Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

January 13, 2023

Administrator
Bywood East Health Care
3427 Central Avenue Northeast
Minneapolis, MN 55418

RE: CCN: 24E185
Cycle Start Date: December 22, 2022

Dear Administrator:

On December 22, 2022, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Pete Cole, RN Unit Supervisor
Metro Team C District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Office/Mobile: (651) 249-1724

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

If substantial compliance with the regulations is not verified by March 22, 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 June 22, 2023 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

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

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

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

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

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4384
Email: holly.zahler@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24E185	A. BUILDING _____ B. WING _____	C 12/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BYWOOD EAST HEALTH CARE	3427 CENTRAL AVENUE NORTHEAST MINNEAPOLIS, MN 55418

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments On 12/19/22, through 12/22/22, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, was conducted during a standard recertification survey. The facility was not in compliance. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulation has been attained.	E 000		
E 007 SS=C	EP Program Patient Population CFR(s): 483.73(a)(3) §403.748(a)(3), §416.54(a)(3), §418.113(a)(3), §441.184(a)(3), §460.84(a)(3), §482.15(a)(3), §483.73(a)(3), §483.475(a)(3), §484.102(a)(3), §485.68(a)(3), §485.542(a)(3), §485.625(a)(3), §485.727(a)(3), §485.920(a)(3), §491.12(a)(3), §494.62(a)(3). [(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 the following:] (3) Address [patient/client] population, including, but not limited to, persons at-risk; the type of services the [facility] has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession	E 007		2/10/23

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

Electronically Signed | 01/19/2023

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 007	Continued From page 1 plans.** *[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. The plan must do all of the following: (3) Address resident population, including, but not limited to, persons at-risk; the type of services the LTC facility has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans. *NOTE: ["Persons at risk" does not apply to: ASC, hospice, PACE, HHA, CORF, CMCH, RHC/FQHC, or ESRD facilities.] This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility All-Risk Emergency Operations Plan failed to address the resident population including, but not limited to, residents most at-risk; the type of services the facility has the ability to provide in an emergency and continuity of operations that could be provided to those residents most at risk. This had the potential to affect all 79 residents residing in the facility. Findings include: The facility Emergency Preparedness Program (EPP) dated 8/21/22, did not identify at-risk residents and services the facility had and/or could provide during an emergency to ensure continuity of care for at-risk residents. During an interview on 12/22/22, at 1:00 p.m. the director of maintenance (DMN) verified the facility	E 007	All residents had the potential to be affected. The Emergency Plan has been reviewed. The shelter in place policy has been reviewed and updated to include identification of at risk residents. The EP committee will meet annually to review.	

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E 007	Continued From page 2 EPP did not identify at-risk residents who may require special services or care during an emergency or services the facility had or could provide at-risk residents to ensure their safety and continuity of care during an emergency. The facility Shelter in Place policy dated 10/22, indicated nursing would assess and identify residents who required services that are not provided by the facility but are medically necessary and coordinate with transportation/emergency transportation to ensure at risk residents continued to receive medically necessary services. The policy lacked an assessment and identification of the at risk population in the facility and the services they would need during an emergency.	E 007		
F 000	INITIAL COMMENTS On 12/19/22, through 12/22/22, a standard recertification survey was conducted at your facility. Complaint investigations were also conducted. Your facility was found to be not in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaint was found to be substantiated: HE185199C (MN80950) with a deficiency cited at F676, and The following complaints were found to be unsubstantiated:	F 000		

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F 000	Continued From page 3 HE185195C (MN81308) HE185196C (MN76141) HE185197C (MN78993) HE185198C (MN78998) HE1856795C (MN85804) HE1856691C (MN84930 and MN84928) HE1856693C (MN88360) HE1856694C (MN87637) HE1856935C (MN89436) The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F 000		
F 550 SS=B	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and	F 550		2/10/23

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F 550	Continued From page 4 promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide a dignified, home-like dining experience, including use of real ceramic dishware and metal utensils, for 5 of 5 residents (R12, R23, R37, R13, R56) observed to eat in their room and/or be identified to consistently eat meals in their rooms. Findings include: During observation of the supper meal in the	F 550	All residents had the potential to be affected. The dietary manger will order a larger supply of non-disposable meal service items. To ensure all residents are provided a dignified dining experience. All dietary staff will be educated on the proper use disposable and non-disposable meal service items. The dietary manager will perform weekly audits for one month and the monthly	

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F 550	Continued From page 5 main dining room, on 12/19/22 at 5:01 p.m., the meal service was started with residents being provided meal on ceramic or hard-plastic plates and regular, metallic utensils. However, on 12/19/22, at 5:31 p.m. nursing assistant (NA)-D was observed coming off the elevator on the 2nd Floor with a single tray which had multiple Styrofoam containers and plastic utensils stacked on it. NA-D stated they were the supper meals for residents in their rooms, and she proceeded to hand these containers out to their respective resident' room. At 5:37 p.m., NA-D was interviewed and stated she had worked at the nursing home for several shifts while being employed from the staffing agency. NA-D verified Styrofoam containers and plastic utensils were used for in-room meal trays; however, then explained the residents' served in the main dining room received ceramic dishware and metal utensils. NA-D was unsure why residents in their rooms got served on disposable dishware while others, in the main dining room, did not. NA-D then proceeded to enter R12 and R23's shared room and provide them their meals on the disposable dishware. R12's quarterly Minimum Data Set (MDS), dated 10/7/22, identified R12 had cognitive impairment, severely impaired decision making, and required extensive assistance with eating. On 12/19/22, at 6:03 p.m. R12 was observed in her room and had been served her meal on the disposable dishware, however, R12 was not interviewable. R23's quarterly MDS, dated 10/14/22, identified R23 had intact cognition. On 12/19/22 at 6:05 p.m., R23 was interviewed about her supper meal which had been served on disposable dishware	F 550	thereafter until substantial compliance is achieved. Results will be present at QAPI.	

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F 550	Continued From page 6 with plastic utensils. R23 stated she was "always" served on such dishware and didn't like using plastic forks and knives adding, "I am sick of plastic silverware." R23 stated she had been told the room trays needed to use disposable dishware as people "kept stealing it [regular dishware]" but expressed frustration as plastic cutlery was difficult to use and "don't work" to cut up meats. R23 stated she didn't tell staff she disliked the disposable items as "they would just laugh at me." A Residents Allowed to Eat in the Room listing, undated, identified additional residents who consistently were served meals, and room trays with disposable dishware as a result, in their room were R37, R13, and R56. On 12/22/22 at 9:57 a.m., the director of nutritional services (DNS) was interviewed. They explained the meal trays used Styrofoam and plastic utensils as the care staff were not returning dishware to the kitchen, so they switched to disposable items. DNS stated they understood no residents, unless on isolation or quarantine, were supposed to be eating in their rooms which was even announced at a previous Resident Council meeting. Further, during subsequent interview on 12/22/22 at 10:35 a.m., DNS verified disposable items, including Styrofoam containers and plastic utensils, had been used for over a year. On 12/22/22 at 10:54 a.m., the administrator was interviewed. He explained they had changed to using disposable items for convenience of the staff, and to help retain their ceramic (i.e., non-disposable) dishware as it was being thrown away and kept going missing.	F 550		

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F 550	Continued From page 7 A facility policy on homelike, dignified dining was not provided.	F 550		
F 570 SS=B	Surety Bond-Security of Personal Funds CFR(s): 483.10(f)(10)(vi) §483.10(f)(10)(vi) Assurance of financial security. The facility must purchase a surety bond, or otherwise provide assurance satisfactory to the Secretary, to assure the security of all personal funds of residents deposited with the facility. This REQUIREMENT is not met as evidenced by: Based on Interview and document review, the facility failed to ensure the surety bond (a contract or promise by a surety or guarantor to pay if a second party fails to meet the obligation) contained sufficient funds to insure and protect the total account balance of the residents' trust fund, which had the potential to affect 51 residents of 78 residents who resided in the facility and kept personal funds with the facility with a positive account balance. Findings include: A Bywood East Health Care Trust Account Balance listing printed 12/21/22, at 12:59 p.m. identified 51 residents had current trust fund accounts with a positive balance. The total balance of the accounts was $82,437.35. The facility's surety bond effective June 14, 2021, noted the current value of the surety bond contained the sum of $80,000, a sum of which was inadequate to cover the amount of the resident trust fund.	F 570	All 51 residents with trust accounts had the potential to be affected. The Surety bond has been raised to $85,000. The current resident trust account balance is $74662.55. The administrator or their designee will do monthly audits to verify that the trust balance does not exceed the surety bond. Results will be presented at QAPI.	2/10/23

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F 570	Continued From page 8 During the entrance conference on 12/19/22, at 12:26 p.m. the administrator stated the surety bond for the facility was short of covering the amount of money in the resident accounts and would provide documentation for the amount in the surety bond, and the balance in the resident accounts. Documentation of the surety bond value, and the resident account balances was requested again on 12/21/22, at 12:00 p.m. The administrator forwarded the document request to the chief financial officer (CFO), on 12/21/22, at 12:01 p.m. The administrator provided a printed copy of the balances at 12/21/22, at 12:59 p.m. that indicated the balance of the resident accounts was $82,437.35. An email from the CFO to the surety bond company indicated the CFO requested an increase in the surety bond amount on 12/21/22, at 12:38 p.m. When interviewed on 12/21/22, at 1:38 p.m. the administrator stated the surety bond of $80,000 would not cover the resident account of $82, 437.35. When interviewed on 12/21/22, at 2:05 p.m. the CFO stated one resident had recently inherited some money, and the facility would need to increase the surety bond. The CFO further indicated the balance supported by the bond had been short for a few weeks, and that it could be while, according to an email she received from the bond company, before the bond amount would be adjusted, but the increase had been requested on 12/21/22.	F 570		

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F 570	Continued From page 9 The Resident Trust Fund and Authorization Policy dated 10/6/22, indicated Bywood maintains a surety bond to insure the security of all personal funds deposited with the facility.	F 570		
F 637 SS=D	Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii) §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to review for and/or complete a significant change in status assessment (SCSA) when two or more areas of change in resident status were identified for 1 of 1 resident (R42) reviewed for activities of daily living (ADL). Findings include: R42's quarterly minimum data set (MDS) dated 10/28/22, identified R42 with bipolar disorder, psychotic disorder, diabetes, delusions, and major depression with intact cognition. In addition, R42 needed extensive assist of 2 staff for toileting and personal hygiene and that she is "always" incontinent of bowel and bladder.	F 637	The resident has a planned discharge date of 1-23-23 in into the community. All residents had the potential to be affected. The Policy for change in resident status will be reviewed. MDS nurse will be educated on change in resident status policy. IDT will review all residents who have a change in condition to determine if a significant change MDS needs to be completed. All results will be presented at QAPI until substantial compliance is achieved.	2/10/23

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F 637	Continued From page 10 R42's care plan interventions dated 8/1/22 indicate R42, "is currently assist +2 for toileting and assist of one (sometimes 2) with wheelchair mobility." R42's progress note dated 10/28/22 stated R42, "needs extensive assistance w/all ADLs, transfers, and states staff feed her as she is unable to do so herself." During observation on 12/20/22 at 3:27 p.m., resident was transferred to her wheelchair with the assistance of one nursing assistant (NA)-F. During interview on 12/21/2022 at 8:25 a.m., with NA-B stated she walks with R42 once a shift. NA-B stated, "it takes just one to transfer" R42 and that R42 is normally continent of bladder when she assisted to the bathroom. On 12/22/22 at 9:22 a.m. and 10:38 a.m., respectively, R42 was observed to self-propel herself in her wheelchair down the hall and to the elevator with no assistance and eat a meal independently. During interview with R42 on 12/19/22 at 1:10 p.m., R42 stated she is able to use the toilet and sense when she needs to void but needs assistance from staff to transfer. R42 further stated on 12/22/22 at 9:22 a.m. that she feeds herself meals with utensils in dining room. During interview with registered nurse (RN)-A on 12/22/22 at 9:32 a.m., RN-A stated that if a resident was improving or declining in any area, that would be communicated to the resident's provider and the interdisciplinary team (IDT), and	F 637		

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F 637	Continued From page 11 that resident would then be reassessed. She stated she was unaware if this had occurred for R42. During interview with registered nurse (RN)-B who is also the facility's MDS coordinator, on 12/22/22 at 9:45 a.m., RN-B stated that a significant change is considered if the change effects how well a resident can perform their ADLs (activities of daily living), whether it be decline or improvement. RN-B stated R-42, "has had some improvement lately. I have seen her in the hallway ambulating with staff, which is great, so she is making improvements." RN-B did not provide reason for failing to initiate a SCSA on R42. During interview with the director of nursing (DON) on 12/22/22 at 1:13 p.m., DON stated that a significant change assessment should be done for residents who are improving. When residents are improving it is discussed amongst the interdisciplinary team (IDT) and subsequently the resident is reassessed, and their care plan should be updated to allow staff to properly care for each resident. The DON did not provide reason for failing to initiate a SCSA on R42.	F 637		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial	F 656		2/10/23

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F 656	Continued From page 12 needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document	F 656	DON will coordinate outside hospice	

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F 656	Continued From page 13 review, the facility failed to ensure a comprehensive care plan was developed and readily available to facilitate coordination of care with an outside hospice agency for 1 of 1 resident (R12) reviewed for hospice care; and failed to ensure a comprehensive care plan for oxygen use was developed to guide care and reduce the risk of complication (i.e., infection, nare [nostril] dryness) for 1 of 2 residents (R7) reviewed who used oxygen. Findings include: R12's quarterly Minimum Data Set (MDS), dated 10/07/22, identified R12 had short and long-term memory impairment, required extensive assistance with activities of daily living (ADLs), and was on hospice care while a resident at the nursing home. On 12/20/22 at 2:53 p.m., R12 was observed laying on her bed in her room. R12 appeared comfortable and without obvious physical signs or symptoms of pain at this time. However, R12 did not meaningfully respond to verbal questions when asked aside from saying, "good," aloud. R12's facility' care plan, dated 7/11/22, identified R12 had new orders for hospice care for a diagnosis of failure to thrive. A goal was listed which read, "[R12] will be kept comfortable through review date," along with interventions to meet this goal which included acknowledge the presence of pain, give as-needed medication for breakthrough pain, and ,"Hospice care to be provided by hospice agency." However, the care plan lacked what, if any, additional services hospice would be providing for R12 (i.e., bathing, nurse assessment), nor how often or when each	F 656	agency to update hospice plan. All residents who are currently enrolled in hospice had the potential to be affected. All residents who are enrolled in hospice will have their care plans reviewed. All residents who are on oxygen had the potential to be affected. R-7 care plan was updated. All current residents with oxygen will be reviewed and all new admissions with oxygen will be reviewed. MDS, QA and DON will be educated on care plan policy to include outside agency care plan. Will audit care plans of current resident on hospice and new admissions that are sign up for hospice monthly until compliance has been achieved. Results will be presented at QAPI.	

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F 656	Continued From page 14 respective discipline (i.e., nursing, social worker) would visit R12 at the nursing home. When interviewed on 12/20/22 at 3:00 p.m., nursing assistant (NA)-D stated she had worked with R12 several times in the past few weeks, however, was unsure of what, if any, services R12's hospice agency was providing for R12. NA-D stated she "once saw a guy" who she thought was from hospice in R12's room; however, added, "I think I saw it [only] once." Further, NA-D stated she was not sure how hospice communicated with staff to notify them when they were going to be onsite or provide cares for R12 adding she "hadn't had such a conversation with them." On 12/21/22 at 9:35 a.m., registered nurse (RN)-A was interviewed. RN-A verified R12 was currently on hospice care with an outside agency and provided a binder from the nursing office labeled, "Hospice Chart," which contained R12's hospice personnel contact information and established R12's hospice care effective 7/6/22. The binder and it's contents were reviewed. Inside, a green-colored sign in sheet was provided which directed, "All Hospice Staff - Complete ALL FOUR columns for Each Visit," with corresponding areas to record the date of visit, staff name, discipline, and anticipated next date. However, there were no recorded social worker visits on the listing(s) inside demonstrating a visit had been completed. In addition, a Hospice Plan of Care Update, dated 11/1/22, identified an effective date through 11/14/22, and listed R12 would have a HHA (home health aide) visit twice a week; social worker visit one to two times every four weeks; skilled nursing visits one to two time	F 656		

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F 656	Continued From page 15 each week; and spiritual care visits one to four times every three months. The listed date(s) of services ran through 12/31/22; however, there was no further, more current care plans or updated interdisciplinary notes contained inside the binder when provided, demonstrating if all these services were still in effect or not (as there were no recorded social worker visits on the sign-in sheets). RN-A stated she was "not sure" when hospice nurses were scheduled to visit, however, RN-A was "sometimes" told prior to them coming of their impending visit. At 9:35 a.m. the director of nursing (DON) joined the interview and stated the current care plan was "old" and needed to be replaced. The DON expressed there had been some issues with getting documentation from the hospice agency adding the nursing home did not "seem to be a priority" for them. On 12/21/22 at 4:09 p.m., hospice registered nurse (RN)-C was interviewed. RN-C verified R12 was on hospice care with their agency and expressed R12 was "coming up" for a face-to-face recertification. RN-C acknowledged the care plan at the nursing home was no longer in effect and explained she would be bringing a new one on her next visit. RN-C stated she had been off work for awhile and so the new one had not been delivered to the nursing home. R7's MDS dated 11/4/22, indicated R7 was cognitively intact, had asthma, chronic obstructive pulmonary disease (COPD), or chronic lung disease, and had shortness of breath when lying flat, sitting at rest, and with exertion. The MDS further indicated R7 used oxygen therapy.	F 656		

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F 656	Continued From page 16 R7's face sheet dated 12/21/22, indicated diagnosis of COPD and influenza A virus. R7's care plan revised 5/12/22, indicated a focus area for ineffective breathing related to the diagnosis of COPD and chronic obstructive asthma, but lacked mention of oxygen use. R7's provider orders dated 8/25/20, indicated R7 used oxygen to keep oxygen saturation greater than 90%. When interviewed on 12/20/22, at 8:55 a.m. R7 had an oxygen tank in her her and R7 stated she used oxygen as needed when she felt short of breath. When interviewed on 12/20/22, at 03:23 p.m. trained medication aide (TMA)-C stated oxygen therapy should addressed on the care plan and acknowledged it was not. When interviewed on 12/20/22, at 3:30 p.m. licensed practical nurse (LPN)-C stated oxygen should be addressed on the care plan, and acknowledged R7's care plan did not mention oxygen therapy. When interviewed on 12/20/22, at 3:31 p.m. registered nurse (RN)-A stated oxygen therapy should be addressed on the care plan, and verified the care plan lacked interventions for oxygen therapy. When interviewed on 12/21/22, at 10:36 a.m. the director of nursing (DON) stated her expectation was for oxygen use to be addressed on the care plan.	F 656		

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F 656	Continued From page 17 The Care Planning Policy dated 10/2022, indicated the resident's care plan should contain measurable objectives to meet the medical, nursing, and psychosocial needs that have been identified in the comprehensive resident assessment.	F 656		
F 676 SS=D	Activities Daily Living (ADLs)/Mntn Abilities CFR(s): 483.24(a)(1)(b)(1)-(5)(i)-(iii) §483.24(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that: §483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section ... §483.24(b) Activities of daily living. The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living: §483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care, §483.24(b)(2) Mobility-transfer and ambulation, including walking, §483.24(b)(3) Elimination-toileting,	F 676		2/10/23

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F 676	Continued From page 18 §483.24(b)(4) Dining-eating, including meals and snacks, §483.24(b)(5) Communication, including (i) Speech, (ii) Language, (iii) Other functional communication systems. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide a bath and provide proper care and treatment, including assistive devices, to maintain or improve the resident's communication abilities, failing to have any interventions in place to properly communicate with 1 of 1 residents (R327) reviewed for Activities of Daily Living (ADL's). Finding Include: R327's Minimum Data Set (MDS) 5 day admission assessment dated 12/8/22, indicated that R327's self-performance with bathing was not assessed. It further lacked information on R327's cognitive status. R327's diagnosis include dementia without behavioral disturbance, mood disturbance and anxiety. R327's admission note in the electronic medical record (EMR) dated 12/8/22, indicated that R327 required an assist of one with ADLs. R327's treatment administration record (TAR) since admission on 12/8/22 indicated no bath or refusals were documented. R327's care plan dated, 12/12/22, did not address interventions for assistance with ADL's.	F 676	R327 has been added to the bath list. All residents had the potential to be affected. Quality of care and Trauma informed care policy and procedure has been reviewed and updated. QA nurse or designee will audit all bath lists after new admissions. MDS, QA and DON will be educated on Quality of care and Trauma informed care policy and procedure. Results will be reviewed at QAPI. R327 care plan will be reviewed and updated. All residents that are assessed to be hard of hearing will have their care plans reviewed and updated to include interventions for communication. Results will be presented at QAPI. MDS, QA and DON will be educated on Quality of care and Trauma informed care policy and procedure. All nursing staff will be educated on Quality of care and Trauma informed care policy and procedure to maintain residents ADL’s. Nursing staff will be assign a module on ADL’s on EduCare.	

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F 676	Continued From page 19 During interview on 12/19/22 at 6:13 p.m., R327 stated she had not had a shower since admission and would like one. During interview on 12/20/22 at 3:09 p.m., nursing assistant (NA)-D stated that staff utilize the bathing schedule, located in a binder at the NA station, to know when to bathe residents. NA-D further stated R327 was due for a bath on Tuesday afternoons and that R327 had not received a bath on the evening shift since admission. NA-D stated staff are expected to notify the nurse when a resident refuses a bath so it can be documented as a refusal in the TAR. During interview on 12/21/22 at 9:05 a.m., with R327's guardian (GH) stated that R327's son visited the facility on 12/17/22 and stated he was very upset, "it didn't even look like she had had a shower since she arrived." GH further stated that hygiene is, "very important" to R327. "She used to be a type of lady that all of her clothes, shoes, and jewelry matched." Facility policy titled Quality of Care and Trauma Informed Care Policy was reviewed which indicated, "A resident must be given appropriate treatment and services to maintain or improve his or her ability to bathe, dress, groom, transfer, ambulate. " Communication R327's initial Minimal Data Set (MDS) dated 12/8/22 stated that R327 had minimal hearing loss. Review of progress notes dated 12/8/22, indicated R327 had difficulty focusing during her initial assessment and displayed confusion. The progress note indicated R327, "Did state at times	F 676		

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F 676	Continued From page 20 difficulty hearing". Interview with R327 on 12/19/22 at 6:16 p.m. stated that staff "communicates" with her "very little". R327's care plan lacked interventions on how to communicate with R327 until 12/19/21 which is 11 days after she was admitted to the facility. Interview with facility nursing assistants (NA)-D and NA-F on 12/20/22 at 3:12 p.m., stated how to communicate with R327 was not care planned and NA-F stated she was not aware that R327 was hard of hearing. NA-D and NA-F stated they would sometimes write things down or point to things to communicate with R327. During interview with facility nursing assistants on 12/21/22 at 9:42 a.m., NA-B stated that there were no interventions on R327's care plan on how to communicate with R327. NA-B stated she, "talks loud" to communicate with R327 and NA-E stated, "She (R327) doesn't communicate with us. I talk to her, and she doesn't talk back." NA-E stated she was unaware if R327 can hear her, "she just doesn't communicate with me". During interview with registered nurse (RN)-A on 12/21/22 at 10:28 a.m., RN-A stated it was not clear on how to communicate with R327 as there was "not much" on the care plan. RN-A stated, "If you go close and face her directly, she tends to understand what you are saying, but I am not sure." During interview with R327's legal guardian (GH), on 12/21/22 at 9:05 a.m., GH stated that R327 is very hard of hearing and had hearing aides prior to being admitted to the facility but had lost them	F 676		

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F 676	Continued From page 21 at home. The facility's policy titled Quality of Care and Trauma Informed Care policy was reviewed and stated, "Each resident must receive, and faculty must provide the necessary care and services to attain and maintain the highest practicable, physical, mental and psychosocial well-being in accordance with the comprehensive assessment and plan of care."	F 676		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure timely assistance with eating was provided to promote adequate nutrition for 1 of 5 residents (R12); and failed to ensure assistance with bathing was provided and recorded for 2 of 5 residents (R23, R55) reviewed for activities of daily living (ADLs) and who required staff assistance to complete their care. Findings include: R12's quarterly Minimum Data Set (MDS), dated 10/7/22, identified R12 had both long and short-term memory impairment and had severely impaired decision making skills. Further, the MDS identified R12 required extensive assistance with eating and demonstrated no rejection of care behavior.	F 677	R12 and R23 will be provided assistance as needed with meals and bathing. All residents who require assistance with eating and bathing had the potential to be affected. Quality of care and Trauma informed care policy and procedure has been reviewed and updated. All nursing staff will be educated on ADL□s. Bath sheets will be audit monthly by the DON or designee until substantial compliance is achieved. Meal assistance will be audited randomly weekly for one quarter or until substantial compliance is achieved. Results will be presented at QAPI.	2/10/23

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F 677	Continued From page 22 R12's care plan, revised 10/2/22, identified R12 was at increased risk of nutritional deficit due to chronic illness and poor oral intake. A goal was listed which read, "Will be as nourished as possible within limitations of disease process," along with several interventions to help R12 meet this goal. These included nutritional supplement as ordered, and, "Encourage to eat 3 meals/day and provide assistance with feeding self." On 12/19/22 at 2:19 p.m., R12 was observed laying in her bed while in her room. R12's hair was unkept and she did not verbally respond to questions when asked. The bedside table had multiple, both open and unopened, containers of Ensure nutritional supplement present on them. At this time, R12's roommate, R23, spoke aloud and stated, "It's so sad what they [staff] do to her." R23 explained R12 is often ignored by staff and added they "don't feed her" always so she will, at times, go without eating meals. R23 stated, "She [R12] deserves better care." During observation of the supper meal, on 12/19/22 at 5:01 p.m., R12 remained laying in her bed while in her room. Nursing assistant (NA)-D entered R12's room and asked her roommate, R23, aloud what she wanted to eat for dinner. NA-D then walked over to R12, who remained in bed with her eyes closed, looked down at a white-colored menu slip and left the room with no verbal interaction to R12. At 5:31 p.m., NA-D walked off the elevator on the unit with a stack of disposable containers and plastic silverware and started passing the meals out to various rooms. A few minutes later, NA-D entered R12's room and placed two covered disposable bowl-shaped containers on R12's bedside table which was	F 677		

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F 677	Continued From page 23 pulled away from the bed. NA-D then turned and walked away from R12 with no verbal interaction, setting up of the meal items, or offer/attempt to assist R12 with eating. At 5:48 p.m., licensed practical nurse (LPN)-B entered R12's room and answered R12's roommate' call light, followed by NA-D. However, they both then left the room without any offer to assist R12 with eating and both of the placed containers remained on the bedside table. At 6:03 p.m. (29 minutes after R12's room tray was delivered), LPN-B again entered the room and visited with R12's roommate about her blood pressure. R12's meal and utensils remained on the bedside table, untouched, along with a white-colored menu slip which identified R12's name, diet, and a section labeled, "Special Notes," which directed, "Requires Feeding Assist." LPN-B then left the room with no attempt or offer to wake or feed R12. At 6:08 p.m. (34 minutes after R12's room tray was delivered) NA-D and trained medication aide (TMA)-D were interviewed and verified neither had offered or attempted to wake and assist R12 with eating, despite NA-D delivering the meal tray over 30 minutes prior. NA-D stated they were "supposed to do it [assist her]" but there was not enough staff present on the unit to help feed residents and ensure call lights got answered timely, so helping with feeding had to wait. NA-D then entered R12's room and discussed feeding R12 with NA-A aloud. Later, on 12/19/22 at 6:24 p.m., NA-A approached the surveyor and expressed R12 did take several bites of the tomato soup when they offered and assisted her following the surveyor' interview. When interviewed on 12/19/22 at 6:31 p.m.,	F 677		

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F 677	Continued From page 24 LPN-B stated R12 needed help with most cares, including eating, and verified staff should have offered or attempted to feed R12 when they served the meal to her. LPN-B added, "I think she needs total assist." LPN-B stated they were aware of the lack of staffing on the unit that night and expressed R12 not being assisted timely with eating was likely due to "just no staff" being present. Further, LPN-B commented they had noticed the coordination of cares (i.e., feeding, toileting) between the NA(s) was "often" poor when not fully staffed. On 12/21/22 at 9:23 a.m. registered nurse (RN)-A verified R12 should have been offered or assisted with eating when the meal tray was served. This was important to do as elderly persons will lose their sense of taste as they age and if the food is cold when provided, they may not eat as much which could impact them nutritionally (i.e., weight loss, malnutrition). R23's quarterly Minimum Data Set (MDS), dated 10/14/22, identified R23 had intact cognition and demonstrated no delusional behavior. Further, the MDS identified, "Section G - Functional Status," which listed space to record R23's bathing assistance and support. This recorded R23 as needing physical assistance with bathing, however, then listed, "Activity itself did not occur during the entire period." When interviewed on 12/19/22 at 2:06 p.m., R23 stated she was supposed to get help that day (12/19/22) with a shower but the person who helps her had already left so she "didn't get it." R23 added, "I'll be lucky if I get one tomorrow." R23 explained she was supposed to get help with	F 677		

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F 677	Continued From page 25 a shower on a weekly basis but often did not get one adding, "To get it [shower], you have to beg." R23's care plan, dated 7/25/22, identified R23 had a potential or actual alteration in ADLs related to anxiety and impaired mobility along with multiple goals for her ADL care including, "[R23] will be clean and well groomed and appropriately dressed through review date." The care plan listed several interventions to help R23 meet these goal(s) including, "Staff to encourage [R23] to take shower/bath on scheduled day and PRN [as needed]." The care plan lacked evidence R23 had a history of refusing ADL cares when offered. On 12/21/22 at 8:49 a.m., nursing assistant (NA)-E was interviewed. NA-E explained R23 returned from the hospital approximately a week prior and needed help with cares adding, "We almost do everything for her." NA-E stated R23 would, at times, refuse care but not often and explained showers and baths were tracked using a paper form in "a shower book" at the nursing desk. NA-E provided a purple-colored binder which contained a bath schedule for the unit, which identified R23 was scheduled for a Monday AM bath, along with various paper forms which had human anatomical forms present on them. The form had four separate spaces for the NA and nurse to sign when a bath or shower and corresponding skin-check were completed, however, the only recorded bathing for R23 was on 12/20/22. There were no other recorded baths, showers, or attempts (including refusals) on these forms. NA-E explained the forms were kept in the binder for a month period but expressed she was not sure what happened to them following adding "someone in the office" dealt with them. NA-E verified there were no other	F 677		

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F 677	Continued From page 26 recorded baths for R23 on the forms and stated she was aware there had been issues with baths not getting completed when there wasn't a shower aide scheduled. NA-E then pointed to a daily staffing list on the counter and said they didn't have a shower aide scheduled for that day (12/21/22) again and added, "I have no idea how we will get them [baths/showers] done." NA-E stated this happened several times a week lately due to poor staffing. R23's medical record was reviewed. R23's POC (Point of Care) Response History ADL - Bathing report, dated 12/21/22, identified a look-back period of 30 days (11/21/22 to 12/21/22) where staff could record the amount of support or assistance R23 needed to complete her bathing. However, there was no data recorded. Further, the medical record lacked any evidence R23 had been offered, assisted with, or refused bathing or showering in the past 30 days. On 12/21/22 at 9:41 a.m., registered nurse (RN)-A was interviewed. RN-A explained "a task" would show up on a scheduled bath day for the NA(s) to complete and record. The nurse would then complete a skin audit and record it in the medical record. RN-A stated R23 had been hospitalized on her scheduled bath day the week prior, however, reviewed the other weeks for the past several weeks and verified it lacked evidence a bath or shower had been attempted, offered, provided or refused. RN-A verified the lack of documentation adding there was "none that I am seeing." When interviewed on 12/21/22 at 12:11 p.m., the director of nursing (DON) stated residents were placed on the bathing schedule when they	F 677		

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F 677	Continued From page 27 admitted to the nursing home and were even able to get multiple baths per week, if requested. When completed, a bath or shower would then be recorded on the paper forms in the binder at the nursing desk. The DON stated R23 could be difficult to bathe, at times, however, acknowledged the documentation and medical record did not provide evidence a bath or shower had been attempted, provided, or refused. The DON stated refusals should be recorded on the paper forms or in the medical record adding, "That would be my expectation." R55's quarterly MDS, dated 12/9/22, indicated R55 was cognitively intact with diagnoses that included diabetes, avoidant personality, major depression, asthma, and a history of homelessness. The MDS indicated R55 exhibited no behaviors and refused care 1-3 days during the assessment period. The MDS also indicated both R55's lower extremities were impaired and R55 required a wheelchair. The MDS lacked assessment of R55's self-performance for presonal hygiene or bathing as indicated by a "-." R55's Care Area Assessment (CAA) dated 9/15/22, indicated R55 triggered for pressure ulcer/injury related to bed mobility not occurring or occurring only once during the assessment period, falls, and pain. R55's care plan dated 9/14/21, indicated R55 had potential/actual alteration for ADLs related to impaired mobility. R55's goals included being clean and well-groomed through the review date. Interventions included encouraging R55 to be as independent as possible and anticipating R55's needs.	F 677		

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F 677	Continued From page 28 R55's care conference note dated 12/20/22, indicated R55 reported chronic pain in his feet and legs and had stopped using his walker recently due to the pain. R55 also reported the pain had been affecting his sleep and activities and rated it 7/10. R55 was considered to be independent with ADLs; however, reported needing assistance with putting his pants and socks on, set up with his meal trays, and assistance with showering. Review of the unit Bath Schedule dated 9/29/22, indicated R55 was to receive a bath on Sunday p.m. and required set-up only and again on Monday a.m. with assistance as needed. The schedule further indicated "all bath/showers must be attempted. Advise nurse of refusals." R55's Bath and Skin reports dated December 2022, indicated the following: 12/4/22, nursing assistant (NA)-A indicated R55 refused a bath/shower 12/7/22, NA-B indicated she assisted R55 with a shower 12/18/22, NA-A indicated R55 refused a shower R55's Bath Schedule indicated R55 should have been offered to receive a shower six times between 12/4/22, and 12/19/22; however, R55 was offered only three showers and refused twice. During an interview on 12/21/22, at 8:59 a.m. R55 stated he was scheduled to get a shower on Sundays or Mondays, however, only NA-B would assist him in the shower and therefore R55 only got a shower when NA-B was working and had	F 677		

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F 677	Continued From page 29 time. R55 stated all of the other staff would just push him into the shower room, set up the supplies and leave him there without assisting him; therefore R55 would refuse to get a shower until a staff member would assist him. R55 stated he had pain in his lower extremities and was unable to lift his feet to wash them. R55 was also unable to wash his "back side" and was further concerned about being able to wash his genitals thoroughly and therefore needed assistance during bathing. During an interview on 12/21/22, at 11:12 a.m. licensed practical nurse (LPN)-A stated R55 needed assistance with one staff for bathing and was unaware if he had been getting his showers as scheduled. LPN-A stated NAs would chart resident baths/showers or refusals on the Bath and Skin report. LPN-A further stated she was unaware of R55 refusing any showers and if he did, he would take one the following day. During an interview on 12/20/22, at 2:54 p.m. NA-A stated R55 should have received a bath once a week according to the Bath Schedule, however, R55 often refused his bath but NA-A did not know why. During an interview on 12/22/22, at 12:15 p.m. NA-B stated she would assist R55 with a shower when she was working and R55 wanted one. NA-B stated other staff would refuse to assist R55 and only set up supplies for him. NA-B stated R55 enjoyed taking showers and if he refused one day, he would take one the following day instead. NA-B also stated R55 was nervous when he stood and held onto the grab bars in the shower because he was afraid of falling. NA-B stated R55 was unable to reach his feet and	F 677		

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F 677	Continued From page 30 needed assistance with washing them. During an interview on 12/21/22, at 2:26 p.m. the director of nursing (DON) stated residents were to receive a bath/shower according to the Bath Schedule. The DON stated NAs were to assist residents with bathing if necessary and perform skin checks during their bath/shower. NAs were to document on the Bath and Skin report when a resident received a bath/shower or refused. A provided Quality of Care & Trauma Informed Care Policy, dated 09/2022, identified the nursing home residents would receive the necessary care to attain or maintain the highest practicable physical, mental, and psychosocial well-being. This listed several elements of care including, "A resident must be given the appropriate treatment and services to maintain or improve his or her ability to bathe, dress, groom, transfer, ambulate."	F 677		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure care and services, including arranging known activities of	F 684	Part 1 R12 hospice records were updated. R12 activities care plan has been update	2/10/23

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F 684	Continued From page 31 interest, were coordinated with an outside hospice agency to promote quality of life and reduce the risk of complication (i.e., pain, depression) for 1 of 1 resident (R12) reviewed for hospice care. In addition, the facility failed to comprehensively assess, develop interventions to promote appropriate bowel management, and ensure conflicting hospital orders for bowel care were addressed and clarified to promote comfort for 1 of 1 resident (R23) reviewed for bowel management; and failed to ensure a developed skin rash was comprehensively assessed, including for causative factors, to ensure healing and efficacy of interventions for 1 of 2 residents (R1) reviewed for non-pressure skin impairments. Findings include: HOSPICE CARE COORDINATION: R12's quarterly Minimum Data Set (MDS), dated 10/7/22, identified R12 had short and long-term memory impairment and severely impaired decision making skills. Further, R12 required extensive assistance with several activities of daily living (ADLs) including dressing and toileting, and received hospice care while a resident of the nursing home. R12's facility care plan, dated 7/11/22, identified R12 had new orders for hospice care for a diagnosis of failure to thrive. A goal was listed which read, "[R12] will be kept comfortable through review date," along with interventions to meet this goal which included acknowledge the presence of pain, give as-needed medication for breakthrough pain, and ,"Hospice care to be provided by hospice agency." However, the care plan lacked what, if any, additional services	F 684	with activities that are person centered. All residents that are on hospice had the potential to be affected. All other residents on hospice have been reviewed and their charts updated. Hospice contracts will be reviewed will with hospice providers. The Quality of care and Trauma informed Care policy has been updated. Part 2 R1 has had a skin assessment completed. R1 has had a skin assessment. Care plan has been updated. All residents have the potential to be affected. Skin policy has been reviewed. (ask Julia if we changed it) Skin assessments will be audited on all residents monthly until substantial compliance has been achieved. Results will be reviewed in QAPI. Part three R 23 orders have been reviewed for bowl management. A comprehensive assessment will be completed on resident, interventions will be care planed. All residents have to potential to be affected. Bowel and assessment has been reviewed and updated, which will include bowl monitoring. Nursing staff will be educated on the new policy and procedures. Audits will be performed, all bowl tracking tools will be reviewed weekly, until substantial compliance has been achieved. Audits will be reviewed at QAPI.	

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F 684	Continued From page 32 hospice would be providing for R12 (i.e., bathing, nurse assessment), nor how often or when each respective discipline (i.e., nursing, social worker) would visit R12 at the nursing home. In addition, the care plan outlined R12 needed assistance to plan her day and demonstrated limited interest in group activities. The care plan outlined, "Resident enjoys watching TV and has stated that she enjoys country music and has a radio in her room." However, the care plan lacked information on what, if any, activities would be provide by the hospice agency. On 12/19/22 at 2:19 p.m., R12 was observed laying in her bed while in her room. R12's hair was unkept and she did not verbally respond to questions when asked. The bedside table had multiple, both open and unopened, containers of Ensure nutritional supplement present on them. At this time, R12's roommate, R23, spoke aloud and stated, "It's so sad what they [staff] do to her." R23 explained R12 is often ignored by staff and added, "She [R12] deserves better care." There was no music or television playing in R12's room at this time. When interviewed on 12/20/22 at 3:00 p.m., nursing assistant (NA)-D stated she had worked with R12 several times in the past few weeks, however, was unsure of what, if any, services R12's hospice agency was providing for R12. NA-D stated she "once saw a guy" who she thought was from hospice in R12's room; however, added, "I think I saw it [only] once." NA-D stated she was not sure how hospice communicated with staff to notify them when they were going to be onsite or provide cares for R12 adding she "hadn't had such a conversation with them." NA-D stated she was unsure what, if any,	F 684		

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F 684	Continued From page 33 activities R12 attended and expressed such information would be "a question for the nurse." However, NA-D expressed she had never seen activities personnel or staff in with R12 doing one-to-one visits and reiterated she was unsure what, if any, other activities R12 participated in or completed. On 12/20/22 at 3:36 p.m., the activities director (AD) was interviewed and reviewed R12's activity schedule and attendance. AD explained R12 did not "really come out of her room" much, so staff tried to do more one-to-one visits with her. AD provided their recorded visits which identified a total of two visits had been completed in December 2022. AD stated she had not been in more often as R12's roommate was ill which caused her apprehension to go into the room. AD then explained a few months prior, she had visited R12 in her room and sang her happy birthday which caused R12's face to "light up like a light bulb." When questioned on how the activities department coordinated with R12's hospice agency, AD responded she was unaware what, if any, activities hospice was doing with R12 as they have "nothing to do with what they do." When asked if they had ever discussed having hospice provide some music therapy for R12, given her reaction to the singing AD just mentioned, AD stated they had not considered it but would write the idea down and visit with the DON about it. On 12/21/22 at 9:35 a.m., registered nurse (RN)-A was interviewed. RN-A verified R12 was currently on hospice care with an outside agency and provided a binder from the nursing office labeled, "Hospice Chart," which was reviewed.	F 684		

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F 684	Continued From page 34 A Nursing Facility Collaboration, dated 7/6/22, identified R12 had been with Hennepin Healthcare Hospice since 7/6/22, and directed the hospice team had established a plan of care to provide and oversee the care for R12. The information outlined a hospice care coordinator would share copies of the hospice care plan, medications and treatment to facilitate coordination of care; and would update the designated contact person with updates to the care plan. The information continued and outlined regular visits would be made to R12 and " ... [hospice staff] will coordinate with your staff during each visit." The information lacked evidence or procedures on how the nursing home would manage, keep, or retain R12's hospice medical record entries. The binder contained a Hospice Plan of Care Update, dated 11/1/22, which identified an effective date through 11/14/22, and listed R12 would have a HHA (home health aide) visit twice a week; social worker visit one to two times every four weeks; skilled nursing visits one to two time each week; and spiritual care visits one to four times every three months. The listed date(s) of services ran through 12/31/22; however, there was no further, more current care plans or updated interdisciplinary notes contained inside the binder when provided, demonstrating if all these services were still in effect or not (as there were no recorded social worker visits on the sign-in sheets). In addition, a green-colored sign in sheet was provided which directed, "All Hospice Staff - Complete ALL FOUR columns for Each Visit," with corresponding areas to record the date of visit, staff name, discipline, and anticipated next	F 684		

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F 684	Continued From page 35 date. This identified the registered nurse care coordinator (RN)-C had visited on 12/8/22 and 12/15/22, with each 'next visit' date being recorded as, "1-2 x wk/ PRN [as needed]." The form identified a care assistant (CA) had visited on 12/12/22 and 12/20/22, with each 'next visit' date being recorded as illegible writing. Further, a spiritual care (SC) member had visited on 12/15/22, with a 'next visit' date recorded as, "1-2 wks [weeks]." However, there were no recorded social worker visits evident in the provided information; nor any evidence of hospice visits prior to 12/8/22; nor any completed hospice progress notes demonstrating what, if any, services or care had been delivered or coordinated with the nursing home. RN-A reviewed the information stated she was "not sure" when hospice nurses were scheduled to visit, however, RN-A was "sometimes" told prior to them coming of their impending visit. At 9:35 a.m. the director of nursing (DON) joined the interview and stated the current care plan was "old" and needed to be replaced. The DON expressed staff, including herself, were often unaware when hospice would be visiting R12 and, when questioned on current cares the hospice agency was providing for R12, the DON responded, "None," adding she had never seen a home health aide visit R12. The DON added, "We're [the nursing home] providing all the cares." Further, the DON acknowledged the lack of any progress notes or evidence of hospice visits prior to 12/8/22, and explained there had been some issues with getting documentation from the hospice agency adding the nursing home did not "seem to be a priority" for them. The	F 684		

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F 684	Continued From page 36 DON expressed she had shared this concern with the hospice agency, however, the response was merely, "OK," and more an acknowledgement than any solution. On 12/21/22 at 4:09 p.m., hospice registered nurse (RN)-C was interviewed. RN-C verified R12 was on hospice care with their agency and expressed R12 was "coming up" for a face-to-face recertification. RN-C described R12 as someone who was typically in bed and had declined over the past few months now needing assistance with "kind of everything." RN-C stated R12 seemed comfortable and without pain, overall, but she acknowledged the care plan at the nursing home was no longer in effect and explained she would be bringing a new one on her next visit (see F656 for additional information). RN-C explained R12's current hospice services included a health aide visit twice a week who helped with bathing and was "just company" for her, along with a weekly nurses' visit to help manage her medications and review her weights. RN-C stated the health aide usually had "set days" onsite and expressed they usually tried to call the nursing home ahead of their visits to announce the care they will provide. RN-C stated nobody had ever shared or expressed a desire to possible add or collaborate on activities for R12, including music therapy, and RN-C verified their hospice agency could provide those services. RN-C explained the collaboration at the nursing home and expressed she had recently switched to working on evening shifts and the communication and collaboration had suffered adding, "It's so hard to get a nurse to get a breakdown of everything going on." A facility' policy on hospice care coordination and	F 684		

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F 684	Continued From page 37 care planning was not provided. BOWEL MANAGEMENT: R23's quarterly Minimum Data Set (MDS), dated 10/14/22, identified R23 had intact cognition and required physical assistance with toileting. Further, the MDS identified R23 did not use any appliances for bowel or bladder (i.e., catheter, ostomy); however, the section to record R23's bowel continence, "H0400. Bowel Continence," was answered, "9. Not rated, resident had an ostomy or did not have a bowel movement for the entire 7 days." R23's most recent BYWO-Bowel Assessment Documentation, dated 10/24/22, identified several sections to be completed to assess for R23's bowel habits and needs including continence, current medical conditions, and medication consumption. However, all of these areas were left blank with a note at the bottom reading, "There was no POC charting done regarding bowel for the current assessment period." However, R23's care plan, dated 7/25/22, identified R23 was " ... considered frequently incontinent of bowel and bladder," and listed several interventions for R23 including, "Bowel and bladder assessment per facility protocol," and, "Staff to observe for changes in elimination pattern. Update MD/NP prn [as needed]." On 12/19/22 at 1:57 p.m., R23 was observed laying in her bed. R23 was interviewed and expressed she was "better today" adding she he had been hospitalized recently and just returned a few days prior. R23 stated she was hospitalized for "a virus" and because she "hadn't shit for a	F 684		

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F 684	Continued From page 38 week." R23 was questioned on a bowel management program being in place (i.e., routine dietary and/or medication approach) and laughed aloud saying, "Are you kidding?" R23 stated the staff at the nursing home didn't offer or help her with her bowels, including a bowel management program, and expressed she felt something needed to be done. R23 added, "I had constipation so bad, they had to dig it out of me [in hospital]." R23's hospital Medicine History and Physical (H&P), dated 12/11/22, identified R23 was admitted to the hospital on 12/11/22 following three days of fever. R23 reported she had not had a bowel movements " ... in approximately 7 days," and upon examination was found with left sided tenderness to palpation. The report identified, "Will schedule senna-docusate and Miralax, and monitor patient closely." However, R23's corresponding hospital After Visit Summary, dated 12/13/22, identified R23 was hospitalized for fever and generalized weakness. However, the provided section listed, "Medication List," lacked any bowel management medications despite the admission H&P directing they would be started. When interviewed on 12/21/22 at 8:57 a.m., nursing assistant (NA)-E stated she was unaware of any bowel-related issues (i.e., constipation) for R23, and expressed R23 had not reported any such concerns to her. However, NA-E explained bowel movements were tracked using the electronic record system and "charted in the POC [point of care." Further, NA-E stated charting wasn't always completed when staffing was short. R23's POC Response History B&B - Bowel and	F 684		

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F 684	Continued From page 39 Bladder Elimination report, dated 11/21/22 to 12/21/22, identified several questions to be recorded by direct care staff including the size of bowel movement and consistency of the stool. However, this report lacked any evidence R23 had a bowel movement during the period with each response for the size of stool being recorded as, "Not Applicable," or, "Response Not Required," or, "None." R23's Medication Administration Record (MAR), dated 12/2022, identified R23's consumed and recorded medications for the month. The MAR outlined no scheduled or as-needed bowel medications were ordered or provided to R23 despite the hospitalization on 12/11/22 to 12/13/22, and multiple recorded entries (i.e., MDS, POC Response History) lacking evidence of regular bowel movements. Further, R23's Extended Care Nursing Home Visit note, dated 12/14/22, identified R23 was seen at the nursing home post-hospitalization by the nurse practitioner (NP). However, the note lacked any evidence R23's bowels, including the need for a bowel management program, had been evaluated or addressed. Further, there was no evidence the NP had clarified the conflicting hospital H&P and After Visit Summary to determine what, if any, medications were needed to promote regular bowel movements for R23. R23's medical record was reviewed and lacked evidence R23 had been comprehensively reassessed for her bowel status, including continence, dietary interventions, and/or management need, following her readmission to the nursing after being hospitalized for several issues including constipation. Further, the record	F 684		

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F 684	Continued From page 40 lacked evidence the conflicting hospital H&P and After Visit Summary (one which outlined medications being started and the other which didn't list any, respectively) had been clarified with the medical provider to determine what, if any, medication support had been implemented or needed for R23's bowel management despite R23 being seen by the NP on 12/14/22. On 12/21/22 at 10:04 a.m., registered nurse (RN)-A was interviewed, and they verified the NA(s) should be recording bowel movements in the POC charting. RN-A explained they were "not sure" of the protocol to follow if constipation or bowel concerns were identified; however, expressed someone should, at minimum, assess for bowel sounds, flatulence, hydration status and do an abdomen check or check if as-needed medication was available or had been used; however, RN-A stated she was "not sure" who was responsible to do this process. Regardless, the nurses could then update the provider to see if "something better" was available to relieve the issues. RN-A reviewed R23's medical record and verified no bowel medications had been started or provided, either scheduled or as-needed, since R23 returned from the hospital; no comprehensive reassessment of R23's bowel status had been conducted; and there was no evidence R23's conflicting hospital-related orders had been clarified with R23's medical provider to determine what, if any, medication approaches were needed. RN-A stated those items should have been completed adding, "if it was documented, it wasn't done." RN-A stated it was important to ensure bowel-related issues were addressed timely as R23's impaired mobility could cause the bowels to "slow down" and lead to further constipation or, even worse, a bowel	F 684		

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F 684	Continued From page 41 impaction. When interviewed on 12/21/22 at 12:18 p.m., the director of nursing (DON) stated R23's medical provider had access to the hospital notes and could have addressed the discrepancy of the orders when she visited on 12/14/22. The DON explained constipation should be addressed with a comprehensive assessment, including review of hydration and activity levels, and appropriate follow-up with the medical provider and dietary department to ensure it was resolved and addressed. The DON stated the lack of dietary interventions for R23's constipation could be "a missing piece" too. The DON verified bowel movements should be recorded in the POC charting, and she expressed they had "noticed that there are some gaps" in documentation so they were looking into re-doing some systems to make them "more user friendly." Further, the DON stated it was important to ensure constipation was assessed and acted upon to promote "quality of life" for the resident. A provided Bowel and Bladder Assessment policy, dated 10/2022, identified each resident with incontinence would be identified and assessed to help achieve continence or restore normal function, as able. However, the policy lacked information on how constipation or identified other concerns with bowel elimination would be assessed, acted upon or addressed. SKIN RASH NOT ASSESSED: R1's quarterly Minimum Data Set (MDS), dated 11/11/22, identified R1 had moderate cognitive impairment and was independent with toileting.	F 684		

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F 684	Continued From page 42 Further, the MDS outlined R1 had no pressure ulcers or other skin impairment (i.e., open lesions, skin tears, moisture-associated skin damage (MASD) present at the time of the review. R1's care plan, dated 11/22/22, identified R1 had potential for an alteration in skin integrity due to incontinence, impaired cognition and diabetes. A series of goals were listed for R1 including, "[R1's] skin will remain intact through review date," along with various interventions to help R1 meet this goal including encouraging physical activity as able, monitoring for edema, and monitoring R1's skin on bath day and as-needed. During the recertification survey, from 12/19/22 to 12/22/22, an interview with R1 was attempted. However, R1 declined to be interviewed. R1's progress notes, dated 12/1/22 to 12/21/22, identified the following: On 12/11/22, R1 was given a shower and redness was noted in his groin. The note identified skin protection cream was applied. Further, on 12/17/22, R1 approached a staff member and reported burning and requested a bath. The note outlined, "This writer assessed residents skin [due to] 'burning' complaint. This writer noted very red areas at right inner thigh and scrotum ... cleansed area with warm water and soap, dried and applied nystatin to red areas ... stated he felt much better and thanked writer ... will place nursing order for area to be cleansed and nystatin applied until resolved. Skin assessment completed." R17's corresponding BYWO - Total Body Skin Assessment, dated 12/17/22, identified an anatomical human body with various sites to	F 684		

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F 684	Continued From page 43 record ulcers or skin impairments. This identified R1 had a, "Rash" present on his inner thigh and scrotum. The assessment concluded with a section labeled, "Summary," which outlined, "Resident has redness at RT [right] inner they [sic] and scrotum. areas cleaned w/soap and water; dried nystatin applied. no other skin concerns were noted. will cont[inue] to monitor." However, the completed assessment and R1's medical record was reviewed and lacked evidence R1's developed rash had been comprehensively assessed, including for causative factors, despite medicated powder now being applied. There was no evidence the facility had determined how the rash had developed or if other modifications to the care plan (i.e., toileting) were needed to help reduce the risk of complication or re-development of the rash. When interviewed on 12/21/22 at 8:46 a.m., nursing assistant (NA)-E stated she was not aware of any skin issues for R1 and had not been told to do anything different for his cares in the past few weeks. On 12/21/22 at 9:07 a.m., registered nurse (RN)-A was interviewed. RN-A explained a developed skin issue, including rash, should be recorded in the medical record under a "Risk Management" area to ensure it was assessed, acted upon and healed. RN-A stated a comprehensive assessment of the area was needed to help determine if the area was moisture related, vascular related, or something else. RN-A reviewed the medical record and stated there had never been an assessment, including under 'risk management', of R1's developed rash completed and there should have been. RN-A stated the developed rash should	F 684		

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F 684	Continued From page 44 have gone "through the protocols" and been assessed. RN-A stated they had received some training on these protocols, however, expressed they had noticed some other staff just "do not follow instructions." A provided Skin Policy and Procedure, dated 9/22, identified a purpose to ensure all resident's skin was intact. A procedure was listed which outlined a total body skin assessment would be completed after admission, and would be repeated when areas on concern were identified. If a concern was identified, the provider would be updated and a treatment plan would be followed as ordered.	F 684		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively assess, develop, and implement person-centered interventions to reduce the risk for pressure	F 686	R25, R55 will have updated care plans to reflect person centred interventions to reduce the risk of pressure injuries. All residents that are at risk for pressure	2/10/23

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F 686	Continued From page 45 injuries for 2 of 2 residents (R25, R55) who were reviewed for pressure injuries. Findings include: R25's quarterly Minimal Data Set (MDS) dated 11/25/22, indicated that R25 cognition was severely impaired with diagnoses of vascular dementia, psychosis, and depression. The MDS also indicated R25 was at risk for pressure ulcer development and needed extensive assistance of 2 staff members with bed mobility and transfers. R25's care plan dated 12/2/22, indicated the following: R25 has a potential for alteration in skin related to impaired cognition, impaired mobility and incontinence. Needs will be anticipated by staff, keep linen clean and wrinkle free, do not slide to prevent shearing and skin monitored on bath/shower day and PRN (as needed). R25's physician orders dated 4/2/22, directed, "Floor nurse please sign off in point of care (POC) that skin was looked over by staff and check that skin check was signed off in POC. Chart refusals/findings. If skin check is refused, please fill that out in skin assessment sheet." Per the EMR, this had not been done since 3/10/22. During an interview on 12/21/22 at 8:43 a.m., registered nurse (RN)-A stated R25's EMR should have weekly skin checks as documented under the Total Body Skin Assessment tab. RN-A confirmed this was not done at all for R25. During observation on 12/21/22, R25 was observed at 7:20 a.m., out of bed and in her broda chair (chair specifically designed for people with limited mobility). An interview with nursing	F 686	injuries had the potential to be affected. All residents that are assessed at risk for pressure injuries will have care plans updated for person cantered interventions. Quality of care and Trauma informed care policy and procedure has been reviewed and updated. MDS, QA and DON will be educated on Quality of care and Trauma informed care policy and procedure. DON or designee will audit all new admissions care plans until substantial compliance is achieved. Results will be presented at QAPI. All nursing staff will be educated on skin policy and procedure and will be assign module on reducing the risk of pressure ulcer on EduCare	

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F 686	Continued From page 46 assistant (NA)-E indicated that R25 was up in her broda chair at 7:00 a.m. Continuous observation from 7:20 a.m. to 10:08 a.m. indicated that R25 was up in her broda chair without staff engagement and without any offloading or position changes during that time. During an interview with RN-A on 12/21/22 at 10:28 a.m., RN-A stated that residents who cannot move on their own and need assistance with repositioning should be shifted in their chair every hour and repositioned in bed every 2 hours. During an interview the director of nursing (DON) on 12/22/22 at 1:13 p.m., stated that a resident who was dependent on staff for movement should have interventions in place for offloading and repositioning. R55's quarterly MDS dated 12/9/22, indicated R55 was cognitively intact with diagnoses that included diabetes, avoidant personality, major depression, asthma, and a history of homelessness. The MDS also indicated both R55's lower extremities were impaired and R55 required a wheelchair. R55's Care Area Assessment (CAA) dated 9/15/22, indicated R55 triggered for pressure ulcer/injury related to bed mobility not occurring or occurring only once during the assessment period. R55's care plan dated 9/14/21, indicated R55 had potential/actual alteration for ADLs related to impaired mobility and pain. Interventions included encouraging R55 to be as independent as possible and anticipating R55's needs.	F 686		

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F 686	Continued From page 47 R55's Braden Scale for Predicting Pressure Sore Risk dated 12/16/22, indicated R55 was not at risk for pressure ulcers/sores and had no impairment or sensory deficit which would limit his ability to feel pain or discomfort. The Braden scale also indicated R55 walked occasionally for short distances and had no mobility limitations. R55 also had no apparent problem with shearing and friction as evidenced by his ability to move in bed and in a chair independently. Review of the unit Bath and Skin Schedule dated 9/29/22, indicated R55 was to receive a bath on Sunday P.M. and required set-up only and again on Monday A.M. with assistance as needed. The schedule further indicated "all bath/showers must be attempted. Advise nurse of refusals." R55's Bath and Skin reports dated December 2022, indicated the following: 12/4/22, nursing assistant (NA)-A indicated R55 refused a bath/shower. No skin assessment was documented. 12/7/22, NA-B indicated she assisted R55 with a shower and R55's skin was "ok." 12/18/22, NA-A indicated R55 refused a shower. No skin assessment was documented. R55's physician progress note dated 12/13/22, indicated R55 was seen for an evaluation of an electric wheelchair. R55 had difficulty getting up from a seated position and needed assistance to walk, which R55 declined to do. The note indicated R55 had a gait impairment due to peripheral neuropathy (disease causing nerve damage to extremities resulting in pain, weakness, and numbness), osteoarthritis (inflammation in the joints), and muscle weakness.	F 686		

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F 686	Continued From page 48 R55's care conference note dated 12/20/22, indicated R55 reported chronic pain in his feet and legs and had stopped using his walker recently due to the pain. R55 was considered to be independent with ADLs; however, reported needing assistance with putting his pants and socks on, set up with his meal trays and assistance with showering. During an interview on 12/21/22, at 8:59 a.m. R55 stated staff would only look at his skin during bath days, but since he was not getting a bath every week, it did not occur often. R55 stated most staff did not assist him during his shower and therefore would only observe his skin "from across the room." R55 further stated he was concerned about his feet, genitals, and "back side" because he could not clean them thoroughly without assistance. During an interview on 12/21/22, at 9:34 a.m. nursing assistant (NA)-C stated it was her first day working at the facility, NA-C stated she was given a list of residents for the unit and told where the Bath Schedule book was. NA-C stated she was told the residents on the unit were "pretty independent" and did not require assistance for bathing, repositioning, or toileting. NA-C also stated she was not given any instruction regarding skin checks and was unaware how they were completed or by whom. During an interview on 12/21/22, at 11:00 a.m. trained medical assistant (TMA)-B stated although R55 walked with a walker approximately a month ago, he was now in his wheelchair "most of the time."	F 686		

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F 686	Continued From page 49 During an interview on 12/21/22, at 11:12 a.m. licensed practical nurse (LPN)-A stated R55 needed assistance with one staff for bathing and was unaware if he had been getting his showers as scheduled. LPN-A stated NAs would chart resident baths/showers or refusals on the Bath and Skin report. LPN-A further stated the NAs would perform skin checks and let the nurse know if there were any concerns. LPN-A stated because R55 was in a wheelchair, he had some risk for skin breakdown, however, LPN-A had not performed any skin checks on R55 because the NAs had not reported any concerns to her. During an interview on 12/21/22, at 2:26 p.m. the director of nursing (DON) stated NAs were supposed to check resident skin during their scheduled bath/shower and report any concerns to the nurse. The DON further stated if a resident refused a bath, the NAs were to notify the nurse and the nurse was to perform a skin check to ensure the resident had not developed any pressure ulcers or other skin issues. The facility Skin policy and procedure dated 9/22, indicated to ensure resident's skin remained intact, the nurse would identify areas of concern to be monitored. Total body skin assessments were to be completed during weekly baths. A resident's care plan would be current and updated at least quarterly and as needed. The policy also indicated refusals of skin checks would be documented in the resident's health record.	F 686		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration.	F 692		2/10/23

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F 692	Continued From page 50 (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to comprehensively reassess and develop interventions to stabilize or reverse weight loss despite ongoing, recorded weight loss and after a medical procedure caused further decline in oral intake for 1 of 2 resident (R69) reviewed for nutrition. Findings include: R69's quarterly Minimum Data Set (MDS), dated 11/18/22, identified R69 had intact cognition and was independent with eating. Further, the MDS outlined R69 was 65 inches tall, weighed 155 pounds (lbs), and had not sustained a weight loss of 5% or 10% weight loss within the past month or six months, respectively.	F 692	All residents had the potential to be affected. R69 has been monitored by nursing staff and dietary staff who has communicated concerns and residents requests to the registered dietician. RD educated staff on tray auditing to ensure that 50% of meal has been consumed and an alternative choice has been offered if less the 50% of tray has been consumed. RD added resident to high-risk nutritional concern list. Nutrition policy and procedure has been reviewed and updated. All dietary staff will be educated on Nutrition policy and procedure. Weekly audits of weight will be preformed	

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F 692	Continued From page 51 R69 most recent BYWO (Bywood) Quarterly Nutritional Assessment, dated 11/13/22, identified R69 consumed a regular, non-therapeutic diet which was regular texture. R69 did not consume supplements and was determined to not be at risk of dehydration. R69 was recorded as being 65" (inches) tall and 155.0 LBS (pounds) at the time which was recorded as "overweight" per the Body Mass Index (BMI). The assessment identified R69 had not sustained any unplanned weight loss and recorded R69 as having "good" meal intakes. Further, the assessment outlined, " ... Weight has remained stable since admission. No nutritional changes warranted at this time ... ". R69's care plan, dated 11/29/22, identified R69 was at nutritional risk due to chronic illness, history of stroke, and an elevated BMI. The care plan listed a goal which read, "Will maintain weight," and several interventions to help R69 meet this goal including encouraging three meals per day, monthly weight monitoring, and providing a regular diet. However, there had been no revision(s) to the interventions listed since 5/23/22. On 12/19/22 at 3:05 p.m., R69 was interviewed and explained she had "lost a lot of weight" in the past few months which was concerning to her. R69 stated she was "very sick" with heart issues and her physicians had even commented they were "worried as I am losing too much weight." When questioned on what the nursing home was doing to help R69 maintain her weight, R69 responded in a laughing tone, "These people? Nothing!" R69's Weight Summary, dated 5/16/22 to	F 692	to identify and unexplained weight loss or gain. Results of audits will be presented at QAPI.	

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F 692	Continued From page 52 12/21/22, identified R69 admitted to the nursing home on 5/16/22, and listed the following recorded weights for her since then as follows: 05/16/22 - 166.0 lbs; 09/02/22 - 162.8 lbs; 11/08/22 - 155.0 lbs; and, 12/12/22 - 152.4 lbs (an 8.19% loss since admission). On 12/21/22 at 11:54 a.m., R69 was observed in her room. R69 had a clear, plastic trash bag in her hands which had a visible red-colored basket inside with various food items including french fries and miniature corn dogs. R69 stated the food was served to her for lunch but the items had no taste and were too hard to swallow adding, "How are old people supposed to eat these?!" R69 reiterated her weight loss and voiced she was "not OK with it," and it was concerning for her. R69 stated she visited with her physician about it and they were hopeful her appetite and weight would stabilize once her heart condition was treated. R69 explained the nursing home provided her snacks and she saved them in a bag on her wall which she showed to the surveyor. The bag was filled with various bags of potato chips and Chex-mix inside; however, R69 stated she rarely ate them as she "don't like them." R69 was questioned on why she felt her weight was still decreasing, despite snacks being present in her room and her being independent with eating, which R69 explained she had recent surgery on her throat due to esophageal varices and she had since been throwing up blood, at times, which caused her to not want to eat. R69 added, "I don't eat because I am scared I am going to throw up."	F 692		

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F 692	Continued From page 53 R69's progress note, dated 12/1/22, identified R69 had an offsite medical appointment with an endoscopy (insertion of a long, flexible tube down your throat and into your esophagus) performed. The note outlined both grade I and grade II varices (abnormal veins in the lower part of the tube running from the throat to the stomach; symptoms can include vomiting blood) were found. Further, on 12/2/22, a note recorded, " ... Writer was informed by the resident that she was throwing up blood ..." In addition, R69's POC (Point of Care) Response History - NUTRITION - Amount Eaten report, dated 12/22/22, identified a look-back period of 30 days of R69's recorded meal intakes. However, the report only identified three meals being recorded for the entire period (on 11/27/22 and 11/28/22). There was no other recorded meal intakes listed or located in the medical record. When interviewed on 12/22/22 at 10:02 a.m., trained medication aide (TMA)-E stated they routinely worked with R69 and described her as "pretty independent" with cares. TMA-E explained R69 ate meals in her room and, at times, in the dining room but described her as a 'picky eater' at times but not on any special diets to her knowledge. However, TMA-E expressed she believed R69 was a "good eater" as her room trays are often empty when returned. TMA-A stated she had heard R69 voice comments about weight loss over the past several weeks but added she felt R69 overreacts about her medical issues. In addition, TMA-A expressed R69 had "mentioned it" with regards to throwing up blood since her procedure a few weeks prior, however, staff had never been able to visualize it themselves yet due to R69 flushing the toilet or	F 692		

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F 692	Continued From page 54 washing it down the sink before they're told of it. Further, TMA-E stated any reports of weight loss should be reported to the nurse and dietary department but then expressed, "I don't know what they do [with it]." On 12/22/22 at 10:47 a.m., licensed practical nurse (LPN)-A was interviewed and explained R69 needed "very minimal assist" with cares. LPN-A stated R69 ate meals in the dining room but, at times, would take the tray back to her room. LPN-A stated she recalled "about a week or two ago" when R69 reported being ill and "not eating much" as a result; however, LPN-A had not heard further complaints about it so she believed it had resolved. LPN-A stated she felt R69 typically ate a "moderate amount" of her meals. Further, LPN-A stated the MDS registered nurse (RN)-B was the person who tracked resident' weights and "keeps an eye out" for issues. When interviewed on 12/22/22 at 11:28 a.m., RN-B stated she was "a part of IDT [interdisciplinary team]" and, as a result, the team "all work together" to manage resident care including weight loss and nutritional needs. RN-B explained weight loss concerns, or issues affecting intakes, should be forwarded to the director of nursing (DON) who could then coordinate with the registered dietician (RD) on approaches and interventions. RN-B reiterated the DON and RD were "really responsible" to monitor weights and adjust the care plan "as needed." RN-B explained she had not spoken to the RD about R69's weight loss or post-procedure needs; however, expressed the last time she completed an MDS for R69 (on 11/18/22) she recalled R69 reporting some difficulty eating and, as a result, was "not eating	F 692		

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F 692	Continued From page 55 much." RN-B verified she had not coordinated or reported R69's newly discovered esophageal varices to the RD, nor had she identified the ongoing weight loss for R69 but added she "certainly will" reach out to the RD and update them. Further, RN-B stated none of the direct care staff had reported potential issues for R69's nutrition (i.e., R69's weight loss comments) to her. R69's medical record was reviewed and lacked evidence R69 had been comprehensively reassessed for her nutritional risks and potential interventions (i.e., diet change, supplement options) to promote intake and adequate nutrition after 11/13/22, despite having continued weight loss; having a medical procedure for esophageal varices which could impact her ability to consume certain foods; and despite R69 reporting concerns with her weight loss to them over the past several weeks. On 12/22/22 at 1:05 p.m., the RD was interviewed. RD explained she felt R69's weight had remained mostly stable, and R69 had not had much success in the past with supplement use. R69 would request certain meals or items and then "get upset" if unable to be provided them, so as a result, they switched her back to a regular diet awhile back. R69 was also a cardiology patient so her weights could likely fluctuate. RD explained meals should be tracked under the POC in the medical record; however, she had noticed them not consistently being done which had been discussed with the nursing home management team. RD verified the meal intakes should be tracked to ensure she had appropriate monitoring and information available when helping to assess residents. RD stated she was	F 692		

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F 692	Continued From page 56 unaware R69 had an endoscopy done several weeks prior and expressed, had she been told, R69 would have been reassessed and speech therapy consulted to develop a plan to ensure R69's nutritional needs were met. RD stated R69 should likely not be provided fried-foods (i.e., french fries) and there were some supplement options which could be attempted which would not agitate esophageal varices. Further, RD acknowledged R69 seemed, per the nursing home medical record, to have lost over eight percent (8%) since she admitted and added, "Different interventions are probably needed." A provided Nutrition Program policy, dated 10/2022, identified all residents would be evaluated "at least monthly" to determine their risk for declining nutritional status, and the RD would review charts to determine each resident's risk. Those determined to be "high risk" would be assessed to determine if their food or fluid intake should be monitored. The policy outlined, "Intake may be monitored daily or three days each month," and a daily intake record would be completed and reviewed by the RD. However, the policy lacked direction or guidance on how to ensure resident reported concerns or acute medical changes would be acted upon or addressed timely.	F 692		
F 697 SS=D	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.	F 697		2/10/23

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F 697	Continued From page 57 This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to comprehensively assess pain interventions and notify the provider of their effectiveness for 1 of 1 residents (R55) whose pain medication had been increased due to worsening pain. Findings include: R55's quarterly MDS dated 12/9/22, indicated R55 was cognitively intact with diagnoses that included diabetes, avoidant personality, major depression, asthma, and a history of homelessness. The MDS indicated R55 had little interest or pleasure in doing things, felt depressed or hopeless, and felt bad about himself for 7-11 days during the assessment period. R55 also felt tired or had little energy, a poor appetite and trouble concentrating for 2-6 days during the assessment period. R55 exhibited no behaviors and refused care 1-3 days during the assessment period. The MDS indicated R55 was independent with locomotion; however, no other activities of daily living were observed to have occurred or occurred only once and personal hygiene was not assessed. The MDS also indicated both R55's lower extremities were impaired and R55 required a wheelchair. The MDS further indicated R55 was not on a scheduled pain medication, an as needed (PRN) pain medication, and did not receive non-medication interventions for pain; however, the MDS indicated a pain assessment interview should have been completed. The pain assessment indicated R55 had 7/10 pain affecting his ability to sleep and limiting his daily activities almost constantly. The MDS further	F 697	R55□s provider will be updated on chronic pain. All residents with pain had the potential to be affected. Pain management P&P has been reviewed. All nurses staff will be educated on Pain management and documentation. Monthly audits of pain assessment tools will be done until substantial compliance has been achieved. Results will be presented at QAPI.	

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F 697	Continued From page 58 indicated R55 had not received any restorative nursing programs including range of motion exercises, walking, or dressing and/or grooming for any of the previous seven days. R55's quarterly MDS pain assessment dated 12/9/22, indicated from 12/3/22 to 12/9/22, R55 reported current pain and pain during the assessment period in his legs and feet. The assessment indicated R55 had not been walking due to the pain and the pain was affecting R55's sleep and activities. Range of motions (ROM) were performed and R55 had some impairment in his lower extremities. R55 was unable to put on his pants and socks and was unable to lift his legs while in a seated position. R55's Care Area Assessment (CAA) dated 9/15/22, indicated R55 triggered for pain. Interventions included all disciplines working together to maintain and improve R55's current level of functioning, avoiding complications, and minimizing risks, and providing symptom relief. The CAA further indicated R55 may have benefited by going to a pain clinic; however, R55 was not utilizing all of the medications/interventions available to him. The CAA indicated R55 rated his worst pain over the previous five-day period as 8/10. R55's care plan dated 9/14/21, indicated R55 had potential/actual alteration for ADLs related to impaired mobility. R55's goals included being clean and well-groomed through the review date. Interventions included encouraging R55 to be as independent as possible, anticipating R55's needs, and reporting any changes in R55's abilities to the provider. R55 also had a potential/actual alteration in pain related to	F 697		

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F 697	Continued From page 59	F 697		

diabetic neuropathy (nerve damage). Interventions included completing a pain assessment quarterly, annually and with a significant change and as needed (PRN).

R55's orders dated 11/1/22, indicated R55 received:

Acetaminophen (Tylenol) 1000 milligrams (mg) every eight hours for mild to moderate pain.
Lidocaine-Prilocaine cream 2.5-2.5% for lower extremity pain as needed and not to exceed twice daily.
Naproxen 500 mg for moderate pain secondary to Tylenol.
R55's orders dated 11/22/22, indicated R55's Lyrica (for diabetic nerve pain) was increased from 100 mg twice a day to 150 mg twice a day.

R55's Pain Level Summary dated November 2022, indicated R55's pain on a 0 to 10 scale was as follows:

11/25/22, 6/10
11/24/22, 7/10
11/14/22, 8/10
11/9/22, 8/10

No pain levels were documented for the month of December 2022.

R55's Abnormal Involuntary Movement Scale (AIMS) dated 12/9/22, indicated R55 refused to stand up and/or walk during the assessment due to increased pain in his feet and legs.

R55's care conference note dated 12/20/22, indicated R55 reported chronic pain in his feet and legs and had stopped using his walker

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F 697	Continued From page 60 recently due to the pain. R55 also reported the pain had been affecting his sleep and activities and rated it 7/10. R55 was considered to be independent with ADLs; however, reported needing assistance with putting his pants and socks on, set up with meal trays, and assistance with showering. During an interview on 12/19/22, at 1:57 p.m. R55 stated his lower back, legs, and feet hurt "all the time," and staff didn't do anything about it. R55 further stated he was unable to stand up or shower himself because of the pain and although the gave him medication "nothing works." During an interview on 12/22/22, at 12:15 p.m. nursing assistant (NA)-B stated R55 used to walk with a walker "all the time" but now only uses his wheelchair. NA-B stated R55 was afraid to fall and became nervous when he would stand although NA-B did not know why. During an interview on 12/22/22, at 11:10 a.m. nurse practitioner (NP)-A stated R55's Lyrica (pain medication) had been increased on 11/22/22, and staff should have been assessing R55's pain daily for effectiveness. NP-A stated she was unaware staff had not been monitoring R55's pain and was also unaware R55's pain continued to affect his ADLs and ability to walk. NP-A further stated she should have been notified of R55's continued pain so a new treatment plan could be considered. During an interview on 12/21/22, at 2:39 p.m. the director of nursing (DON) stated pain assessments were only completed during quarterly assessments. The DON further stated since R55's pain continued to be seven or eight	F 697		

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F 697	Continued From page 61 out of 10 and had not changed, the staff did not need to monitor or assess it. The facility Pain Management Policy and Procedure dated 9/20/22, indicated staff will ask a resident and record their pain prior to administering pain medication and again one to two hours after administering pain medication to monitor effectiveness, using a pain scale of 0-10. The policy also indicated to evaluate the effectiveness of a resident's pain management interventions in the electronic medical record (EMAR). Staff were to contact the provider if pain medication was ineffective or if the resident required dosage adjustments.	F 697		
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on interview, observation, and document review, the facility failed to ensure assessment of the resident's condition and monitoring for complications before and after dialysis for 1 of 1 resident (R72) reviewed for dialysis. R72's quarterly Minimum Data Set (MDS) dated 11/18/22, indicated R72 was admitted on 8/16/22 and was cognitively intact. The MDS further indicated R72 required dialysis, and had diagnoses of end stage renal disease (ESRD) and diabetes type II.	F 698	A dialysis assessment will be obtained for R72 after every dialysis appointment. All residents that require dialysis had the potential to be affected. The dialysis policy and procedure has been reviewed and updated. All nurses will be educated on the updated dialysis policy and procedure. Weekly audits of dialysis assessments will be done until substantial compliance is achieved. Results will be presented at QAPI.	2/10/23

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F 698	Continued From page 62 R72's progress notes for December 2022, lacked mention of dialysis, assessment of R72 condition before and after dialysis, and assessments of the arteriovenous graft (AVG) (a tube place under the skin that can be accessed by a needle for dialysis) after dialysis treatments. R72's provider orders lacked assessment orders for the AVG. Orders dated 8/17/22, indicated check R72's weight monthly. R72's medical record contained no dialysis assessments or notes from R72's dialysis appointments. R72's provider order dated 8/16/22, indicated dialysis three times a week, on Mondays, Wednesdays, and Fridays. R72's provider orders dated 12/14/22, indicated monthly blood pressure monitoring for psychotropic medications, but no lacked orders for blood pressuring monitoring before and after dialysis treatments. R72's care conference note dated 12/1/22, indicated R72 attended dialysis three times a week. R72's medication administration record (MAR)/treatment administration record (TAR) for December 2022, lacked documentation of AVG assessment. R72's weight summary printed 12/21/21, indicated weights assessed three times since 10/1/22, on 10/6/22, 11/6/22, and 12/1/22.	F 698		

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F 698	Continued From page 63 R72's care plan dated 11/22/22, indicated R72 was at risk for complications related to dialysis for ESRD with interventions for the nurse to check bruit and thrill on AVG on left upper arm, but lacked direction on how often the assessment should occur. The care plan indicated R72 attended dialysis on Mondays, Wednesdays, and Fridays. When interviewed on 12/19/22, at 5:46 p.m. R72 stated staff did not regularly assess his AVG or weigh him before or after dialysis. R72 stated he was unsure what staff were supposed to do with the shunt. R72 stated he returned from dialysis at 4:45 p.m. on 12/19/22, and no staff had assessed his shunt. When interviewed on 12/22/22, at 1:52 p.m. registered nurse (RN)-A stated after a resident returned from dialysis a nurse should assess the resident. RN-A stated there should be a post-dialysis assessment form to complete, but the facility did not have this assessment form available in the electronic health record. RN-A stated the assessment should include the resident vital signs, state of mind, skin condition, a weight before ad after dialysis, the thrill (vibration or pulse felt on the AVG), and bruit (swishing sound heard with a stethoscope). RN-A further stated the assessment after dialysis should be on the care plan for every resident who is on dialysis. RN-A confirmed R72's medical record lacked any dialysis assessment forms, or post-dialysis assessments, or post-dialysis progress notes. RN-A further stated there should be a provider order to perform the assessments and confirmed there was no dialysis assessment order for R72.	F 698		

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F 698	Continued From page 64 When interviewed on 12/22/22, at 2:15 p.m. the administrator stated he would expect an assessment would be completed following dialysis treatments, and expected nursing staff would document the assessment, and follow the dialysis policy. The Policy and Procedure for Emergency Care of a Resident Receiving Dialysis dated 1/2020 indicated the following: It is the policy of Bywood East to have a comprehensive care plan and an emergency plan for a resident who receives dialysis treatment. 1. Staff to check fistula for thrill and bruit at least daily and document on Medex (the electronic health record). 2. Staff to check site every day for any signs of infection, redness, swelling, warmth, or pain.	F 698		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed	F 755		2/10/23

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F 755	Continued From page 65 pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to ensure a prescribed medication was available for 1 of 1 residents (R59) who missed multiple doses of his medication for post traumatic stress disorder (PTSD). Findings include: R59's annual Minimum Data Set (MDS) dated 10/28/22, indicated R59 had mild cognitive deficits. The MDS indicated R59 had trouble falling or staying asleep or sleeping too much; however, did not indicate the frequency of occurrence during the assessment period. R59's diagnoses included major depressive disorder, post-traumatic stress disorder (PTSD), bipolar disorder, suicidal ideations, unspecified mood disorder, victim of crime and terrorism, and psychoactive substance abuse-induced mood disorder. R59's Care Area Assessment (CAA) dated	F 755	R59 □s medication have been obtained and administered, see MAR. All residents are at risk to be affected. Missing medication policy has been reviewed. Nurses and TMA□s will be educated on Missing medication policy. Resident charts will be audited by DON or designee monthly for missing medication until substantial compliance is achieved. Results will be presented at QAPI.	

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F 755	Continued From page 66 11/3/22, indicated R59 triggered for cognitive loss/dementia, mood, psychotropic medication use, and pain. R59's care plan dated 11/1/21, indicated R59 occasionally attended activities; however, refused activities due to staying in bed until late morning or later. R59 had a potential for decreased mood related to a diagnosis of PTSD. Interventions included R59 taking his medications as prescribed. R59's physician orders indicated R59 was prescribed prazosin (for the treatment of nightmares related to PTSD) 1 milligram (mg) at bedtime beginning 11/1/21. R59's medication administration record (MAR) dated December 2022, indicated R59 did not receive his prozasin for PTSD from 12/1/22, to 12/13/22, on 12/15/22, and from 12/17/22, to 12/21/22, for a total of 19 missed doses. R59's progress notes dated 12/2/22, indicated R59 was admitted to the hospital. R59's progress notes dated 12/4/22, indicated R59 returned to the facility. R59's progress notes dated 12/15/22, indicated the pharmacy was called in an attempt to reorder R59's prazosin; however, because the prescription was more than a year old, a new prescription would need to be written before the medication could be reordered. A voice message was left for nurse practitioner (NP)-A. R59's Discharge Orders dated 12/4/22, indicated R59 had Planned Discharge Orders that included	F 755		

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F 755	Continued From page 67 prazosin 1 mg. The orders indicated to "Ask about: Which instructions should I use?" The orders further indicated R59 was to continue to take prazosin 1 mg capsule by mouth at bedtime; however, the order indicated R59 had zero refills available. During an interview on 12/20/22, at 9:32 a.m. R59 stated he was unaware how long it had been since he had taken the prazosin but was aware he was supposed to be taking it. R59 stated he knew he needed it and that he had been more depressed and less motivated without it. R59 stated he had trouble staying asleep during the night and woke up often. During an interview on 12/20/22, at 3:35 p.m. trained medical assistant (TMA)-A stated she R59's prazosin had been out for two to three weeks and believed nursing was aware because she saw a progress note regarding this, dated 12/15/22. TMA-A further stated R59 was usually "pretty active" during the day but had been sleeping more lately. During an interview on 12/21/22, at 11:25 a.m. licensed practical nurse (LPN)-A stated since the progress note dated 12/15/22, indicated NP-A had been notified, it was "in her court to take care of." LPN-A stated although the providers were in the facility twice a week, she did not know why R59's unordered prazosin had not been addressed yet. LPN-A stated she had not been notified of any changes in R59's behaviors but would be concerned about his sleeping patterns since the medication is for nightmares related to PTSD. During an interview on 12/22/22, at 10:59 a.m.	F 755		

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F 755	Continued From page 68 NP-A stated she would have expected the staff to notify her when a resident ran out of medication and required an order to refill it. NP-A further stated she had not received a message from the staff indicating R59 had run out of his prazosin and needed a new prescription written so it could be refilled. NP-A also stated if a resident was out of a medication they needed at bedtime, the staff should have contacted the on-call provider to get a refill immediately. NP-A further stated she would have expected staff to follow up with her sooner so R59 did not go three weeks without his PTSD medication. NP-A's concern was R59 having increased nightmares or sleep disturbances. During an interview on 12/21/22, at 2:14 p.m. the director of nursing (DON) stated when a resident's medication was not available, staff should fill out a missing medication. The DON stated she received the forms and verified there was no missing medication form filled out for R59. The DON further stated R59 should not have missed his PTSD medication for three weeks and did not know why it was not addressed prior to 12/15/22, or why R59 still had not received it. The facility Hospital Return Admission policy dated indicated to check orders against resident's current orders and make necessary changes according to the Transcribing New or Changed Order document. the policy also indicated staff were to que all orders to be checked by another nurse and date and sign every page with an order on it to indicated it was completed.	F 755		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use	F 758		2/10/23

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F 758	Continued From page 69 CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is	F 758		

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F 758	Continued From page 70 appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure appropriate side effect monitoring was completed, in accordance with the care plan and standard of care, with consumed antipsychotic medication for 1 of 5 residents (R1) reviewed for unnecessary medication use. Findings include: A National Library of Medicine (NIH) Management of Commons Adverse Effects of Antipsychotic Medication article, dated 9/2018, identified the elderly were at risk of adverse effects (i.e., falls) of antipsychotic medication. The article outlined, "All antipsychotics carry some risk of orthostatic hypotension ... [which can] lead to dizziness, syncope, falls ... it should be evaluated by both history and measurement ... Risk factors include systemic diseases causing autonomic instability (e.g., diabetes, alcohol dependence, Parkinson's disease), dehydration, drug-drug interactions, and age." R1's quarterly Minimum Data Set (MDS), dated 11/11/22, identified R1 had moderate cognitive impairment and several medical diagnoses	F 758	R1 ortho blood pressures were taken and charted in medical record. All residents had the potential to be affected. The medication administration policy and procedure has been reviewed and updated. All nurses and TMA□s have been educated on the medication administration policy and procedure. All current residents will be audited by DON or designee to ensure ortho BP is obtained monthly for those on psychotropic medications. Audits will continue monthly until substantial compliance is achieved. Results will be presented at QAPI.	

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F 758	Continued From page 71 including non-traumatic brain dysfunction, diabetes mellitus, and seizure disorder. Further, R1 demonstrated both hallucinations and delusional behaviors during the review period and was independent with transfers and bed mobility. R1's signed Order Summary Report, dated 12/14/22, identified R1's current physician-ordered medications. This included Paxil (an anti-depressant medication) 40 milligrams (mg) everyday, and Seroquel (an antipsychotic medication) 100 mg twice daily, and 200 mg once daily (400 mg total dose/day). The report also listed an order which directed, "Symptom and Side Effects Monitoring ...," and outlined several symptoms to be monitoring R1 for each shift which included dry mouth, vision changes, sedation, and slurred speech. However, the report lacked any directions, guidance, or orders to monitor for orthostatic hypotension despite the ordered psychotropic medications. R1's care plan, dated 11/22/22, identified R1 consumed psychotropic medications related to depression. A goal was listed which read, "[R1] will be free from complications of psychotropic medication," and listed several interventions to help R1 meet this goal including, "Orthostatic BP [blood pressure] per facility policy and PRN [as needed]." During the recertification survey, from 12/19/22 to 12/22/22, an interview with R1 was attempted. However, R1 declined to be interviewed. On 12/21/22 at 8:39 a.m., nursing assistant (NA)-E stated R1 varied in his abilities to complete care, at times being independent and other times needing "great help." NA-E stated R1	F 758		

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F 758	Continued From page 72 was not ambulatory, however, did often transfer himself from his bed to wheelchair and vice-versa. Further, NA-E stated she had never heard R1 complain of being dizzy or lightheaded with these transfers. R1's Blood Pressure Summary report, printed 12/22/22, identified R1's collected and recorded blood pressures. The last time any evidence of orthostatic blood pressures being collected was 9/5/22 (over three months prior). Further, R1's medical record, including Treatment Administration Record (TAR), were reviewed and lacked evidence any additional orthostatic blood pressures had been collected or assessed to ensure R1 remained free of orthostatic hypotension (low blood pressure which happens when standing after sitting or lying down; can be a side effect of medications). When interviewed on 12/21/22 at 12:20 p.m., the director of nursing (DON) stated orthostatic blood pressure should be collected on a monthly basis which was facility' policy. The DON reviewed R1's medical record and verified it lacked evidence this had been done. The DON stated she would review further and provide additional information, if able. On 12/22/22 at 9:19 a.m., registered nurse (RN)-A was interviewed. RN-A verified R1 did self-transfer from his bed to wheelchair, at times, and expressed R1 would even walk for periods but "not long distance." RN-A reviewed R1's medical record and verified R1 consumed multiple psychotropic medications, including Seroquel, and expressed she was unsure of facility' policy on orthostatic blood pressure monitoring. RN-A explained she had completed	F 758		

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F 758	Continued From page 73 orthostatic blood pressures on other residents, however, the task had flagged to be done in the TAR. RN-A reviewed the record and stated R1's current TAR and physician orders lacked this order, so it likely had not triggered for them to be done. RN-A stated R1's orthostatic blood pressures should be monitored as his medications could cause "a drop in blood pressure" with position changes and could lead to a fall. On 12/22/22 at 1:45 p.m., the consulting pharmacist (CP) was interviewed. CP explained, in her opinion and "standard," the orthostatic blood pressures should be collected "at least monthly." CP stated she "spot checked" for these during her reviews, however, expressed they were important to do as atypical antipsychotic medication (i.e., Seroquel) could cause orthostatic hypotension, and CP reiterated the "standard of practice" was to complete and record these blood pressures. CP stated they would ensure the lack of collected or completed orthostatic blood pressures for R1 would be addressed on her next medication regimen review (MRR). A provided Consent to Administer Psychotropic Medication Policy & Procedure, undated, identified the nursing home would monitor and document for Tardive Dyskinesia " ... and other known side effects," when a resident started or was admitted on a psychotropic medication. A policy on orthostatic blood pressures was not provided.	F 758		
F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2)	F 760		2/10/23

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F 760	Continued From page 74 The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on interview, and document review, the facility failed to ensure insulin was administered as ordered for 1 of 1 resident (R70), resulting in a significant medication error. Findings include: R70's quarterly Minimum Data Set (MDS) dated 9/30/22, indicated R70 was admitted on 6/24/22, and was cognitively intact, independent in activities of daily living (ADLs), and a diagnosis of diabetes. The MDS did not indicate insulin use in the seven-day look-back period. R70's provider orders dated 12/19/22, indicated R70 used Lantus insulin 100 units/milliliter (u/ml) 38 units at bedtime injected subcutaneously (under the skin) and Novolog insulin 100 u/ml, 12 units three times daily for diabetes management. Previous orders for Lantus and Novolog started on 6/24/22, upon admission. R70's care plan dated 7/1/22, indicated R70 could not administer his own medications due to forgetfulness. R70's medication administration record (MAR) for December 2022, indicated R70 missed 3 of 18 doses of Lantus on 12/3/22, 12/12/22, and 12/16/22. The MAR also indicated R70 missed 2 of 80 doses of Novolog 12/3/22 and 12/12/22, with no explanation in the MAR nor in the progress notes.	F 760	A med error report for R70 has been done, and the provider has been notified. All residents had the potential to be affected. Med Error policy and procedure has been reviewed and updated. All nurses have been educated on the medication error policy and procedure. Resident charts will be audited by DON or designee monthly for missing medication entries until substantial compliance is achieved. Results will be presented at QAPI.	

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F 760	Continued From page 75 When interviewed on 12/19/22, at 6:53 p.m. R70 stated he had been diabetic for many years, but sometimes the facility staff did not administer his insulin as ordered, and he had missed a few doses, but did not recall how many, but was fearful he would lose his eyesight if his diabetes was not managed correctly. When interviewed on 12/22/22, at 1:09 p.m. trained medication aide (TMA)-A stated he did not know what to do if a resident missed insulin but would report it to the nurses. When interviewed on 12/22/22, at 1:47 p.m. registered nurse (RN)-A stated she did not know why R70 missed doses of insulin and acknowledged there was no information in the medical record about why doses were missed. RN-A stated if the doses were refused, the nurse would notify the provider and request an order to hold the insulin, but that had not been done for any of the missed doses. RN-A stated a resident can feel poorly if their blood glucose levels are too high. When interviewed on 12/22/22, 02:14 p.m. the administrator stated he expected staff to administer medications as ordered, or document why medications were missed. The Policy and Procedure for Administration of Insulin dated 10/2022, indicated the nurse will administer insulin per the provider orders.	F 760		
F 804 SS=D	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides-	F 804		2/10/23

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F 804	Continued From page 76 §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on observations, interview, and record review, the facility failed to ensure food served to the residents was palatable and at the proper temperature for 2 residents (R36 and R55) who were reviewed for food concerns Findings include: During interview with R36 on 12/19/22 at 1:36 p.m., R36 stated that he did not like the food, and it is served, "ice cold". R36 stated that staff were aware of the cold food and was told that "there is nothing" they can do about it. During an interview with R55 on 12/19/22, at 1:55 p.m., R55 stated he ate breakfast that day because it was cereal, but R55 did not eat lunch because it was hard and cold. R55 further stated the hot food was not hot and the staff microwaved everything. On 12/20/22 at 8:11 a.m., the director of nutritional services (DNS) was asked to obtain temperatures of the food on the steam table to be provided to residents in the dining room. The following results revealed: Oatmeal was 84 degrees Fahrenheit (F) Cream of Wheat was 92F	F 804	All residents had the potential to be affected. Steamtable has been replaced and is fully operational. Food temp log sheets and temperature specifications have been reviewed. All dietary staff with be educated on food temp specifications and log sheets. Dietary manager will audit steamtable weekly to ensure proper function. Dietary manger will audit food temp log sheets weekly for one month and then monthly until substantial compliance is achieved. Dietary manager will survey residents at monthly food council meeting for resident satisfaction of food temperature and quality. Results of audits will be presented at QAPI.	

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F 804	Continued From page 77 Orange juice was 54F The DNS stated that the steam table "is not working properly" and that a few temps are, "too low" and the juice is, "a little high" and should be on ice packs. On 12/21/22 at 11:47 a.m., the DNS was asked to temp the lunch meal food. The following results revealed: Corn dogs at 110F Mixed vegetables at 104F Apple juice at 69F. On 12/22/22 at 4:45 p.m., the administrator stated they knew the steam table was not working and that they were working on getting an electrician in to the facility to fix it. A policy on proper food temperatures was requested and not received.	F 804		
F 888 SS=C	COVID-19 Vaccination of Facility Staff CFR(s): 483.80(i)(1)-(3)(i)-(x) §483.80(i) COVID-19 Vaccination of facility staff. The facility must develop and implement policies and procedures to ensure that all staff are fully vaccinated for COVID-19. For purposes of this section, staff are considered fully vaccinated if it has been 2 weeks or more since they completed a primary vaccination series for COVID-19. The completion of a primary vaccination series for COVID-19 is defined here as the administration of a single-dose vaccine, or the administration of all required doses of a multi-dose vaccine.	F 888		2/10/23

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F 888	Continued From page 78 §483.80(i)(1) Regardless of clinical responsibility or resident contact, the policies and procedures must apply to the following facility staff, who provide any care, treatment, or other services for the facility and/or its residents: (i) Facility employees; (ii) Licensed practitioners; (iii) Students, trainees, and volunteers; and (iv) Individuals who provide care, treatment, or other services for the facility and/or its residents, under contract or by other arrangement. §483.80(i)(2) The policies and procedures of this section do not apply to the following facility staff: (i) Staff who exclusively provide telehealth or telemedicine services outside of the facility setting and who do not have any direct contact with residents and other staff specified in paragraph (i)(1) of this section; and (ii) Staff who provide support services for the facility that are performed exclusively outside of the facility setting and who do not have any direct contact with residents and other staff specified in paragraph (i)(1) of this section. §483.80(i)(3) The policies and procedures must include, at a minimum, the following components: (i) A process for ensuring all staff specified in paragraph (i)(1) of this section (except for those staff who have pending requests for, or who have been granted, exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations) have received, at a minimum, a single-dose COVID-19 vaccine, or the first dose of the primary vaccination series for a multi-dose COVID-19	F 888		

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F 888	Continued From page 79 vaccine prior to staff providing any care, treatment, or other services for the facility and/or its residents; (iii) A process for ensuring the implementation of additional precautions, intended to mitigate the transmission and spread of COVID-19, for all staff who are not fully vaccinated for COVID-19; (iv) A process for tracking and securely documenting the COVID-19 vaccination status of all staff specified in paragraph (i)(1) of this section; (v) A process for tracking and securely documenting the COVID-19 vaccination status of any staff who have obtained any booster doses as recommended by the CDC; (vi) A process by which staff may request an exemption from the staff COVID-19 vaccination requirements based on an applicable Federal law; (vii) A process for tracking and securely documenting information provided by those staff who have requested, and for whom the facility has granted, an exemption from the staff COVID-19 vaccination requirements; (viii) A process for ensuring that all documentation, which confirms recognized clinical contraindications to COVID-19 vaccines and which supports staff requests for medical exemptions from vaccination, has been signed and dated by a licensed practitioner, who is not the individual requesting the exemption, and who is acting within their respective scope of practice as defined by, and in accordance with, all applicable State and local laws, and for further ensuring that such documentation contains: (A) All information specifying which of the authorized COVID-19 vaccines are clinically contraindicated for the staff member to receive and the recognized clinical reasons for the	F 888		

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F 888	Continued From page 80 contraindications; and (B) A statement by the authenticating practitioner recommending that the staff member be exempted from the facility's COVID-19 vaccination requirements for staff based on the recognized clinical contraindications; (ix) A process for ensuring the tracking and secure documentation of the vaccination status of staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations, including, but not limited to, individuals with acute illness secondary to COVID-19, and individuals who received monoclonal antibodies or convalescent plasma for COVID-19 treatment; and (x) Contingency plans for staff who are not fully vaccinated for COVID-19. Effective 60 Days After Publication: §483.80(i)(3)(ii) A process for ensuring that all staff specified in paragraph (i)(1) of this section are fully vaccinated for COVID-19, except for those staff who have been granted exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations; This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure 2 of 81 staff members, including both direct and non-direct care staff, were vaccinated with a complete primary series of COVID-19 vaccine and/or had an approved or pending exemption on record. This resulted in a vaccination rate of 97.5% and had potential to affect all 79 residents in the facility.	F 888	All staff who filed exemption for Covid-19 and those who did not get “fully vaccinated” have provided a letter of exemption which has been placed in their personal file and uploaded to the facility’s files. This was verified on 1/23/2023 by the IP. The two employees who only received the	

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F 888	Continued From page 81 Findings include: The Centers for Medicare and Medicaid (CMS) QSO-23-02-ALL, dated 10/26/22, identified the revised guidance for staff vaccination requirements. The QSO outlined the requirement for full staff vaccination had been enforced since February 2022, and listed a section labeled, "Vaccination Enforcement," which outlined, "CMS expects all providers' and suppliers' staff to have received the appropriate number of doses of the primary vaccine series unless exempted as required by law, or delayed as recommended by the CDC [Centers for Disease Control]. Facility staff vaccination rates under 100% constitute noncompliance under the rule." During the recertification survey, from 12/19/22 to 12/22/22, evidence of staff vaccinations was requested. An undated Staff COVID Vaccine Status listing, provided by the infection preventionist (IP), demonstrated all staff members vaccination status with completed primary series date(s), and any provided booster doses of COVID-19 vaccines. This listing identified a total of 81 staff members. However, two staff members, licensed practical nurse (LPN)-A and housekeeper (HSK)-A, only had the first dose of a two-dose primary vaccine series completed, on 5/11/22 and 8/17/22, respectively. Further, the listing listed a sub-section labeled, "EXEMPT STAFF," which listed a total of six staff members; however, LPN-A and HSK-A were not listed. A series of documents for LPN-A were presented. This included an appointment confirmation print-out which identified LPN-A had two doses	F 888	first dose of a multi dose Covid-19 vaccine have been added to the exemption sub-category on the facility's vaccination record on 1/23/2023. Employee vaccine policy was reviewed and updated on 1/23/2023 to include precautions that exempt staff will take to ensure ongoing safety of our residents and other staff. The employee vaccine policy was reviewed and updated to include that all new staff except those who have been granted exemption will be audited upon hire to ensure compliance and to ensure they have received, at a minimum, a single-dose Covid-19 vaccine or the first dose of the primary vaccination series for a multi-dose Covid-19 vaccine prior to staff providing any care, treatment, or other services for the facility and/or its residents. All medical exemption letters will need to be reviewed and signed by the employee's provider or our in-house physician or medical director. The exemption letter must include: o Which of the Covid-19 vaccines are contraindicated and why. o A statement made by the authenticating provider recommending the staff member be exempt from the facility's vaccine policy based on recognized clinical contraindications Contingency plans for staff who are not fully vaccinated for Covid-19. Staff will not be able to work or return to work until they provide documentation that they have either been fully vaccinated, are in there 2 week window and are not eligible for their	

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F 888	Continued From page 82 scheduled to be given including 5/11/22, and the second dose on 6/8/22. However, LPN-A's CDC COVID-19 Vaccination Record Card, which identified LPN-A's name, date of birth, and administered vaccine doses, identified only a single dose of the Moderna vaccine was given on 5/11/22. No additional doses were recorded. On 12/21/22 at 1:01 p.m., LPN-A was interviewed and verified she only had received one dose of the Moderna (i.e., two-part series) vaccine, as she got sick after the first dose and then decided she did not want the second dose. LPN-A stated the nursing home did not direct or ask her to complete an exemption afterward, rather she was told she just had to test on a weekly basis and wear an N95 mask when doing direct patient care. There was no additional information presented demonstrating why HSK-A's primary vaccination series was not completed despite the first dose being administered four months prior on the facility' record. On 12/22/22 at 10:41 a.m., the administrator stated he had visited with the director of nursing (DON) and they verified the two staff members were not fully vaccinated and both continued working at the nursing home on a routine basis. The administrator explained they were going to have the employees apply for an exemption but then they "forgot to follow-up." The administrator added, "We missed it." A provided COVID-19 Vaccine Policy & Procedure, dated 9/2022, identified a purpose of establishing a process to comply with the Federal mandate for all staff to be vaccinated against	F 888	next dose, or have provided an exemption letter. Vaccination rates and information will be presented at quarterly QAPI meetings.	

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	24E185	A. BUILDING _____ B. WING _____	C 12/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BYWOOD EAST HEALTH CARE	3427 CENTRAL AVENUE NORTHEAST MINNEAPOLIS, MN 55418

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F 888	Continued From page 83 COVID-19. The policy defined, "Full Vaccinated," as being two weeks or more outside of a complete primary vaccination services. Further, a section labeled, "Staff Vaccine Requirements," directed all staff were required to have received their second dose (of a two part series vaccine) by 2/28/22, unless eligible for an exemption as allowed by law.	F 888		

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	24E185	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**12/21/2022**

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 12/21/2022. At the time of this survey, Bywood East Health Care was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.	K 000		

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

Electronically Signed | 01/19/2023

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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BYWOOD EAST HEALTH CARE	**3427 CENTRAL AVENUE NORTHEAST** **MINNEAPOLIS, MN 55418**

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K 000	Continued From page 1 Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. Bywood East Health Care is a 3-story building with a partial basement that was built in 1968 and was determined to be built of Type II(222) construction. This facility is fully protected throughout by an automatic fire sprinkler system and has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 96 beds and had a	K 000		

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K 000	Continued From page 2 census of 77 at the time of the survey. The requirements at 42 CFR, Subpart 483.70(a), are NOT MET as evidenced by:	K 000		
K 211 SS=E	Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain a clear path of egress per NFPA 101 (2012 edition), Life Safety Code, sections 19.2.1 and 7.1.10.1. This deficient finding could have a patterned impact on the residents within the facility. Findings include: On 12/21/2022 between 08:45 AM and 11:00 AM, it was revealed by observation that the exit corridor in the basement had carts, furniture, and other things obstructing the path of egress. An interview with the Director of Facilities and Maintenance verified this deficient finding at the time of discovery.	K 211	All items were removed from the means of egress and verified by the maintenance director. Signs will be posted stating items are not to be placed in the means of egress. Daily checks will be performed to ensure compliance. Maintenance department, housekeeping department and/or their designee will be responsible for maintaining ongoing compliance. DOC 1/5/23	2/10/23
K 225 SS=E	Stairways and Smokeproof Enclosures CFR(s): NFPA 101 Stairways and Smokeproof Enclosures	K 225		2/10/23

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K 225	Continued From page 3 Stairways and Smokeproof enclosures used as exits are in accordance with 7.2. 18.2.2.3, 18.2.2.4, 19.2.2.3, 19.2.2.4, 7.2 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain stairwell enclosures per NFPA 101 (2012 edition), Life Safety Code, sections 19.2.2.3, 7.2.2.5.1.1, and 7.1.3.2 (1). This deficient finding could have a patterned impact on the residents within the facility. Findings include: On 12/21/2022 between 08:45 AM and 11:00 AM, it was revealed by observation that there was a penetration into the north stairwell from security camera wires that were not sealed off. An interview with the Director of Facilities and Maintenance verified this deficient finding at the time of discovery.	K 225	Areas of penetration were seal with 3M intumescent fire caulk. A task has been created in TELS for semi-annual smoke barrier and fire wall inspections. Maintenance department is responsible for maintaining ongoing compliance. DOC 1/9/23	
K 321 SS=E	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4.	K 321		2/10/23

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K 321	Continued From page 4 Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain oxygen storage rooms per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.2.4, 8.7.1.1 (1), 19.3.2.1.3, 19.3.2.1.5 (1), and 7.2.1.8.1. This deficient finding could have a patterned impact on the residents within the facility. Findings include: On 12/21/2022 between 08:45 AM and 11:00 AM, it was revealed by observation that the elevator/ boiler room door was propped open with a rubber wedge. An interview with the Director of Facilities and Maintenance verified this deficient finding at the	K 321	All doorstops have been removed from the area. Signs will be posted that this door is not to be propped open. Daily checks will be performed to ensure ongoing compliance. Maintenance and or their designee will be responsible for maintaining ongoing compliance. DOC 12/21/22	

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K 321	Continued From page 5 time of discovery.	K 321		
K 363 SS=E	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485	K 363		2/10/23

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K 363	Continued From page 6 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain corridor doors per NFPA 101 (2012 edition), Life Safety Code, section 19.3.6.3.10. This deficient finding could have an patterned impact on the residents within the facility. Findings include: On 12/21/2022 between 08:45 AM and 11:00 AM, it was revealed by observation that the housekeeping office door in the basement was being held open with a plastic binder wedged under the door. An interview with the Director of Facilities and Maintenance verified this deficient finding at the time of discovery.	K 363	All doorstops have been removed from the area. Signs will be posted that this door is not to be propped open. Daily checks will be performed to ensure ongoing compliance. Maintenance and or their designee will be responsible for maintaining ongoing compliance. DOC 12/21/22	
K 511 SS=D	Utilities - Gas and Electric CFR(s): NFPA 101 Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2	K 511		2/10/23

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K 511	Continued From page 7 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain clearance in front of electrical equipment per NFPA 101 (2012 edition), Life Safety Code, sections 19.5.1.1 and 9.1.2, and NFPA 70 (2011 edition), National Electrical Code, section 110.26. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 12/21/2022 between 08:45 AM and 11:00 AM, it was revealed by observation that there were carts and cleaning equipment stored in front of the electrical panels in the boiler/ elevator room. An interview with the Director of Facilities and Maintenance verified this deficient finding at the time of discovery.	K 511	All items have been removed from the designated area. Black and yellow caution tape will be placed on the floor to designate area surrounding electrical panels. Sings will also be posted stating there are to be no items in designated area. Task created in TELS for quarterly inspections of hazardous areas. Maintenance and or their designee will be responsible for maintaining ongoing compliance. DOC 1/31/23	
K 522 SS=E	HVAC - Any Heating Device CFR(s): NFPA 101 HVAC - Any Heating Device Any heating device, other than a central heating plant, is designed and installed so combustible materials cannot be ignited by device, and has a safety feature to stop fuel and shut down equipment if there is excessive temperature or ignition failure. If fuel fired, the device also: * is chimney or vent connected. * takes air for combustion from outside. * provides for a combustion system separate from occupied area atmosphere. 19.5.2.2 This REQUIREMENT is not met as evidenced by:	K 522		2/24/23

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K 522	Continued From page 8 Based on observation and staff interview, the facility failed to keep combustibles clear of heating devices per NFPA 101 (2012 edition), Life Safety Code, section 19.5.2.2. This deficient finding could have a patterned impact on the residents within the facility. Findings include: 1. On 12/21/2022 between 08:45 AM and 11:00 AM, it was revealed by observation that there were resident belongings piled on the baseboard heater in resident room 303. 2. On 12/21/2022 between 08:45 AM and 11:00 AM, it was revealed by observation that there were resident belongings piled on the baseboard heater in resident room 304. 3. On 12/21/2022 between 08:45 AM and 11:00 AM, it was revealed by observation that there were resident belongings piled on the baseboard heater in resident room 305. 4. On 12/21/2022 between 08:45 AM and 11:00 AM, it was revealed by observation that there were resident belongings piled on the baseboard heater in resident room 204. An interview with the Director of Facilities and Maintenance verified this deficient finding at the time of discovery.	K 522	All items have been removed from areas of concern. Signs will be posted in resident rooms A task will be created in TELS for monthly inspections. Maintenance and or their designee will be responsible for maintaining ongoing compliance. DOC 2/24/23	
K 920 SS=E	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only	K 920		2/10/23

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K 920	Continued From page 9 used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the usage of electrical adaptive devices NFPA 99 (2012 edition), Health Care Facilities Code, sections 10.5.2.3.1 and 10.2.4.2.1, NFPA 101 (2012 edition), Life Safety Code, section 9.1.2, NFPA 70, (2011 edition), National Electrical Code, sections 400.8, and UL 1363. These deficient findings could have a patterned impact on the residents within the facility. Findings include: 1. On 12/21/2022 between 08:45 AM and 11:00 AM, it was revealed by observation that there was a power strip plugged into another power strip in	K 920	All extension cords and piggyback power strips have been removed. Quarterly inspections will be done to ensure ongoing compliance. A task was created in TELLS for quarterly inspections. Maintenance and or their designee will be responsible for maintaining ongoing compliance. DOC 1/10/23	

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K 920	Continued From page 10 the business office. 2. On 12/21/2022 between 08:45 AM and 11:00 AM, it was revealed by observation that there were two refrigerators plugged into one power strip in the insulin room. 3. On 12/21/2022 between 08:45 AM and 11:00 AM, it was revealed by observation that there was a refrigerator and a printer plugged into an extension cord in the administrator's office. 4. On 12/21/2022 between 08:45 AM and 11:00 AM, it was revealed by observation that there was a T.V. plugged into an extension cord in room 103. An interview with the Director of Facilities and Maintenance verified this deficient finding at the time of discovery.	K 920		

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

March 1, 2023

Administrator
Bywood East Health Care
3427 Central Avenue Northeast
Minneapolis, MN 55418

RE: CCN: 24E185
Cycle Start Date: December 22, 2022

Dear Administrator:

On January 13, 2023, we informed you that we may impose enforcement remedies.

On February 14, 2023, the Minnesota Department of Health completed a revisit and it has been determined that your facility is not in substantial compliance. The most serious deficiencies in your facility were found to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy(ies) listed below to the CMS Region V Office for imposition. The CMS Region V Office concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Mandatory Denial of Payment for new Mediare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective March 22, 2023

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective March 22, 2023. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective March 22, 2023.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

This Department is also recommending that CMS impose a civil money penalty. You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

- Civil money penalty. (42 CFR 488.430 through 488.444)

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $11,292, has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by March 22, 2023, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Bywood East Health Care will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from March 22, 2023. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

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. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

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.

DEPARTMENT CONTACT

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

Pete Cole, RN Unit Supervisor
Metro Team C District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: peter.cole@state.mn.us
Office/Mobile: (651) 249-1724

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health - Health Regulation Division staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their 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 SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by June 22, 2023 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 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.

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Steven.Delich@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Steven Delich, Program Representative at (312) 886-5216. Information may also be emailed to Steven.Delich@cms.hhs.gov.

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.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

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

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
March 22, 2023

Administrator
Bywood East Health Care
3427 Central Avenue Northeast
Minneapolis, MN 55418

RE: CCN: 24E185
Cycle Start Date: December 22, 2022

Dear Administrator:

On March 1, 2023, we notified you a remedy was imposed. On March 16, 2023 the Minnesota Department(s) of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of March 10, 2023.

As authorized by CMS the remedy of:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective March 22, 2023 did not go into effect. (42 CFR 488.417 (b))

In our letter of January 13, 2023, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from June 22, 2023 due to denial of payment for new admissions. Since your facility attained substantial compliance on March 10, 2023, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24E185	A. BUILDING _____ B. WING _____	R-C 02/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BYWOOD EAST HEALTH CARE	3427 CENTRAL AVENUE NORTHEAST MINNEAPOLIS, MN 55418

(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 2/14/23, an onsite revisit was conducted to determine compliance with CMS Appendix Z, Emergency Preparedness Requirements, cited as out of compliance during a standard recertification survey exited on 12/22/22. Bywood East Health Care was found to have corrected and be back in compliance with Appendix Z Emergency Preparedness Requirements.	{E 000}		
{F 000}	INITIAL COMMENTS On 2/14/23, an onsite revisit was conducted to follow up on deficiencies related to a recertification survey exited on 12/22/22. Bywood East Health Care was found to remain out of compliance with the requirements of 42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities. The following tags were recited: F570, F698 In addition, the complaints cited at the time of the standard recertification survey were reviewed for compliance. HE185199C (MN80950) was found to be corrected. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	{F 000}		
{F 570}	Surety Bond-Security of Personal Funds	{F 570}		3/7/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		03/08/2023

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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{F 570} SS=B	Continued From page 1 CFR(s): 483.10(f)(10)(vi) §483.10(f)(10)(vi) Assurance of financial security. The facility must purchase a surety bond, or otherwise provide assurance satisfactory to the Secretary, to assure the security of all personal funds of residents deposited with the facility. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the purchased surety bond (a contract or promise by a surety or guarantor to pay if a second party fails to meet the obligation) had sufficient coverage to protect the total account balance(s) of resident's trust funds. This had potential to affect 64 of 64 residents identified to have such an account while at the nursing home. Findings include: A provided Bywood East Health Care SNF Trust - Current Account Balance listing, dated 2/14/23, identified all current resident trust accounts at the nursing home. This identified a total of 64 different residents had accounts with a positive balance, along with a total account balance recorded as $107,074.39. However, the provided Western Surety Company Rider, dated 12/29/22, identified the facility's surety bond had only $85,000 dollars of coverage. On 2/14/23, at 12:30 p.m. the administrator and director of nursing (DON) were interviewed. The administrator acknowledged the surety bond was cited as being insufficient on the recent recertification survey (exited 12/22/22) and, as a	{F 570}	All 63 residents with trust accounts had the potential to be affected The surety bond has been raised to $110,000 The current resident trust account balance is 105,210.30 The CFO and business manager and their designee will do monthly audits to verify that the trust balance does not exceed the surety bond. Results will be presented at QAPI	

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{F 570}	Continued From page 2	{F 570}		

result, they raised the bond coverage to $85,000 (dollars). However, in the meantime, a resident had deposited a large sum of money into their account which caused the account balances to exceed the raised surety bond coverage. This was identified on an audit completed a few weeks prior and, as a result, the administrator verbally asked the chief financial officer (CFO) to raise the surety bond coverage; however, it had not happened thus far. The administrator stated he could not recall what, if any, response was made by the CFO when the request was made, and he explained the process for requesting an increase in the bond coverage was "a bit blurry," but reiterated contacting the CFO with the requested seemed like "a logical step." The administrator verified he had only contacted the CFO about the issue and did not contact the facility's ownership directly to have it raised. Further, the administrator stated there "was not" any further follow-up on the concern since it was identified a few weeks prior until today (2/14/23) when survey entered to review the information. The administrator provided several emails for review.

An electronic mail (e-mail) message from the President of the company, dated 2/14/23 at 9:51 a.m., identified the need to increase the surety bond to $110,000 dollars had been identified. The message was sent from the President to several persons including the CFO and concluded with, "How do we do this??"

A subsequent e-mail message from the CFO, dated 2/14/23 at 10:02 a.m., was sent to the administrator and outlined the CFO informed the President of the company the bond coverage needed to be increased and the President " ... has personally requested the increase ... I will let

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{F 570}	Continued From page 3 you know as soon as I get a response and/or the new bond." The administrator expressed it was important to ensure the bond coverage met the posted account balances at all times so the resident' funds were protected "in case the money is suddenly not there anymore [i.e., stolen]." There was no additional evidence or documentation provided demonstrating the bond coverage had been increased, or even attempted to have been increased, until 2/14/23 when the survey entered to review the information despite the bond coverage falling well short of the posted and tracked resident trust account funds. A facility policy on surety bond coverage was requested, however, none was received.	{F 570}		
{F 698} SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide an ongoing assessment of the resident's condition and monitoring for complications pre and post dialysis treatment for 1 of 1 resident (R72) reviewed who received hemodialysis. Findings include:	{F 698}	A dialysis Run paperwork will be obtained for R72 after every dialysis appointment. All residents that require dialysis had the potential to be affected. The dialysis policy and procedure has been reviewed and updated to include to make sure run paperwork is sent with resident after dialysis. Floor nurse will	3/10/23

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{F 698}	Continued From page 4 R72's quarterly Minimum Data Set (MDS) dated 11/18/22, indicated R72 was cognitively intact, had diagnoses of diabetes and end stage renal disease and received dialysis. R72's provider order summary reviewed 2/14/23, lacked orders for dialysis every Monday, Wednesday, and Friday. The orders lacked indication of monitoring or assessments before after return from dialysis. R72's care plan with review date of 8/24/22 indicated "nurse to check for thrill and bruit on AV graft [a synthetic tube used to surgically connect the artery and vein] located on upper left arm." R72's treatment administration record (TAR) for January and February 2023 lacked indication to monitor or assess the AV graft dialysis access before and after each dialysis session. During interview with R72 on 2/14/23 at 10:25 a.m., R72 stated facility staff, "never ask to look at thrill and bruit" when he returns from three time a week dialysis sessions. R72 stated that he returns every time from dialysis with a folder showing what his vital signs were during the session and how much fluid was removed during the session. During interview with licensed practical nurse (LPN)-A on 2/14/23 at 10:27 a.m., stated there were no orders in R72's electronic medical record (EMR) to indicate if R72 had dialysis and the orders lacked pre and post dialysis assessment monitoring by facility staff. LPN-A stated medical orders must first be placed in the EMR which would then flow to the TAR for staff to document	{F 698}	assess resident after each dialysis treatment. All nurses will be educated on the updated dialysis policy and procedure. Weekly audits of dialysis run paperwork will be done until substantial compliance is achieved Results will be presented at QAPI.	

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{F 698}	Continued From page 5 their treatments. During interview with director of nursing on 2/14/23 at 12:09 p.m., DON stated R72's EMR lacked documentation that the facility assessed or monitored R72 pre and post dialysis which included ongoing monitoring for dialysis related complications. DON stated the expectation for staff was to document R72's pre and post dialysis assessments following every dialysis session. The DON stated the quality assurance nurse (QAN) is responsible for dialysis audits to ensure documentation is being done. During interview with quality assurance nurse (QAN) on 2/14/23 at 1:34 p.m., QAN stated dialysis assessment includes the dialysis "run sheet" from the dialysis center which documents the residents vital signs, weight before and after the session including the amount of fluid removed. The QAN stated the dialysis center was "supposed to fax us the run sheet" following every dialysis session for R72. QAN stated that she instructed facility nurses to be "looking for the run sheet when he comes back" and to document in the EMR under progress notes after every dialysis session. The QAN stated R72's EMR lacked documentation that the facility assessed or monitored R72 pre and post dialysis which includes ongoing monitoring for dialysis related complications which "could be blood pressure changes, infection to the site and excess bleeding". During interview with dialysis registered nurse (DRN)-A on 2/15/23 at 9:19 a.m., DRN-A stated the dialysis center "usually sends post treatment reports with the resident and sometimes we fax" to the long term care facility when session is	{F 698}		

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{F 698}	Continued From page 6 completed. DRN-A stated R72's long term care facility, "never call me" and that "it is really difficult to reach anybody over there." During interview with dialysis patient care technician (DPCT)-A on 2/15/23 at 9:30 a.m., DPCT-A stated, "honestly there is no communication" between the dialysis center and R72's long term care facility. DPCT-A stated, "now we send treatment run sheets" with the R72 when every session is completed. In addition, "we were not asked to provide those until you guys [Minnesota Department of Health] got involved. They are asking for them now." DPCT-A stated the dialysis center has not faxed or heard from R72's facility since the end of January 2023. Facility policy on dialysis was requested and not received.	{F 698}		