, MN 55106

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F 880	Continued From page 47 manager, licensed practical nurse (LPN)- C stated nursing assistants were expected to keep catheter bags from touching the floor and the catheter bags should be in a privacy bag. LPN-C verified R69's catheter bag was resting on the floor although secured to the bed frame and should not have been touching the floor but in a privacy bag. During interview on 9/20/23 at 1:33 p.m., NA-D stated should have changed gloves after providing perianal cares and should have used another washcloth to clean the blood from R69's left leg which had blood on it from the bleeding catheter insertion site. The facility Prevention of Catheter-Associated Urinary Tract dated 2017, indicated though prevalence of indwelling urinary catheter use in the long-term care setting is lower than in the acute care setting, catheter-associated UTI (CAUTI) can led to such complications as cystitis, pyelonephritis, bacteremia, and septic shock. These complications associated with CAUTI can result in a decline in resident function and mobility, acute care hospitalizations, and increased mortality. Prevention is key.	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245365	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**09/21/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CERENITY MARIAN OF ST PAUL LLC	**200 EARL STREET** **SAINT PAUL, MN 55106**

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K 000	INITIAL COMMENTS The Minnesota Department of Public Safety conducted an annual Life Safety recertification survey, State Fire Marshal Division, on September 21,2023. At the time of this survey, Cerenity Marian of St. Paul was found 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, the Health Care Facilities Code. Cerenity Care Center Marian is a 5-story building with a partial basement. The building was constructed at 3 different times. The original building was constructed in 1963 and was determined to be of Type I(332) construction. In 1969 a 2 story addition was constructed above the 3rd story that was determined to be of type I(332) construction. In 2002 a 1 story addition was constructed to the north that was determined to be type I(332) construction. The building is protected by a full fire sprinkler system. The facility has a fire alarm system with full corridor smoke detection, resident rooms and spaces open to the corridors that are monitored for automatic fire department notification. The facility has a capacity of 90 beds and had a census of 72 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is MET.	K 000		

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

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.