Electronically delivered

January 27, 2023

Administrator
Avera Morningside Heights Care Center
300 South Bruce Street
Marshall, MN 56258

Re: Reinspection Results
Event ID: GBRM12

Dear Administrator:

On December 20, 2022 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on October 28, 2022. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

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

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
January 27, 2023

Administrator
Avera Morningside Heights Care Center
300 South Bruce Street
Marshall, MN 56258

RE: CCN: 245228
Cycle Start Date: October 28, 2022

Dear Administrator:

On November 28, 2022, we notified you a remedy was imposed. On December 20, 2022 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 December 8, 2022.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective December 28, 2022 did not go into effect. (42 CFR 488.417 (b))

In our letter of November 28, 2022, 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 December 13, 2022 due to denial of payment for new admissions. Since your facility attained substantial compliance on December 8, 2022, 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 Therefore, the NATCEP prohibition is rescinded.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
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

Electronically delivered
November 28, 2022

Administrator
Avera Morningside Heights Care Center
300 South Bruce Street
Marshall, MN 56258

RE: CCN: 245228
Cycle Start Date: October 28, 2022

Dear Administrator:

On October 28, 2022, a survey was completed at your facility by the Minnesota Department(s) of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the electronically delivered CMS-2567, whereby significant 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:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective December 28, 2022.

- Directed plan of correction (DPOC), Federal regulations at 42 CFR § 488.424. Please see electronically attached documents for the DPOC.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective December 28, 2022. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective December 28, 2022.

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:

- Civil money penalty (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

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 December 28, 2022, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Avera Morningside Heights Care Center will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from December 28, 2022. 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:

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health - 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 April 28, 2023 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.

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,

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

Electronically delivered
November 28, 2022

Administrator
Avera Morningside Heights Care Center
300 South Bruce Street
Marshall, MN 56258

Re: State Nursing Home Licensing Orders
Event ID: GBRM11

Dear Administrator:

The above facility was surveyed on October 24, 2022 through October 28, 2022 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

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

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

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

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

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

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

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

Please feel free to call me with any questions.

Sincerely,

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 A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	245228		C **10/28/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVERA MORNINGSIDE HEIGHTS CARE CENTER	**300 SOUTH BRUCE STREET** **MARSHALL, MN 56258**

(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 Surveyor: 34083 On 10/24/22 through 10/28/22, a survey for compliance with Appendix Z, Emergency Preparedness Requirements for Long Term Care facilities, §483.73(b)(6) was conducted during a standard recertification survey. The facility was NOT in compliance. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulation has been attained.	E 000		
E 020 SS=C	Policies for Evac. and Primary/Alt. Comm. CFR(s): 483.73(b)(3) §403.748(b)(3), §416.54(b)(2), §418.113(b)(6)(ii), §441.184(b)(3), §460.84(b)(3), §482.15(b)(3), §483.73(b)(3), §483.475(b)(3), §485.68(b)(1), §485.625(b)(3), §485.727(b)(1), §485.920(b)(2), §491.12(b)(1), §494.62(b)(2) [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years	E 020		12/8/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		12/08/2022

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	245228		C 10/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVERA MORNINGSIDE HEIGHTS CARE CENTER	300 SOUTH BRUCE STREET MARSHALL, MN 56258

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E 020	Continued From page 1 [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:] [(3) or (1), (2), (6)] Safe evacuation from the [facility], which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s); and primary and alternate means of communication with external sources of assistance. *[For RNHCIs at §403.748(b)(3) and ASCs at §416.54(b)(2):] Safe evacuation from the [RNHCI or ASC] which includes the following: (i) Consideration of care needs of evacuees. (ii) Staff responsibilities. (iii) Transportation. (iv) Identification of evacuation location(s). (v) Primary and alternate means of communication with external sources of assistance. * [For CORFs at §485.68(b)(1), Clinics, Rehabilitation Agencies, OPT/Speech at §485.727(b)(1), and ESRD Facilities at §494.62(b)(2):] Safe evacuation from the [CORF; Clinics, Rehabilitation Agencies, and Public Health Agencies as Providers of Outpatient Physical Therapy and Speech-Language Pathology Services; and ESRD Facilities], which includes staff responsibilities, and needs of the patients. * [For RHCs/FQHCs at §491.12(b)(1):] Safe evacuation from the RHC/FQHC, which includes appropriate placement of exit signs; staff	E 020		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	245228		C 10/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVERA MORNINGSIDE HEIGHTS CARE CENTER	300 SOUTH BRUCE STREET MARSHALL, MN 56258

(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 020	Continued From page 2 responsibilities and needs of the patients. This REQUIREMENT is not met as evidenced by: Surveyor: 44658 Based on interview and document review the facility failed to ensure emergency preparedness policies included procedures for residents who refused to leave the facility during an emergency evacuation. This had the potential to affect all 69 residents and staff in the building. Findings include: During an interview on 10/27/22, at 11:00 a.m. the Quality Coordinator (QC) stated she did not recall the facility having a policy or procedure to address a resident who refused to leave during an emergency evacuation. Review of the facility Fire Response and Evacuation Plan dated 10/2022, lacked a procedure in the event a resident refused to leave the facility during an emergency evacuation.	E 020	The facility reviewed the Emergency Shelter in Place, Relocation and Evacuation Plan. The policy was updated to include the plan for situations where resident refuse to evacuate on date 12/2/22 The facility trained the updated policy with the staff on 12/6/22, 12/7/22, 12/8/22	
F 000	INITIAL COMMENTS Surveyor: 34083 On 10/24/22 through 10/28/22, a standard recertification survey was conducted at your facility. A complaint investigation was 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 complaints were found to be SUBSTANTIATED H5228035C (MN82447),	F 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 000	Continued From page 3 H52285143C (MN85027), and H52285077C (MN86082), however NO deficiencies were cited due to actions implemented by the facility prior to survey. The following complaint was also found to be SUBSTANTIATED: H52285146C (MN87174), and had a deficiency cited at F656. The following complaints were found to be UNSUBSTANTIATED: H52285144C (MN83743) and H52285149C (MN86301). The following complaint was also found to be UNSUBSTANTIATED: H52285145C (MN83502), however a related deficiency was cited at F657. 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 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive	F 578		12/8/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 578	Continued From page 4 the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Surveyor: 38687 Based on interview and document review, the facility failed to ensure the accuracy of 1 of 1 resident (R41) medical record when R41 had	F 578	The facility reviewed and updated the policy to correct the concerns identified in the survey process on 11/1/22 The team was trained on the new policy and the updates on 11/30/22, 12/6/22,	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	245228		C 10/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVERA MORNINGSIDE HEIGHTS CARE CENTER	300 SOUTH BRUCE STREET MARSHALL, MN 56258

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F 578	Continued From page 5 conflicting end of life (code status) documentation. Findings include: R41's current, undated "electronic medical record (EMR) identified R41 was marked as "full resuscitation" (wanting all lifesaving measures including cardio pulmonary resuscitation (CPR)). R41's October 2021, POLST (Physician Orders for Life Sustaining Treatment) form identified R41 wished to be a Do Not Resuscitate (DNR) with selective treatment of antibiotic use. Interview on 10/26/22 at 2:18 p.m., with the director of nursing (DON) identified she was unaware of the conflicting information of R41's code status. She stated "Full resuscitation may be the same as DNR with selective treatment. That could be just how they [staff] have to put that into the computer system". She was unsure if that would be considered conflicting information, but agreed both the POLST and EMR should match. She agreed R41 could potentially received CPR against his wishes in an emergent situation occurred. No policy relating to Advanced Directives was provided by the end of survey.	F 578	12/7/22, 12/8/22. An audit was completed on 10/28/22 of a 100% of the current resident charts for their POLST documents and that the information matched. Any discrepancies were corrected in the resident's charts to reflect the correct information The process changes are the following: The social worker is responsible for obtaining the POLST document upon admission or at the initial care conference. The POLST document will then be scanned into the resident's chart. The nursing supervisor will verify the code status and compare it to what is in the EMR system and update if necessary. The advance directive on the resident R41 was corrected to reflect the correct status in the EMR as the POLST 10/28/22 Audits: 100% of charts will be audited on admissions and readmissions. Audits will be completed monthly until 100% compliance is met. the frequency will be monthly x 3 months. then 20% of admissions and readmissions quarterly x3 quarters.	
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations	F 609		12/8/22

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F 609	Continued From page 6 involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Surveyor: 44658 Based on interview and record review, the facility failed to develop and/or implement policies and procedures for ensuring the reporting of a reasonable suspicion of crime in accordance with section 1150B of the Act related to misappropriation of property to the State Agency (SA) no later than 24 hours when 1 of 1 resident (R4) alleged she was missing $200.00 from her billfold. Findings include:	F 609	The vulnerable adult policy and process was reviewed on 11/11/22. The vulnerable adult policy and process was trained with staff on 11/30/22, 12/6/22, 12/7/22, 12/8/22. The investigation was submitted to MDH on 10/26/22 and the police were called and arrived for the investigation on 10/26/22 and opened case # 22-16559. Family was contacted and reported that the resident attended a recent wedding and gave her grandkids money at the wedding. The Marshall police department was contacted on 12/1/22 and they have	

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F 609	Continued From page 7 R4's annual Minimum Data Set (MDS) dated 10/26/22, indicated R4 had intact cognition, was independent with eating but required extensive assistance of two staff for all other activities of daily living (ADLs). R4's diagnoses included stroke, and depression. R4's care plan dated 10/24/22, indicated R4 was at risk for psychosocial wellbeing and mood related to depression, loss of independence, and a change in her daily routine. Interventions included monitoring R4 and performing assessments as needed. R4's care plan also indication R4 had no current communication concerns and was able to make her needs known. During an interview on 10/25/22, at 8:35 a.m. R4 stated she put money she received from family and friends into her billfold, wrapped it in a red towel, and put it in a drawer. R4 stated a couple of weeks ago she discovered $200.00 was missing from her wallet. R4 reported the missing money to licensed practical nurse (LPN)-B, however, no one ever came and spoke to her which upset R4. R4 stated she did not fill out a form regarding the missing money and was not aware there was a grievance process. During an interview on 10/26/22, at 2:50 p.m. LPN-B stated R4 told her she was missing $200.00 about a month ago. LPN-B stated she looked around R4's room but didn't find any money and was unaware of a billfold or red towel. LPN-B spoke to R4's family member who told LPN-B they did not know of anyone giving R4 any money or that R4 had any money, therefore, LPN-B did not fill out a Quality Measure (QM-grievance form) or contact the administrator	F 609	not closed the case yet. Audit: Observation audits will be completed of the daily taped report. 5x/weeks x 4; 2x/week x 4; 1x/week x4; 2x/month x3.	

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F 609	Continued From page 8 per the facility policy. During an interview on 10/26/22, at 3:07 p.m. the director of nursing (DON) stated she was unaware R4 was missing money and would have expected a QM form to be filled out and the policy followed regarding misappropriation of money when R4 first reported she was missing $200.00. The facility Vulnerable Adult Abuse Prevention Plan dated 9/2022, indicated misappropriation of resident property was the deliberate misplacement, or wrongful, temporary or permanent use of a resident's belongings or money with the resident's consent. The facility will respond to all incidents of abuse and/or neglect by conducting an investigation to determine why abuse, neglect, or misappropriation occurred and what changes are needed to prevent further occurrences. All alleged violations involving abuse, neglect or misappropriation are to be reported immediately, but not later than 2 hours if the allegation involves abuse or resulted in serious bodily injury; or not later than 24 hours if the events did not involve abuse and do not result in serious bodily injury. Staff must report to the administrator. Staff were to investigate incidents and all persons on/in the area of the incident were to be interviewed.	F 609		
F 645 SS=F	PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3) §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with:	F 645		12/8/22

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F 645	Continued From page 9 (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services; or (ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission- (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability. §483.20(k)(2) Exceptions. For purposes of this section- (i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital. (ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual- (A) Who is admitted to the facility directly from a	F 645		

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F 645	Continued From page 10 hospital after receiving acute inpatient care at the hospital, (B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and (C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services. §483.20(k)(3) Definition. For purposes of this section- (i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1). (ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter. This REQUIREMENT is not met as evidenced by: Surveyor: 38687 Based on interview and document review, the facility failed to ensure 1 of 1 resident (R3) with failed to ensure 1 of 1 resident received a Pre-Admission Screening and Resident Review (PASARR) Level II to ensure coordination of mental health services. Findings include: Review of the 7/24/17 (PASARR Level I) identified it was done prior to R3's admission. R3 was noted to have a diagnosed mental illness of Bipolar disorder, depression, anxiety disorder and personality disorder. There was no indication upon admission to the facility an addition	F 645	The facility reviewed the Pre-Admission Policy on 11/1/22. The staff were trained on the policy updates on 11/30/22, 12/6/22, 12/7/22, 12/8/22. The facility completed an audit on 10/28/22 of 100% of the current resident charts for their scanned PASARR's. They found 8 charts that did not have a PASARR scanned correctly in their charts, a list was created and given to the social worker to contact senior linkage line and obtain them. As of 11/30/22 we were waiting for 3 outstanding PASARR's it was determined that those 3 were admitted before the Senior Linkage Line existed The facility re-assessed the resident R3	

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F 645	Continued From page 11 assessment occurred. R3's current, undated care plan identified she had an entry for Psychological Well Being/Mood related to a diagnoses of anxiety and depression, loss of independence, and chronic pain. There were no personalized interventions listed other than R3 was to "maintain mood" and "maintain interests in previous activities". There was no mention of R3's diagnoses of Bipolar disorder, depression, anxiety disorder and personality disorder or how staff were to care for her and ensure she received professional services. R3's 2/9/22, annual Minimum Data Set, Section D-Mood identified R3 had little interest in doing things, felt down, depressed or hopeless, Had trouble falling or staying asleep, felt tired or had little energy, had poor appetite or was overeating, had trouble concentrating on things, moved or spoke slowly that other people had noticed, or was fidgety or restless with a total severity score of 15, indicating she had moderately severe depression. Interview on 10/24/22 at 7:15 p.m. with R3 identified she has been depressed. Since at least 4 to 5 moths ago, she felt like she "wasn't getting the proper care" but acknowledged she does see a mental health professional after she had requested it. They were working on getting her "medications straight". Interview on 10/26/22 at 5:00 p.m. with the administrator identified she agreed R3 needed to have a PASARR Level II re-assessed in order for staff to develop a thorough care plan so the facility social worker and contracted mental health providers had provided additional care for R3	F 645	for her PASARR Level II in order to develop a thorough care plan. The updates to the process are the following: The admission coordinator will obtain all PASRR's and scan them into the resident charts upon admission. The social worker will be the backup if the admission coordinator is gone. If the resident triggers a Level II PASARR the admission coordinator will work with the discharging social worker to ensure that they get that completed prior to admitting to the facility. After the admission the social worker will follow up with the county to obtain a copy for the resident's chart. Audits: 100% of the charts will be audited monthly until we have 100% compliance x 3 months: then 20% of admissions quarterly x 3 quarters.	

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F 645	Continued From page 12 after admission and when R3's mood decreased. Review of the current, 7/3/19, Preadmission Screening and OBRA, at https://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=ID_000814, identified if the OBRA Level I screening indicated a person had a diagnosis or suspected diagnosis of developmental disabilities or related conditions, he/she also must receive an OBRA Level II evaluative report before he/she can be admitted to an MA-certified nursing facility (NF). If a person experiences a significant change of condition, the lead agency must complete a new OBRA Level II evaluative report. (Note: At the federal level, these evaluations are called resident reviews.) A "significant change" was noted as a major decline or improvement in person ' s status that: 1) Will not normally resolve itself without staff intervention or standard disease-related clinical interventions, and the person cannot prevent the decline (i.e., not considered "self-limiting") 2) Affected more than one area of the person ' s health status 3) Required multidisciplinary review and/or revision of the person ' s care plan. No policy related to PASARR Level II screening was provided by the end of survey.	F 645		
F 656 SS=F	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §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	F 656		12/8/22

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F 656	Continued From page 13 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 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. This REQUIREMENT is not met as evidenced by: Surveyor: 38687	F 656	The facility reviewed the Care Plan policy	

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F 656	Continued From page 14 Based on interview and document review, the facility failed to ensure development of comprehensive care plans were developed and implemented for each resident, included measurable objectives and timeframe's to meet a resident's medical, nursing, and mental and psychosocial needs and include services to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being for 16 of 18 sampled residents (R3, R4, R5, R11, R20, R31, R41, R42, R43, R50, R54, R56, R57, R121, R122, and R127). This had the potential to affect all 69 residents. Findings include: R5's current, undated care plan identified R5 was admitted to the facility in November, 2021 and had diagnoses of cancer, high blood pressure, GERD, diabetes, high cholesterol. thyroid disorder, anxiety disorder, . R5's care plan identified problems noted for bladder incontinence, communication and cognitive concerns, was a fall risk, was on hospice, was on a constant carb diabetic diet, chronic pain, psychosocial well-being/mood, activities, medication side effects, and skin integrity. R5 had little to no specific person-centered goals or interventions identified on the care plan according to existing diagnoses or needs. R5 recieved an anti-coagulant and the care plan made no mention of any bleeding precautions. R3's current, undated care plan identified R3 was admitted to the facility in July, 2017. R3's care plan identified problems noted for psychosocial well being, Activities of Daily Living (ADL) status, bowel and bladder incontinence, communication	F 656	11/16/22. The staff were trained on the updated policy and processes on 11/30/22, 12/6/22, 12/7/22, 12/8/22. Meditech hands on training for all staff has been scheduled for ongoing training.and has been added to the new hire training for all staff. The care plans were audited for 100% of the facility. A plan has been developed to update each resident's care plan with person centered items. The following has been updated: R5 has had resident goals and interventions added to the care plan. Bleeding precautions were also added to the residents care plan. R3 has been updated with the residents' goals and interventions for side effects from psychotropic drug use and behavior interventions. The plan for restorative therapy to reduce the contractures has been noted in the care plan. R41 has had their care plan updated with resident centered goals and interventions that relate to their diagnoses. R56's Care plan has been updated to include the indication of the catheter to be secured to the resident's leg with a leg strap to keep the catheter in place. Person centered goals and interventions have been identified and updated in her R31 Care plan has been updated to direct staff to use a gait belt for all transfers with the resident. Goals and Interventions have been updated in the resident's care plan. choking. R50 non pharmacological interventions have been updated in the care plan as	

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F 656	Continued From page 15 and cognitive ability, fall risk, oral and respiratory status, blood sugar status, nutrition, pain, activity involvement, was at risk for medication side effects, and skin integrity. R3 was at risk for side effects from psychotropic drug use related to behaviors, however no interventions were placed on the care plan specific to R3.R3 also had contractures and the need for restorative therapy was also not noted on the care plan. Throughout R3's care plan, R3 had little to no specific person-centered goals or interventions identified according to existing diagnoses or needs. R41's current, undated care plan identified R3 was admitted to the facility in October, 2021 with diagnoses of dementia, enlarged prostate, diabetes, glaucoma and was legally blind, high cholesterol, and a below the knee amputation. R14 had little to no specific person-centered goals or interventions identified on the care plan according to existing diagnoses or needs. R56's current, undated care plan identified R56 was admitted to the facility in March 2021 and had diagnoses of heart failure, neurogenic bladder, high cholesterol, paraplegia, MS, anxiety, depression, pressure ulcer to her left buttock- Stage III, and dysphagia. She had identified problems of ADL status, catheter use, ostomy care, communication and cognitive ability, fall risk, nutritional status, chronic pain, psychosocial well-being, activity involvement, skin integrity. R56 was noted to have a suprapubic (tube placed in opening into bladder through stomach) catheter with interventions to clean and change the catheter bag monthly. The care plan also had a discrepancy and noted R56 was to have her Foley (tube inserted into urethra, then into the bladder) flushed twice per day. Staff were	F 656	well as person centered goals R11 His care plan has been updated to address his agitation and PTSD and the interventions to handle his behaviors and diagnosis. His medications have been updated in his care plan along with monitoring for side effects. R42 Person centered goals have been placed in her care plan as well as interventions to address her potential for R121 care plan was reviewed, the resident expired R122 care plan was reviewed, the resident discharged R127 Care plan was reviewed, the resident expired R20 care plan has been updated to reflect his behaviors and interventions used by staff when those behaviors occur. R54 the care plan has been updated to reflect individualized interventions to prevent falls and minimize pain. R43 the care plan was updated to reflect interventions for staff to ensure communication to meet needs and prevent elopement. he enjoyed, medications have been update and all side effects as well. CPAP cares and interventions have also been updated in his care plan. R4 Care plan was updated to reflect interventions related to using her call light and using the bathroom unattended and fall reduction R57 care plan has been updated with interventions to increased the resident activity involvement and what activities The audits and topic have been added to the Quality Score card and agenda to	

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F 656	Continued From page 16 to place a pad under R56 if it leaked. There was also a notation to "cath secure change" however, there was no indication what that meant or how staff was to ensure her catheter remained secured to her leg. R56 had little to no specific person-centered goals or interventions identified on the care plan according to existing diagnoses or needs. R31's 9/7/22, quarterly Minimum Data Set (MDS) identified she had intact cognition with diagnoses of Parkinson's disease, glaucoma, retention of urine, constipation, and pain. R31 was to have had extensive assistance of 2 staff for transfers between surfaces and required the use of a wheelchair. Observation on 10/27/22 at approximately 9:45 a.m. identified R31 was being transferred with nurse aide (NA)-H identified she was in process of performing a pivot transfer to R31. NA-H was observed grabbing onto the back side of R31's elastic waistband pants, and pivoting R31 from her wheelchair to a chair without use of a gait belt. R31's current, undated care plan identified R31 was admitted to the facility in March 2022. R31 was at risk for falls as evidence by a history of falls, impaired balance, Parkinson's disease, urinary tract infections, and impaired mobility. There were no interventions identified on the care plan reflective of her MDS assessment. R31 had a problem noted with Activities of Daily Living (ADL) and required assistance with ADL's. R31 was noted to transfer/pivot with use of a gait belt and a walker. There was no mention R31 required 2 staff for safety.	F 656	review at the QA meetings monthly. Audit: 100% of charts will be audited 1 care plan per unit will be audited weekly x4; 1 care plan per unit monthly x 3 ; 1 care plan per unit quarterly.	

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F 656	Continued From page 17 Review of the 6/24/22,current nurse aide (NA) care plan identified under the section "Care Plan/Special Needs/Special Diet" the only notation for NA staff was that she "likes makeup and recliner". Her ADL's were listed as "A1" (assistance of 1). There was no indication why the nurse aide care plans did not contain critical elements of resident care needed or why it had not been revised recently. Interview and observation on 10/27/22 at 10:00 a.m. with the administrator and director of nursing identified all residents were to have gait belts in their rooms for potential transfers. Both agreed NA-H should have used the resident's gait belt. The administrator and DON agreed there was the potential for harm for an accidental fall due to staff not using the appropriate equipment. The administrator was unsure why the nurse aide care plans were not up to date or reflective of what resident's care was required but did acknowlege their current computer software was "not friendly to long term care (LTC) use" and was not able to be resident specific. Both agreed care plans failed to detail resident specific needs. Surveyor: 34083 R11's undated care plan failed to identify safety measures for behaviors of anxiety with agitation, attempted elopement, wandering and self-transfers with resulting falls. R11 also had a diagnosis of PTSD with delusions of still being in war and the care plan failed to include interventions to manage his issues. R11 had signed provider orders for Lorazepam for his anxiety, Oxycodone for pain, Insulin for diabetes,	F 656		

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F 656	Continued From page 18 and Tramadol for pain. His medications were not identified on the care plan with monitoring for potential side effects. R42's current undated, care plan identified R42 was admitted to the facility on 8/26/2019, and had diagnoses of at risk for aspiration, Alzheimer's disease with behavioral disturbance, delirium, high blood pressure (HTN), chronic obstructive pulmonary disease (COPD), Osteoarthritis, peripheral vascular disease (PVD), hypothyroidism. R42's care plan identified problems of Alzheimer's dementia, fall risk with a history of falls prior to admission which resulted in a left hip fracture with surgical repair, activity involvement, nutritional status with offer preferred supplement for weight loss and wound healing, and at risk for pain evidence by a history of venous stasis ulcers, and arthritis in her shoulders. The care plan also listed R42 was receiving hospice services. R42 had little to no specific person-centered goals or interventions identified on her care plan according to existing diagnoses or needs. R42 had also been identified as having issues with the potential for choking and there were no interventions or monitoring mentioned. R50's current undated, care plan identified R5 was admitted to the facility on 11/20/09 and had diagnoses of a Stage 3 pressure ulcer (PU) to his right buttock, neurogenic bladder, paraplegia, dyspnea, history of below the knee amputation, muscle spasms, hyponatremia, colostomy, chronic pain syndrome, and hypotension. R50's care plan identified problems with skin integrity, risk for skin breakdown due to	F 656		

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F 656	Continued From page 19 immobility, history of pressure ulcers, history of skin grafts, contractures, noncompliance with repositioning at times, urostomy and colostomy sites, nutritional status-with offered high protein snacks related to his wounds and needed encouragement to eat, at risk for pain but and listed on scheduled pain medication, but no non-pharmacological interventions listed, and psychosocial wellbeing/mood identified. Throughout R50's care plan, R50 had little to no specific person-centered goals or interventions identified according to his specific diagnoses or needs. R121's undated, care plan identified R121 was admitted to the facility on 11/25/19, and had diagnoses of malnutrition, hyperlipidemia, dementia, adjustment disorder with depressed mood, Parkinson's Disease, HTN, osteoarthritis. R121 had experienced an injury of unknown origin with bruising under his left arm pit that extended to his chest area and under his right upper arm. R121 was developing increased weakness and it was thought the bruising was a result of use of and EZ stand lift and not being able to support his weight on his legs. R121's current, undated care plan identified problems of communication ability/cognition, ADLs, bowel, and bladder incontinence, fall risk, psychosocial wellbeing/mood, chronic pain, and nutritional status. Throughout R121's care plan, R121 had little to no specific person-centered goals or interventions identified according to his specific diagnoses or needs as he continued to have physical decline. R122's, undated care plan identified R122 was admitted to the facility on 4/12/22 and discharged	F 656		

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F 656	Continued From page 20 on 7/20/22, following an extended hospitalization. R122 had diagnoses of self-neglect, insomnia, chronic heart failure, anxiety, hypotension, atrial fibrillation (a-fib- an irregular heart rthymn), physical deconditioning, lymphedema, left ventricular hypertrophy (LVH) (left side of heart not pumping effectively), Asthma, COPD, morbid obesity, hypothyroidism, HTN, and depressive disorder. R122's care plan identified problems of ADLs, bladder incontinence, communication ability, fall risk, acute/chronic pain, psychosocial wellbeing/mood activity involvement, and medication side effects. R122 had little to no specific person-centered goals or interventions identified on the care plan according to existing diagnoses or needs. R122 was also identified as having psychological issues and was seen by a provider, but the care plan made no mention of behavioral or psychological interventions. R127's undated care plan identified R127 was admitted to the facility on 2/18/20 and died on 8/23/22. R127's discharge summary listed diagnoses of postmenopausal vaginal bleeding, hospice care, chronic kidney disease stage IV, diabetes type 2; anemia, diabetic neuropathy, hypothyroidism, CAD, hypotension, mixed incontinence, chronic anticoagulation, HTN, memory deficit. R127's care plan listed problems of ADLs, bowel and bladder incontinence, communication/cognition ability, fall risk, activity involvement, anticoagulant therapy, blood sugar status, respiratory status, and hospice care. R127 had little to no specific person-centered goals or interventions identified on the care plan	F 656		

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F 656	Continued From page 21 according to existing diagnoses or needs Surveyor: 39988 R20's 9/12/22, significant change Minimum Data Set (MDS) assessment identified severe cognitive impairment with inattention and disorganized thinking. R20 had verbal, physical and other behaviors during the assessment period. R20 required extensive assist with cares, R20 took an antipsychotic 6, antianxiety 2, and pain medication 4 of the 7 look back period. R20's undated, care plan identified Communication deficit as evidenced by advanced dementia with moderate cognitive losses, problem understanding others, and was mostly non-verbal. The goal was to maintain communication and cognition. Interventions identified care conference as needed, family notification as needed, BIMS interview as needed, communication as needed, nurse observation as needed, notify provider of critical results as needed, and hearing aid/glasses's every 12 hours. The care plan further identified fall risk as evidenced by history of falls, impaired balance, hypertension medication, impaired mobility, and impaired cognition. The goal was to prevent falls and injury. Interventions included balance and functional range of motion as needed and fall risk assessment as need. Psychosocial well being and mood was identified as a problem as evidenced by withdrawal from care and activities, grief over loss of status, daily routine is very different from prior pattern in community, and strong identification with past. The goal was to establish own goals, strong identification with past, and maintain mood. Interventions included an individual abuse	F 656		

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F 656	Continued From page 22 prevention plan, alcoholic beverages as needed, insomnia assessment as needed, staff observation as needed, social service assessment as need, PTSD screen as needed, PHQ-9 as needed, Behavior/mood observation every 12 hours, elopement risk as needed, AIMS assessment as needed, and behavior/mood assessment every 12 hours. R20's care plan lacked individualized interventions for staff to follow to ensure communication to meet needs, to prevent falls, and to identify if R20 was displaying any target behaviors as there were none identified. Interview on 10/26/22 at 1:45 p.m., with registered nurse (RN)-A identified R20 had been seen by psych for medication adjustments related to his physical behaviors. She revealed side effects of medication were being monitored and agreed that the target behaviors were not identified on the care plan but staff charted any behaviors that occurred. Review of 10/21/22, Behavior health note by psychiatric provider identified R20 had diagnosis of vascular dementia with behavioral disturbance, psychotic disorder wit delusions and hallucinations. R20 behaviors had been physical aggression to staff, raising hands and shake fist at caregivers, shoved staff, poked staff in eye, punched staff in face, kicked at wife. None of this information had been identified on R20's care plan. R54's 8/20/22, significant change MDS assessment identified moderate cognitive impairment. R54 required extensive assist with cares and transfers. R54 had history of falls, took daily diuretic, and had occasional pain.	F 656		

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F 656	Continued From page 23 R54's undated, care plan identified fall risk as evidenced by history of falls, impaired balance, psychotropic drugs, hypertension medications, diuretic medication, impaired mobility, and impaired cognition. The goal was to prevent falls and injury. Interventions included balanced and functional range of motion as needed and fall risk assessment as needed. The care plan identified chronic pain as evidenced by peripheral vascular disease, and lymphedema. The goal was to be free from pain and residents to have acceptable level of pain. Interventions included pain interview as needed and pain assessment as needed. R54's care plan lacked individualized interventions to prevent falls and to minimize pain for staff to follow. R43's 9/21/22, annual MDS assessment identified severe cognitive impairment with inattention and disorganized thinking. R43 required extensive assist with cares and was identified to have had 2 or more falls. R43 took a daily antipsychotic, antidepressant, and a daily hypnotic. R43's undated, care plan identified a communication deficit as evidenced by Parkinson's dementia with moderate to severe cognitive losses's, was able to make self understood but sometimes talked nonsensical, his orientation fluctuated, he had problems understanding others, and memory impairments. The goal was to maintain communications and cognition. Interventions included care conference summary as needed, family notifications as needed, BIMS interview as needed, communication as needed, nurse observation as needed, notify provider with critical results as	F 656		

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F 656	Continued From page 24 needed, hearing aide and glasses's every 12 hours. The care plan identified elopement as a problem with wander guard placed related to ability to wander, cognitive loss and desire to go outside. The goal was R43 will not leave facility unattended. Interventions included wander guard alarm check daily using wander guard pocket reader and elopement risk as needed. R43's care plan lacked individualized interventions for staff to follow to ensure communication to meet needs and initialized interventions to prevent elopement. Surveyor: 44658 R4's care plan dated 10/24/22, indicated R4 had a concern for bladder and bowel due to frequent incontinence of urine. Interventions included recording R4's output and scanning R4's bladder as needed. R4 had a risk for falls related to a history of falls with an injury, impaired balance, the use of psychotropic and high blood pressure medications, and impaired mobility and cognition. Interventions included balance/functional range of motion (ROM) daily and keeping R4's bed at a level so R4 could sit on the edge of the bed at a 90-degree angle with her feet flat on the floor to allow for a safe transfer from bed. The care plan lacked interventions related to R4's fall while using the restroom unattended, R4 not activating her call light, and attempting to self-transfer. R57's quarterly Minimum Data Set (MDS) dated 10/5/22, indicated R57 had severe cognitive deficits. R57 required supervision of one staff for	F 656		

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F 656	Continued From page 25 eating and extensive assistance of two staff for all other activities of daily living (ADLs). R57 had diagnoses that included insomnia, Alzheimer's and dementia with behavioral disturbances, Multiple Sclerosis (MS), memory loss, and obstructive sleep apnea (OSA-sleep-related breathing disorder causing the airway to become obstructed and occasional to frequent cessation of breathing). R57's Care Area Assessment (CAA) dated 4/22/22, indicated R57 triggered for cognitive loss/dementia, due to Alzheimer's and dementia, instructing a continuation of the item on R57's care plan. R57 triggered for communication secondary to being hard of hearing and instructing a continuation of the item on the care plan. R57 also triggered for mood state due to a history of depression, instructing a continuation of the item on the care plan. R57's care plan dated 10/25/22, indicated R57 was at risk for a communication deficit related to hearing loss, difficulty making himself understood and understanding others and declining cognition. Interventions included notifying a provider with critical results as needed, MDS nursing observations as needed, completing a Brief Interview for Mental Status (BIMS) as needed, notifying family as needed, and completing a care conference summary as needed. The care plan lacked resident-centered interventions to assist, maintain, or improve R57's communication deficits. The care plan also indicated R57 was at risk for psychosocial well-being evidenced by withdrawal from activities, grief over loss of roles/status, daily routine very different from prior pattern in the community and having a strong identification with the past. Interventions included	F 656		

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F 656	Continued From page 26 visiting with R57 about past agricultural business and discussing his memory book and pictures. R57's care plan further indicated R57 had a deficit related to activities due to a lack of interest. Interventions included daily activity review, an activity evaluation, MDS preferences to be reviewed as needed, and a spiritual assessment to be completed. The care plan lacked indications of R57's preferences for activities or an individualized plan to increase R57's involvement in activities. R57 had respiratory concerns related to OSA and using a CPAP. Interventions included putting the CPAP on every night and cleaning it weekly. No other interventions or instructions regarding the use of the CPAP machine were indicated. R57's care plan also indicated R57 was at risk for psychosocial wellbeing. Interventions included monitoring R57 for side effects related to the use of Seroquel; however, R57 was no longer taking the antipsychotic medication. The care plan lacked evidence R57 had been evaluated for dementia to develop a resident-centered plan to decrease R57's repetitive behaviors and lacked indication that R57 was taking Depakote (an anti-convulsant used also as an antipsychotic) or interventions to monitor for side effects related to the medication. Review of the 3/23/22, Facility Wide Risk Assessment identified the facility provided person centered care. Staff were to find out the resident's likes and dislikes and what makes for a good day and incorporate that information into the care planning process and to to ensure staff had the information. Review of August 2020, Care Planning policy identified a person centered care plan would recognize what was important to the resident with	F 656		

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F 656	Continued From page 27 regard to daily routines and activities, what supports the resident required, and having an understanding of the resident' life prior to residing in the nursing home.	F 656		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Surveyor: 44658	F 657	The facility reviewed the Care Plan policy 11/16/22.	12/8/22

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F 657	Continued From page 28 Based on interview, and record review the facility failed to review and revise a care plan for 1 of 1 (R4) residents who had an unwitnessed fall after being left on the toilet and attempting to self-transfer. Findings include: Review of the 5/12/22, report to the State Agency (SA) indicated R4 was found laying on the floor outside her bathroom door with her clothing halfway up. Review of the 5/16/22, 5-day Investigation Report indicated R4 had not activated her call light for assistance prior to self-transferring from the bathroom. R4 was found on the floor outside the bathroom. R4 reported pain to her neck and pelvis and was transferred to the emergency department for evaluation. R4 did not sustain any fractures; however, was diagnosed with a urinary tract infection (UTI) and returned to the facility the same day. The report indicated R4 would continue to be an assist of one staff member and the intervention to prevent a reoccurrence was to keep R4's wheelchair close to her with the brake on in the event she attempts to self-transfer. R4's annual Minimum Data Set (MDS) dated 10/26/22, indicated R4 had intact cognition, was independent with eating but required extensive assistance of two staff for all other activities of daily living (ADLs). R4's diagnoses included falls, cervical muscle strain, anemia (low iron), emphysema (a lung disease resulting in shortness of breath), arthritis of the neck, elbow, shoulder, lumbar disc (lower back) disease, osteopenia (low bone density resulting in frail bones), ambulatory dysfunction, stroke, fracture	F 657	The staff were trained on the updated policy and processes on 11/30/22, 12/6/22, 12/7/22, 12/8/22. Meditech hands on training for all staff will be started on (insert date) and completed on (Insert date) and has been added to the new hire training for all staff. R4's care plan has been updated to reflect the interventions regarding her call light and fall reduction on The audits and topic has been added to the score card reviewed at the monthly quality meeting and the agenda items as well. Audit: 100% of charts will be audited 1 care plan per unit will be audited weekly x4; 1 care plan per unit monthly x 3 ; 1 care plan per unit quarterly.	

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F 657	Continued From page 29 of the pelvis, and amputation of the fifth toe. R4's Care Area Assessments (CAAs) dated 11/24/21, indicated R4 triggered for ADL function related to a decline in ADL function and falls. R4 also triggered for falls due to a fall history, requiring assistance with ADLs and balance. Risks included falls, pain, injury, and decline in overall condition. Interventions included a continuation of the concern on R4's care plan. R4's care plan dated 10/24/22, indicated R4 had a concern for bladder and bowel due to frequent incontinence of urine. Interventions included recording R4's output and scanning R4's bladder as needed. R4 had a risk for falls related to a history of falls with an injury, impaired balance, the use of psychotropic and high blood pressure medications, and impaired mobility and cognition. Interventions included balance/functional range of motion (ROM) daily and keeping R4's bed at a level so R4 could sit on the edge of the bed at a 90-degree angle with her feet flat on the floor to allow for a safe transfer from bed. The care plan lacked interventions related to R4's fall while using the restroom unattended, R4 not activating her call light, and attempting to self-transfer. R4's progress note dated 5/12/22, indicated R4 was found lying on her left side on the floor between her bedroom and bathroom doors with her pants and underwear around her ankles. R4 complained of lower back pain, tingling to both her hands, and refused to move her lower extremities. R4 was unable to tell staff what she was doing at the time of the fall; however, R4 was last seen on the toilet at 2:15 p.m. and was found on the floor at 2:25 p.m. R4's Care Assessments dated 5/12/22, indicated	F 657		

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F 657	Continued From page 30 R4 was at a high risk for falls. Interventions put in place to prevent future falls indicated no referrals made at the time. Post fall actions indicated to use the call light and post fall education included calling for assistance; however, the resident's readiness to learn was documented as cognitively unable. R4's Clinical Note dated 5/13/22, indicated R4 had a urinary analysis (UA) completed secondary to a fall the previous day. Per facility staff R4 was asymptomatic and was not complaining of urinary frequency, infrequency, or urgency and had no fever. An order for a urine culture (UC) was placed and due to R4's lack of symptoms, treatment for a UTI would be delayed pending the UC results. During an interview on 10/25/22, at 8:23 a.m. R4 stated her one concern was being left in the bathroom. R4 stated she had had multiple strokes and could fall easily because she got dizzy which made her scared to move. R4 stated she would pull the call light, but she felt the staff did not respond quick enough. R4 stated her doctor told her she was not to be left alone while in the bathroom, the facility, or outside due to safety concerns. R4 did not recall her previous fall; however, stated she had almost fallen before. During an interview on 10/27/22, licensed practical nurse (LPN)-B stated R4 didn't remember to use her call light and should not be left unattended in the bathroom; however, R4's care plan was not updated regarding falls because the fall was attributed to R4's UTI, and not due to staff or environmental factors. The facility Fall Prevention and Management	F 657		

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F 657	Continued From page 31 policy dated 5/2022, indicated staff were to assess and identify residents at risk for fall and take precautionary measures to prevent falls and fall related injuries. Clinical assessments of resident risk factors were used to create appropriate interventions. If a resident was determined to be at risk for falling, the nurse will incorporate the appropriate fall prevention interventions into the resident's plan of care. A gait belt was to be used with all assisted transfers and assisted ambulation. Fall preventions were to be customized to each resident's unique needs and risk factors. Resident falls will be documented, and the resident care plan will be updated with new interventions as necessary. Resident care sheets include interventions from the resident's care plan to address fall prevention. After a fall, licensed staff will review the resident's care plan and note the date and time of the fall on the plan of care, making necessary revisions to address risk factors related to the fall.	F 657		
F 688 SS=E	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility	F 688		12/8/22

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F 688	Continued From page 32 receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Surveyor: 38687 Based on observation, interview, and document review, the facility failed to ensure 4 of 4 residents (R3, R5, R51, R56, and R57) recieved restorative range of motion (ROM) therapy to prevent potential decline in ROM and/or contractures. Findings include: R3's 2/9/22 annual MDS identified she required extensive assist of 1 staff for ADL and had no impairment marked on the MDS to her upper or lower body, and used a walker or wheelchair for ambulation. R3's current, undated care plan identified R3 was admitted to the facility in July, 2017. R3's care plan identified problems noted for psychosocial well-being, was noted to require assistance of 2 staff with most Activities of Daily Living (ADL) status. There was no mention R3 had contractures of her left hand, not that she was to have worn a brace on her left hand to prevent further deterioration and contracture or required the splint to be refitted. Observation and interview on 10/24/22 at 7:10 p.m., with R3 identified she remarked she had a "frozen left ankle". She has rheumatoid arthritis (RA). The brace for her hand "doesnt fit... it squishes them together". She hadn't been refitted. She used to be an occupational therapist	F 688	The facility policy was reviewed and updated on 11/30/22. The staff were trained on the updated policy 11/30/22, 12/6/22, 12/7/22, 12/8/22 The nursing and therapy team met on 11/30/22 to review and determine which residents must have ROM exercises daily and updated their care plans, work lists and daily assignment sheets to reflect so. The activities department has added an exercise group which provides 8 opportunities a month for resident movement, that was started on 11/3/22. The supervisors will be doing observations and coaching with their teams on the identified residents to assure that it is being done and documented. Therapy will huddle with the team daily to discuss any ROM concerns and any additional residents they feel would benefit from ROM cares in their care plans. The following was done with the identified residents: R3 Residents care plan has been updated to include ROM exercised and use of her orthotics. R5 ROM exercises have been added to her care plan R56 training was completed on her orthotics and the care plan updated to reflect the ROM interventions and goals R51 care plan has been updated and	

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F 688	Continued From page 33 and was quite familiar with restorative therapy. She gets no ROM from staff. The facility cut thier restorative program and to her knowledge, they havent gotten anyone else and "apparently arent planning to". R3's fingers on her left hand were visibly contracted and her feet turned inward. Buried in the corner, under a piece of luggage were her orthotics. R5's 10/20/22, Significant Change Minimum Data Set (MDS) identified she had severely impaired cognition due to needed to be prompted to recall words, her inattention and ability to stay focused during the interview, and disorganized thinking. R5 required extensive assistance from 1 staff for bed mobility, transfer, dressing, eating, toilet use and personal hygiene. R5 was marked no impairment to her upper and lower extremities. R5 received no restorative therapy from a restorative program. R5's current, undated care plan identified R5 was admitted to the facility in November 2021 and had diagnoses of cancer, high blood pressure, GERD, diabetes, high cholesterol. thyroid disorder, anxiety disorder. R5's care plan identified problems noted for bladder incontinence, communication and cognitive concerns, was a fall risk, was on hospice, was on a constant carb diabetic diet, chronic pain, psychosocial well-being/mood, activities, medication side effects, and skin integrity. R5 had no mention Interview on 10/25/22 at 2:54 p.m., with R5 identified she doesnt get any ROM therapy from staff. She would be at risk for ROM decline. R56's 4/20/22, Significant Change MDS identified she had intact cognition, and was marked	F 688	interventions and goals placed for the ROM exercises. R51 Care plan has been reviewed and ROM goals and interventions placed. 11 additional residents have been identified to benefit from a program that includes ROM activities and their care plans have been updated. The audits have been added to the quality score card and also the agenda for discussion monthly at the quality meetings. Audits: 100% observation audits 2 audits per week x4 ; 4 audits per month x 3 ; 4 audits per quarter.	

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F 688	Continued From page 34 completely independent with all ADL, despite being a paraplegic. There was no restorative therapy noted on the assessment. R56's current, undated care plan identified R56 was admitted to the facility in March 2021 and had diagnoses of heart failure, neurogenic bladder, high cholesterol, paraplegia, MS, anxiety, depression, pressure ulcer to her left buttock-Stage III, and dysphagia (difficulty swallowing). She had identified problems of ADL status, catheter use, ostomy care, communication and cognitive ability, fall risk, nutritional status, chronic pain, psychosocial well-being, activity involvement, skin integrity. R56 had little to no specific person-centered goals or interventions identified on the care plan according to existing diagnoses or needs. Observation and interview on 10/25/22 at 9:42 a.m., with nurse aide (NA)-G immediately prior to R56's dressing change identified R56 was visibly severely contracted in upper and lower limbs due to her MS and paraplegia diagnoses. identified there are no specific staff for restorative any longer. That program was discontinued. All NAs were now responsible to do restorative ROM, but they "just dont have the time". When they are able to do ROM for residents, they are supposed to document in the electronic medical record when it's completed. No orthotics were identified having been applied. R56's Occupational Therapy (OT) progress notes identified on: 1) 8/11/22, OT put on R56's bilateral hand orthotics and educated the restorative aide (RA) on how to put them on. Staff left the orthotics on for 75 minutes and checked for	F 688		

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F 688	Continued From page 35 redness/discomfort. The RA was educated and shown how to perform passive ROM (PROM) (staff are required to perform due to residents' inability to move extremities). 2) 8/12/22, OT performed the PROM and put on R56's orthotics to her hands. Nursing staff were educated on proper methods doe donning and doffing (on and off) of the orthotics. 3) 8/15/22, OT noted they had washed, dried and applied lotion to R56's left elbow crease as it was "showing white maceration [skin breakdown due to moisture] and had a foul odor due to being in a chronically flexed position". OT provided gentle PROM to her bilateral upper extremities due to "significant tightness/contractures noted". R56 had pain in her left (L) wrist when the OT attempted to place her wrist in a neutral position. R56 had "significant wrist extension contracture which is currently unsupported". OT then adjusted her L elbow orthotic into a more flexed position to accommodate her current flexion contracture for better support. 4) 8/29/22, OT documented PROM was completed by OT to her upper body. R56 had facial grimacing during her should exercises specifically. R56's spouse was present with him reporting R56's right (R) ROM was "normal up until recently". OT noted contractures beginning at the R elbow. 5) 9/13/22, R56 reported she "doesn't go into her wheelchair much". R56 was in her bed in the supine (lying on back) position with her elbows in flexion and her left upper extremity supinated with contracture in her fingers. Communication was provided to nursing staff for potential of positioning side lying and in wheelchair to provide repositioning and stretching. R56's orthotics were placed in her lower drawer of her dresser "near her bed for ease, as they were observed by T to	F 688		

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F 688	Continued From page 36 be in her recliner with Hoer lift and tangled." 6) 9/14/22, OT completed a pictorial program with written instruction for staff to increase ease of donning splints and preventing further contracture development. 7) 9/16/22, R56 reported staff ae stretching her arms, but cannot recall if it occurs daily. 8) 9/19/22, OT provided PROM and again educated staff on how to apply R56's orthotics for 30 minutes and check for redness and pain. 9) OT once more educated staff on completing PROM prior to donning her orthotics. 10) 10/14/22, OT noted R56 reported staff were not putting on her orthotics nor were they doing PROM and said it had not been completed "in a long time". 11) 10/17/22, R56 had facial grimacing while OT provided PROM to her R shoulder. Ot once again stressed to staff the importance of providing PROM as she is completely dependent for all positioning and use of her extremities. There was no mention if OT's continued concerns were brought forth to management, or if management routinely audited OT notes for residents at risk to identify the lack of staff care with PROM. Interview on 10/26/22 at 1:50 p.m. identified R56 was once more observed without any orthotics applied and was lying in bed. R56 said she has them for her right elbow (she thinks) but was unsure if staff were applying them as ordered. R56 family member was also there and reported R56 rarely had her orthotics applied. Interview on 10/27/22 at 12:19 p.m., with the director of therapy (DT) identified R56 is receiving OT now and has been for a while. OT has been working with R56 to find the right hand splints for	F 688		

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F 688	Continued From page 37 her. R56 was on physical therapy (PT) from July to August 2022, but has since competed PT. After it was brought to the administrator's attention about residents not receiving restorative therapy from staff, OT was and has been currently training staff right now on her upper extremities. R56 "can't move and really needs staff to do everything for her". OT works upper and PT normally worked her lower extremities. Her upper body is maintaining, but her lower extremities have not been getting restorative PROM therapy at all and "is likely declining". R56 was to be screened next month to see if she has had any decline. Interview on 10/28/22 at 8:48 a.m., with the administrator identified the facility's restorative program was "cut" due to budgetary cuts. Upper management wanted staff NA's to do it, but she acknowledged they "don't have time". She agreed this had the potential for harm and was affecting resident care. Since becoming aware by surveyors during the survey process ROM was not being done, she was now going to have PT work with those residents who are affected and at risk for further decline. The administrator also agreed R56 and R3's orthotics were not being applied as ordered. Surveyor: 44658 R51's quarterly minimum data set (MDS) dated 9/28/22, indicated R51 had severe cognitive deficits and required extensive assistance of one staff for eating and extensive assistance of two staff for all other activities of daily living (ADLs). R51's diagnoses included constipation, disturbances of salivary secretion, anxiety, spinal stenosis, Parkinson's disease with dementia, and a fall resulting in a hip fracture.	F 688		

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F 688	Continued From page 38 During an interview on 10/24/22, at 7:26 a.m. family member (FM)-F stated R51 was receiving restorative therapy prior to the program being canceled a few months prior. R51 was supposed to do ROM exercises but since the staff had not been assisting him, FM-F had been trying to do the exercises with him. During an interview on 10/27/22, at 12:18 p.m. physical therapist (PT)-B stated she recommended passive ROM (PROM) exercises for R51 to keep his legs stretched out so he could continue to transfer with the EZ stand (a device that assists residents to stand up during transfers and requires only one staff to operate) and not downgrade to a Hoyer lift (a device that lifts a resident lying in a sling, requiring no effort from the resident and two staff to operate). However, PT-B also stated the nursing assistants (NAs) told her they did not have time to assist R51 with his PROM exercises. R51's PROM exercise log dated October 2022, indicated R51 received PROM exercises as follows: -10/3 -10/9 -10/10 -10/12 -10/17 -10/18 -10/22 -10/23 R51 did not receive PROM exercises for 15 out of 23 days. R57's quarterly MDS dated 10/5/22, indicated R57 had severe cognitive deficits and required	F 688		

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F 688	Continued From page 39 supervision with assistance of staff for eating and extensive assistance of two staff for all other ADLs. R57's diagnoses included a pressure injury on his coccyx (tailbone), fall resulting in pain to his left shoulder and a head abrasion, dementia with behavioral disturbance, major depression, constipation, spastic paraplegia due to multiple sclerosis (MS), ambulatory dysfunction, MS, and gait abnormality. R57's care plan dated 10/25/22, indicated R57 required assistance with some or all ADLs. Interventions included R57 participating in a restorative therapy program 4-6 times per week. R57 was also at risk for falls due to a history of falls, impaired balance, mobility, and cognition. Interventions included balance/functional ROM as needed. R57's CAAs dated 4/22/22, indicated R57 triggered for ADL functional/rehabilitation potential, falls, and pressure ulcers. R57's Restorative Nursing Program form dated 8/15/22, indicated PT-B recommended R57 complete or attempt knee extension stretches, hip adductor stretches, active leg kicks, and crunches while reaching, five days a week to maintain ROM of both his lower extremities for optimal positioning in his wheelchair. R57's Caregiver Education form dated 9/29/22, indicated PT-B recommended left arm PROM stretches in bed, wheelchair, or recliner to be completed daily. R57's Physical Therapy Discharge Summary dated 9/29/22, indicated R57 completed 2 out of 3 PT goals and had a follow-up maintenance program for upper extremity PROM. Discharge	F 688		

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F 688	Continued From page 40 recommendations included daily PROM to left upper extremity. No documentation was provided to indicate R57 received any ROM/PROM exercises after his discharge from therapy services on 9/29/22. R57's Care Conference Summary dated 10/12/22, indicated R57 was no longer receiving therapy services but family was interested in R57 being on a maintenance program to be able to keep the abilities he had. During an interview on 10:25/22, at 11:22 a.m. FM-E stated because of R57's MS, he got "really stiff." He was getting therapy for 15 minutes a few times a week before it was discontinued last month. During an interview on 10/26/22, at 2:02 p.m. PT-B and occupational therapist (OT)-C stated R57 was discharged from OT on 9/16/22, and from PT on 9/29/22 because his progress plateaued. The facility no longer had a restorative aid (RA), therefore, therapy printed range of motion (ROM) exercises for the nursing assistants (NAs) to complete with the residents; however, they did not believe the exercises were being done which caused residents' mobilities to decline and be referred back to therapy. PT-B stated residents weren't being walked and were struggling to participate in their surface-to-surface transfers. PT-B and OT-C stated it was a frustrating cycle. During an interview on 10/27/22, at 10:33 a.m. R57's FM-E stated she was unaware staff were supposed to continue providing ROM exercises for R57 after he had discharged from therapy.	F 688		

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F 688	Continued From page 41 FM-E further stated staff had not been doing exercises with R57, but she would like them to so R57 could maintain his mobility as long as possible. During an interview on 10/27/22, at 1:49 p.m. NA-F stated therapy would send a form to the NAs with instructions for ROM exercises to be completed with the residents after they were discharged from therapy. NA-F stated R57 was supposed to have ROM exercises completed; however, NA-F did not know how often. NA-F also stated she did not do ROM exercises with R57 when she transferred him out of bed and assisted him with his cares that morning. During an interview on 1/27/22, at 1:57 p.m. licensed practical nurse (LPN)-B stated she would submit a referral to therapy if a resident's activities of daily living (ADLs) and/or strength declined. LPN-B stated since the RA program ended, she noticed an increase in the number of residents whose mobility and strength were declining because the NAs often did not have time to complete the recommended ROM exercises with the residents. During an interview on 10/27/22, at 5:17 p.m. RN-F stated a form was sent to her and the NAs if a resident discharged from therapy services but would benefit from a maintenance exercise program. The staff should communicate during the morning huddle and verbal handoff report if a resident had a recommended exercise program. RN-F stated it had been tough to maintain resident abilities since the RA program ended. RN-F stated when a resident declined in ADLs and transfers, they may end up requiring a two staff assist instead of one which would increase	F 688		

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F 688	Continued From page 42 the NAs' workload and decrease resident independence. A resident would then be referred back to therapy and the cycle would continue. During an interview on 10/27/22, at 11:59 a.m. the director of therapy (DT) stated most residents were put on a restorative program after discharge from therapy to maintain their function; however, since the facility no longer had an RA, the NAs were supposed to complete ROM exercises with the residents. The DT stated a written recommendation for an exercise plan was sent to registered nurse (RN)-F who may add it to a resident's care plan, and another copy to the resident's unit for the NAs to review. Therapy would also screen the residents three months after discharge from therapy services to assess their progress. DT stated the failure to complete maintenance exercises resulted in residents being referred back to therapy due to a decline in their mobility and strength. R57 had been on and off therapy a few times since he had admitted to the facility in February 2022, and was discharged from therapy last month after plateauing. A recommendation for ROM exercises was sent to RN-F and the NAs so R57 could continue to maintain his mobility. During an interview on 10/27/22, at 3:17 p.m. the director of nursing (DON) stated it had been a challenge since the RA program ended in July and there were areas of improvement needed regarding the resident exercise program. The DON further stated the facility had a goal to include exercises as a resident activity; however, that had not been implemented. There was no policy specific to providing ROM supplied by the end of the survey.	F 688		

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F 689 SS=E	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Surveyor: 44658 Based on observation, interview, and record review the facility failed to ensure the environment was free from hazards when a staff's injectable mediation was found to be accessible to residents in an unlocked refrigerator 1 of 1 dayroom refridgerator. This had the potential to affect all 19 residents who resided on the unit. Further, the facility failed to safely transfer 1 of 1 resident (R31) using a gait belt and the assistance of 2 staff when R31 was transferred by 1 staff from her wheelchair to her recliner. FOOD and MEDICATION STORAGE During an observation on 10/26/22, at 9:05 a.m. a small refrigerator labeled "Staff Food + Drinks only!! Please initial and date items" was found unlocked and accessible to all residents, staff, and visitors, in the resident day room. A locking mechanism was on the outside of the refrigerator; however, the lock was affixed to a shelf inside the refrigerator without a key. The refrigerator was full of food and a red emergency Glucagon 1 milligram (mg) injection kit in a clear, plastic bag with a pharmacy label indicating it belonged to a facility staff member was on the top door-shelf.	F 689	The facility reviewed the food and medication storage policy on 11/30/22 The staff were trained in the food and medication storage policy on 11/30/22, 12/6/22, 12/7/22, 12/8/22. The staff mini refrigerators were removed from all living rooms in the facility immediately on 10/26/22 and relocated to a secured area off the units. The staff medication was also removed immediately and placed in a secured cooler on 10/26/22 and the employee coached on the requirements for personal medication The Safe Transfer policy was reviewed on 12/1/22. The staff were trained on the policy on 11/30/22, 12/6/22, 12/7/22, 12/8/22. An audit was completed of 100% of the current residents of who has the need for gait belts, this was completed on (insert date) Current gait belts have been numbered for the room they belongs to and placed in each of those resident's room.	12/8/22

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F 689	Continued From page 44 Two unidentified residents were watching TV in the dayroom and no staff were present. During an interview on 10/26/22, at 9:14 a.m. licensed practical nurse (LPN)-B stated the refrigerator should have been locked so residents and visitors weren't able to access the staff food. LPN-B also stated the staff emergency Glucagon kit should not have been in a refrigerator designated for food or unlocked allowing visitors and residents access to it. During an interview on 10/26/22, at 9:36 a.m. the director of nursing (DON) stated staff medication should not be stored in a refrigerator with food. The medication should have been stored in a locked refrigerator designated for medication and the staff refrigerator should have been locked to ensure residents don't have access to food items they should not have. The facility Falls and Accident policy dated 11/2021, defined accidents as any unexpected or unintentional incident, which results or may result in injury or illness to a resident and a hazard as elements of the resident environment that have the potential to cause injury or illness. Staff would ongoingly assess the physical environment regarding potential hazards, including access to sharps. Any deficiencies I the safety of the physical environment would be immediately addressed. Surveyor: 38687 TRANSFER R31's 9/7/22, quarterly Minimum Data Set (MDS) identified she had intact cognition with diagnoses of Parkinson's disease, glaucoma, retention of urine, constipation, and pain. R31 was to have	F 689	Additional gait belts have been purchased to have available to staff on each unit. Audits: 100% observation audits 2 observations per unit per week x4; 8 (2 per unit observations per month x 3; 8 observations quarterly.	

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F 689	Continued From page 45 had extensive assistance of 2 staff for transfers between surfaces and required the use of a wheelchair. Observation on 10/27/22 at approximately 9:45 a.m. identified R31 was being transferred with nurse aide (NA)-H identified she was in process of performing a pivot transfer to R31. NA-H was observed grabbing onto the back side of R31's elastic waistband pants, and pivoting R31 from her wheelchair to a chair without use of a gait belt. R31's current, undated care plan identified R31 was admitted to the facility in March 2022. R31 was at risk for falls as evidence by a history of falls, impaired balance, Parkinson's disease, urinary tract infections, and impaired mobility. There were no interventions identified on the care plan reflective of her MDS assessment. R31 had a problem noted with Activities of Daily Living (ADL) and required assistance with ADL's. R31 was noted to transfer/pivot with use of a gait belt and a walker. There was no mention R31 required 2 staff for safety. Review of the 6/24/22,current nurse aide (NA) care plan identified under the section "Care Plan/Special Needs/Special Diet" the only notation for NA staff was that she "likes makeup and recliner". Her ADL's were listed as "A1" (assistance of 1). There was no indication why the nurse aide care plans did not contain critical elements of resident care needed or why it had not been revised recently. Interview and observation on 10/27/22 at 10:00 a.m. with the administrator and director of nursing identified all residents were to have gait belts in	F 689		

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F 689	Continued From page 46 their rooms for potential transfers. Both agreed NA-H should have used the resident's gait belt. The administrator and DON agreed there was the potential for harm for an accidental fall due to staff not using the appropriate equipment. The administrator was unsure why the nurse aide care plans were not up to date or reflective of what resident's care was required. Review of the February 2019, Ambulation policy identified the purpose was to ensure the facility provided a safe transfer for residents when family members would accompany and ambulate with them. There was no mention of how staff were to safely transfer a resident.	F 689		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition	F 690		12/8/22

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F 690	Continued From page 47 demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Surveyor: 38687 Based on observation, interview, and document review, the facility failed to intervene for 1 of 1 resident (R51) with a strict bowel regimen and ensure catheter leg straps were used to prevent pain, discomfort, or potential infection or injury to 1 of 1 resident (R56). Findings include: BLADDER R56's 4/20/22, Significant Change MDS identified she had intact cognition, and was marked completely independent with all ADL despite being a paraplegic. There was no restorative therapy noted on the assessment. R56's current, undated care plan identified R56 was admitted to the facility in March 2021 and had diagnoses of heart failure, neurogenic bladder, high cholesterol, paraplegia, MS, anxiety, and depression. She had identified	F 690	The facility reviewed the policy on Urinary Incontinence Prevention /Management program and indwelling foley catheter management as well as Bowel Management LTC on 12/1/22. The staff were trained on both policies on 11/30/22, 12/6/22, 12/7/22, 12/8/22. The Resident care plans for both (R56) and (R51) were updated to reflect the needs to be addressed and what needs to be done. An audit of 100% of the current residents who have catheters was conducted to make sure the care plans were updated, and the correct equipment being used. We have determined that the policy and procedure was not being followed for the bowel management and the retraining and audits will ensure that the residents bowel management needs are addressed per the policy. Audits: 100% observation audits	

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F 690	Continued From page 48 problems of ADL status, catheter use, communication and cognitive ability, and had chronic pain. R56 was noted to have a suprapubic (tube placed in opening into bladder through stomach) catheter with interventions to clean and change the catheter bag monthly. The care plan also had a discrepancy and noted R56 was to have her Foley (tube inserted into urethra, then into the bladder) flushed twice per day. Staff were to place a pad under R56 if it leaked. There was also a notation to "cath secure change" however, there was no indication what that meant or how staff was to ensure her catheter remained secured to her leg. Observation and interview on 10/26/22 at 1:50 p.m., with R56 identified she was visibly grimacing and complained of having some "discomfort" today. R56's family member was present but went into the hall to find staff. R56 declined further interview. Interview on 10/26/22 at 1:54 p.m., with trained medication aide (TMA)-A identified R56 was upset because her catheter may have "fallen out" and staff were waiting on the nurse to assess her. R56 had a Foley catheter and was paralyzed and unable to move her lower body. Interview on 10/26/22 at 1:58 p.m., with licensed practical nurse (LPN)-B identified she was the only nurse on the floor that day. She was unaware R56's catheter had potentially "come out". LPN-B noted she would check on R56 right away. Further interview on 10/26/22 at 2:38 p.m., with TMA-A identified R56 was assessed by LPN-B. R56's catheter had not "come out" but was "just leaking".	F 690	2 observations of residents with catheters per week x 4; 4 observations per month x 3 ; 4 observations quarterly. 2 observations of residents with bowel management plans per week x 4; 4 observations per month x 3 ; 4 observations quarterly.	

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F 690	Continued From page 49 Further interview on 10/26/22 at 2:50 p.m., with LPN-B identified R56's catheter had not come out, but it was being pulled on via gravity, and that was causing her pain. Staff often failed to place a secure leg strap on all residents who had catheters. Using a leg strap to secure the catheter would offload the pressure caused by the bag being hung on the bed and getting heavy with captured urine. "This has been an ongoing issue". The facility was "trying to teach staff to make sure they provided appropriate cares, but in her opinion, it was unsuccessful. She has brought this up to management. All nurse aides (NAs) and nurses should know a Foley catheter was to be secured by a leg strap. LPN-B was unsure if this was care planned and staff educated to R56's care plan. "They should be looking at the electronic (EMR) care plan". R56's 6/24/22, NA care plan, made no mention R56 had a catheter. Interview on 10/26/22 at 4:06 p.m., with the infection preventionist (IP) identified she started mid November 2021. The IP was unaware of complications from R56 not having a leg strap on her catheter to secure it. The IP stated catheter infections were "always high" at the facility. The IP agreed staff failing to use appropriate catheter leg straps for residents led to tubes inadvertently slipping out and increased the rate of urinary tract infections (UTI). Interview on 10/28/22 at 11:19 a.m., with the administrator identified she agreed there was no clear direction on catheter care or ensuring R56 or other residents with catheters had notations to ensure catheters were secured properly. Care	F 690		

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F 690	Continued From page 50 plans were a common issue with the software the facility used, and not able to be modified easily. Review of the April 2022 Long Term Care Cleaning/Care of Catheter Bags policy identified staff were to keep the bag below the level of the bladder, monitor tubing for kinks. There was no mention in the policy staff should secure the catheter tubing with a leg strap to avoid complications such as pain or infection. Surveyor: 44658 BOWEL REGIMEN R51's quarterly Minimum Data Set (MDS) dated 9/28/22, indicated R51 had severe cognitive deficits and was unable to complete the Brief Interview for Mental Status (BIMS) assessment. R51 required extensive assistance of one staff for eating and extensive assistance of two staff for all other activities of daily living (ADLs). R51's MDS Section H-Bladder and Bowel, lacked indication R51 had incidents of constipation. R51's diagnoses included constipation, disturbances of salivary secretion, anxiety, spinal stenosis, Parkinson's disease with dementia, and a fall resulting in a hip fracture. R51's Care Area Assessment (CAA) dated 4/14/22, indicated R51 triggered for delirium and cognitive loss/dementia with risks including decreased cognition resulting in increased behaviors and an inability to make his needs known. R51's CAA did not indicate R51 had concerns regarding constipation or bowel incontinence. R51's care plan dated 10/25/22, indicated R51	F 690		

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F 690	Continued From page 51 had bowel and bladder incontinence. Interventions included recording R51's output every six hours. R57 also had concerns related to medication side effects that included constipation and fecal impaction. R51's physician orders dated 10/25/22, indicated R51 received bisacodyl 10 milligrams (mg) rectal suppository daily as needed for constipation, polyethylene glycol 3350 (Miralax) 8.5 grams every other day and Senna 8.6 mg (a stool softener) twice daily. Review of the facility Admission/Standing Orders dated 6/22, indicated polyethylene glycol 3350 17 mg orally as needed for constipation; Milk of Magnesium (MOM) 30 milliliters (ml) orally as needed for constipation if polyethylene glycol 3350 was not effective within 6 hours times one dose.; bisacodyl suppository (rectal) 10 mg could be given as needed daily for constipation if polyethylene glycol 3350 and Milk of Magnesia were not effective times one dose. If not effective, notify provider. R51's bowel continence log dated 9/1/22, to 10/27/22, indicated R51 went three or more days without a bowel movement from: -9/1/22, at 2:00 a.m. to 9/4/22, 8:00 a.m. -9/4/22, at 8:00 a.m. to 9/8/22, at 3:13 p.m. -9/12/22, at 8:00 a.m. to 9/16/22, at 6:04 a.m. -9/24/22, at 10:28 p.m. to 9/28/22, at 10:17 p.m. -9/30/22, at 2:57 p.m. to 10/4/22, at 10:01 p.m. -10/6/22, at 8:00 p.m. to 10/10/22, at 8:00 a.m. -10/10/22, at 8:00 a.m. to 10/13/22, at 8:00 a.m. -10/15/22, at 3:08 p.m. to 10/19/22, at 2:50 p.m. -10/19/22, at 2:50 p.m. to 10/23/22, at 8:00 p.m. -10/24/22, at 8:00 p.m. to at least 10/27/22, at 2:48 p.m.	F 690		

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F 690	Continued From page 52 R51's medication administration record (MAR) dated 9/1/22, thru 10/27/22, indicated R57 received a 10 milligram (mg) of bisacodyl (a suppository) on: -10/4/22 at 3:12 p.m. -10/13/22, at 7:25 a.m. -10/19/22, at 7:13 a.m. During an interview on 10/24/22, at 7:18 p.m. family member (FM)-F stated staff were to be monitoring R51's bowel movements daily. FM-F stated R51 should have been given a suppository on the morning of the third day of him not having a BM. However, because it was an "as needed" medication, the trained medical assistants (TMAs) would forget to tell the nurse and R51 wouldn't get the suppository when he should. FM-F stated R51 went four days without a BM last week and she had to tell the nursing staff to give him a suppository which made FM-F "so mad" because it increased R51's pain and wears him out for the whole day. During an observation on 10/26/22, from 7:26 a.m. R51 was overheard in his room, moaning, and saying "hello?" multiple times. During an interview on 10/27/22, at 2:08 p.m. licensed practical nurse (LPN)-B stated she had repeatedly informed staff to monitor R51's BMs and if he hadn't had one for two days, to give him prune juice or "something" to help him move his bowels. LPN-B stated the facility Standing House Orders (SHO) indicated a suppository should be given on the morning of the third day a resident had not had a BM. LPN-B stated R51 should have received a suppository the previous morning but did not get one until that day. LPN-B further	F 690		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 690	Continued From page 53 stated R51 would get worn out and moan a lot if staff waited until the fourth day to give the suppository. During an interview on 10/27/22, at 2:55 p.m. the director of nursing (DON) stated resident BMs should have been monitored daily and residents who had not had a BM for two days should be given a suppository on the morning of the third day to avoid obstruction, impaction, and pain. The DON further stated when R51 didn't get a suppository until the fourth day of not moving his bowels, he would have increased behaviors and fatigue. A facility policy on the treatment of constipation and bowel movement monitoring was requested but not received.	F 690		
F 695 SS=E	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Surveyor: 44658 Based on observation, interview, and record review the facility failed to ensure staff were appropriately trained and applied a continuous positive airway pressure (CPAP) machine with the	F 695	The facility reviewed the policy on O2 Equipment on 12/1/22. The facility policy on Liquid Oxygen Therapy was updated to speak to the changing of the o2 tubing on 12/1/22, The staff were trained on the policy and	12/8/22

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F 695	Continued From page 54 use of distilled water. The facility also failed to ensure there was a method to identify when O2 tubing needed to be replaced or changed for 3 of 3 (R15, R16, R27) residents. Furthermore, the facility failed to ensure caution signs were place on 3 of 3 (R15, R16, R27) resident doors to identify when oxygen was in use. Findings include: During an observation and interview on 10/25/22, at 11:16 a.m. R57's ResMed AirSense 10 CPAP machine was on his bedside table, the attached humidified water container was dry, and no distilled water was found in R57's room. R57's family member (FM)-E, who was in the room, verified there was no distilled water in R57's room, closet, or bathroom. During an observation and interview on 10/26/22, at 8:38 a.m. R57's CPAP machine was on his nightstand, the attached container for the humidified water was dry and no distilled water was found in his room. Trained medical assistant (TMA)-E stated the night nursing assistant (NA) would put the CPAP on R57 at night and the morning NA would take it off and clean it. TMA-E also stated she was told R57 woke up yelling during the previous night, so the staff removed the CPAP mask from his face. Review of the Resmed AirSense 10 user guide dated February 2021, (document.resmed.com) indicated adverse effects for the use of the CPAP were: Dryness of the nose, mouth, or throat Nosebleed Bloating	F 695	procedures of the O2 equipment 11/30/22, 12/6/22, 12/7/22, 12/8/22. The storage rooms on each floor have been stocked with par levels of distilled water on 12/1/22. Bags have been purchased for the O2 tubbing with dates to indicate the change dates on 12/1/22 Caution signs O2 being used signs have been placed outside 11 resident rooms who currently receives O2 treatments door on 12/8/22 The topic and audits have been added to the Quality Score card and the agenda for monthly quality meetings. Audits: 100% observations 2 observations of residents with CPAP, neb and/or oxygen per week x 4; 4 observations per month x 3; 4 observations quarterly.	

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F 695	Continued From page 55 Ear or sinus discomfort Eye irritation Skin rashes Instructions for use of the CPAP indicated to open the water tub and fill it with distilled water up to the maximum water level mark. Do not fill the water tub with hot water. Close the water tub and insert it into the side of the device. After stopping therapy, a Sleep Report would be generating including an indicator for the proper functioning of the humidifier. The humidifier moistens the air and is designed to make therapy more comfortable. Ensure the CPAP machine is lower than the patient's head to prevent the mask and air tubing from filling with water. R57's quarterly Minimum Data Set (MDS) dated 10/5/22, indicated R57 had severe cognitive deficits. R57 required supervision of one staff for eating and extensive assistance of two staff for all other activities of daily living (ADLs). R57 had diagnoses that included insomnia, Alzheimer's and dementia with behavioral disturbances, Multiple Sclerosis (MS), memory loss, and obstructive sleep apnea (OSA-sleep-related breathing disorder causing the airway to become obstructed and occasional to frequent cessation of breathing). R57's Care Area Assessment (CAA) dated 4/22/22, lacked indication R57 had a respiratory concern or used a CPAP machine. R57's care plan dated 10/25/22, indicated R57 required assistance with some or all ADLs and required the use of adaptive equipment. R57 had communication deficits related to hearing loss,	F 695		

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F 695	Continued From page 56 problems making himself understood and understanding others due to declining cognition. R57 also had respiratory concerns related to OSA and using a CPAP. Interventions included putting the CPAP on every night and cleaning it weekly. No other interventions or instructions for the application or use of the CPAP were indicated. During an interview on 10/26/22, at 10:04 a.m. TMA-F stated although she got R57 up that morning, she had not emptied or cleaned the water out of R57's CPAP machine. TMA-F then verified R57's CPAP machine did not have any water in the humidifier container. TMA-F also stated there should have been a bottle of distilled water in R57's room to use in his CPAP and did not know why it wasn't there. During an interview on 10/26/22, at 12:36 p.m. overnight NA-E stated she applied R57's CPAP in the evenings and that R57 did not need water in his CPAP machine. During an interview on 10/26/22, at 2:34 p.m. overnight NA-D stated R57 had not refused or resisted using his CPAP machine when she applied it to his face; however, NA-D would reposition R57's CPAP during the night if he knocked it off. NA-D further stated she had never put water in R57's CPAP machine because it was unnecessary. R15's quarterly MDS dated 8/17/22, indicated R15 had intact cognition, was independent for eating but required extensive assistance of two staff for all other ADLs. The MDS lacked indication that R15 was on oxygen therapy.	F 695		

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F 695	Continued From page 57 R15's diagnoses included congestive heart failure (CHF), shortness of breath, lower leg edema (water retention), obstructive sleep apnea (OSA), atrial fibrillation (an irregular heartbeat), and rhinitis (inflammation of the nasal passages). R15's physician orders dated 9/21/22, indicated R15 was on humidified oxygen therapy requiring the oxygen filter, tubing, and humidifier to be changed. During an observation on 10/25/22, at 12:03 p.m. R15 was in her room with 2 liters per minute (LPM) oxygen being delivered by nasal cannula from a large oxygen tank. The oxygen and nasal cannula tubing lacked a label to indicate when they had last been changed. Additionally, no caution or safety sign was posted outside R15's door to indicate oxygen was being used in the room. Documentation indicating R15's tubing and humidifier was being changed weekly was requested but not available. R16's quarterly MDS dated 8/17/22, indicated R16 had mild cognitive deficits, was independent for eating, required extensive assistance of one staff for all other ADLs and was on oxygen therapy. R16 had diagnoses that included aortic stenosis (hardening of the aortic heart vessel), chronic respiratory failure, chronic obstructive pulmonary disease (COPD), anxiety, heart failure, dementia, and oxygen dependence. R16's Oxygen Tubing Change History indicated R16's oxygen tubing had been changed as follows: -10/24/22	F 695		

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F 695	Continued From page 58 -10/3/22 -9/3/22 -8/27/22 -8/13/22 -8/6/22 -7/30/22 -7/23/22 -7/17/22 -7/2/22 R16's oxygen tubing was not changed seven out of the 17-week log. During an observation on 10/26/22, at 11:02 a.m. R16 was in a recliner in her room with 2 LPM humidified oxygen being delivered by nasal cannula from a large oxygen tank. A second large oxygen tank was also in the room, unused. The oxygen, and cannula tubing, and humidified water container lacked a label to indicate when they were last changed. There was also no caution or safety sign outside R16's door indicating oxygen was being used in the room. During an interview on 10/27/22, at 3:24 p.m. the director of nursing (DON) stated NAs put the CPAP masks on residents at night, then nursing staff should do hourly checks to ensure they were working properly. The DON stated R57's CPAP should have been filled with distilled water according to the manufacturer's recommendations to avoid dryness and/or night-time behaviors. The DON also stated staff should label the oxygen, and nasal cannula tubing, and water containers to indicate when they were last changed, and caution signs should be posted outside resident rooms when the residents were using oxygen. The DON further stated staff should document in a resident's chart, when they changed the tubing and water	F 695		

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F 695	Continued From page 59 containers to ensure they were changed weekly. A facility policy for CPAP machine application and use was requested but not provided. Surveyor: 39988 R27's 8/30/22, significant change Minimum Data Set (MDS) assessment identified R27 had difficulty staying focused, was easily distracted, and had a hard time keeping track of what was said. R27 required extensive assistance of 2 staff for all cares. R27 had chronic obstructive pulmonary disease (COPD), Alzheimer's disease, diabetes, and history of acute respiratory failure. R27 required oxygen therapy and was receiving hospice services. R27's current care plan identified respiratory status as active with a start date of 10/24/22, as evidenced by COPD. Maintain respiratory status, nebulizer tubing change every Monday at 8:00 a.m. Oxygen therapy to keep oxygen saturation above 90% titration between 1-4 liters via nasal cannula, wean as tolerated. Oxygen filter, clean and change per protocol, oxygen humidifier change per protocol, and oxygen tubing change per protocol all initiated on 7/29/22. The facility revised the care plan on 10/24/22, after surveyor inquired about how the facility tracked that tubing was being changed for the nebulizer and oxygen being used. Following revision the care plan still lacked evidence of a schedule for changing the oxygen tubing. R27's Active Medication List printed 10/25/22, identified Albuterol/ipratropium 3 milliliters (ML) inhalation nebulizer treatment every 6 hours scheduled.	F 695		

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F 695	Continued From page 60 Observation and interview on 10/25/22 at 10:03 a.m., R27 stated she has used oxygen for a long time. R27's oxygen tubing was undated. There was no sign on R27's door indicating she was on oxygen therapy. Observation on 10/26/22 at 9:35 a.m., R27's nebulizer treatment mask was still attached to the machine sitting on bedside table and the tubing was undated. Observation on 10/26/22 at 11:50 a.m., R27's nebulizer treatment mask was still attached to the machine on bedside table and tubing was undated. Interview on 10/26/22 at 11:05 with trained medication aide (TMA)-C revealed that the oxygen tubing and nebulizer tubing should be changed weekly and dated. She agreed with no date or charting that there would be no way to know when last changed. Interview on 10/27/22 at 1:00 p.m., with director of nursing (DON) confirmed she had entered the order to change oxygen and nebulizer tubing every 7 days. She confirmed that previous to today there would have been no way to know if the tubing had been getting changed as it was not being date or charted. She further confirmed that no one on oxygen had a sign outside of their room identifying that oxygen was in use and there should be. Review of the May 2022, Liquid Oxygen Therapy Use in LTC policy identified that cannula's and bubblers should be changed on a weekly basis, the same day of week. There was no mention of	F 695		

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F 695	Continued From page 61 changing the tubing for oxygen or nebulizer's in the policy.	F 695		
F 732 SS=F	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the	F 732		12/8/22

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F 732	Continued From page 62 posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Surveyor: 39988 Based on observation and interview the facility failed to ensure daily nurse staffing information was posted on each of the 2 floors of the facility in a visible prominent place readily accessible to visitor and resident within the nursing home. This had the potential to affect all 69 residents and visitors who wanted to review this information. Interview on 10/25/22 at 2:19 p.m., with trained medication aide (TMA)-D identified that there was no posting of staff on duty anyplace for residents or visitors to view. That information was only accessible on the computer. She was unaware if any paper form with that information was posted in the building. Interview on 10/25/22 at 2:20 with registered nurse (RN)-E identified that nurse staffing information was located on the computer and then on weekends it is on paper. She was unaware if any paper form was posted in the building that showed nurse staffing information. Observation on 10/25/22 at 2:32 p.m., daily nursing staff posting was found by the elevators to go down to the lower level hanging on the wall at wheelchair height below a poster along with several other papers which were all on hooks in a clear plastic protective sleeve. This location was straight down the hall from the entrance to the building located by a conference room. From the front door entrance both resident living	F 732	The facility updated the Staff Nurse Posting policy to reflect the updates on 12/1/22. The staff have been trained on the updated policy and where the report is located on 11/30/22, 12/6/22, 12/7/22, 12/8/22. The new location has been established and the hours posted on the ground floor by the elevator and the posting area has been moved upstairs to be located in the front lobby on 12/6/22. Families will be communicated to on the location of the nurse hours posting locations at the family council meeting on 12/15/22. Residents were communicated to on the location of the nurse hours posting at the resident council meeting on 12/8/22. We have added this audit and topic to be discussed at our monthly quality meetings and also our monthly resident council meetings. Audits: 100% observations 2 observations per week until 100% compliance. x 3 months then 10 observations quarterly.	

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F 732	Continued From page 63 quarters where located to the right of the main entrance and then divided into 2 hallways of resident rooms. The nursing staff posting was not visible to resident or visitors unless they went to the elevator and looked through the multiple items hanging on the wall. There was no posting of nurse staffing located in the lower level which also had 2 divided areas of resident rooms. Interview on 10/25/22 at 2:29 p.m., with administrator agreed that the staff posting was not placed on both floors of the building. Observation on 10/26/22 at 9:04 a.m., of the staff posting located by the first floor elevators was dated 10/25/22 from yesterday and not current. There were no other postings observed on either floor of the building. Observation on 10/27/22 at 9:19 a.m., unable to locate any nurse staff posting for the day on lower level. On first floor next to elevators is the staff posting in a clear plastic protective sleeve hanging on the wall at wheelchair height that has current date on it. Interview on 10/27/22 at 12:41 p.m.., with family member (FM)-C identified she was unaware of any type of information being posted in the building like that and stated that would be kind of nice to know. Interview on 10/27/22 at 12:43 p.m., with FM-D identified they had no idea that there was any type of information about how many staff were working and had never seen anything like that before. Interview on 10/27/22 at 3:52 p.m., with director	F 732		

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F 732	Continued From page 64 of nursing (DON) agreed that the staff posting was not visible and prominent to visitors or residents in its current location. She confirmed there had never been staff posting located on the lower level as it had only been placed by the elevators. She confirmed the current location was not by the entrance and agreed visitors and residents would not know where to even look for if they wanted to review. A policy for nursing staff posting was requested but not provided.	F 732		
F 744 SS=E	Treatment/Service for Dementia CFR(s): 483.40(b)(3) §483.40(b)(3) A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being. This REQUIREMENT is not met as evidenced by: Surveyor: 44658 Based on observation, interview, and record review the facility failed to develop and implement a person-centered dementia care and treatment plan for 1 of 1 (R57) residents with dementia. In addition, the facility failed to ensure 6 of 8 staff received specialized dementia training on how to care for residents with dementia. Findings include: R57's quarterly Minimum Data Set (MDS) dated 10/5/22, indicated R57 had severe cognitive deficits. R57 required supervision of one staff for eating and extensive assistance of two staff for all	F 744	The facility reviewed their policy on dementia training and updated it on 11/28/22. The facility reviewed the current training for staff and updated it to meet the required training items The staff have all received the new updated training and are completing that training. The resident R57 care plan was updated to include resident -centered interventions to aide in his communication deficits. The audits have been placed on our quality score card and the topic on the quality agenda for our monthly meetings. Audits:	12/8/22

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F 744	Continued From page 65 other activities of daily living (ADLs). R57 had diagnoses that included major depressive disorder, psychotic disorder due to another medical condition with delusions, agitation due to dementia, insomnia, Alzheimer's and vascular dementia with behavioral disturbances, and memory loss. R57's annual MDS dated 7/7/22, indicated in Section F-Preferences - Routine & Activities, an interview for daily activity preference should not be conducted. R57's preferences were assessed by the staff as follows: -Yes: Reading newspapers, books, and magazines, listening to music, being around animals such as pets, and spending time outdoors. -No: Keeping up with the news, doing things in groups, participating in favorite activities, spending time away from the facility, and religious activities/practices. R57's Care Area Assessment (CAA) dated 4/22/22, indicated R57 triggered for cognitive loss/Dementia and was at risk for cognitive decline, changes in mood and behaviors, and inability to make needs known. R57 also triggered for mood and was at risk for worsening signs and symptoms, isolation, and behaviors. R57's care plan dated 10/25/22, indicated R57 was at risk for a communication deficit related to hearing loss, difficulty making himself understood and understanding others and declining cognition. Interventions included notifying a provider with critical results as needed, MDS nursing observations as needed, completing a Brief Interview for Mental Status (BIMS) as needed,	F 744	100% observations 2 observations per unit per week x4; 8 units observations per month; 8 observations quarterly	

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F 744	Continued From page 66 notifying family as needed, and completing a care conference summary as needed. The care plan lacked resident-centered interventions to assist, maintain, or improve R57's communication deficits. The care plan also indicated R57 was at risk for psychosocial well being evidenced by withdrawal from activities, grief over loss of roles/status, daily routine very different from prior pattern in the community and having a strong identification with the past. Interventions included visiting with R57 about past agricultural business and discussing his memory book and pictures. R57's care plan further indicated R57 had a deficit related to activities due to a lack of interest. Interventions included daily activity review, an activity evaluation, MDS preferences to be reviewed as needed, and a spiritual assessment to be completed. The care plan lacked indications of R57's preferences for activities or an individualized plan to increase R57's involvement in activities. The care plan also lacked evidence R57 had been evaluated for dementia to develop a resident-centered plan to decrease R57's repetitive behaviors R57's Care Conference Summary dated 7/19/22, indicated R57 had multiple medication changes due to psychological adjustments. R57 would also refuse to attend activities or say he didn't "want to bother anyone." The summary indicated for staff to encourage R57 to attend more activities to keep R57 busy and keep his mind "off of things." R57's Care Conference Summary dated 10/12/22, indicated R57 attended a few activities but generally did not stay long unless it was a one-to-one interaction.	F 744		

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F 744	Continued From page 67 R57's Activity Attendance Review dated October 2022, indicated out of 27 days, R57 only watched TV for 15 days, watched TV/computer/social time and or reading for 10 days, played a card game 1 day, attended an outing 1 day and attended 2 church services. R57's Behavior/Mood Assessment dated October 2022, was as follows: -10/1/22, at 8:00 p.m. R57 was yelling and calling for help. Staff spoke to him, and he is now sleeping well. -10/2/22, at 8:00 p.m. R57 was yelling and calling for help. Staff spoke to him, and he is now sleeping well. -10/4/22, at 8:00 a.m. R57 hollered out one time. FM-E redirected and R57 has remained calm. -10/7/22, at 8:00 a.m. some yelling out -10/7/22, at 8:00 p.m. R57 was yelling "help me" when staff was in his room setting up medications. Staff tried unsuccessfully to calm R57. -10/10/22, at 8:00 a.m. hollering out around lunch and early afternoon. Gave R57 newspaper, drink, book and turned on the TV to redirect but was unsuccessful. R57 calmed down around 2:30 p.m. and was moved to a recliner to relax. -10/10/22, at 10:30 p.m. R57 was yelling and calling for "help." Staff spoke to resident who stated he was "fine." R57 slept well the rest of the night. -10/12/22, at 8:00 a.m. R57 yelled "help me, help me." -10/14/22, at 8:00 a.m. R57 yelled "help me, help me." Redirected and brought to different area, however, R57 did not stop hollering until FM-E came for lunch. -10/16/22, at 8:00 p.m. R57 was yelling and	F 744		

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F 744	Continued From page 68 calling out for help. Sometimes used abusive language; however, was okay. -10/17/22, at 8:00 p.m. R57 was yelling and calling for help. -10/18/22, at 8:00 a.m. R57 had yelled all afternoon, has had many medication changes after consult with provider. -10/19/22, at 8:00 a.m. R57 had been yelling since he woke up. Was calm when he had 1:1 care. -10/20/22, at 8:00 p.m. yelling help me, help me. -10/21/22, at 8:00 a.m. yelling help me, help me. -10/22/22, at 8:00 a.m. yelling, calling out. -10/22/22, at 8:00 p.m. R57 was yelling and appeared confused, calling for help and asking aides what they were doing. -10/23/22, at 8:00 p.m. yelling and calling for help. -10/24/22, at 8:00 p.m. yelling out and calling for help. -10/25/22, at 8:00 p.m. R57 was yelling and calling for help and asking what was being done. During an observation on 10/26/22, at 8:38 a.m. R57 was waking up and laying in bed as trained medical assistant (TMA)-E was preparing R57's medications in his room. TMA-E picked up the bed controller at the foot of R57's bed and began raising the head of the bed. R57 began yelling out "Wait! Stop!" but TMA-E continued to raise the head of the bed without slowing or stopping, telling R57, "It's fine". R57 responded "No it's not"! TMA-E then told R57 she needed to give him his medications. After assisting R57 with his medications, R57 began asking "What's going on?" repeatedly. TMA-E did not respond to R57 until after the third time, telling R57 he had an appointment, and the nursing assistants (NAs) would be coming in to get him up. R57 asked what the appointment was for, but TMA-E did not	F 744		

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F 744	Continued From page 69 respond and left the room. R57, still sitting straight up in bed, began saying "help me please," "what's going on?" and "nobody will talk to me" repeatedly. TMA-E was summoned back to the room but was unable to provide details regarding R57's appointment. TMA-E lowered the head of R57's bed then left the room. During an interview on 10/26/22, at 9:58 a.m. family member (FM)-E stated she felt the staff were ignoring R57 and his "dementia phase" was not being "delt with." FM-E would appreciate more attention to his dementia, stating when R57 was yelling he usually needed help with something or wanted something to do because R57 did not like to sit still. During an interview on 10/26/22, at 11:03 a.m. TMA-E stated dementia training was completed online but she could not recall interventions for residents with dementia except that a resident with dementia's thinking was their reality and "we just go with it". TMA-E stated they would give residents a newspaper or books to read but that most just watched TV. There were also puzzles in a cabinet that were brought out around the holidays for the residents to work on. TMA-E stated R57 yelled for help and would say no one was talking to him, "all day, every day," and "at some point you just leave him in a safe setting and leave him be." TMA-E stated although he can be pleasant to have a conversation with, R57 could also be rude and "it makes you not want to talk to him." TMA-E further stated the facility did not have the staff to sit and interact with him. During an interview on 10/26/22, at 1:29 p.m. licensed practical nurse (LPN)-B stated R57 liked to be involved in things and have one-to-one	F 744		

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F 744	Continued From page 70 attention, which the staff didn't have time to provide. The activities coordinator (AC) attempted to play cards with him the previous day but R57 kept yelling out. LPN-B stated the staff would have R57 sit out in the day room to take a nap which worked "pretty good." R57 also liked watching TV and reading magazines. LPN-B had looked through his memory book with him once which brought R57 joy because he would remember the photos. During an interview on 10/27/22, at 10:33 a.m. R57 stated he would get sad because he doesn't have enough interaction with people. He would prefer to talk to people instead of watch TV all day. R57 also stated there wasn't much for him to do. FM-E, who was visiting R57, stated R57 used to be a farmer and enjoyed being outdoors, watching people come and go, and building things like the birdhouse project the facility had organized previously. During an interview on 10/27/22, at 12:56 p.m. the AC stated because he recently started the position in May 2022, he had not had a chance to do an assessment on R57's activity preferences or spend one to one time with him, but the AC was aware R57 attended church services on Thursdays. The AC stated there was bingo every Monday and Wednesday, but R57 did not like to attend, and movie-night one Friday a month; however, R57's yelling would occasionally disturb the movie. The AC was aware R57 had a memory book and photo album in his room for staff to get to know R57 better and connect with him, but he had not looked at them or shared them with R57. The AC stated he played Uno (a card game) with R57 on Monday because FM-E stated R57 enjoyed the game; however, R57 did not appear	F 744		

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F 744	Continued From page 71 to remember how to play. The AC would occasionally sit with R57 when he would yell and R57 would be agreeable to the AC pushing him around the facility in his wheelchair. When AC asked R57 if he was aware he was yelling, R57 would say no. The AC further stated he "hadn't done a lot with the men" and was trying to find ideas because most of them did not like craft projects. During an interview on 10/27/22, at 3:03 p.m. the director of nursing (DON) stated R57's behaviors were mostly verbal outbursts. The DON stated she believed it had been hard for R57 to adjust to the facility because he had a private nurse at home and really embraced the one-to-one interaction. When staff talked to R57, he was "good", but would start yelling when staff walked away from him. There was no policy specific to behaviors and/or monitoring provided by the end of the survey.	F 744		
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	F 755		12/8/22

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F 755	Continued From page 72 biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Surveyor: 38687 Based on observation, interview and document review, the facility failed to administer medication according to manufacture's instructions and physician order for 1 of 25 observations. Additionally, the fcility failed to ensure the correct dose of Depakote (anti-siezure medication) was administered during a Gradual Dose Reduction (GDR) for 1 of 1 resident (R57). Findings include: Observation and interview on 10/25/22 at 5:00 p.m., with registered nurse (RN)- A as she prepared to administer R36's Novolog 70/30 Flex Pen insulin 30 units subcutaneous (SQ). RN-A was observed preparing to administer the insulin by cleansing the attachment site for the needle,	F 755	The facility reviewed the current Medication Administration policy and updates were made on 12/1/22. The staff were trained on the updated policy and procedures on11/30/22, 12/6/22, 12/7/22, 12/8/22. The Charge nurses will be expected to verify medication received matches what is in the order. Audits: 100% observation 2 observations per week x 4; 4 observations per month x 3; 4 observations per quarter.	

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F 755	Continued From page 73 attaching the needle to the pen and priming with 1 unit of insulin. RN-A dialed the pen to the 30 unit mark and administered the insulin to R36. She reported she always primed the insulin pen with one unit as that was what the facility policy identified. RN-A reported she had not read the insert provided with the insulin pens and was not aware of the instructions to prime with 2 units before administering the ordered insulin dose. Review of the manufacture's instructions for priming of the insulin Flex Pen identified following attachment of a new sterile needle, the pen was to be primed with 2 units of insulin before dialing the ordered insulin dose to be administered. Interview on 10/25/22 at 5:15 p.m., with licensed practical nurse (LPN)-B who was also the supervisor for the unit, reported she was not aware of the manufacture instruction to prime the Novolog Flex Pen with 2 units and waste prior to administration of the ordered dose. Interview on 10/28/22 at 9:30 a.m., with the director of nursing (DON) voiced her expectation that manufacture's recommendations be followed when priming and administering insulin with insulin pens. R57's quarterly Minimum Data Set (MDS) dated 10/5/22, indicated R57 had severe cognitive deficits. R57 had diagnoses that included major depressive disorder, psychotic disorder due to another medical condition with delusions, agitation due to dementia, insomnia, Alzheimer's and vascular dementia with behavioral disturbances, and memory loss. R57's physician orders dated 10/18/22, at 1:45	F 755		

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F 755	Continued From page 74 p.m. indicated R57 was to have a GDR of his Depakote as follows: Depakote Sprinkles 125 milligrams (mg) -Take 2 capsules (250 mg) 3 times per day (750 mg) for 3 days from 10/19/22, to 10/21/22. -Take 1 capsule (125 mg) 3 times per day (350 mg) for 3 days from 10/22/22, to 10/24/22. -Take 2 capsules (250 mg) 2 times per day (500 mg, an increase) for 3 days from 10/25/22, to 10/27/22. -Take 2 capsules (250 mg) 1 time per day (250 mg) daily for 3 days from 10/27/22, to 10/29/22, then discontinue. R57's physician orders dated 10/18/22, at 2:54 p.m. indicated R57's corrected GDR was as follows: -Take 2 capsules (250 mg) 3 times per day (750 mg) for 3 days from 10/19/22, to 10/21/22. -Take 1 capsule (125 mg) 3 times per day (350 mg) for 3 days from 10/22/22, to 10/24/22. -Take 2 capsules (125 mg) 2 times per day (250 mg, corrected) for 3 days from 10/25/22, to 10/27/22. -Take 2 capsules (125 mg) 1 time per day (125 mg, corrected) daily for 3 days from 10/27/22, to 10/29/22, then discontinue. R57's Orders with Administration record from 10/1/22, thru 10/27/22, indicated the original, incorrect gradual dose reduction order was entered into R57's electronic medical record (EMR); however, the pharmacy delivered R57's Depakote in accordance with the correct GDR order; therefore, R57 was administered incorrect doses and/or no doses of Depakote as indicated below:	F 755		

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F 755	Continued From page 75 -10/19/22, to 10/20/22, Depakote 250 mg three times per day. -10/21/22, to 10/23/22, Depakote 125 mg three times per day. -10/24/22, Depakote 125 mg twice. -10/25/22, Depakote 250 mg twice. -10/26/22, Depakote 125 mg once. -10/27/22, Depakote 125 mg once. During at interview on 10/26/22, at 1:29 p.m. licensed practical nurse (LPN)-B stated the provider had ordered a gradual dose reduction (GDR) for R57's Depakote; however, the pharmacy had been sending incorrect doses. LPN-B stated because the pharmacy did not send the correct dose, R57 did not receive his morning dose of 125 mg of Depakote prior to leaving for an appointment with his family member (FM)-E that day. LPN-B stated "poor" FM-E "is probably going crazy" due to R57's likely increases in behaviors. LPN-B further stated she told the prior evening staff to order more Depakote; however, it did not appear to have been done. LPN-B stated the order on 10/24/22, for 125 mg twice a day for a total of 250 mg was correct. LPN-B also stated the order on 10/25/22, for 250 mg twice a day for a total of 500 mg was also correct although R57 was supposed to be on a GDR. LPN-B further stated the staff who received R57's Depakote from the pharmacy should have verified the dose was correct against the order. Furthermore, the staff administering the medication should have verified the medication card dose matched the order prior to administering the medication, and any discrepancies should have been verified with the pharmacy. During an interview on 10/27/22, at 3:57 p.m. the pharmacist (PH) stated the pharmacy received	F 755		

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F 755	Continued From page 76 multiple prescriptions on 10/18/22, for R57's Depakote medication. At 1:54 p.m. an order was received indicating R57's GDR for his Depakote beginning on 10/19/22; however, there was a discrepancy. The order indicated the dose on 10/25/22, increased from R57's prescribed dose on 10/24/22, instead of decreasing. The PH contacted the provider and at 2:46 p.m. on 10/18/22, the pharmacy received a corrected order to indicate R57 should have received 125 mg of Depakote twice a day from 10/25/22, to 10/27/22. During an interview on 10/27/22, at 3:30 p.m. the director of nursing (DON) stated staff were expected to verify medication received from the pharmacy matches what is on the order. The DON also stated staff should verify they are administering the correct dose of a medication to a resident and clarify any discrepancies with the provider and/or pharmacist prior to administering it. Review of the May 2023 policy Medication Administration identified all medications were to be stored and administered according to manufacture's guidelines.	F 755		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.	F 761		12/8/22

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F 761	Continued From page 77 §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Surveyor: 34083 Based on observation and interview the facility failed to ensure medications were stored securely in 3 of 25 rooms on the Horizons unit, and in 2 of 12 rooms on the Transitions unit. Findings include: During an observation and interview on 10/26/22, at 10:04 a.m. R57's in-room medicine cabinet used to store R57's non-narcotic, facility medications, was found unlocked.. Family member (FM)-E and trained medical assistant (TMA)-F were present in the room. TMA-F stated the cabinet should have been locked. Observation on 10/28/22 at 8:06 a.m. with LPN-C on the Horizons unit identified Rooms 2, 18, and 33 were unsecured with the attached touch pad	F 761	The facility reviewed the Mediation Storage policy on 12/1/22. Trained the staff on the policy and also how to report a broken piece of equipment 11/30/22, 12/6/22, 12/7/22, 12/8/22. The broken lock was fixed immediately by the Maintenace team on 10/28/22. Audits: 100% observations 2 observations per unit x 4 ; 8 observations per month x 3; 8 observations per quarter.	

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F 761	Continued From page 78 lock mounted on the door of the cabinet. Rooms 2 and 33 were noted to not have the lock engaged, but room 18 the lock was nonfunctioning. Observation on 10/28/22 at 8:30 a.m., on the Transitions unit with RN-F identified Room 7 and 10 had in room medication cabinets that were not secured. Both RN-F and LPN-C confirmed that anyone entering the identified rooms could have had access to the medications stored in the cabinets and they should have been secured immediately following administration of any medications. Interview on 10/28/22 at 9:15 a.m. with RN-D the nursing supervisor, reported her expectation for in room medication cabinets be locked when medications were not being administered and if there was a problem with the locking mechanism it should be reported immediately to maintenance. Until the lock was repaired, she stated any medications were to be removed and stored in a secure location until the issue was resolved. Interview on 10/28/22 at 10:55 a.m., with the administrator reported she had not been made aware of an issue with the locking mechanism on room 18's medication storage cabinet and her expectation was for a work to be submitted immediately. She verbalized she should have been made aware of the concern immediately by staff and intervention implemented. A policy for in room medication storage was requested but not provided prior to exit.	F 761		

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F 812	Continued From page 79	F 812		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Surveyor: 44658 Based on observation, interview, and document review the facility failed to ensure potentially hazardous food was cooled properly in the refrigerator after being cooked and failed to ensure food was properly labeled and dated after being removed from their original packaging. In addition, the facility failed to ensure fans were positioned to avoid blowing from a dirty environment to a clean environment in the dish washing area of the main kitchen. These deficient practices had the potential to affect all 68 residents who ate from the main kitchen.	F 812	The facility reviewed the Cooling of Potentially Hazardous Foods policy and process on 11/30/22. Trained the dietary cooks on the policy updates on 12/1/22,12/2/22 and 12/6/22. The facility reviewed and updated the LTC Food Safety & Sanitation policy and process on 11/30/22. The staff have been trained on the updated policy and process on 12/6/22. New hire training module was created for the updated policies. Additional fan on the cart was removed on 10/25/22. The fan above the pots and pans sink was	12/8/22

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F 812	Continued From page 80 During the initial kitchen observation and interviews on 10/24/22, from 2:15 p.m. to 5:30 p.m. with the dietary director (DD), the following was observed: Main kitchen dry storage: -Dry, white rice in a large plastic bucket approximately 1/6th full, with no expiration date or fill date -Dry, wild rice in a large plastic bucket, full, with no expiration date or fill date -Multiple large cans of food approximately 6 pounds (lbs) 11 ounces (oz) including but not limited to pineapple tidbits, various tomatoes (diced, sliced), ketchup, and spaghetti sauce were removed from their original shipping box and stored on the shelf without an expiration date. -Chocolate sheet cake on cart covered with plastic wrap, expiration labeled "X 31" (no month). -An opened and used apple juice box (46 fluid oz) expiration labeled "X 30" (no month). Main kitchen refrigerator: -A tray of wrapped, half-sandwiches on a shelf contained: two egg salad, six turkey, and six ham sandwiches all labeled with an expiration of "X 29" (no month). -Three, uncovered trays of two-dozen, pasteurized eggs, lacked an expiration date. -Three, uncovered metal containers filled with frozen veggies, on a cart, lacked a label indicating when they were opened or intended to be used by. Main kitchen freezer:	F 812	removed on 12/6/22. Audits were completed of the food storage locations in the main kitchen and the four kitchen areas in the long term care units to check for expiration dates on food items were correctly labeled with the month/date/year completed on 12/7/22. Audit: 100% observations 2 observations per unit per week x 3; 4 observations per month; 4 observations per quarter.	

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F 812	Continued From page 81 -A clear, plastic bag containing approximately a dozen, frozen, red meat patties unlabeled with no expiration date. -Unknown, frozen, breaded food item in metal container with no lid, label, or expiration date. During an interview at approximately 3:00 p.m. the Cook (CK)-B stated the uncovered, breaded food item in a small metal container was frozen shrimp she had just put in there to defrost for the evening meal. CK-B asked this surveyor if they should be covered. CK-B also stated she assumed the meat patties were placed in the freezer that day but was not sure. Main kitchen cooler: -Five large turkey breasts, wrapped in foil then cut entirely lengthwise, exposing the meat, were on a cart in the back of the freezer, directly under the fan. Large, plastic ice packs had been folded in half and stuffed inside each turkey breast. During an observation and interview on 10/24/22, at 4:20 p.m. registered dietician (RD)-B temp'd the turkey breasts as follows: 75 degrees Fahrenheit 90 degrees Fahrenheit 80 degrees Fahrenheit 82 degrees Fahrenheit 80 degrees Fahrenheit During an interview on 10/24/22, at 4:35 p.m. CK-B stated she cooked the turkey breasts to 168 degrees Fahrenheit that afternoon, then put them in the cooler at 1:00 p.m. They would be sliced the next day, then served the day after that. CK-B stated the ice packs were placed in the turkey	F 812		

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F 812	Continued From page 82 breasts to speed the cooling process. CK-B further stated although the ServSafe food handler certification course she completed, advised cooling meat in cold water, CK-B found that unappetizing and refused to do it. Main kitchen: -Two large metal carts (approximately 18" wide by 24" deep by 30" high) on wheels were stored under an industrial sink. One contained, and was labeled "sugar," (white) the other contained, and was labeled "flour" (white). The carts lacked and expiration date or when they were last filled. -Multiple bulbs of garlic in an open plastic tub dated 6/3. Some of the bulbs were soft and/or a dark brown in color. During an interview at approximately 3:50 p.m. the DD stated she did not know how long garlic was good for and that she would probably toss them. The DD further stated there was no specific length of time for how long they would keep garlic. Main Kitchen Dish Washing area: -An industrial carpet and floor dryer/fan was placed on a cart between where the dirty pots and pans were cleaned in three metal sinks and where they were placed on shelves to dry after being sanitized. The fan was covered in dust and dirt and blowing air onto the clean pots and pans from approximately five feet away. Another wall mounted fan was in the ceiling corner above the dirty pots and pans area, also blowing in the direction of the clean drying racks. During an interview on 10/24/22, at approximately	F 812		

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F 812	Continued From page 83 5:30 p.m. dietary aid (DA)-A stated they used the industrial fan on the cart to help dry the clean pots and pans faster. The corner ceiling fan also helped dry the pots and pans as well as keep the staff cool. During an observation and interview on 10/24/22, at 5:05 p.m. in the first-floor kitchenette refrigerator, two open and uncovered trays containing 27 pasteurized eggs lacked a label to indicated when they were opened or when they would expire. DA-B stated she did not know when the eggs were put into the refrigerator or when they would expire. During an interview on 10/25/22, at 9:35 a.m. dietary director (DD) stated the cans of food should have been labeled with an expiration date after they were removed from their original shipping boxes. The DD also stated staff should be writing expiration dates with the month and day they expire to avoid confusion and serving expired food to residents. Cooked meat should be cooled according to the guidelines to lessen the possibility of bacterial growth and to ensure the residents don't get sick. The DD stated the sugar and flour in the metal carts were good for approximately eight to nine months and the carts would be washed prior to refilling them; however, there was no documentation to indicate when the sugar or flour was put into the carts and, therefore, the DD did not know when they would expire. The DD further stated fans blowing from a dirty area to a clean area would be a concern for cross contamination. The facility referenced the "Food Storage Guide. Answer the Question ...How long can I store before its quality deteriorates or it's no longer safe	F 812		

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F 812	Continued From page 84 to eat?" article by Julie Garden-Robinson. NDSU Extension Service; dated February 2012 as the facility policy on food storage. The article indicated white flour was to be stored in an airtight container in the refrigerator for 6-8 months. Shell eggs were to be stored covered for 3 weeks. The facility Chill Down Log undated, indicated if the initial food temperature was greater than 140 degrees Fahrenheit, check the food frequently until the food reaches 140 degrees Fahrenheit or less. After 2 hours of cooling, if the food temp is 41 degrees Fahrenheit or less, the cooling process was complete. If the food temp was between 42-70 degrees Fahrenheit, continue to cool the food and re-check the temperature after an additional 2 hours. However, if the food temperature is above 70 degrees Fahrenheit, the food must be discarded or properly reheated to 165 degrees Fahrenheit for 15 seconds then begin the cooling process again. No other facility policy on food storage or labeling was provided.	F 812		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program.	F 880		12/8/22

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F 880	Continued From page 85 The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and	F 880		

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F 880	Continued From page 86 (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Surveyor: 44658 Based on observation, interview, and document review, the facility failed to: 1) Ensure 1 of 1 resident (R33) was placed into transmission based precautions (TBP)and tested immediately after showing symptoms of COVID. This had the potential to affect 1 other resident (R8) who shared a table with R33 at each meal. 2) Ensure appropriate hand hygiene was maintained during 1 of 1 IV antibiotic administration. 3) Appropriately clean all 6 of 6 whirlpool tubs and appropriately launder and transport and store linen on the Meadows and Garden wings located on the 1st floor. 4) Implement appropriate infection control (IC) technique during 1 of 1 dressing change for R56. 5) Maintain 1 of 1 resident (R27) nebulizer machine in a sanitary manner. Findings include:	F 880	The facility policy on Transmission Based Precautions was reviewed on 12/1/22. The facility policy of hand hygiene was reviewed on 12/1/22. The facility policy on equipment cleaning in LTC was reviewed and updated on 12/2/22. The facility policy on infection control standard of precautions on 12/2/22. The facility policy and process on Laundry in LTC was reviewed and updated on 12/1/22. Training with staff on all infection prevention items was completed on 12-4-2022 and 12-8-2022. Training was also added to the new hire training materials. Processes developed per manufacturer infection for use on whirlpools that are in use. One whirlpool was taken out of service. New process developed for storage of	

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F 880	Continued From page 87 Transmission Based Precautions and Testing of COVID Symptomatic Residents R33's annual Minimum Data Set (MDS) dated 9/7/22, indicated R33 had intact cognition, was independent with eating, required extensive assistance of one staff for bed mobility and limited assistance with all other activities of daily living (ADLs). R33's diagnoses included prostate cancer, coronary artery disease, high blood pressure, and kidney disease. R33's Care Area Assessment (CAA) dated 9/7/22, indicated R33 triggered for communication, ADL function, falls, and pressure ulcers. R33's care plan dated 9/1/22, indicated R33 was at risk for communication related to new onset of cognitive losses resulting in poor recall and safety awareness. R33's progress note dated 10/26/22, at 7:59 a.m. indicated R33 had been having a cough and nasal congestion since receiving his immunizations six days prior. R33 stated he felt fine except for the infrequent cough he had. R33's SARS-CoV-2 (PCR) test dated 10/26/22, at 9:15 a.m. indicated R33 was positive for COVID-19. During an observation on 10/26/22, at 7:54 a.m. from approximately 40 feet down the hallway, outside the resident dining room, licensed practical nurse (LPN)-B was overheard asking R33 if his cough had improved since the previous day. R33 stated it was a "bad head cold" he couldn't get rid of and felt worse. LPN-B took	F 880	linen including ted hose. Along with new process and new policy implemented for laundry process to ensure cross contamination does not occur. Audits: COVID - 100% observations 2 observations per unit per week x 4' 8 observations per month x3; 8 observations quarterly Hand Hygiene- 100% observations 30 observations per month Tub Cleaning - 2 observations per unit per week x 4; 8 observations per month x 3; 8 observations quarterly. Laundry - 2 observations per unit per week x 4; 8 observations per month x 3; 8 observations quarterly.	

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F 880	Continued From page 88 R33's blood pressure, temperature and oxygen level and reported them as "fine", telling R33 she would inform the provider. R33 then self-propelled his wheelchair into the resident dining room, without a mask, where other residents were seated for breakfast. During an interview on 10/26/22, at 11:20 a.m. LPN-B stated she tested R33 for COVID-19 at 8:45 a.m. using a rapid antigen test that indicated R33 was positive for COVID-19. Thirty minutes later, LPN-B tested R33 for COVID-19 using a polymerase chain reaction (PCR) test which also indicated R33 was positive. LPN-B stated R33 received a COVID-19 booster and influenza vaccine on 10/20/22. On 10/22/22, R33 began having diarrhea, however, R33 had a history of diarrhea and therefore the staff did not believe it was a concern. On 10/24/22, R33 began having nasal congestion but he believed it was a result of being outside that day. On 10/25/22, LPN-B stated R33 developed a cough, and she should have quarantined him on transmission-based precautions (TBP) and tested him for COVID-19 at that time but did not. LPN-B stated she also failed to notify the provider of R33's new onset of symptoms until today, 10/26/22. LPN-B further stated she should have redirected R33 to his room, placed him on TBP, and tested him for COVID-19 instead of allowing him to eat breakfast with other residents in the dining room that morning. The facility COVID-19 Outbreak Guidelines policy dated 10/2022, indicated the facility should have a plan in place to identify a COVID-19 outbreak, and the process to prevent further transmission. A single new case of COVID-19 in any resident should be evaluated to determine if others in the	F 880		

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F 880	Continued From page 89 facility could have been exposed. No further documentation was provided regarding the facility process for identifying and responding to a resident with a new onset of COVID-19 symptoms. IV Antibiotic Therapy R64's quarterly Minimum Data Set (MDS) dated 10/12/22, indicated R64 had mild cognitive deficits, required supervision for eating and extensive assistance for all other activities of daily living (ADLs). R64 had diagnoses that included hypothyroidism (low functioning thyroid), heart failure, chronic obstructive pulmonary disease (COPD), Alzheimer's and dementia, malnutrition, a chronic non-pressure ulcer of the foot, and osteomyelitis of the foot (a bone infection). During an interview on 10/25/22, at 10:38 a.m. R64 stated she was receiving an antibiotic (Ceftriaxone 2 grams in 50 milliliters normal saline) intravenously (IV) for an infection in her foot that went into the bone. During an observation an interview on 10/26/22, at 8:28 a.m. licensed practical nurse (LPN)-A was observed attaching an intravenous (IV) antibiotic medication to an IV line in R64's right arm without wearing gloves. The medication pump alarmed with an error and LPN-A attempted to troubleshoot the occlusion by touching the pump machine, tubing and R64's arm and clothing without first performing hand hygiene. LPN-A stated she should have worn gloves to administer the IV medication, removed them, then performed hand hygiene prior to touching anything else to avoid cross contamination.	F 880		

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F 880	Continued From page 90 During an observation and interview on 10/26/22, at 7:15 a.m. multiple pairs of compression socks were observed hanging over hallway handrails in front of rooms 123, 128, 134, 137, and 138. Nursing assistant (NA)-Carla was then observed walking out of a resident room, approximately 50 feet down the hallway, holding dirty bed linen against her uniform, and without wearing gloves. NA- disposed of the dirty linen in a laundry bin and walked back towards the resident room without performing hand hygiene. NA- stated because there was only "one dirty spot" on the sheets, she didn't think contamination would be a concern. NA- further stated the overnight staff would hang the socks on the handrails to dry because there was not a "good" place to hang them in the resident rooms and there was more "air flow" in the hallways. There was no specific policy related to IV antibiotics provided by the end of the survey. Surveyor: 38687 WHIRLPOOL TUB CLEANING Observation and interview on 10/26/22 at 3:50 p.m., with bath aide (BA)-F identified BA-F was beginning her cleaning and disinfecting of the whirlpool tub. BA-F had scrubs on and applied no personal protective equipment (PPE) (gloves, gown and goggles) prior to beginning the process. The tub was an Apollo whirlpool tub with water jets. BA-F began her process by opening pouring MasterCare one-step disinfectant/cleaner straight in without using any measurement. BA-F then used a toilet brush (designated for this use) to clean any debris from the sides of the tub. BA-F then filled the tub with water passed the	F 880		

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F 880	Continued From page 91 level of the water jets and turned the jets on and washed the top of the whirlpool chair. The sides of the tub were visibly dry before 60 seconds had elapsed. BA-F allowed the whirlpool jets to run until it caused bubbles to fill the tub. BA-F then used the sprayer to rinse out the tub. The process took less than 8 minutes. BA-F was unaware of any instructions for use on how to appropriately clean and disinfect the tub by the manufacturer. She was taught this way, and taught others to clean and disinfect the tub using this method. BA-F was unaware she should wear PPE during the cleaning and disinfection process. Review of the Apollo Advantage Bathing System manual located at https://apollobath.com/wp-content/uploads/2021/09/CD0012-Advantage-Operation-Manual.pdf, identified use of other manufacturer's cleaners and disinfectants was not recommended and could compromise the overall process. The tub came with a hose and compartment for their cleaning and disinfecting processes. The manufacturer recommended use of Cid-A-L cleaner and disinfectant. Staff were to clean and disinfect the whirlpool tub using the following process for: Cleaning 1) Place the chair in the tub, release the carrier from the tub, and close the door. 2) Close the Tub Drain. Turn the Selector Knob to "TUB CLEANER" and the Control Knob to "On." 3) Turn the whirlpool on. After the Turbo Clean (Trademark) mixture has come out of the jets for about 30 seconds or when there is about 2 inches of cleaning solution in the foot well; turn the Selector Knob to "Rinse." 4) Lift seat bottom off chair, (pull up from back of	F 880		

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F 880	Continued From page 92 seat). Use the cleaning solution to scrub the tub, chair and underneath seat bottom. When clear water comes out of all the jets, turn the whirlpool off. 5) Turn the Control Knob to "Off" and open the Tub Drain. 6) Use the shower wand to rinse the tub and chair. Disinfection 1) Place the chair in the tub, release the carrier from the tub, and close the door. 2) Close the Tub Drain. Turn the Selector Knob to "DISINFECTANT" and the Control Knob to "On." 3) Turn the whirlpool on. When there is about 2 inches of disinfectant in the foot well, turn the whirlpool off. Turn the Control Knob to "Off." 4) Lift seat bottom off chair, (pull up from back of seat). Use the disinfecting solution to scrub the tub, chair and underneath seat bottom. 5) Leave wet for 10 minutes (wet contact time for all surfaces). Open the Tub Drain. 6) After 10 minutes, turn the Selector Knob to "Rinse" and the Control Knob to "On." Turn the whirlpool on. When clear water comes out of all the jets, turn the whirlpool off. Turn the Control Knob to "Off." 7) Use the shower wand to rinse the tub and chair. LAUNDRY Observations of laundry processes on the first floor identified on: 1) 10/24/22 at 2:25 p.m., of the laundry room in the Gardens wing identified the laundry room was small, had a washer and dryer located inside it with automated chemicals were tubed into the	F 880		

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F 880	Continued From page 93 washing machine. Empty laundry baskets were stacked on top of the dryer. There was no visible sorting area to separate dirty linen from clean linen, and no sorting table for folding clean linen. Linen left in this room was uncovered and exposed to potential air contaminates when the laundry area was not separated. 2) 10/25/22 at 8:11 a.m., a laundry basket full of resident clothing was sitting on the floor in the hallway, uncovered, in a laundry basket outside R32's room. 3) 10/25/22 at 8:21 a.m., R56's clothing was sitting in an open laundry basket clean, uncovered outside the room in the hallway. 4) 10/25/22 at 8:22 a.m., R32's and R56's clothing baskets remained uncovered in the hallway and were still there at 8:50 a.m. Further observation on 10/27/22 at 8:04 a.m., R39's bathroom was visible from the hall. On the floor in the bathroom sat the same white laundry baskets seen previously throughout the facility with clean laundry, now holding dirty laundry and sitting on the bathroom floor. Review of the February 2020, Laundry and Linen procedures policy identified PPE was to be worn by laundry personnel when handling soiled linen. Laundry and linen employees were to receive 1 on 1 training by the manager including infection prevention and appropriate linen handling. Collection carts for soiled linen were to be used by the facility. Clean linen was to be placed on a covered cart and stored in an enclosed linen cart which was to be wheeled in patient areas. There was to be a counter to fold clean linen. There was no mention of using routine laundry baskets to both hold dirty and clean linens or how staff would ensure those baskets were cleaned appropriately.	F 880		

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F 880	Continued From page 94 DRESSING CHANGE Observation on 10/25/22 at 9:42 a.m. with registered nurse (RN)-A performing a dressing change to R56's pressure ulcers with assistance from nurse aide (NA)-G identified R56 was paralyzed and was unable to move her arms and legs independently. NA-G rolled R56 towards her so RN-A could perform the dressing change. RN-A had sterile dressings on a barrier on R56's bedside table. RN-A washed, dried her hands, and applied clean gloves. R56 had multiple areas in varied stages of healing. RN-A measured each wound with different paper measuring tapes using the same gloves touching the different pressure ulcer areas. RN-A needed a Q-tip to measure depth of 1 area, and without removing gloves, she went to R56's closet, and retrieved a tub of clean dressing supplies with her soiled gloves, touching those clean supplies and returning them to the cupboard. After finishing measuring all of the wound/pressure ulcer areas, RN-A then set the contaminated wound measuring tapes on top of the sterile dressings she had on the bedside table, along with her contaminated pen she used to record those measurements on the measuring tapes. She then proceeded to grab the bottle of wound wash and sterile 4x4's with her soiled gloves, and washed each wound using the same contaminated 4x4 gauze pads, cross contaminating the wounds. RN-A then applied bordered foam dressing without removing her contaminated gloves or performing hand hygiene and donning new gloves, and proceeded to apply the once sterile dressings to R56's wounds. RN-A then removed her same contaminated gloves at the end of the procedure and washed her hands. RN-A was unable to be interviewed immediately	F 880		

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F 880	Continued From page 95 after the dressing change due to her needing to assist another resident immediately after. Interview on 10/26/22 at 4:06 p.m., with the infection preventionist (IP) identified she performed environmental audits 2 x per year with the adjoining hospital safety advisor. She was unaware laundry was being cleaned and stored in the manners described above. She agreed definite processes needed to be changed to ensure cross contamination did not occur and laundry was handled and transported appropriately. She also noted she always had high increases of UTI in the facility and not disinfecting the whirlpool tubs appropriately could lead to an increase in urinary tract infections (UTI). The IP agreed RN-A should have performed appropriate hand hygiene and glove changes between tasks. RN-A should have also not contaminated clean or sterile dressing supplies. This was a cause of concern and cross contamination of R56's wounds. There was no policy related to appropriate hand hygiene or glove use provided by the end of the survey. Surveyor: 39988 NEBULIZER R27's 8/30/22, significant change Minimum Data Set (MDS) assessment identified R27 had difficulty staying focused, was easily distracted, and had a hard time keeping track of what was said. R27 required extensive assistance of 2 staff for all cares. R27 had chronic obstructive pulmonary disease (COPD), Alzheimer's disease, diabetes, and history of acute respiratory failure.	F 880		

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F 880	Continued From page 96 R27 required oxygen therapy and was receiving hospice services. R27's current care plan identified respiratory status as active with a start date of 10/24/22, as evidenced by COPD. Maintain respiratory status, nebulizer tubing change every Monday at 8:00 a.m. R27's Active Medication List printed 10/25/22, identified Albuterol/ipratropium 3 milliliters (ML) inhalation nebulizer treatment every 6 hours scheduled. Observation on 10/25/22 at 10:03 a.m., R27 nebulizer mask was still connected to the machine with some moisture noted inside mask, the mask was laying in a basket on top of some papers next to the nebulizer machine. Observation on 10/26/22 at 9:35 a.m., R27's nebulizer treatment mask was still attached to the machine sitting on bedside table. Observation on 10/26/22 at 11:50 a.m., R27's nebulizer treatment mask was still attached to the machine on bedside table. Interview on 10/26/22 at 11:05 with trained medication aide (TMA)-C revealed that the person working on the medication cart and assisting with the nebulizer treatment would be the person responsible for cleaning the nebulizer equipment. The medication staff should rinse the mask and port that the medication goes in and set it on a clean paper towel to dry after each administration.	F 880		

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F 880	Continued From page 97 Interview on 10/26/22 at 1:15 p.m., with registered nurse (RN)-D confirmed that the protocol was to clean and place the nebulizer supplies on a clean paper towel to dry after each use. Interview on 10/27/22 at 1:00 p.m., with director of nursing (DON) confirmed staff should be rinsing and leaving the nebulizer supplies on a clean paper towel to dry after each use along with replacing supply's weekly. Review of October 2022, Avera LTC Disinfection of Non-Critical Patient Care Equipment policy identified Nebulizer's supplies were to be rinsed, and set on clean paper towel and covered with another paper towel to dry in the residents room until the next treatment. Every 24 hours staff will disassemble all nebulizer equipment and wash with soap and rinse and air dry on a clean paper towel covered by another paper towel. Nebulizer supplies should be replaced weekly or more often based on manufacturer instructions for use.	F 880		

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: Surveyor: 34083 On 10/24/22 through 110/28/22, a standard licensing survey was conducted completed at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found NOT in compliance with the MN State	2 000		

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2 000	Continued From page 1 Licensure. The following licensing orders were issued: 0302, 0565, 0620, 0895, 0910, 1095, 1100, 1375, 1580, 1610, and 1980. The following complaints were found to be SUBSTANTIATED: H5228035C (MN82447), H52285143C (MN85027), and H52285077C (MN86082), however, NO licensing orders were issued. The following complaint was found to be SUBSTANTIATED: H52285146C (MN87174), with a licensing order issued at 0565. The following complaints were found to be UNSUBSTANTIATED: H52285144C (MN83743) and H52285149C (MN86301) and H52285145C (MN83502). Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor ' s findings are the Suggested Method of Correction and Time Period for Correction. You have agreed to participate in the electronic	2 000		

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2 000	Continued From page 2 receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm. The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		
2 302	MN State Statute 144.6503 Alzheimer's disease or related disorder train ALZHEIMER'S DISEASE OR RELATED DISORDER TRAINING: MN St. Statute 144.6503 (a) If a nursing facility serves persons with Alzheimer's disease or related disorders, whether in a segregated or general unit, the facility's direct care staff and their supervisors must be trained in dementia care.	2 302		12/8/22

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2 302	Continued From page 3 (b) Areas of required training include: (1) an explanation of Alzheimer's disease and related disorders; (2) assistance with activities of daily living; (3) problem solving with challenging behaviors; and (4) communication skills. (c) The facility shall provide to consumers in written or electronic form a description of the training program, the categories of employees trained, the frequency of training, and the basic topics covered. (d) The facility shall document compliance with this section. This MN Requirement is not met as evidenced by: Surveyor: 39988 Based on interview and document review the facility failed to ensure 6 out of 8 staff reviewed (licensed practical nurse (LPN)A, nursing assistant (NA)-B, NA-C, NA-D, NA-E, and the administrator) received dementia or Alzheimer's training upon hire and annually per the facility policy. Findings include: During record review of Alzheimer's disease or related disorder training that encompassed explanation of Alzheimer's disease and related disorders, assistance with activities of daily living, problem solving with challenging behaviors, and communication skills identified the following: 1) LPN-A had only received training in dementia communication and working with difficult and	2 302	The facility reviewed their policy on dementia training and updated it on 11/28/22. The facility reviewed the current training for staff and updated it to meet the required training items The staff have all received the new updated training and are completing that training. The resident R57 care plan was updated to include resident -centered interventions to aide in his communication deficits. Audits: 100% observations 2 observations per unit per week x4; 8 units observations per month; 8 observations quarterly	

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2 302	Continued From page 4 combative people. LPN-A's training record lacked evidence of understanding dementia and assistance with activities of daily living. 2) NA-B had only received training in dementia communication and working with difficult and combative people. NA-B's training record lacked evidence of understanding dementia and assistance with activities of daily living. 3) NA-C had only received training in dementia communication and working with difficult and combative people. NA-C's training record lacked evidence of understanding dementia and assistance with activities of daily living. 4) NA-D had only received training in dementia communication and working with difficult and combative people. NA-D's training record lacked evidence of understanding dementia and assistance with activities of daily living. 5) NA-E had only received training in dementia communication. NA-E's training record lacked evidence of working with difficult and combative people, understanding dementia and assistance with activities of daily living. 6) The administrator had only received training in dementia communication. The administrator's training record lacked evidence of being trained in working with difficult and combative people, understanding dementia and assistance with activities of daily living. Interview on 10/27/22 at 3:38 p.m., with director of nursing (DON) confirmed all staff should be having Alzheimer's training upon hire and yearly. She revealed that the facility policy did not include all the training requirements. Her expectation would be that all staff working with residents should complete the required Alzheimer's training. Interview on 10/27/22 at 3:45 p.m. with administrator agreed that all staff had not	2 302		

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	00343		C 10/28/2022

NAME OF PROVIDER OR SUPPLIER: AVERA MORNINGSIDE HEIGHTS CARE CENTE

STREET ADDRESS, CITY, STATE, ZIP CODE: 300 SOUTH BRUCE STREET MARSHALL, MN 56258

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2 302	Continued From page 5 completed all the required components of Alzheimer's training. Review of the May 2022, Alzheimer's Disease/Staff Training policy identified the areas of training to include Alzheimer's Disease and related disorders, managing challenging behaviors, understanding abuse, communication with patients with dementia, and preventing abuse. The policy lacked identified training for assistance with activities of daily living. Review of the 3/23/22, Facility Wide Risk Assessment identified staff development training would include care and management of the resident with Alzheimer's or other dementia, providing services to individuals with cognitive impairment, and dementia management training. SUGGESTED METHOD OF CORRECTION: The DON or designee could enroll all direct care staff in the appropriate Alzheimer's training courses and notify them of a timeline for completion. The DON could ensure all direct care staff complete the missed courses via an audit, and could develop a regular audit of facility education course completion to be done following new staff orientation and throughout the year as appropriate. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 302		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident.	2 565		12/8/22

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2 565	Continued From page 6 This MN Requirement is not met as evidenced by: Surveyor: 44658 Based on interview and document review, the facility failed to ensure development of comprehensive care plans were developed and implemented for each resident, included measurable objectives and timeframe's to meet a resident's medical, nursing, and mental and psychosocial needs and include services to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being for 16 of 18 sampled residents (R3, R4, R5, R11, R20, R31, R41, R42, R43, R50, R54, R56, R57, R121, R122, and R127). Findings include: R5's current, undated care plan identified R5 was admitted to the facility in November, 2021 and had diagnoses of cancer, high blood pressure, GERD, diabetes, high cholesterol. thyroid disorder, anxiety disorder, . R5's care plan identified problems noted for bladder incontinence, communication and cognitive concerns, was a fall risk, was on hospice, was on a constant carb diabetic diet, chronic pain, psychosocial well-being/mood, activities, medication side effects, and skin integrity. R5 had little to no specific person-centered goals or interventions identified on the care plan according to existing diagnoses or needs. R5 recieved an anti-coagulant and the care plan made no mention of any bleeding precautions.	2 565	The facility reviewed the Care Plan policy 11/16/22. The staff were trained on the updated policy and processes on 11/30/22, 12/6/22, 12/7/22, 12/8/22. Meditech hands on training for all staff has been scheduled for ongoing training.and has been added to the new hire training for all staff. The care plans were audited for 100% of the facility. A plan has been developed to update each resident's care plan with person centered items. The following has been updated: R5 has had resident goals and interventions added to the care plan. Bleeding precautions were also added to the residents care plan. R3 has been updated with the residents' goals and interventions for side effects from psychotropic drug use and behavior interventions. The plan for restorative therapy to reduce the contractures has been noted in the care plan. R41 has had their care plan updated with resident centered goals and interventions that relate to their diagnoses. R56's Care plan has been updated to include the indication of the catheter to be secured to the resident's leg with a leg strap to keep the catheter in place. Person centered goals and interventions have been identified and updated in her R31 Care plan has been updated to direct staff to use a gait belt for all transfers with	

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2 565	Continued From page 7 R3's current, undated care plan identified R3 was admitted to the facility in July, 2017. R3's care plan identified problems noted for psychosocial well being, Activities of Daily Living (ADL) status, bowel and bladder incontinence, communication and cognitive ability, fall risk, oral and respiratory status, blood sugar status, nutrition, pain, activity involvement, was at risk for medication side effects, and skin integrity. R3 was at risk for side effects from psychotropic drug use related to behaviors, however no interventions were placed on the care plan specific to R3.R3 also had contractures and the need for restorative therapy was also not noted on the care plan. Throughout R3's care plan, R3 had little to no specific person-centered goals or interventions identified according to existing diagnoses or needs. R41's current, undated care plan identified R3 was admitted to the facility in October, 2021 with diagnoses of dementia, enlarged prostate, diabetes, glaucoma and was legally blind, high cholesterol, and a below the knee amputation. R14 had little to no specific person-centered goals or interventions identified on the care plan according to existing diagnoses or needs. R56's current, undated care plan identified R56 was admitted to the facility in March 2021 and had diagnoses of heart failure, neurogenic bladder, high cholesterol, paraplegia, MS, anxiety, depression, pressure ulcer to her left buttock- Stage III, and dysphagia. She had identified problems of ADL status, catheter use, ostomy care, communication and cognitive ability, fall risk, nutritional status, chronic pain, psychosocial well-being, activity involvement, skin integrity. R56 was noted to have a suprapubic (tube placed in opening into bladder through stomach) catheter with interventions to clean and	2 565	the resident. Goals and Interventions have been updated in the resdients care plan. choking. R50 non pharmacological interventions have been updated in the care plan as well as person centered goals R11 His care plan has been updated to address his agitation and PTSD and the interventions to handle his behaviors and diagnosis. His medications have been updated in his care plan along with monitoring for side effects. R42 Person centered goals have been placed in her care plan as well as interventions to address her potential for R121 care plan was reviewed, the resident has expired. R122 care plan was reviewed, the resident has discharged. R127 Care plan was reviewed, the resident has expired. R20 care plan has been updated to reflect his behaviors and interventions used by staff when those behaviors occur. R54 the care plan has been updated to reflect individualized interventions to prevent falls and minimize pain. R43 the care plan was updated to reflect interventions for staff to ensure communication to meet needs and prevent elopement. he enjoyed, medications have been update and all side effects as well. CPAP cares and interventions have also been updated in his care plan. R4 Care plan was updated to reflect interventions related to using her call light and using the bathroom unattended and fall reduction R57 care plan has been updated with	

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2 565	Continued From page 8 change the catheter bag monthly. The care plan also had a discrepancy and noted R56 was to have her Foley (tube inserted into urethra, then into the bladder) flushed twice per day. Staff were to place a pad under R56 if it leaked. There was also a notation to "cath secure change" however, there was no indication what that meant or how staff was to ensure her catheter remained secured to her leg. R56 had little to no specific person-centered goals or interventions identified on the care plan according to existing diagnoses or needs. R31's 9/7/22, quarterly Minimum Data Set (MDS) identified she had intact cognition with diagnoses of Parkinson's disease, glaucoma, retention of urine, constipation, and pain. R31 was to have had extensive assistance of 2 staff for transfers between surfaces and required the use of a wheelchair. Observation on 10/27/22 at approximately 9:45 a.m. identified R31 was being transferred with nurse aide (NA)-H identified she was in process of performing a pivot transfer to R31. NA-H was observed grabbing onto the back side of R31's elastic waistband pants, and pivoting R31 from her wheelchair to a chair without use of a gait belt. R31's current, undated care plan identified R31 was admitted to the facility in March 2022. R31 was at risk for falls as evidence by a history of falls, impaired balance, Parkinson's disease, urinary tract infections, and impaired mobility. There were no interventions identified on the care plan reflective of her MDS assessment. R31 had a problem noted with Activities of Daily Living (ADL) and required assistance with ADL's. R31 was noted to transfer/pivot with use of a gait belt	2 565	interventions to increased the resident activity involvement and what activities Audit: 100% of charts will be audited 1 care plan per unit will be audited weekly x4; 1 care plan per unit monthly x 3 ; 1 care plan per unit quarterly.	

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2 565	Continued From page 9 and a walker. There was no mention R31 required 2 staff for safety. Review of the 6/24/22,current nurse aide (NA) care plan identified under the section "Care Plan/Special Needs/Special Diet" the only notation for NA staff was that she "likes makeup and recliner". Her ADL's were listed as "A1" (assistance of 1). There was no indication why the nurse aide care plans did not contain critical elements of resident care needed or why it had not been revised recently. Interview and observation on 10/27/22 at 10:00 a.m. with the administrator and director of nursing identified all residents were to have gait belts in their rooms for potential transfers. Both agreed NA-H should have used the resident's gait belt. The administrator and DON agreed there was the potential for harm for an accidental fall due to staff not using the appropriate equipment. The administrator was unsure why the nurse aide care plans were not up to date or reflective of what resident's care was required but did acknowlege their current computer software was "not friendly to long term care (LTC) use" and was not able to be resident specific. Both agreed care plans failed to detail resident specific needs. R20's 9/12/22, significant change Minimum Data Set (MDS) assessment identified severe cognitive impairment with inattention and disorganized thinking. R20 had verbal, physical and other behaviors during the assessment period. R20 required extensive assist with cares, R20 took an antipsychotic 6, antianxiety 2, and pain medication 4 of the 7 look back period. R20's undated, care plan identified	2 565		

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2 565	Continued From page 10 Communication deficit as evidenced by advanced dementia with moderate cognitive losses, problem understanding others, and was mostly non-verbal. The goal was to maintain communication and cognition. Interventions identified care conference as needed, family notification as needed, BIMS interview as needed, communication as needed, nurse observation as needed, notify provider of critical results as needed, and hearing aid/glasses's every 12 hours. The care plan further identified fall risk as evidenced by history of falls, impaired balance, hypertension medication, impaired mobility, and impaired cognition. The goal was to prevent falls and injury. Interventions included balance and functional range of motion as needed and fall risk assessment as need. Psychosocial well being and mood was identified as a problem as evidenced by withdrawal from care and activities, grief over loss of status, daily routine is very different from prior pattern in community, and strong identification with past. The goal was to establish own goals, strong identification with past, and maintain mood. Interventions included an individual abuse prevention plan, alcoholic beverages as needed, insomnia assessment as needed, staff observation as needed, social service assessment as need, PTSD screen as needed, PHQ-9 as needed, Behavior/mood observation every 12 hours, elopement risk as needed, AIMS assessment as needed, and behavior/mood assessment every 12 hours. R20's care plan lacked individualized interventions for staff to follow to ensure communication to meet needs, to prevent falls, and to identify if R20 was displaying any target behaviors as there were none identified. Interview on 10/26/22 at 1:45 p.m., with	2 565		

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2 565	Continued From page 11 registered nurse (RN)-A identified R20 had been seen by psych for medication adjustments related to his physical behaviors. She revealed side effects of medication were being monitored and agreed that the target behaviors were not identified on the care plan but staff charted any behaviors that occurred. Review of 10/21/22, Behavior health note by psychiatric provider identified R20 had diagnosis of vascular dementia with behavioral disturbance, psychotic disorder wit delusions and hallucinations. R20 behaviors had been physical aggression to staff, raising hands and shake fist at caregivers, shoved staff, poked staff in eye, punched staff in face, kicked at wife. None of this information had been identified on R20's care plan. R54's 8/20/22, significant change MDS assessment identified moderate cognitive impairment. R54 required extensive assist with cares and transfers. R54 had history of falls, took daily diuretic, and had occasional pain. R54's undated, care plan identified fall risk as evidenced by history of falls, impaired balance, psychotropic drugs, hypertension medications, diuretic medication, impaired mobility, and impaired cognition. The goal was to prevent falls and injury. Interventions included balanced and functional range of motion as needed and fall risk assessment as needed. The care plan identified chronic pain as evidenced by peripheral vascular disease, and lymphedema. The goal was to be free from pain and residents to have acceptable level of pain. Interventions included pain interview as needed and pain assessment as needed. R54's care plan lacked individualized interventions to prevent falls and to minimize pain	2 565		

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2 565	Continued From page 12 for staff to follow. R43's 9/21/22, annual MDS assessment identified severe cognitive impairment with inattention and disorganized thinking. R43 required extensive assist with cares and was identified to have had 2 or more falls. R43 took a daily antipsychotic, antidepressant, and a daily hypnotic. R43's undated, care plan identified a communication deficit as evidenced by Parkinson's dementia with moderate to severe cognitive losses's, was able to make self understood but sometimes talked nonsensical, his orientation fluctuated, he had problems understanding others, and memory impairments. The goal was to maintain communications and cognition. Interventions included care conference summary as needed, family notifications as needed, BIMS interview as needed, communication as needed, nurse observation as needed, notify provider with critical results as needed, hearing aide and glasses's every 12 hours. The care plan identified elopement as a problem with wander guard placed related to ability to wander, cognitive loss and desire to go outside. The goal was R43 will not leave facility unattended. Interventions included wander guard alarm check daily using wander guard pocket reader and elopement risk as needed. R43's care plan lacked individualized interventions for staff to follow to ensure communication to meet needs and initialized interventions to prevent elopement. R4's care plan dated 10/24/22, indicated R4 had a concern for bladder and bowel due to frequent incontinence of urine. Interventions included recording R4's output and scanning R4's bladder	2 565		

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2 565	Continued From page 13 as needed. R4 had a risk for falls related to a history of falls with an injury, impaired balance, the use of psychotropic and high blood pressure medications, and impaired mobility and cognition. Interventions included balance/functional range of motion (ROM) daily and keeping R4's bed at a level so R4 could sit on the edge of the bed at a 90-degree angle with her feet flat on the floor to allow for a safe transfer from bed. The care plan lacked interventions related to R4's fall while using the restroom unattended, R4 not activating her call light, and attempting to self-transfer. R57's quarterly Minimum Data Set (MDS) dated 10/5/22, indicated R57 had severe cognitive deficits. R57 required supervision of one staff for eating and extensive assistance of two staff for all other activities of daily living (ADLs). R57 had diagnoses that included insomnia, Alzheimer's and dementia with behavioral disturbances, Multiple Sclerosis (MS), memory loss, and obstructive sleep apnea (OSA-sleep-related breathing disorder causing the airway to become obstructed and occasional to frequent cessation of breathing). R57's Care Area Assessment (CAA) dated 4/22/22, indicated R57 triggered for cognitive loss/dementia, due to Alzheimer's and dementia, instructing a continuation of the item on R57's care plan. R57 triggered for communication secondary to being hard of hearing and instructing a continuation of the item on the care plan. R57 also triggered for mood state due to a history of depression, instructing a continuation of the item on the care plan. R57's care plan dated 10/25/22, indicated R57 was at risk for a communication deficit related to hearing loss, difficulty making himself understood	2 565		

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2 565	Continued From page 14 and understanding others and declining cognition. Interventions included notifying a provider with critical results as needed, MDS nursing observations as needed, completing a Brief Interview for Mental Status (BIMS) as needed, notifying family as needed, and completing a care conference summary as needed. The care plan lacked resident-centered interventions to assist, maintain, or improve R57's communication deficits. The care plan also indicated R57 was at risk for psychosocial well-being evidenced by withdrawal from activities, grief over loss of roles/status, daily routine very different from prior pattern in the community and having a strong identification with the past. Interventions included visiting with R57 about past agricultural business and discussing his memory book and pictures. R57's care plan further indicated R57 had a deficit related to activities due to a lack of interest. Interventions included daily activity review, an activity evaluation, MDS preferences to be reviewed as needed, and a spiritual assessment to be completed. The care plan lacked indications of R57's preferences for activities or an individualized plan to increase R57's involvement in activities. R57 had respiratory concerns related to OSA and using a CPAP. Interventions included putting the CPAP on every night and cleaning it weekly. No other interventions or instructions regarding the use of the CPAP machine were indicated. R57's care plan also indicated R57 was at risk for psychosocial wellbeing. Interventions included monitoring R57 for side effects related to the use of Seroquel; however, R57 was no longer taking the antipsychotic medication. The care plan lacked evidence R57 had been evaluated for dementia to develop a resident-centered plan to decrease R57's repetitive behaviors and lacked indication that R57 was taking Depakote (an anti-convulsant used also as an antipsychotic) or	2 565		

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2 565	Continued From page 15 interventions to monitor for side effects related to the medication. Review of the 3/23/22, Facility Wide Risk Assessment identified the facility provided person centered care. Staff were to find out the resident's likes and dislikes and what makes for a good day and incorporate that information into the care planning process and to to ensure staff had the information. Review of August 2020, Care Planning policy identified a person centered care plan would recognize what was important to the resident with regard to daily routines and activities, what supports the resident required, and having an understanding of the resident' life prior to residing in the nursing home. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures related to ensuring the care plan for each individual resident is followed. The director of nursing or designee could develop a system to educate staff and develop a monitoring system to ensure staff are providing care as directed by the written plan of care. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 565		
2 620	MN Rule 4658.0445 Subp. 4 A-N Clinical Record; Admission Information Subp. 4. Admission information. Identification information must be collected and maintained for each resident upon admission and must include, at a minimum:	2 620		12/8/22

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2 620	Continued From page 16 A. the resident's legal name and preferred name; B. previous address; C. social security number; D. gender; E. marital status; F. date and place of birth; G. date and hour of admission; H. advance directives, & Do Not Resuscitate (DNR) & Do Not Intubate (DNI) status, if any; I. name, address, and telephone number of designated relative or significant other, if any; J. name, address, and telephone number of person to be notified in an emergency; legal representative, designated representative, or representative payee, if any; K. legal representative, designated representative, or representative payee, if any; L. religious affiliation, place of worship, and clergy member; M. hospital preference; and N. name of attending physician. This MN Requirement is not met as evidenced by: Surveyor: 38687 Based on interview and document review, the facility failed to ensure the accuracy of 1 of 1 resident (R41) medical record when R41 had conflicting end of life (code status) documentation. Findings include: R41's current, undated "electronic medical record	2 620	The facility reviewed and updated the policy to correct the concerns identified in the survey process on 11/1/22 The team was trained on the new policy and the updates on 11/30/22, 12/6/22, 12/7/22, 12/8/22. An audit was completed on 10/28/22 of a 100% of the current resident charts for their POLST documents and that the information matched. Any discrepancies were corrected in the	

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	00343		C 10/28/2022

NAME OF PROVIDER OR SUPPLIER
AVERA MORNINGSIDE HEIGHTS CARE CENTE

STREET ADDRESS, CITY, STATE, ZIP CODE
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2 620	Continued From page 17 (EMR) identified R41 was marked as "full resuscitation" (wanting all lifesaving measures including cardio pulmonary resuscitation (CPR)). R41's October 2021, POLST (Physician Orders for Life Sustaining Treatment) form identified R41 wished to be a Do Not Resuscitate (DNR) with selective treatment of antibiotic use. Interview on 10/26/22 at 2:18 p.m., with the director of nursing (DON) identified she was unaware of the conflicting information of R41's code status. She stated "Full resuscitation may be the same as DNR with selective treatment. That could be just how they [staff] have to put that into the computer system". She was unsure if that would be considered conflicting information, but agreed both the POLST and EMR should match. She agreed R41 could potentially received CPR against his wishes in an emergent situation occurred. No policy relating to Advanced Directives was provided by the end of survey. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee should review policies and procedures for advanced directives, physician orders and/or a POLST to ensure records a re consistent and maintained accurate throughout the medical record upon admission, quarterly, and with any significant change such as the election of a hospice benefit. The DON should also ensure a process for inputting this changed data appropriately into the electronic medical record. Staff should be educated on the need to clarify discrepancies in advanced directives, POLST, and/or physician orders. The DON or designee should review the resident affected, and all other current residents	2 620	resident's charts to reflect the correct information The process changes are the following: The social worker is responsible for obtaining the POLST document upon admission or at the initial care conference. The POLST document will then be scanned into the resident's chart. The nursing supervisor will verify the code status and compare it to what is in the EMR system and update if necessary. The advance directive on the resident R41 was corrected to reflect the correct status in the EMR as the POLST 10/28/22 Audits: 100% of charts will be audited on admissions and readmissions. Audits will be completed monthly until 100% compliance is met. the frequency will be monthly x 3 months. then 20% of admissions and readmissions quarterly x3 quarters.	

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2 620	Continued From page 18 to ensure accuracy of code status and audit any newly admitted resident EMR. The results of those audits should go to the Quality Assurance Performance Improvement (QAPI) committee for a specific time until compliance is achieved and maintained to determine compliance or the need for further monitoring. TIME PERIOD FOR CORRECTION: Twenty One (21) days	2 620		
2 895	MN Rule 4658.0525 Subp. 2.B Rehab - Range of Motion Subp. 2. Range of motion. A supportive program that is directed toward prevention of deformities through positioning and range of motion must be implemented and maintained. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: B. a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and to prevent further decrease in range of motion. This MN Requirement is not met as evidenced by: Surveyor: 44658 Based on observation, interview, and document review, the facility failed to ensure 4 of 4 residents (R3, R5, R51, R56, and R57) recieved restorative range of motion (ROM) therapy to prevent potential decline in ROM and/or contractures.	2 895	The facility policy was reviewed and updated on 11/30/22. The staff were trained on the updated policy 11/30/22, 12/6/22, 12/7/22, 12/8/22 The nursing and therapy team met on 11/30/22 to review and determine which residents must have ROM exercises daily and updated their care plans, work lists	12/8/22

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2 895	Continued From page 19 Findings include: R3's 2/9/22 annual MDS identified she required extensive assist of 1 staff for ADL and had no impairment marked on the MDS to her upper or lower body, and used a walker or wheelchair for ambulation. R3's current, undated care plan identified R3 was admitted to the facility in July, 2017. R3's care plan identified problems noted for psychosocial well-being, was noted to require assistance of 2 staff with most Activities of Daily Living (ADL) status. There was no mention R3 had contractures of her left hand, not that she was to have worn a brace on her left hand to prevent further deterioration and contracture or required the splint to be refitted. Observation and interview on 10/24/22 at 7:10 p.m., with R3 identified she remarked she had a "frozen left ankle". She has rheumatoid arthritis (RA). The brace for her hand "doesnt fit... it squishes them together". She hadn't been refitted. She used to be an occupational therapist and was quite familiar with restorative therapy. She gets no ROM from staff. The facility cut thier restorative program and to her knowledge, they havent gotten anyone else and "apparently arent planning to". R3's fingers on her left hand were visibly contracted and her feet turned inward. Buried in the corner, under a piece of luggage were her orthotics. R5's 10/20/22, Significant Change Minimum Data Set (MDS) identified she had severely impaired cognition due to needed to be prompted to recall words, her inattention and ability to stay focused during the interview, and disorganized thinking.	2 895	and daily assignment sheets to reflect so. The activities department has added an exercise group which provides 8 opportunities a month for resident movement, that was started on 11/3/22 The following was done with the identified residents: R3 Residents care plan has been updated to include ROM exercised and use of her orthotics. R5 ROM exercises have been added to her care plan R56 training was completed on her orthotics and the care plan updated to reflect the ROM interventions and goals R51 care plan has been updated and interventions and goals placed for the ROM exercises. R51 Care plan has been reviewed and ROM goals and interventions placed. 11 additional residents have been identified to benefit from a program that includes ROM activities and their care plans have been updated. Audits: 100% observation audits 2 audits per week x4 ; 4 audits per month x 3 ; 4 audits per quarter.	

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2 895	Continued From page 20 R5 required extensive assistance from 1 staff for bed mobility, transfer, dressing, eating, toilet use and personal hygiene. R5 was marked no impairment to her upper and lower extremities. R5 received no restorative therapy from a restorative program. R5's current, undated care plan identified R5 was admitted to the facility in November 2021 and had diagnoses of cancer, high blood pressure, GERD, diabetes, high cholesterol. thyroid disorder, anxiety disorder. R5's care plan identified problems noted for bladder incontinence, communication and cognitive concerns, was a fall risk, was on hospice, was on a constant carb diabetic diet, chronic pain, psychosocial well-being/mood, activities, medication side effects, and skin integrity. R5 had no mention Interview on 10/25/22 at 2:54 p.m., with R5 identified she doesnt get any ROM therapy from staff. She would be at risk for ROM decline. R56's 4/20/22, Significant Change MDS identified she had intact cognition, and was marked completely independent with all ADL, despite being a paraplegic. There was no restorative therapy noted on the assessment. R56's current, undated care plan identified R56 was admitted to the facility in March 2021 and had diagnoses of heart failure, neurogenic bladder, high cholesterol, paraplegia, MS, anxiety, depression, pressure ulcer to her left buttock-Stage III, and dysphagia (difficulty swallowing). She had identified problems of ADL status, catheter use, ostomy care, communication and cognitive ability, fall risk, nutritional status, chronic pain, psychosocial well-being, activity involvement, skin integrity. R56 had little to no	2 895		

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2 895	Continued From page 21 specific person-centered goals or interventions identified on the care plan according to existing diagnoses or needs. Observation and interview on 10/25/22 at 9:42 a.m., with nurse aide (NA)-G immediately prior to R56's dressing change identified R56 was visibly severely contracted in upper and lower limbs due to her MS and paraplegia diagnoses. identified there are no specific staff for restorative any longer. That program was discontinued. All NAs were now responsible to do restorative ROM, but they "just dont have the time". When they are able to do ROM for residents, they are supposed to document in the electronic medical record when it's completed. No orthotics were identified having been applied. R56's Occupational Therapy (OT) progress notes identified on: 1) 8/11/22, OT put on R56's bilateral hand orthotics and educated the restorative aide (RA) on how to put them on. Staff left the orthotics on for 75 minutes and checked for redness/discomfort. The RA was educated and shown how to perform passive ROM (PROM) (staff are required to perform due to residents' inability to move extremities). 2) 8/12/22, OT performed the PROM and put on R56's orthotics to her hands. Nursing staff were educated on proper methods doe donning and doffing (on and off) of the orthotics. 3) 8/15/22, OT noted they had washed, dried and applied lotion to R56's left elbow crease as it was "showing white maceration [skin breakdown due to moisture] and had a foul odor due to being in a chronically flexed position". OT provided gentle PROM to her bilateral upper extremities due to "significant tightness/contractures noted". R56 had pain in her left (L) wrist when the OT	2 895		

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2 895	Continued From page 22 attempted to place her wrist in a neutral position. R56 had "significant wrist extension contracture which is currently unsupported". OT then adjusted her L elbow orthotic into a more flexed position to accommodate her current flexion contracture for better support. 4) 8/29/22, OT documented PROM was completed by OT to her upper body. R56 had facial grimacing during her should exercises specifically. R56's spouse was present with him reporting R56's right (R) ROM was "normal up until recently". OT noted contractures beginning at the R elbow. 5) 9/13/22, R56 reported she "doesn't go into her wheelchair much". R56 was in her bed in the supine (lying on back) position with her elbows in flexion and her left upper extremity supinated with contracture in her fingers. Communication was provided to nursing staff for potential of positioning side lying and in wheelchair to provide repositioning and stretching. R56's orthotics were placed in her lower drawer of her dresser "near her bed for ease, as they were observed by T to be in her recliner with Hoer lift and tangled." 6) 9/14/22, OT completed a pictorial program with written instruction for staff to increase ease of donning splints and preventing further contracture development. 7) 9/16/22, R56 reported staff ae stretching her arms, but cannot recall if it occurs daily. 8) 9/19/22, OT provided PROM and again educated staff on how to apply R56's orthotics for 30 minutes and check for redness and pain. 9) OT once more educated staff on completing PROM prior to donning her orthotics. 10) 10/14/22, OT noted R56 reported staff were not putting on her orthotics nor were they doing PROM and said it had not been completed "in a long time". 11) 10/17/22, R56 had facial grimacing while OT	2 895		

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2 895	Continued From page 23 provided PROM to her R shoulder. Ot once again stressed to staff the importance of providing PROM as she is completely dependent for all positioning and use of her extremities. There was no mention if OT's continued concerns were brought forth to management, or if management routinely audited OT notes for residents at risk to identify the lack of staff care with PROM. Interview on 10/26/22 at 1:50 p.m. identified R56 was once more observed without any orthotics applied and was lying in bed. R56 said she has them for her right elbow (she thinks) but was unsure if staff were applying them as ordered. R56 family member was also there and reported R56 rarely had her orthotics applied. Interview on 10/27/22 at 12:19 p.m., with the director of therapy (DT) identified R56 is receiving OT now and has been for a while. OT has been working with R56 to find the right hand splints for her. R56 was on physical therapy (PT) from July to August 2022, but has since competed PT. After it was brought to the administrator's attention about residents not receiving restorative therapy from staff, OT was and has been currently training staff right now on her upper extremities. R56 "can't move and really needs staff to do everything for her". OT works upper and PT normally worked her lower extremities. Her upper body is maintaining, but her lower extremities have not been getting restorative PROM therapy at all and "is likely declining". R56 was to be screened next month to see if she has had any decline. Interview on 10/28/22 at 8:48 a.m., with the administrator identified the facility's restorative program was "cut" due to budgetary cuts. Upper	2 895		

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2 895	Continued From page 24 management wanted staff NA's to do it, but she acknowledged they "don't have time". She agreed this had the potential for harm and was affecting resident care. Since becoming aware by surveyors during the survey process ROM was not being done, she was now going to have PT work with those residents who are affected and at risk for further decline. The administrator also agreed R56 and R3's orthotics were not being applied as ordered. R51's quarterly minimum data set (MDS) dated 9/28/22, indicated R51 had severe cognitive deficits and required extensive assistance of one staff for eating and extensive assistance of two staff for all other activities of daily living (ADLs). R51's diagnoses included constipation, disturbances of salivary secretion, anxiety, spinal stenosis, Parkinson's disease with dementia, and a fall resulting in a hip fracture. During an interview on 10/24/22, at 7:26 a.m. family member (FM)-F stated R51 was receiving restorative therapy prior to the program being canceled a few months prior. R51 was supposed to do ROM exercises but since the staff had not been assisting him, FM-F had been trying to do the exercises with him. During an interview on 10/27/22, at 12:18 p.m. physical therapist (PT)-B stated she recommended passive ROM (PROM) exercises for R51 to keep his legs stretched out so he could continue to transfer with the EZ stand (a device that assists residents to stand up during transfers and requires only one staff to operate) and not downgrade to a Hoyer lift (a device that lifts a resident lying in a sling, requiring no effort from the resident and two staff to operate). However,	2 895		

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2 895	Continued From page 25 PT-B also stated the nursing assistants (NAs) told her they did not have time to assist R51 with his PROM exercises. R51's PROM exercise log dated October 2022, indicated R51 received PROM exercises as follows: -10/3 -10/9 -10/10 -10/12 -10/17 -10/18 -10/22 -10/23 R51 did not receive PROM exercises for 15 out of 23 days. R57's quarterly MDS dated 10/5/22, indicated R57 had severe cognitive deficits and required supervision with assistance of staff for eating and extensive assistance of two staff for all other ADLs. R57's diagnoses included a pressure injury on his coccyx (tailbone), fall resulting in pain to his left shoulder and a head abrasion, dementia with behavioral disturbance, major depression, constipation, spastic paraplegia due to multiple sclerosis (MS), ambulatory dysfunction, MS, and gait abnormality. R57's care plan dated 10/25/22, indicated R57 required assistance with some or all ADLs. Interventions included R57 participating in a restorative therapy program 4-6 times per week. R57 was also at risk for falls due to a history of falls, impaired balance, mobility, and cognition. Interventions included balance/functional ROM as needed. R57's CAAs dated 4/22/22, indicated R57 triggered for ADL functional/rehabilitation	2 895		

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2 895	Continued From page 26 potential, falls, and pressure ulcers. R57's Restorative Nursing Program form dated 8/15/22, indicated PT-B recommended R57 complete or attempt knee extension stretches, hip adductor stretches, active leg kicks, and crunches while reaching, five days a week to maintain ROM of both his lower extremities for optimal positioning in his wheelchair. R57's Caregiver Education form dated 9/29/22, indicated PT-B recommended left arm PROM stretches in bed, wheelchair, or recliner to be completed daily. R57's Physical Therapy Discharge Summary dated 9/29/22, indicated R57 completed 2 out of 3 PT goals and had a follow-up maintenance program for upper extremity PROM. Discharge recommendations included daily PROM to left upper extremity. No documentation was provided to indicate R57 received any ROM/PROM exercises after his discharge from therapy services on 9/29/22. R57's Care Conference Summary dated 10/12/22, indicated R57 was no longer receiving therapy services but family was interested in R57 being on a maintenance program to be able to keep the abilities he had. During an interview on 10:25/22, at 11:22 a.m. FM-E stated because of R57's MS, he got "really stiff." He was getting therapy for 15 minutes a few times a week before it was discontinued last month. During an interview on 10/26/22, at 2:02 p.m. PT-B and occupational therapist (OT)-C stated	2 895		

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2 895	Continued From page 27 R57 was discharged from OT on 9/16/22, and from PT on 9/29/22 because his progress plateaued. The facility no longer had a restorative aid (RA), therefore, therapy printed range of motion (ROM) exercises for the nursing assistants (NAs) to complete with the residents; however, they did not believe the exercises were being done which caused residents' mobilities to decline and be referred back to therapy. PT-B stated residents weren't being walked and were struggling to participate in their surface-to-surface transfers. PT-B and OT-C stated it was a frustrating cycle. During an interview on 10/27/22, at 10:33 a.m. R57's FM-E stated she was unaware staff were supposed to continue providing ROM exercises for R57 after he had discharged from therapy. FM-E further stated staff had not been doing exercises with R57, but she would like them to so R57 could maintain his mobility as long as possible. During an interview on 10/27/22, at 1:49 p.m. NA-F stated therapy would send a form to the NAs with instructions for ROM exercises to be completed with the residents after they were discharged from therapy. NA-F stated R57 was supposed to have ROM exercises completed; however, NA-F did not know how often. NA-F also stated she did not do ROM exercises with R57 when she transferred him out of bed and assisted him with his cares that morning. During an interview on 1/27/22, at 1:57 p.m. licensed practical nurse (LPN)-B stated she would submit a referral to therapy if a resident's activities of daily living (ADLs) and/or strength declined. LPN-B stated since the RA program ended, she noticed an increase in the number of	2 895		

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2 895	Continued From page 28 residents whose mobility and strength were declining because the NAs often did not have time to complete the recommended ROM exercises with the residents. During an interview on 10/27/22, at 5:17 p.m. RN-F stated a form was sent to her and the NAs if a resident discharged from therapy services but would benefit from a maintenance exercise program. The staff should communicate during the morning huddle and verbal handoff report if a resident had a recommended exercise program. RN-F stated it had been tough to maintain resident abilities since the RA program ended. RN-F stated when a resident declined in ADLs and transfers, they may end up requiring a two staff assist instead of one which would increase the NAs' workload and decrease resident independence. A resident would then be referred back to therapy and the cycle would continue. During an interview on 10/27/22, at 11:59 a.m. the director of therapy (DT) stated most residents were put on a restorative program after discharge from therapy to maintain their function; however, since the facility no longer had an RA, the NAs were supposed to complete ROM exercises with the residents. The DT stated a written recommendation for an exercise plan was sent to registered nurse (RN)-F who may add it to a resident's care plan, and another copy to the resident's unit for the NAs to review. Therapy would also screen the residents three months after discharge from therapy services to assess their progress. DT stated the failure to complete maintenance exercises resulted in residents being referred back to therapy due to a decline in their mobility and strength. R57 had been on and off therapy a few times since he had admitted to the facility in February 2022 and was discharged	2 895		

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	00343		C 10/28/2022

NAME OF PROVIDER OR SUPPLIER: AVERA MORNINGSIDE HEIGHTS CARE CENTE

STREET ADDRESS, CITY, STATE, ZIP CODE: 300 SOUTH BRUCE STREET MARSHALL, MN 56258

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2 895	Continued From page 29 from therapy last month after plateauing. A recommendation for ROM exercises was sent to RN-F and the NAs so R57 could continue to maintain his mobility. During an interview on 10/27/22, at 3:17 p.m. the director of nursing (DON) stated it had been a challenge since the RA program ended in July and there were areas of improvement needed regarding the resident exercise program. The DON further stated the facility had a goal to include exercises as a resident activity; however, that had not been implemented. There was no policy specific to providing ROM supplied by the end of the survey. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review all residents at risk for limited range of motion to assure they are receiving the necessary treatment/services to prevent further limitation in range of motion. The director of nursing or designee, could conduct random audits of the delivery of care to ensure appropriate care and services are implemented. The results of the audits could be brought to the quality assurance committee for review. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 895		
2 910	MN Rule 4658.0525 Subp. 5 A.B Rehab - Incontinence Subp. 5. Incontinence. A nursing home must have a continuous program of bowel and bladder management to reduce incontinence and the unnecessary use of catheters. Based on the	2 910		12/8/22

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2 910	Continued From page 30 comprehensive resident assessment, a nursing home must ensure that: A. a resident who enters a nursing home without an indwelling catheter is not catheterized unless the resident's clinical condition indicates that catheterization was necessary; and B. a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This MN Requirement is not met as evidenced by: Surveyor: 38687 Based on observation, interview, and document review, the facility failed to intervene for 1 of 1 resident (R51) with a strict bowel regimen and ensure catheter leg straps were used to prevent pain, discomfort, or potential infection or injury to 1 of 1 resident (R56). Findings include: BLADDER R56's 4/20/22, Significant Change MDS identified she had intact cognition, and was marked completely independent with all ADL despite being a paraplegic. There was no restorative therapy noted on the assessment. R56's current, undated care plan identified R56 was admitted to the facility in March 2021 and had diagnoses of heart failure, neurogenic bladder, high cholesterol, paraplegia, MS, anxiety, and depression. She had identified problems of ADL status, catheter use,	2 910	The facility reviewed the policy on Urinary Incontinence Prevention /Management program and indwelling foley catheter management as well as Bowel Management LTC on 12/1/22. The staff were trained on both policies on 11/30/22, 12/6/22, 12/7/22, 12/8/22. The Resident care plans for both (R56) and (R51) were updated to reflect the needs to be addressed and what needs to be done. An audit of 100% of the current residents who have catheters was conducted to make sure the care plans were updated, and the correct equipment being used. Audits: 100% observation audits 2 observations of residents with catheters per week x 4; 4 observations per month x 3 ; 4 observations quarterly.	

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2 910	Continued From page 31 communication and cognitive ability, and had chronic pain. R56 was noted to have a suprapubic (tube placed in opening into bladder through stomach) catheter with interventions to clean and change the catheter bag monthly. The care plan also had a discrepancy and noted R56 was to have her Foley (tube inserted into urethra, then into the bladder) flushed twice per day. Staff were to place a pad under R56 if it leaked. There was also a notation to "cath secure change" however, there was no indication what that meant or how staff was to ensure her catheter remained secured to her leg. Observation and interview on 10/26/22 at 1:50 p.m., with R56 identified she was visibly grimacing and complained of having some "discomfort" today. R56's family member was present but went into the hall to find staff. R56 declined further interview. Interview on 10/26/22 at 1:54 p.m., with trained medication aide (TMA)-A identified R56 was upset because her catheter may have "fallen out" and staff were waiting on the nurse to assess her. R56 had a Foley catheter and was paralyzed and unable to move her lower body. Interview on 10/26/22 at 1:58 p.m., with licensed practical nurse (LPN)-B identified she was the only nurse on the floor that day. She was unaware R56's catheter had potentially "come out". LPN-B noted she would check on R56 right away. Further interview on 10/26/22 at 2:38 p.m., with TMA-A identified R56 was assessed by LPN-B. R56's catheter had not "come out" but was "just leaking". Further interview on 10/26/22 at 2:50 p.m., with	2 910		

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2 910	Continued From page 32 LPN-B identified R56's catheter had not come out, but it was being pulled on via gravity, and that was causing her pain. Staff often failed to place a secure leg strap on all residents who had catheters. Using a leg strap to secure the catheter would offload the pressure caused by the bag being hung on the bed and getting heavy with captured urine. "This has been an ongoing issue". The facility was "trying to teach staff to make sure they provided appropriate cares, but in her opinion, it was unsuccessful. She has brought this up to management. All nurse aides (NAs) and nurses should know a Foley catheter was to be secured by a leg strap. LPN-B was unsure if this was care planned and staff educated to R56's care plan. "They should be looking at the electronic (EMR) care plan". R56's 6/24/22, NA care plan, made no mention R56 had a catheter. Interview on 10/26/22 at 4:06 p.m., with the infection preventionist (IP) identified she started mid November 2021. The IP was unaware of complications from R56 not having a leg strap on her catheter to secure it. The IP stated catheter infections were "always high" at the facility. The IP agreed staff failing to use appropriate catheter leg straps for residents led to tubes inadvertently slipping out and increased the rate of urinary tract infections (UTI). Interview on 10/28/22 at 11:19 a.m., with the administrator identified she agreed there was no clear direction on catheter care or ensuring R56 or other residents with catheters had notations to ensure catheters were secured properly. Care plans were a common issue with the software the facility used, and not able to be modified easily.	2 910		

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2 910	Continued From page 33 Review of the April 2022 Long Term Care Cleaning/Care of Catheter Bags policy identified staff were to keep the bag below the level of the bladder, monitor tubing for kinks. There was no mention in the policy staff should secure the catheter tubing with a leg strap to avoid complications such as pain or infection. BOWEL REGIMEN R51's quarterly Minimum Data Set (MDS) dated 9/28/22, indicated R51 had severe cognitive deficits and was unable to complete the Brief Interview for Mental Status (BIMS) assessment. R51 required extensive assistance of one staff for eating and extensive assistance of two staff for all other activities of daily living (ADLs). R51's MDS Section H-Bladder and Bowel, lacked indication R51 had incidents of constipation. R51's diagnoses included constipation, disturbances of salivary secretion, anxiety, spinal stenosis, Parkinson's disease with dementia, and a fall resulting in a hip fracture. R51's Care Area Assessment (CAA) dated 4/14/22, indicated R51 triggered for delirium and cognitive loss/dementia with risks including decreased cognition resulting in increased behaviors and an inability to make his needs known. R51's CAA did not indicate R51 had concerns regarding constipation or bowel incontinence. R51's care plan dated 10/25/22, indicated R51 had bowel and bladder incontinence. Interventions included recording R51's output every six hours. R57 also had concerns related to medication side effects that included constipation and fecal impaction.	2 910		

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2 910	Continued From page 34 R51's physician orders dated 10/25/22, indicated R51 received bisacodyl 10 milligrams (mg) rectal suppository daily as needed for constipation, polyethylene glycol 3350 (Miralax) 8.5 grams every other day and Senna 8.6 mg (a stool softener) twice daily. Review of the facility Admission/Standing Orders dated 6/22, indicated polyethylene glycol 3350 17 mg orally as needed for constipation; Milk of Magnesium (MOM) 30 milliliters (ml) orally as needed for constipation if polyethylene glycol 3350 was not effective within 6 hours times one dose.; bisacodyl suppository (rectal) 10 mg could be given as needed daily for constipation if polyethylene glycol 3350 and Milk of Magnesia were not effective times one dose. If not effective, notify provider. R51's bowel continence log dated 9/1/22, to 10/27/22, indicated R51 went three or more days without a bowel movement from: -9/1/22, at 2:00 a.m. to 9/4/22, 8:00 a.m. -9/4/22, at 8:00 a.m. to 9/8/22, at 3:13 p.m. -9/12/22, at 8:00 a.m. to 9/16/22, at 6:04 a.m. -9/24/22, at 10:28 p.m. to 9/28/22, at 10:17 p.m. -9/30/22, at 2:57 p.m. to 10/4/22, at 10:01 p.m. -10/6/22, at 8:00 p.m. to 10/10/22, at 8:00 a.m. -10/10/22, at 8:00 a.m. to 10/13/22, at 8:00 a.m. -10/15/22, at 3:08 p.m. to 10/19/22, at 2:50 p.m. -10/19/22, at 2:50 p.m. to 10/23/22, at 8:00 p.m. -10/24/22, at 8:00 p.m. to at least 10/27/22, at 2:48 p.m. R51's medication administration record (MAR) dated 9/1/22, thru 10/27/22, indicated R57 received a 10 milligram (mg) of bisacodyl (a suppository) on: -10/4/22 at 3:12 p.m. -10/13/22, at 7:25 a.m.	2 910		

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2 910	Continued From page 35 -10/19/22, at 7:13 a.m. During an interview on 10/24/22, at 7:18 p.m. family member (FM)-F stated staff were to be monitoring R51's bowel movements daily. FM-F stated R51 should have been given a suppository on the morning of the third day of him not having a BM. However, because it was an "as needed" medication, the trained medical assistants (TMAs) would forget to tell the nurse and R51 wouldn't get the suppository when he should. FM-F stated R51 went four days without a BM last week and she had to tell the nursing staff to give him a suppository which made FM-F "so mad" because it increased R51's pain and wears him out for the whole day. During an observation on 10/26/22, from 7:26 a.m. R51 was overheard in his room, moaning, and saying "hello?" multiple times. During an interview on 10/27/22, at 2:08 p.m. licensed practical nurse (LPN)-B stated she had repeatedly informed staff to monitor R51's BMs and if he hadn't had one for two days, to give him prune juice or "something" to help him move his bowels. LPN-B stated the facility Standing House Orders (SHO) indicated a suppository should be given on the morning of the third day a resident had not had a BM. LPN-B stated R51 should have received a suppository the previous morning but did not get one until that day. LPN-B further stated R51 would get worn out and moan a lot if staff waited until the fourth day to give the suppository. During an interview on 10/27/22, at 2:55 p.m. the director of nursing (DON) stated resident BMs should have been monitored daily and residents who had not had a BM for two days should be	2 910		

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2 910	Continued From page 36 given a suppository on the morning of the third day to avoid obstruction, impaction, and pain. The DON further stated when R51 didn't get a suppository until the fourth day of not moving his bowels, he would have increased behaviors and fatigue. A facility policy on the treatment of constipation and bowel movement monitoring was requested but not received. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review all physician orders for residents with catheters and/or specific bowel treatments to ensure cares are performed as ordered. The director of nursing or designee, could conduct routine audits to ensure appropriate care and services were implemented as ordered. The results of those audits should be taken to the QAPI committee for a determined amount of time to ensure compliance or the need for further monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	2 910		
21095	MN Rule 4658.0650 Subp. 4 Food Supplies; Storage of Nonperishable food Subp. 4. Storage of nonperishable food. Containers of nonperishable food must be stored a minimum of six inches above the floor in a manner that protects the food from splash and other contamination, and that permits easy cleaning of the storage area. Containers may be stored on equipment such as dollies, racks, or pallets, provided the equipment is easily movable and constructed to allow for easy cleaning. Nonperishable food and containers of	21095		12/8/22

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21095	Continued From page 37 nonperishable food must not be stored under exposed or unprotected sewer lines or similar sources of potential contamination. The storage of nonperishable food in toilet rooms or vestibules is prohibited. This MN Requirement is not met as evidenced by: Surveyor: 44658 Based on observation, interview, and document review the facility failed to ensure potentially hazardous food was cooled properly in the refrigerator after being cooked and failed to ensure food was properly labeled and dated after being removed from their original packaging. These deficient practices had the potential to affect all 68 residents who ate from the main kitchen. During the initial kitchen observation and interviews on 10/24/22, from 2:15 p.m. to 5:30 p.m. with the dietary director (DD), the following was observed: Main kitchen dry storage: -Dry, white rice in a large plastic bucket approximately 1/6th full, with no expiration date or fill date -Dry, wild rice in a large plastic bucket, full, with no expiration date or fill date -Multiple large cans of food approximately 6 pounds (lbs) 11 ounces (oz) including but not limited to pineapple tidbits, various tomatoes (diced, sliced), ketchup, and spaghetti sauce were removed from their original shipping box and stored on the shelf without an expiration date.	21095	The facility reviewed the Cooling of Potentially Hazardous Foods policy and process on 11/30/22. Trained the dietary cooks on the policy updates on 12/1/22,12/2/22 and 12/6/22. The facility reviewed and updated the LTC Food Safety & Sanitation policy and process on 11/30/22. The staff have been trained on the updated policy and process on 12/6/22. New hire training module was created for the updated policies. Additional fan on the cart was removed on 10/25/22. The fan above the pots and pans sink was removed on 12/6/22. Audits were completed of the food storage locations in the main kitchen and the four kitchen areas in the long term care units to check for expiration dates on food items were correctly labeled with the month/date/year completed on 12/7/22. Audit: 100% observations 2 observations per unit per week x 3; 4 observations per month; 4 observations per quarter.	

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21095	Continued From page 38 -Chocolate sheet cake on cart covered with plastic wrap, expiration labeled "X 31" (no month). -An opened and used apple juice box (46 fluid oz) expiration labeled "X 30" (no month). Main kitchen refrigerator: -A tray of wrapped, half-sandwiches on a shelf contained: two egg salad, six turkey, and six ham sandwiches all labeled with an expiration of "X 29" (no month). -Three, uncovered trays of two-dozen, pasteurized eggs, lacked an expiration date. -Three, uncovered metal containers filled with frozen veggies, on a cart, lacked a label indicating when they were opened or intended to be used by. Main kitchen freezer: -A clear, plastic bag containing approximately a dozen, frozen, red meat patties unlabeled with no expiration date. -Unknown, frozen, breaded food item in metal container with no lid, label, or expiration date. During an interview at approximately 3:00 p.m. the Cook (CK)-B stated the uncovered, breaded food item in a small metal container was frozen shrimp she had just put in there to defrost for the evening meal. CK-B asked this surveyor if they should be covered. CK-B also stated she assumed the meat patties were placed in the freezer that day but was not sure. Main kitchen cooler: -Five large turkey breasts, wrapped in foil then cut entirely lengthwise, exposing the meat, were	21095		

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21095	Continued From page 39 on a cart in the back of the freezer, directly under the fan. Large, plastic ice packs had been folded in half and stuffed inside each turkey breast. During an observation and interview on 10/24/22, at 4:20 p.m. registered dietician (RD)-B temp'd the turkey breasts as follows: 75 degrees Fahrenheit 90 degrees Fahrenheit 80 degrees Fahrenheit 82 degrees Fahrenheit 80 degrees Fahrenheit During an interview on 10/24/22, at 4:35 p.m. CK-B stated she cooked the turkey breasts to 168 degrees Fahrenheit that afternoon, then put them in the cooler at 1:00 p.m. They would be sliced the next day, then served the day after that. CK-B stated the ice packs were placed in the turkey breasts to speed the cooling process. CK-B further stated although the ServSafe food handler certification course she completed, advised cooling meat in cold water, CK-B found that unappetizing and refused to do it. Main kitchen: -Two large metal carts (approximately 18" wide by 24" deep by 30" high) on wheels were stored under an industrial sink. One contained, and was labeled "sugar," (white) the other contained, and was labeled "flour" (white). The carts lacked and expiration date or when they were last filled. -Multiple bulbs of garlic in an open plastic tub dated 6/3. Some of the bulbs were soft and/or a dark brown in color. During an interview at approximately 3:50 p.m. the DD stated she did not know how long garlic was good for and that she would probably toss	21095		

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21095	Continued From page 40 them. The DD further stated there was no specific length of time for how long they would keep garlic. Main Kitchen Dish Washing area: -An industrial carpet and floor dryer/fan was placed on a cart between where the dirty pots and pans were cleaned in three metal sinks and where they were placed on shelves to dry after being sanitized. The fan was covered in dust and dirt and blowing air onto the clean pots and pans from approximately five feet away. Another wall mounted fan was in the ceiling corner above the dirty pots and pans area, also blowing in the direction of the clean drying racks. During an interview on 10/24/22, at approximately 5:30 p.m. dietary aid (DA)-A stated they used the industrial fan on the cart to help dry the clean pots and pans faster. The corner ceiling fan also helped dry the pots and pans as well as keep the staff cool. During an observation and interview on 10/24/22, at 5:05 p.m. in the first-floor kitchenette refrigerator, two open and uncovered trays containing 27 pasteurized eggs lacked a label to indicated when they were opened or when they would expire. DA-B stated she did not know when the eggs were put into the refrigerator or when they would expire. During an interview on 10/25/22, at 9:35 a.m. dietary director (DD) stated the cans of food should have been labeled with an expiration date after they were removed from their original shipping boxes. The DD also stated staff should be writing expiration dates with the month and day they expire to avoid confusion and serving	21095		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	00343		C 10/28/2022

NAME OF PROVIDER OR SUPPLIER: AVERA MORNINGSIDE HEIGHTS CARE CENTE

STREET ADDRESS, CITY, STATE, ZIP CODE: 300 SOUTH BRUCE STREET MARSHALL, MN 56258

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21095	Continued From page 41 expired food to residents. Cooked meat should be cooled according to the guidelines to lessen the possibility of bacterial growth and to ensure the residents don't get sick. The DD stated the sugar and flour in the metal carts were good for approximately eight to nine months and the carts would be washed prior to refilling them; however, there was no documentation to indicate when the sugar or flour was put into the carts and, therefore, the DD did not know when they would expire. The DD further stated fans blowing from a dirty area to a clean area would be a concern for cross contamination. The facility referenced the "Food Storage Guide. Answer the Question ...How long can I store before its quality deteriorates or it's no longer safe to eat?" article by Julie Garden-Robinson. NDSU Extension Service; dated February 2012 as the facility policy on food storage. The article indicated white flour was to be stored in an airtight container in the refrigerator for 6-8 months. Shell eggs were to be stored covered for 3 weeks. The facility Chill Down Log undated, indicated if the initial food temperature was greater than 140 degrees Fahrenheit, check the food frequently until the food reaches 140 degrees Fahrenheit or less. After 2 hours of cooling, if the food temp is 41 degrees Fahrenheit or less, the cooling process was complete. If the food temp was between 42-70 degrees Fahrenheit, continue to cool the food and re-check the temperature after an additional 2 hours. However, if the food temperature is above 70 degrees Fahrenheit, the food must be discarded or properly reheated to 165 degrees Fahrenheit for 15 seconds then begin the cooling process again.	21095		

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21095	Continued From page 42 No other facility policy on food storage or labeling was provided. SUGGESTED METHOD OF CORRECTION: The dietary manager (DM) and registered dietician (RD) could re-educate dietary staff on the policies and procedures related to labeling and storage of foods. The DM could conduct random audits to ensure compliance and the RD should oversee the completion of those audits. The DM or RD should bring the results of those audit results to the Quality Assurance Performance Improvement (QAPI) committee for review. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21095		
21100	MN Rule 4658.0650 Subp. 5 Food Supplies; Storage of Perishable food Subp. 5. Storage of perishable food. All perishable food must be stored off the floor on washable, corrosion-resistant shelving under sanitary conditions, and at temperatures which will protect against spoilage. This MN Requirement is not met as evidenced by: Surveyor: 44658 Based on observation, interview, and document review the facility failed to ensure potentially hazardous food was cooled properly in the refrigerator after being cooked and failed to ensure food was properly labeled and dated after being removed from their original packaging. These deficient practices had the potential to affect all 68 residents who ate from the main	21100	The facility reviewed and updated the LTC Food Safety & Sanitation policy and process on 11/30/22. The staff have been trained on the updated policy and process on 12/6/22. New hire training module was created for the updated policies. Additional fan on the cart was removed on 10/25/22. The fan above the pots and pans sink was	12/8/22

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21100	Continued From page 43 kitchen. During the initial kitchen observation and interviews on 10/24/22, from 2:15 p.m. to 5:30 p.m. with the dietary director (DD), the following was observed: Main kitchen dry storage: -Dry, white rice in a large plastic bucket approximately 1/6th full, with no expiration date or fill date -Dry, wild rice in a large plastic bucket, full, with no expiration date or fill date -Multiple large cans of food approximately 6 pounds (lbs) 11 ounces (oz) including but not limited to pineapple tidbits, various tomatoes (diced, sliced), ketchup, and spaghetti sauce were removed from their original shipping box and stored on the shelf without an expiration date. -Chocolate sheet cake on cart covered with plastic wrap, expiration labeled "X 31" (no month). -An opened and used apple juice box (46 fluid oz) expiration labeled "X 30" (no month). Main kitchen refrigerator: -A tray of wrapped, half-sandwiches on a shelf contained: two egg salad, six turkey, and six ham sandwiches all labeled with an expiration of "X 29" (no month). -Three, uncovered trays of two-dozen, pasteurized eggs, lacked an expiration date. -Three, uncovered metal containers filled with frozen veggies, on a cart, lacked a label indicating when they were opened or intended to be used by.	21100	removed on 12/6/22. Audits were completed of the food storage locations in the main kitchen and the four kitchen areas in the long term care units to check for expiration dates on food items were correctly labeled with the month/date/year completed on 12/7/22. Audit: 100% observations 2 observations per unit per week x 3; 4 observations per month; 4 observations per quarter.	

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21100	Continued From page 44 Main kitchen freezer: -A clear, plastic bag containing approximately a dozen, frozen, red meat patties unlabeled with no expiration date. -Unknown, frozen, breaded food item in metal container with no lid, label, or expiration date. During an interview at approximately 3:00 p.m. the Cook (CK)-B stated the uncovered, breaded food item in a small metal container was frozen shrimp she had just put in there to defrost for the evening meal. CK-B asked this surveyor if they should be covered. CK-B also stated she assumed the meat patties were placed in the freezer that day but was not sure. Main kitchen cooler: -Five large turkey breasts, wrapped in foil then cut entirely lengthwise, exposing the meat, were on a cart in the back of the freezer, directly under the fan. Large, plastic ice packs had been folded in half and stuffed inside each turkey breast. During an observation and interview on 10/24/22, at 4:20 p.m. registered dietician (RD)-B temp'd the turkey breasts as follows: 75 degrees Fahrenheit 90 degrees Fahrenheit 80 degrees Fahrenheit 82 degrees Fahrenheit 80 degrees Fahrenheit During an interview on 10/24/22, at 4:35 p.m. CK-B stated she cooked the turkey breasts to 168 degrees Fahrenheit that afternoon, then put them in the cooler at 1:00 p.m. They would be sliced the next day, then served the day after that. CK-B stated the ice packs were placed in the turkey	21100		

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21100	Continued From page 45 breasts to speed the cooling process. CK-B further stated although the ServSafe food handler certification course she completed, advised cooling meat in cold water, CK-B found that unappetizing and refused to do it. Main kitchen: -Two large metal carts (approximately 18" wide by 24" deep by 30" high) on wheels were stored under an industrial sink. One contained, and was labeled "sugar," (white) the other contained, and was labeled "flour" (white). The carts lacked and expiration date or when they were last filled. -Multiple bulbs of garlic in an open plastic tub dated 6/3. Some of the bulbs were soft and/or a dark brown in color. During an interview at approximately 3:50 p.m. the DD stated she did not know how long garlic was good for and that she would probably toss them. The DD further stated there was no specific length of time for how long they would keep garlic. Main Kitchen Dish Washing area: -An industrial carpet and floor dryer/fan was placed on a cart between where the dirty pots and pans were cleaned in three metal sinks and where they were placed on shelves to dry after being sanitized. The fan was covered in dust and dirt and blowing air onto the clean pots and pans from approximately five feet away. Another wall mounted fan was in the ceiling corner above the dirty pots and pans area, also blowing in the direction of the clean drying racks. During an interview on 10/24/22, at approximately 5:30 p.m. dietary aid (DA)-A stated they used the	21100		

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21100	Continued From page 46 industrial fan on the cart to help dry the clean pots and pans faster. The corner ceiling fan also helped dry the pots and pans as well as keep the staff cool. During an observation and interview on 10/24/22, at 5:05 p.m. in the first-floor kitchenette refrigerator, two open and uncovered trays containing 27 pasteurized eggs lacked a label to indicated when they were opened or when they would expire. DA-B stated she did not know when the eggs were put into the refrigerator or when they would expire. During an interview on 10/25/22, at 9:35 a.m. dietary director (DD) stated the cans of food should have been labeled with an expiration date after they were removed from their original shipping boxes. The DD also stated staff should be writing expiration dates with the month and day they expire to avoid confusion and serving expired food to residents. Cooked meat should be cooled according to the guidelines to lessen the possibility of bacterial growth and to ensure the residents don't get sick. The DD stated the sugar and flour in the metal carts were good for approximately eight to nine months and the carts would be washed prior to refilling them; however, there was no documentation to indicate when the sugar or flour was put into the carts and, therefore, the DD did not know when they would expire. The DD further stated fans blowing from a dirty area to a clean area would be a concern for cross contamination. The facility referenced the "Food Storage Guide. Answer the Question ...How long can I store before its quality deteriorates or it's no longer safe to eat?" article by Julie Garden-Robinson. NDSU Extension Service; dated February 2012 as the	21100		

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21100	Continued From page 47 facility policy on food storage. The article indicated white flour was to be stored in an airtight container in the refrigerator for 6-8 months. Shell eggs were to be stored covered for 3 weeks. The facility Chill Down Log undated, indicated if the initial food temperature was greater than 140 degrees Fahrenheit, check the food frequently until the food reaches 140 degrees Fahrenheit or less. After 2 hours of cooling, if the food temp is 41 degrees Fahrenheit or less, the cooling process was complete. If the food temp was between 42-70 degrees Fahrenheit, continue to cool the food and re-check the temperature after an additional 2 hours. However, if the food temperature is above 70 degrees Fahrenheit, the food must be discarded or properly reheated to 165 degrees Fahrenheit for 15 seconds then begin the cooling process again. No other facility policy on food storage or labeling was provided. SUGGESTED METHOD OF CORRECTION: The dietary manager (DM) and registered dietician (RD) could re-educate dietary staff on the policies and procedures related to labeling and storage of foods. The DM could conduct random audits to ensure compliance and the RD should oversee the completion of those audits. The DM or RD should bring the results of those audit results to the Quality Assurance Performance Improvement (QAPI) committee for review. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21100		

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21375	Continued From page 48	21375		
21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment. This MN Requirement is not met as evidenced by: Surveyor: 38687 Based on observation, interview, and document review, the facility failed to: 1) Ensure 1 of 1 resident (R33) was placed into transmission based precautions (TBP)and tested immediately after showing symptoms of COVID. This had the potential to affect 1 other resident (R8) who shared a table with R33 at each meal. 2) Ensure appropriate hand hygiene was maintained during 1 of 1 IV antibiotic administration. 3) Appropriately clean all 6 of 6 whirlpool tubs and appropriately launder and transport and store linen on the Meadows and Garden wings located on the 1st floor. 4) Implement appropriate infection control (IC) technique during 1 of 1 dressing change for R56. 5) Maintain 1 of 1 resident (R27) nebulizer machine in a sanitary manner. Findings include: Transmission Based Precautions and Testing of COVID Symptomatic Residents R33's annual Minimum Data Set (MDS) dated 9/7/22, indicated R33 had intact cognition, was independent with eating, required extensive	21375	The facility policy on Transmission Based Precautions was reviewed on 12/1/22. The facility policy of hand hygiene was reviewed on 12/1/22. The facility policy on equipment cleaning in LTC was reviewed and updated on 12/2/22. The facility policy on infection control standard of precautions on 12/2/22. The facility policy and process on Laundry in LTC was reviewed and updated on 12/1/22. Training with staff on all infection prevention items was completed on 12-4-2022 and 12-8-2022. Training was also added to the new hire training materials. Processes developed per manufacturer infection for use on whirlpools that are in use. One whirlpool was taken out of service. New process developed for storage of linen including ted hose. Along with new process and new policy implemented for laundry process to ensure cross contamination does not occur. Audits: COVID - 100% observations 2 observations per unit per week x 4' 8	12/8/22

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21375	Continued From page 49 assistance of one staff for bed mobility and limited assistance with all other activities of daily living (ADLs). R33's diagnoses included prostate cancer, coronary artery disease, high blood pressure, and kidney disease. R33's Care Area Assessment (CAA) dated 9/7/22, indicated R33 triggered for communication, ADL function, falls, and pressure ulcers. R33's care plan dated 9/1/22, indicated R33 was at risk for communication related to new onset of cognitive losses resulting in poor recall and safety awareness. R33's progress note dated 10/26/22, at 7:59 a.m. indicated R33 had been having a cough and nasal congestion since receiving his immunizations six days prior. R33 stated he felt fine except for the infrequent cough he had. R33's SARS-CoV-2 (PCR) test dated 10/26/22, at 9:15 a.m. indicated R33 was positive for COVID-19. During an observation on 10/26/22, at 7:54 a.m. from approximately 40 feet down the hallway, outside the resident dining room, licensed practical nurse (LPN)-B was overheard asking R33 if his cough had improved since the previous day. R33 stated it was a "bad head cold" he couldn't get rid of and felt worse. LPN-B took R33's blood pressure, temperature and oxygen level and reported them as "fine", telling R33 she would inform the provider. R33 then self-propelled his wheelchair into the resident dining room, without a mask, where other residents were seated for breakfast. During an interview on 10/26/22, at 11:20 a.m.	21375	observations per month x3; 8 observations quarterly Hand Hygiene- 100% observations 30 observations per month Tub Cleaning - 2 observations per unit per week x 4; 8 observations per month x 3; 8 observations quarterly. Laundry - 2 observations per unit per week x 4; 8 observations per month x 3; 8 observations quarterly.	

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21375	Continued From page 50 LPN-B stated she tested R33 for COVID-19 at 8:45 a.m. using a rapid antigen test that indicated R33 was positive for COVID-19. Thirty minutes later, LPN-B tested R33 for COVID-19 using a polymerase chain reaction (PCR) test which also indicated R33 was positive. LPN-B stated R33 received a COVID-19 booster and influenza vaccine on 10/20/22. On 10/22/22, R33 began having diarrhea, however, R33 had a history of diarrhea and therefore the staff did not believe it was a concern. On 10/24/22, R33 began having nasal congestion but he believed it was a result of being outside that day. On 10/25/22, LPN-B stated R33 developed a cough, and she should have quarantined him on transmission-based precautions (TBP) and tested him for COVID-19 at that time but did not. LPN-B stated she also failed to notify the provider of R33's new onset of symptoms until today, 10/26/22. LPN-B further stated she should have redirected R33 to his room, placed him on TBP, and tested him for COVID-19 instead of allowing him to eat breakfast with other residents in the dining room that morning. The facility COVID-19 Outbreak Guidelines policy dated 10/2022, indicated the facility should have a plan in place to identify a COVID-19 outbreak, and the process to prevent further transmission. A single new case of COVID-19 in any resident should be evaluated to determine if others in the facility could have been exposed. No further documentation was provided regarding the facility process for identifying and responding to a resident with a new onset of COVID-19 symptoms. IV Antibiotic Therapy	21375		

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21375	Continued From page 51 R64's quarterly Minimum Data Set (MDS) dated 10/12/22, indicated R64 had mild cognitive deficits, required supervision for eating and extensive assistance for all other activities of daily living (ADLs). R64 had diagnoses that included hypothyroidism (low functioning thyroid), heart failure, chronic obstructive pulmonary disease (COPD), Alzheimer's and dementia, malnutrition, a chronic non-pressure ulcer of the foot, and osteomyelitis of the foot (a bone infection). During an interview on 10/25/22, at 10:38 a.m. R64 stated she was receiving an antibiotic (Ceftriaxone 2 grams in 50 milliliters normal saline) intravenously (IV) for an infection in her foot that went into the bone. During an observation an interview on 10/26/22, at 8:28 a.m. licensed practical nurse (LPN)-A was observed attaching an intravenous (IV) antibiotic medication to an IV line in R64's right arm without wearing gloves. The medication pump alarmed with an error and LPN-A attempted to troubleshoot the occlusion by touching the pump machine, tubing and R64's arm and clothing without first performing hand hygiene. LPN-A stated she should have worn gloves to administer the IV medication, removed them, then performed hand hygiene prior to touching anything else to avoid cross contamination. During an observation and interview on 10/26/22, at 7:15 a.m. multiple pairs of compression socks were observed hanging over hallway handrails in front of rooms 123, 128, 134, 137, and 138. Nursing assistant (NA)-Carla was then observed walking out of a resident room, approximately 50 feet down the hallway, holding dirty bed linen against her uniform, and without wearing gloves. NA- disposed of the dirty linen in a laundry bin	21375		

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21375	Continued From page 52 and walked back towards the resident room without performing hand hygiene. NA- stated because there was only "one dirty spot" on the sheets, she didn't think contamination would be a concern. NA- further stated the overnight staff would hang the socks on the handrails to dry because there was not a "good" place to hang them in the resident rooms and there was more "air flow" in the hallways. WHIRLPOOL TUB CLEANING Observation and interview on 10/26/22 at 3:50 p.m., with bath aide (BA)-F identified BA-F was beginning her cleaning and disinfecting of the whirlpool tub. BA-F had scrubs on and applied no personal protective equipment (PPE) (gloves, gown and goggles) prior to beginning the process. The tub was an Apollo whirlpool tub with water jets. BA-F began her process by opening pouring MasterCare one-step disinfectant/cleaner straight in without using any measurement. BA-F then used a toilet brush (designated for this use) to clean any debris from the sides of the tub. BA-F then filled the tub with water passed the level of the water jets and turned the jets on and washed the top of the whirlpool chair. The sides of the tub were visibly dry before 60 seconds had elapsed. BA-F allowed the whirlpool jets to run until it caused bubbles to fill the tub. BA-F then used the sprayer to rinse out the tub. The process took less than 8 minutes. BA-F was unaware of any instructions for use on how to appropriately clean and disinfect the tub by the manufacturer. She was taught this way, and taught others to clean and disinfect the tub using this method. BA-F was unaware she should wear PPE during the cleaning and disinfection process.	21375		

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	00343		C 10/28/2022

NAME OF PROVIDER OR SUPPLIER: AVERA MORNINGSIDE HEIGHTS CARE CENTE

STREET ADDRESS, CITY, STATE, ZIP CODE: 300 SOUTH BRUCE STREET MARSHALL, MN 56258

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21375	Continued From page 53 Review of the Apollo Advantage Bathing System manual located at https://apollobath.com/wp-content/uploads/2021/09/CD0012-Advantage-Operation-Manual.pdf, identified use of other manufacturer's cleaners and disinfectants was not recommended and could compromise the overall process. The tub came with a hose and compartment for their cleaning and disinfecting processes. The manufacturer recommended use of Cid-A-L cleaner and disinfectant. Staff were to clean and disinfect the whirlpool tub using the following process for: Cleaning 1) Place the chair in the tub, release the carrier from the tub, and close the door. 2) Close the Tub Drain. Turn the Selector Knob to "TUB CLEANER" and the Control Knob to "On." 3) Turn the whirlpool on. After the Turbo Clean (Trademark) mixture has come out of the jets for about 30 seconds or when there is about 2 inches of cleaning solution in the foot well; turn the Selector Knob to "Rinse." 4) Lift seat bottom off chair, (pull up from back of seat). Use the cleaning solution to scrub the tub, chair and underneath seat bottom. When clear water comes out of all the jets, turn the whirlpool off. 5) Turn the Control Knob to "Off" and open the Tub Drain. 6) Use the shower wand to rinse the tub and chair. Disinfection 1) Place the chair in the tub, release the carrier from the tub, and close the door. 2) Close the Tub Drain. Turn the Selector Knob to "DISINFECTANT" and the Control Knob to "On." 3) Turn the whirlpool on. When there is about 2	21375		

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21375	Continued From page 54 inches of disinfectant in the foot well, turn the whirlpool off. Turn the Control Knob to "Off." 4) Lift seat bottom off chair, (pull up from back of seat). Use the disinfecting solution to scrub the tub, chair and underneath seat bottom. 5) Leave wet for 10 minutes (wet contact time for all surfaces). Open the Tub Drain. 6) After 10 minutes, turn the Selector Knob to "Rinse" and the Control Knob to "On." Turn the whirlpool on. When clear water comes out of all the jets, turn the whirlpool off. Turn the Control Knob to "Off." 7) Use the shower wand to rinse the tub and chair. LAUNDRY Observations of laundry processes on the first floor identified on: 1) 10/24/22 at 2:25 p.m., of the laundry room in the Gardens wing identified the laundry room was small, had a washer and dryer located inside it with automated chemicals were tubed into the washing machine. Empty laundry baskets were stacked on top of the dryer. There was no visible sorting area to separate dirty linen from clean linen, and no sorting table for folding clean linen. Linen left in this room was uncovered and exposed to potential air contaminates when the laundry area was not separated. 2) 10/25/22 at 8:11 a.m., a laundry basket full of resident clothing was sitting on the floor in the hallway, uncovered, in a laundry basket outside R32's room. 3) 10/25/22 at 8:21 a.m., R56's clothing was sitting in an open laundry basket clean, uncovered outside the room in the hallway. 4) 10/25/22 at 8:22 a.m., R32's and R56's clothing baskets remained uncovered in the	21375		

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21375	Continued From page 55 hallway and were still there at 8:50 a.m. Further observation on 10/27/22 at 8:04 a.m., R39's bathroom was visible from the hall. On the floor in the bathroom sat the same white laundry baskets seen previously throughout the facility with clean laundry, now holding dirty laundry and sitting on the bathroom floor. Review of the February 2020, Laundry and Linen procedures policy identified PPE was to be worn by laundry personnel when handling soiled linen. Laundry and linen employees were to receive 1 on 1 training by the manager including infection prevention and appropriate linen handling. Collection carts for soiled linen were to be used by the facility. Clean linen was to be placed on a covered cart and stored in an enclosed linen cart which was to be wheeled in patient areas. There was to be a counter to fold clean linen. There was no mention of using routine laundry baskets to both hold dirty and clean linens or how staff would ensure those baskets were cleaned appropriately. DRESSING CHANGE Observation on 10/25/22 at 9:42 a.m. with registered nurse (RN)-A performing a dressing change to R56's pressure ulcers with assistance from nurse aide (NA)-G identified R56 was paralyzed and was unable to move her arms and legs independently. NA-G rolled R56 towards her so RN-A could perform the dressing change. RN-A had sterile dressings on a barrier on R56's bedside table. RN-A washed, dried her hands, and applied clean gloves. R56 had multiple areas in varied stages of healing. RN-A measured each wound with different paper measuring tapes using the same gloves touching the different pressure ulcer areas. RN-A needed a Q-tip to measure	21375		

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21375	Continued From page 56 depth of 1 area, and without removing gloves, she went to R56's closet, and retrieved a tub of clean dressing supplies with her soiled gloves, touching those clean supplies and returning them to the cupboard. After finishing measuring all of the wound/pressure ulcer areas, RN-A then set the contaminated wound measuring tapes on top of the sterile dressings she had on the bedside table, along with her contaminated pen she used to record those measurements on the measuring tapes. She then proceeded to grab the bottle of wound wash and sterile 4x4's with her soiled gloves and washed each wound using the same contaminated 4x4 gauze pads, cross contaminating the wounds. RN-A then applied bordered foam dressing without removing her contaminated gloves or performing hand hygiene and donning new gloves and proceeded to apply the once sterile dressings to R56's wounds. RN-A then removed her same contaminated gloves at the end of the procedure and washed her hands. RN-A was unable to be interviewed immediately after the dressing change due to her needing to assist another resident immediately after. Interview on 10/26/22 at 4:06 p.m., with the infection preventionist (IP) identified she performed environmental audits 2 x per year with the adjoining hospital safety advisor. She was unaware laundry was being cleaned and stored in the manners described above. She agreed definite processes needed to be changed to ensure cross contamination did not occur and laundry was handled and transported appropriately. She also noted she always had high increases of UTI in the facility and not disinfecting the whirlpool tubs appropriately could lead to an increase in urinary tract infections (UTI). The IP agreed RN-A should have performed appropriate hand hygiene and glove	21375		

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21375	Continued From page 57 changes between tasks. RN-A should have also not contaminated clean or sterile dressing supplies. This was a cause of concern and cross contamination of R56's wounds. There was no policy related to appropriate hand hygiene or glove use provided by the end of the survey. NEBULIZER R27's 8/30/22, significant change Minimum Data Set (MDS) assessment identified R27 had difficulty staying focused, was easily distracted, and had a hard time keeping track of what was said. R27 required extensive assistance of 2 staff for all cares. R27 had chronic obstructive pulmonary disease (COPD), Alzheimer's disease, diabetes, and history of acute respiratory failure. R27 required oxygen therapy and was receiving hospice services. R27's current care plan identified respiratory status as active with a start date of 10/24/22, as evidenced by COPD. Maintain respiratory status, nebulizer tubing changes every Monday at 8:00 a.m. R27's Active Medication List printed 10/25/22, identified Albuterol/ipratropium 3 milliliters (ML) inhalation nebulizer treatment every 6 hours scheduled. Observation on 10/25/22 at 10:03 a.m., R27 nebulizer mask was still connected to the machine with some moisture noted inside mask, the mask was laying in a basket on top of some papers next to the nebulizer machine.	21375		

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21375	Continued From page 58 Observation on 10/26/22 at 9:35 a.m., R27's nebulizer treatment mask was still attached to the machine sitting on bedside table. Observation on 10/26/22 at 11:50 a.m., R27's nebulizer treatment mask was still attached to the machine on bedside table. Interview on 10/26/22 at 11:05 with trained medication aide (TMA)-C revealed that the person working on the medication cart and assisting with the nebulizer treatment would be the person responsible for cleaning the nebulizer equipment. The medication staff should rinse the mask and port that the medication goes in and set it on a clean paper towel to dry after each administration. Interview on 10/26/22 at 1:15 p.m., with registered nurse (RN)-D confirmed that the protocol was to clean and place the nebulizer supplies on a clean paper towel to dry after each use. Interview on 10/27/22 at 1:00 p.m., with director of nursing (DON) confirmed staff should be rinsing and leaving the nebulizer supplies on a clean paper towel to dry after each use along with replacing supply's weekly. Review of October 2022, Avera LTC Disinfection of Non-Critical Patient Care Equipment policy identified Nebulizer's supplies were to be rinsed and set on clean paper towel and covered with another paper towel to dry in the resident's room until the next treatment. Every 24 hours staff will disassemble all nebulizer equipment and wash with soap and rinse and air dry on a clean paper towel covered by another paper towel. Nebulizer	21375		

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21375	Continued From page 59 supplies should be replaced weekly or more often based on manufacturer instructions for use. SUGGESTED METHODS OF CORRECTION The ICP or designee could review facility policies/procedures regarding appropriate infection control technique during dressing changes. The ICP or designee could provide staff education regarding the policies and educate staff on appropriate IC technique while performing dressing changes. The ICP or designee should complete timely audits to ensure policies are being followed to ensure on-going competence. The ICP, or designee should take education verifications and the audits to the Quality Assurance Performance Improvement (QAPI) committee to determine compliance or the need for continued monitoring. The DON (Director of Nursing) or designee should review/revise facility policies to ensure appropriate screening, notification of signs and symptoms of illness, daily cumulative tracking and trending of all illnesses in the facility, immediate implementation of droplet precautions, and appropriate use of PPE are implemented to mitigate potential COVID-19 transmission. The DON or designee could educate all staff on existing or revised policies and perform ongoing continuous audits to ensure compliance. The results of those audits should be taken to QAPI to determine compliance. The DON (Director of Nursing) or designee should review/revise facility policies to ensure they contain all components of an infection control program to mitigate transmission of potential infections. The DON or designee could educate all staff on existing or revised policies and perform audits to ensure the policies are	21375		

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21375	Continued From page 60 being followed. The results of those audits should be taken to Quality Assurance Performance Improvement committee to determine compliance and the need for further monitoring. Time Period for Correction: Twenty-one (21) days.	21375		
21580	MN Rule 4658.1325 Subp. 7 Administration of Medications; Requirements Subp. 7. Administration requirements. The administration of medications must include the complete procedure of checking the resident's record, transferring individual doses of the medication from the resident's prescription container, and distributing the medication to the resident. This MN Requirement is not met as evidenced by: Surveyor: 38687 Based on observation, interview and document review, the facility failed to administer medication according to manufacture's instructions and physician order for 1 of 25 observations. Additionally, the fcility failed to ensure the correct dose of Depakote (anti-siezure medication) was administered during a Gradual Dose Reduction (GDR) for 1 of 1 resident (R57). Findings include: Observation and interview on 10/25/22 at 5:00 p.m., with registered nurse (RN)- A as she prepared to administer R36's Novolog 70/30 Flex	21580	The facility reviewed the current Medication Administration policy and updates were made on 12/1/22. The staff were trained on the updated policy and procedures on11/30/22, 12/6/22, 12/7/22, 12/8/22. The Charge nurses will be expected to verify medication received matches what is in the order. Audits: 100% observation 2 observations per week x 4; 4 observations per month x 3; 4 observations per quarter.	12/8/22

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21580	Continued From page 61 Pen insulin 30 units subcutaneous (SQ). RN-A was observed preparing to administer the insulin by cleansing the attachment site for the needle, attaching the needle to the pen and priming with 1 unit of insulin. RN-A dialed the pen to the 30 unit mark and administered the insulin to R36. She reported she always primed the insulin pen with one unit as that was what the facility policy identified. RN-A reported she had not read the insert provided with the insulin pens and was not aware of the instructions to prime with 2 units before administering the ordered insulin dose. Review of the manufacture's instructions for priming of the insulin Flex Pen identified following attachment of a new sterile needle, the pen was to be primed with 2 units of insulin before dialing the ordered insulin dose to be administered. Interview on 10/25/22 at 5:15 p.m., with licensed practical nurse (LPN)-B who was also the supervisor for the unit, reported she was not aware of the manufacture instruction to prime the Novolog Flex Pen with 2 units and waste prior to administration of the ordered dose. Interview on 10/28/22 at 9:30 a.m., with the director of nursing (DON) voiced her expectation that manufacture's recommendations be followed when priming and administering insulin with insulin pens. R57's quarterly Minimum Data Set (MDS) dated 10/5/22, indicated R57 had severe cognitive deficits. R57 had diagnoses that included major depressive disorder, psychotic disorder due to another medical condition with delusions, agitation due to dementia, insomnia, Alzheimer's and vascular dementia with behavioral disturbances, and memory loss.	21580		

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21580	Continued From page 62 R57's physician orders dated 10/18/22, at 1:45 p.m. indicated R57 was to have a GDR of his Depakote as follows: Depakote Sprinkles 125 milligrams (mg) -Take 2 capsules (250 mg) 3 times per day (750 mg) for 3 days from 10/19/22, to 10/21/22. -Take 1 capsule (125 mg) 3 times per day (350 mg) for 3 days from 10/22/22, to 10/24/22. -Take 2 capsules (250 mg) 2 times per day (500 mg, an increase) for 3 days from 10/25/22, to 10/27/22. -Take 2 capsules (250 mg) 1 time per day (250 mg) daily for 3 days from 10/27/22, to 10/29/22, then discontinue. R57's physician orders dated 10/18/22, at 2:54 p.m. indicated R57's corrected GDR was as follows: -Take 2 capsules (250 mg) 3 times per day (750 mg) for 3 days from 10/19/22, to 10/21/22. -Take 1 capsule (125 mg) 3 times per day (350 mg) for 3 days from 10/22/22, to 10/24/22. -Take 2 capsules (125 mg) 2 times per day (250 mg, corrected) for 3 days from 10/25/22, to 10/27/22. -Take 2 capsules (125 mg) 1 time per day (125 mg, corrected) daily for 3 days from 10/27/22, to 10/29/22, then discontinue. R57's Orders with Administration record from 10/1/22, thru 10/27/22, indicated the original, incorrect gradual dose reduction order was entered into R57's electronic medical record (EMR); however, the pharmacy delivered R57's Depakote in accordance with the correct GDR order; therefore, R57 was administered incorrect doses and/or no doses of Depakote as indicated below:	21580		

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21580	Continued From page 63 -10/19/22, to 10/20/22, Depakote 250 mg three times per day. -10/21/22, to 10/23/22, Depakote 125 mg three times per day. -10/24/22, Depakote 125 mg twice. -10/25/22, Depakote 250 mg twice. -10/26/22, Depakote 125 mg once. -10/27/22, Depakote 125 mg once. During at interview on 10/26/22, at 1:29 p.m. licensed practical nurse (LPN)-B stated the provider had ordered a gradual dose reduction (GDR) for R57's Depakote; however, the pharmacy had been sending incorrect doses. LPN-B stated because the pharmacy did not send the correct dose, R57 did not receive his morning dose of 125 mg of Depakote prior to leaving for an appointment with his family member (FM)-E that day. LPN-B stated "poor" FM-E "is probably going crazy" due to R57's likely increases in behaviors. LPN-B further stated she told the prior evening staff to order more Depakote; however, it did not appear to have been done. LPN-B stated the order on 10/24/22, for 125 mg twice a day for a total of 250 mg was correct. LPN-B also stated the order on 10/25/22, for 250 mg twice a day for a total of 500 mg was also correct although R57 was supposed to be on a GDR. LPN-B further stated the staff who received R57's Depakote from the pharmacy should have verified the dose was correct against the order. Furthermore, the staff administering the medication should have verified the medication card dose matched the order prior to administering the medication, and any discrepancies should have been verified with the pharmacy. During an interview on 10/27/22, at 3:57 p.m. the pharmacist (PH) stated the pharmacy received	21580		

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21580	Continued From page 64 multiple prescriptions on 10/18/22, for R57's Depakote medication. At 1:54 p.m. an order was received indicating R57's GDR for his Depakote beginning on 10/19/22; however, there was a discrepancy. The order indicated the dose on 10/25/22, increased from R57's prescribed dose on 10/24/22, instead of decreasing. The PH contacted the provider and at 2:46 p.m. on 10/18/22, the pharmacy received a corrected order to indicate R57 should have received 125 mg of Depakote twice a day from 10/25/22, to 10/27/22. During an interview on 10/27/22, at 3:30 p.m. the director of nursing (DON) stated staff were expected to verify medication received from the pharmacy matches what is on the order. The DON also stated staff should verify they are administering the correct dose of a medication to a resident and clarify any discrepancies with the provider and/or pharmacist prior to administering it. Review of the May 2023 policy Medication Administration identified all medications were to be stored and administered according to manufacture's guidelines. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures for medication administration. The director of nursing or designee could develop a system to educate staff and develop a monitoring system to ensure medication were correctly administered. The quality assurance committee could monitor these measures to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) days	21580		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	00343		C 10/28/2022

NAME OF PROVIDER OR SUPPLIER: AVERA MORNINGSIDE HEIGHTS CARE CENTE

STREET ADDRESS, CITY, STATE, ZIP CODE: 300 SOUTH BRUCE STREET MARSHALL, MN 56258

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21610	MN Rule 4658.1340 Subp. 1 Medicine Cabinet and Preparation Area;Storage Subpart 1. Storage of drugs. A nursing home must store all drugs in locked compartments under proper temperature controls, and permit only authorized nursing personnel to have access to the keys. This MN Requirement is not met as evidenced by: Surveyor: 44658 Based on observation and interview the facility failed to ensure medications were stored securely in 3 of 25 rooms on the Horizons unit, and in 2 of 12 rooms on the Transitions unit. Findings include: During an observation and interview on 10/26/22, at 10:04 a.m. R57's in-room medicine cabinet used to store R57's non-narcotic, facility medications, was found unlocked.. Family member (FM)-E and trained medical assistant (TMA)-F were present in the room. TMA-F stated the cabinet should have been locked. Observation on 10/28/22 at 8:06 a.m. with LPN-C on the Horizons unit identified Rooms 2, 18, and 33 were unsecured with the attached touch pad lock mounted on the door of the cabinet. Rooms 2 and 33 were noted to not have the lock engaged, but room 18 the lock was nonfunctioning. Observation on 10/28/22 at 8:30 a.m., on the Transitions unit with RN-F identified Room 7 and 10 had in room medication cabinets that were not secured.	21610	The facility reviewed the Mediation Storage policy on 12/1/22. Trained the staff on the policy and also how to report a broken piece of equipment 11/30/22, 12/6/22, 12/7/22, 12/8/22. The broken lock was fixed immediately by the Maintenance team on 10/28/22. Audits: 100% observations 2 observations per unit x 4 ; 8 observations per month x 3; 8 observations per quarter.	12/8/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: ____ B. WING ____	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER: AVERA MORNINGSIDE HEIGHTS CARE CENTE

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21610	Continued From page 66 Both RN-F and LPN-C confirmed that anyone entering the identified rooms could have had access to the medications stored in the cabinets and they should have been secured immediately following administration of any medications. Interview on 10/28/22 at 9:15 a.m. with RN-D the nursing supervisor, reported her expectation for in room medication cabinets be locked when medications were not being administered and if there was a problem with the locking mechanism it should be reported immediately to maintenance. Until the lock was repaired, she stated any medications were to be removed and stored in a secure location until the issue was resolved. Interview on 10/28/22 at 10:55 a.m., with the administrator reported she had not been made aware of an issue with the locking mechanism on room 18's medication storage cabinet and her expectation was for a work to be submitted immediately. She verbalized she should have been made aware of the concern immediately by staff and intervention implemented. A policy for in room medication storage was requested but not provided prior to exit. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON) and consulting pharmacist could review and revise policies and procedures for proper storage of medications. Nursing staff could be educated as necessary to the importance of properly securing medications. The DON or designee, along with the pharmacist, could conduct audits on a regular basis to ensure compliance.	21610		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: ____ B. WING ____	(X3) DATE SURVEY COMPLETED
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21610	Continued From page 67 TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21610		
21980	MN St. Statute 626.557 Subd. 3 Reporting - Maltreatment of Vulnerable Adults Subd. 3. Timing of report. (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless: (1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, clause (4). (b) A person not required to report under the provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point. (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency. (e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause	21980		12/8/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: ____ B. WING ____	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER: AVERA MORNINGSIDE HEIGHTS CARE CENTE

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21980	Continued From page 68 (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead agency shall consider this information when making an initial disposition of the report under subdivision 9c. This MN Requirement is not met as evidenced by: Surveyor: 44658 Based on interview and record review, the facility failed to develop and/or implement policies and procedures for ensuring the reporting of a reasonable suspicion of crime in accordance with section 1150B of the Act related to misappropriation of property to the State Agency (SA) no later than 24 hours when 1 of 1 resident (R4) alleged she was missing $200.00 from her billfold. Findings include: R4's annual Minimum Data Set (MDS) dated 10/26/22, indicated R4 had intact cognition, was independent with eating but required extensive assistance of two staff for all other activities of daily living (ADLs). R4's diagnoses included stroke, and depression. R4's care plan dated 10/24/22, indicated R4 was	21980	The vulnerable adult policy and process was reviewed on 11/11/22. The vulnerable adult policy and process was trained with staff on 11/30/22, 12/6/22, 12/7/22, 12/8/22. The investigation was submitted to MDH on 10/26/22 and the police were called and arrived for the investigation on 10/26/22 and opened case # 22-16559. Family was contacted and reported that the resident attended a recent wedding and gave her grandkids money at the wedding. The Marshall police department was contacted on 12/1/22 and they have not closed the case yet. Audit: Observation audits will be completed of the daily taped report. 5x/weeks x 4; 2x/week x 4; 1x/week x4; 2x/month x3.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: ____ B. WING ____	(X3) DATE SURVEY COMPLETED
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21980	Continued From page 69 at risk for psychosocial wellbeing and mood related to depression, loss of independence, and a change in her daily routine. Interventions included monitoring R4 and performing assessments as needed. R4's care plan also indication R4 had no current communication concerns and was able to make her needs known. During an interview on 10/25/22, at 8:35 a.m. R4 stated she put money she received from family and friends into her billfold, wrapped it in a red towel, and put it in a drawer. R4 stated a couple of weeks ago she discovered $200.00 was missing from her wallet. R4 reported the missing money to licensed practical nurse (LPN)-B, however, no one ever came and spoke to her which upset R4. R4 stated she did not fill out a form regarding the missing money and was not aware there was a grievance process. During an interview on 10/26/22, at 2:50 p.m. LPN-B stated R4 told her she was missing $200.00 about a month ago. LPN-B stated she looked around R4's room but didn't find any money and was unaware of a billfold or red towel. LPN-B spoke to R4's family member who told LPN-B they did not know of anyone giving R4 any money or that R4 had any money, therefore, LPN-B did not fill out a Quality Measure (QM-grievance form) or contact the administrator per the facility policy. During an interview on 10/26/22, at 3:07 p.m. the director of nursing (DON) stated she was unaware R4 was missing money and would have expected a QM form to be filled out and the policy followed regarding misappropriation of money when R4 first reported she was missing $200.00.	21980		

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21980	Continued From page 70 The facility Vulnerable Adult Abuse Prevention Plan dated 9/2022, indicated misappropriation of resident property was the deliberate misplacement, or wrongful, temporary or permanent use of a resident's belongings or money with the resident's consent. The facility will respond to all incidents of abuse and/or neglect by conducting an investigation to determine why abuse, neglect, or misappropriation occurred and what changes are needed to prevent further occurrences. All alleged violations involving abuse, neglect or misappropriation are to be reported immediately, but not later than 2 hours if the allegation involves abuse or resulted in serious bodily injury; or not later than 24 hours if the events did not involve abuse and do not result in serious bodily injury. Staff must report to the administrator. Staff were to investigate incidents and all persons on/in the area of the incident were to be interviewed. SUGGESTED METHOD OF CORRECTION: The administrator or designee could develop/revise policies or procedures to ensure timely reporting of all allegations of abuse, neglect, oir misappropriation of property are within appropriate timeframes for reporting. The facility should re-educate staff to policies and procedures, and audit all complaints of alleged abuse or neglect in a measurable and specific way. The results of those audits should be taken to the Quality Assurance Performance Improvement (QAPI) committee to determine the need for further monitoring or compliance. Those audits should be ongoing and random after compliance is determined by QAPI to ensure compliance is being maintained. TIME PERIOD FOR CORRECTION: 21 DAYS	21980		

Electronically delivered
November 28, 2022

Administrator
Avera Morningside Heights Care Center
300 South Bruce Street
Marshall, MN 56258

RE: CCN: 245228
Cycle Start Date: October 28, 2022

Dear Administrator:

On October 28, 2022, a survey was completed at your facility by the Minnesota Department(s) of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the electronically delivered CMS-2567, whereby significant 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:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective December 28, 2022.

- Directed plan of correction (DPOC), Federal regulations at 42 CFR § 488.424. Please see electronically attached documents for the DPOC.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective December 28, 2022. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective December 28, 2022.

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:

- Civil money penalty (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

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 December 28, 2022, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Avera Morningside Heights Care Center will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from December 28, 2022. 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:

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health - 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 April 28, 2023 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.

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,

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

Electronically delivered
November 28, 2022

Administrator
Avera Morningside Heights Care Center
300 South Bruce Street
Marshall, MN 56258

Re: State Nursing Home Licensing Orders
Event ID: GBRM11

Dear Administrator:

The above facility was surveyed on October 24, 2022 through October 28, 2022 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

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

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

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

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

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

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

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

Please feel free to call me with any questions.

Sincerely,

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 A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	245228		C **10/28/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVERA MORNINGSIDE HEIGHTS CARE CENTER	**300 SOUTH BRUCE STREET** **MARSHALL, MN 56258**

(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 Surveyor: 34083 On 10/24/22 through 10/28/22, a survey for compliance with Appendix Z, Emergency Preparedness Requirements for Long Term Care facilities, §483.73(b)(6) was conducted during a standard recertification survey. The facility was NOT in compliance. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulation has been attained.	E 000		
E 020 SS=C	Policies for Evac. and Primary/Alt. Comm. CFR(s): 483.73(b)(3) §403.748(b)(3), §416.54(b)(2), §418.113(b)(6)(ii), §441.184(b)(3), §460.84(b)(3), §482.15(b)(3), §483.73(b)(3), §483.475(b)(3), §485.68(b)(1), §485.625(b)(3), §485.727(b)(1), §485.920(b)(2), §491.12(b)(1), §494.62(b)(2) [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years	E 020		12/8/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		12/08/2022

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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	245228		C 10/28/2022

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E 020	Continued From page 1 [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:] [(3) or (1), (2), (6)] Safe evacuation from the [facility], which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s); and primary and alternate means of communication with external sources of assistance. *[For RNHCIs at §403.748(b)(3) and ASCs at §416.54(b)(2):] Safe evacuation from the [RNHCI or ASC] which includes the following: (i) Consideration of care needs of evacuees. (ii) Staff responsibilities. (iii) Transportation. (iv) Identification of evacuation location(s). (v) Primary and alternate means of communication with external sources of assistance. * [For CORFs at §485.68(b)(1), Clinics, Rehabilitation Agencies, OPT/Speech at §485.727(b)(1), and ESRD Facilities at §494.62(b)(2):] Safe evacuation from the [CORF; Clinics, Rehabilitation Agencies, and Public Health Agencies as Providers of Outpatient Physical Therapy and Speech-Language Pathology Services; and ESRD Facilities], which includes staff responsibilities, and needs of the patients. * [For RHCs/FQHCs at §491.12(b)(1):] Safe evacuation from the RHC/FQHC, which includes appropriate placement of exit signs; staff	E 020		

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E 020	Continued From page 2 responsibilities and needs of the patients. This REQUIREMENT is not met as evidenced by: Surveyor: 44658 Based on interview and document review the facility failed to ensure emergency preparedness policies included procedures for residents who refused to leave the facility during an emergency evacuation. This had the potential to affect all 69 residents and staff in the building. Findings include: During an interview on 10/27/22, at 11:00 a.m. the Quality Coordinator (QC) stated she did not recall the facility having a policy or procedure to address a resident who refused to leave during an emergency evacuation. Review of the facility Fire Response and Evacuation Plan dated 10/2022, lacked a procedure in the event a resident refused to leave the facility during an emergency evacuation.	E 020	The facility reviewed the Emergency Shelter in Place, Relocation and Evacuation Plan. The policy was updated to include the plan for situations where resident refuse to evacuate on date 12/2/22 The facility trained the updated policy with the staff on 12/6/22, 12/7/22, 12/8/22	
F 000	INITIAL COMMENTS Surveyor: 34083 On 10/24/22 through 10/28/22, a standard recertification survey was conducted at your facility. A complaint investigation was 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 complaints were found to be SUBSTANTIATED H5228035C (MN82447),	F 000		

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F 000	Continued From page 3 H52285143C (MN85027), and H52285077C (MN86082), however NO deficiencies were cited due to actions implemented by the facility prior to survey. The following complaint was also found to be SUBSTANTIATED: H52285146C (MN87174), and had a deficiency cited at F656. The following complaints were found to be UNSUBSTANTIATED: H52285144C (MN83743) and H52285149C (MN86301). The following complaint was also found to be UNSUBSTANTIATED: H52285145C (MN83502), however a related deficiency was cited at F657. 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 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive	F 578		12/8/22

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F 578	Continued From page 4 the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Surveyor: 38687 Based on interview and document review, the facility failed to ensure the accuracy of 1 of 1 resident (R41) medical record when R41 had	F 578	The facility reviewed and updated the policy to correct the concerns identified in the survey process on 11/1/22 The team was trained on the new policy and the updates on 11/30/22, 12/6/22,	

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F 578	Continued From page 5 conflicting end of life (code status) documentation. Findings include: R41's current, undated "electronic medical record (EMR) identified R41 was marked as "full resuscitation" (wanting all lifesaving measures including cardio pulmonary resuscitation (CPR)). R41's October 2021, POLST (Physician Orders for Life Sustaining Treatment) form identified R41 wished to be a Do Not Resuscitate (DNR) with selective treatment of antibiotic use. Interview on 10/26/22 at 2:18 p.m., with the director of nursing (DON) identified she was unaware of the conflicting information of R41's code status. She stated "Full resuscitation may be the same as DNR with selective treatment. That could be just how they [staff] have to put that into the computer system". She was unsure if that would be considered conflicting information, but agreed both the POLST and EMR should match. She agreed R41 could potentially received CPR against his wishes in an emergent situation occurred. No policy relating to Advanced Directives was provided by the end of survey.	F 578	12/7/22, 12/8/22. An audit was completed on 10/28/22 of a 100% of the current resident charts for their POLST documents and that the information matched. Any discrepancies were corrected in the resident's charts to reflect the correct information The process changes are the following: The social worker is responsible for obtaining the POLST document upon admission or at the initial care conference. The POLST document will then be scanned into the resident's chart. The nursing supervisor will verify the code status and compare it to what is in the EMR system and update if necessary. The advance directive on the resident R41 was corrected to reflect the correct status in the EMR as the POLST 10/28/22 Audits: 100% of charts will be audited on admissions and readmissions. Audits will be completed monthly until 100% compliance is met. the frequency will be monthly x 3 months. then 20% of admissions and readmissions quarterly x3 quarters.	
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations	F 609		12/8/22

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F 609	Continued From page 6 involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Surveyor: 44658 Based on interview and record review, the facility failed to develop and/or implement policies and procedures for ensuring the reporting of a reasonable suspicion of crime in accordance with section 1150B of the Act related to misappropriation of property to the State Agency (SA) no later than 24 hours when 1 of 1 resident (R4) alleged she was missing $200.00 from her billfold. Findings include:	F 609	The vulnerable adult policy and process was reviewed on 11/11/22. The vulnerable adult policy and process was trained with staff on 11/30/22, 12/6/22, 12/7/22, 12/8/22. The investigation was submitted to MDH on 10/26/22 and the police were called and arrived for the investigation on 10/26/22 and opened case # 22-16559. Family was contacted and reported that the resident attended a recent wedding and gave her grandkids money at the wedding. The Marshall police department was contacted on 12/1/22 and they have	

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F 609	Continued From page 7 R4's annual Minimum Data Set (MDS) dated 10/26/22, indicated R4 had intact cognition, was independent with eating but required extensive assistance of two staff for all other activities of daily living (ADLs). R4's diagnoses included stroke, and depression. R4's care plan dated 10/24/22, indicated R4 was at risk for psychosocial wellbeing and mood related to depression, loss of independence, and a change in her daily routine. Interventions included monitoring R4 and performing assessments as needed. R4's care plan also indication R4 had no current communication concerns and was able to make her needs known. During an interview on 10/25/22, at 8:35 a.m. R4 stated she put money she received from family and friends into her billfold, wrapped it in a red towel, and put it in a drawer. R4 stated a couple of weeks ago she discovered $200.00 was missing from her wallet. R4 reported the missing money to licensed practical nurse (LPN)-B, however, no one ever came and spoke to her which upset R4. R4 stated she did not fill out a form regarding the missing money and was not aware there was a grievance process. During an interview on 10/26/22, at 2:50 p.m. LPN-B stated R4 told her she was missing $200.00 about a month ago. LPN-B stated she looked around R4's room but didn't find any money and was unaware of a billfold or red towel. LPN-B spoke to R4's family member who told LPN-B they did not know of anyone giving R4 any money or that R4 had any money, therefore, LPN-B did not fill out a Quality Measure (QM-grievance form) or contact the administrator	F 609	not closed the case yet. Audit: Observation audits will be completed of the daily taped report. 5x/weeks x 4; 2x/week x 4; 1x/week x4; 2x/month x3.	

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F 609	Continued From page 8 per the facility policy. During an interview on 10/26/22, at 3:07 p.m. the director of nursing (DON) stated she was unaware R4 was missing money and would have expected a QM form to be filled out and the policy followed regarding misappropriation of money when R4 first reported she was missing $200.00. The facility Vulnerable Adult Abuse Prevention Plan dated 9/2022, indicated misappropriation of resident property was the deliberate misplacement, or wrongful, temporary or permanent use of a resident's belongings or money with the resident's consent. The facility will respond to all incidents of abuse and/or neglect by conducting an investigation to determine why abuse, neglect, or misappropriation occurred and what changes are needed to prevent further occurrences. All alleged violations involving abuse, neglect or misappropriation are to be reported immediately, but not later than 2 hours if the allegation involves abuse or resulted in serious bodily injury; or not later than 24 hours if the events did not involve abuse and do not result in serious bodily injury. Staff must report to the administrator. Staff were to investigate incidents and all persons on/in the area of the incident were to be interviewed.	F 609		
F 645 SS=F	PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3) §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with:	F 645		12/8/22

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F 645	Continued From page 9 (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services; or (ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission- (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability. §483.20(k)(2) Exceptions. For purposes of this section- (i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital. (ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual- (A) Who is admitted to the facility directly from a	F 645		

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F 645	Continued From page 10 hospital after receiving acute inpatient care at the hospital, (B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and (C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services. §483.20(k)(3) Definition. For purposes of this section- (i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1). (ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter. This REQUIREMENT is not met as evidenced by: Surveyor: 38687 Based on interview and document review, the facility failed to ensure 1 of 1 resident (R3) with failed to ensure 1 of 1 resident received a Pre-Admission Screening and Resident Review (PASARR) Level II to ensure coordination of mental health services. Findings include: Review of the 7/24/17 (PASARR Level I) identified it was done prior to R3's admission. R3 was noted to have a diagnosed mental illness of Bipolar disorder, depression, anxiety disorder and personality disorder. There was no indication upon admission to the facility an addition	F 645	The facility reviewed the Pre-Admission Policy on 11/1/22. The staff were trained on the policy updates on 11/30/22, 12/6/22, 12/7/22, 12/8/22. The facility completed an audit on 10/28/22 of 100% of the current resident charts for their scanned PASARR's. They found 8 charts that did not have a PASARR scanned correctly in their charts, a list was created and given to the social worker to contact senior linkage line and obtain them. As of 11/30/22 we were waiting for 3 outstanding PASARR's it was determined that those 3 were admitted before the Senior Linkage Line existed The facility re-assessed the resident R3	

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F 645	Continued From page 11 assessment occurred. R3's current, undated care plan identified she had an entry for Psychological Well Being/Mood related to a diagnoses of anxiety and depression, loss of independence, and chronic pain. There were no personalized interventions listed other than R3 was to "maintain mood" and "maintain interests in previous activities". There was no mention of R3's diagnoses of Bipolar disorder, depression, anxiety disorder and personality disorder or how staff were to care for her and ensure she received professional services. R3's 2/9/22, annual Minimum Data Set, Section D-Mood identified R3 had little interest in doing things, felt down, depressed or hopeless, Had trouble falling or staying asleep, felt tired or had little energy, had poor appetite or was overeating, had trouble concentrating on things, moved or spoke slowly that other people had noticed, or was fidgety or restless with a total severity score of 15, indicating she had moderately severe depression. Interview on 10/24/22 at 7:15 p.m. with R3 identified she has been depressed. Since at least 4 to 5 moths ago, she felt like she "wasn't getting the proper care" but acknowledged she does see a mental health professional after she had requested it. They were working on getting her "medications straight". Interview on 10/26/22 at 5:00 p.m. with the administrator identified she agreed R3 needed to have a PASARR Level II re-assessed in order for staff to develop a thorough care plan so the facility social worker and contracted mental health providers had provided additional care for R3	F 645	for her PASARR Level II in order to develop a thorough care plan. The updates to the process are the following: The admission coordinator will obtain all PASRR's and scan them into the resident charts upon admission. The social worker will be the backup if the admission coordinator is gone. If the resident triggers a Level II PASARR the admission coordinator will work with the discharging social worker to ensure that they get that completed prior to admitting to the facility. After the admission the social worker will follow up with the county to obtain a copy for the resident's chart. Audits: 100% of the charts will be audited monthly until we have 100% compliance x 3 months: then 20% of admissions quarterly x 3 quarters.	

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F 645	Continued From page 12 after admission and when R3's mood decreased. Review of the current, 7/3/19, Preadmission Screening and OBRA, at https://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=ID_000814, identified if the OBRA Level I screening indicated a person had a diagnosis or suspected diagnosis of developmental disabilities or related conditions, he/she also must receive an OBRA Level II evaluative report before he/she can be admitted to an MA-certified nursing facility (NF). If a person experiences a significant change of condition, the lead agency must complete a new OBRA Level II evaluative report. (Note: At the federal level, these evaluations are called resident reviews.) A "significant change" was noted as a major decline or improvement in person ' s status that: 1) Will not normally resolve itself without staff intervention or standard disease-related clinical interventions, and the person cannot prevent the decline (i.e., not considered "self-limiting") 2) Affected more than one area of the person ' s health status 3) Required multidisciplinary review and/or revision of the person ' s care plan. No policy related to PASARR Level II screening was provided by the end of survey.	F 645		
F 656 SS=F	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §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	F 656		12/8/22

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F 656	Continued From page 13 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 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. This REQUIREMENT is not met as evidenced by: Surveyor: 38687	F 656	The facility reviewed the Care Plan policy	

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F 656	Continued From page 14 Based on interview and document review, the facility failed to ensure development of comprehensive care plans were developed and implemented for each resident, included measurable objectives and timeframe's to meet a resident's medical, nursing, and mental and psychosocial needs and include services to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being for 16 of 18 sampled residents (R3, R4, R5, R11, R20, R31, R41, R42, R43, R50, R54, R56, R57, R121, R122, and R127). This had the potential to affect all 69 residents. Findings include: R5's current, undated care plan identified R5 was admitted to the facility in November, 2021 and had diagnoses of cancer, high blood pressure, GERD, diabetes, high cholesterol. thyroid disorder, anxiety disorder, . R5's care plan identified problems noted for bladder incontinence, communication and cognitive concerns, was a fall risk, was on hospice, was on a constant carb diabetic diet, chronic pain, psychosocial well-being/mood, activities, medication side effects, and skin integrity. R5 had little to no specific person-centered goals or interventions identified on the care plan according to existing diagnoses or needs. R5 recieved an anti-coagulant and the care plan made no mention of any bleeding precautions. R3's current, undated care plan identified R3 was admitted to the facility in July, 2017. R3's care plan identified problems noted for psychosocial well being, Activities of Daily Living (ADL) status, bowel and bladder incontinence, communication	F 656	11/16/22. The staff were trained on the updated policy and processes on 11/30/22, 12/6/22, 12/7/22, 12/8/22. Meditech hands on training for all staff has been scheduled for ongoing training.and has been added to the new hire training for all staff. The care plans were audited for 100% of the facility. A plan has been developed to update each resident's care plan with person centered items. The following has been updated: R5 has had resident goals and interventions added to the care plan. Bleeding precautions were also added to the residents care plan. R3 has been updated with the residents' goals and interventions for side effects from psychotropic drug use and behavior interventions. The plan for restorative therapy to reduce the contractures has been noted in the care plan. R41 has had their care plan updated with resident centered goals and interventions that relate to their diagnoses. R56's Care plan has been updated to include the indication of the catheter to be secured to the resident's leg with a leg strap to keep the catheter in place. Person centered goals and interventions have been identified and updated in her R31 Care plan has been updated to direct staff to use a gait belt for all transfers with the resident. Goals and Interventions have been updated in the resident's care plan. choking. R50 non pharmacological interventions have been updated in the care plan as	

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F 656	Continued From page 15 and cognitive ability, fall risk, oral and respiratory status, blood sugar status, nutrition, pain, activity involvement, was at risk for medication side effects, and skin integrity. R3 was at risk for side effects from psychotropic drug use related to behaviors, however no interventions were placed on the care plan specific to R3.R3 also had contractures and the need for restorative therapy was also not noted on the care plan. Throughout R3's care plan, R3 had little to no specific person-centered goals or interventions identified according to existing diagnoses or needs. R41's current, undated care plan identified R3 was admitted to the facility in October, 2021 with diagnoses of dementia, enlarged prostate, diabetes, glaucoma and was legally blind, high cholesterol, and a below the knee amputation. R14 had little to no specific person-centered goals or interventions identified on the care plan according to existing diagnoses or needs. R56's current, undated care plan identified R56 was admitted to the facility in March 2021 and had diagnoses of heart failure, neurogenic bladder, high cholesterol, paraplegia, MS, anxiety, depression, pressure ulcer to her left buttock- Stage III, and dysphagia. She had identified problems of ADL status, catheter use, ostomy care, communication and cognitive ability, fall risk, nutritional status, chronic pain, psychosocial well-being, activity involvement, skin integrity. R56 was noted to have a suprapubic (tube placed in opening into bladder through stomach) catheter with interventions to clean and change the catheter bag monthly. The care plan also had a discrepancy and noted R56 was to have her Foley (tube inserted into urethra, then into the bladder) flushed twice per day. Staff were	F 656	well as person centered goals R11 His care plan has been updated to address his agitation and PTSD and the interventions to handle his behaviors and diagnosis. His medications have been updated in his care plan along with monitoring for side effects. R42 Person centered goals have been placed in her care plan as well as interventions to address her potential for R121 care plan was reviewed, the resident expired R122 care plan was reviewed, the resident discharged R127 Care plan was reviewed, the resident expired R20 care plan has been updated to reflect his behaviors and interventions used by staff when those behaviors occur. R54 the care plan has been updated to reflect individualized interventions to prevent falls and minimize pain. R43 the care plan was updated to reflect interventions for staff to ensure communication to meet needs and prevent elopement. he enjoyed, medications have been update and all side effects as well. CPAP cares and interventions have also been updated in his care plan. R4 Care plan was updated to reflect interventions related to using her call light and using the bathroom unattended and fall reduction R57 care plan has been updated with interventions to increased the resident activity involvement and what activities The audits and topic have been added to the Quality Score card and agenda to	

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F 656	Continued From page 16 to place a pad under R56 if it leaked. There was also a notation to "cath secure change" however, there was no indication what that meant or how staff was to ensure her catheter remained secured to her leg. R56 had little to no specific person-centered goals or interventions identified on the care plan according to existing diagnoses or needs. R31's 9/7/22, quarterly Minimum Data Set (MDS) identified she had intact cognition with diagnoses of Parkinson's disease, glaucoma, retention of urine, constipation, and pain. R31 was to have had extensive assistance of 2 staff for transfers between surfaces and required the use of a wheelchair. Observation on 10/27/22 at approximately 9:45 a.m. identified R31 was being transferred with nurse aide (NA)-H identified she was in process of performing a pivot transfer to R31. NA-H was observed grabbing onto the back side of R31's elastic waistband pants, and pivoting R31 from her wheelchair to a chair without use of a gait belt. R31's current, undated care plan identified R31 was admitted to the facility in March 2022. R31 was at risk for falls as evidence by a history of falls, impaired balance, Parkinson's disease, urinary tract infections, and impaired mobility. There were no interventions identified on the care plan reflective of her MDS assessment. R31 had a problem noted with Activities of Daily Living (ADL) and required assistance with ADL's. R31 was noted to transfer/pivot with use of a gait belt and a walker. There was no mention R31 required 2 staff for safety.	F 656	review at the QA meetings monthly. Audit: 100% of charts will be audited 1 care plan per unit will be audited weekly x4; 1 care plan per unit monthly x 3 ; 1 care plan per unit quarterly.	

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F 656	Continued From page 17 Review of the 6/24/22,current nurse aide (NA) care plan identified under the section "Care Plan/Special Needs/Special Diet" the only notation for NA staff was that she "likes makeup and recliner". Her ADL's were listed as "A1" (assistance of 1). There was no indication why the nurse aide care plans did not contain critical elements of resident care needed or why it had not been revised recently. Interview and observation on 10/27/22 at 10:00 a.m. with the administrator and director of nursing identified all residents were to have gait belts in their rooms for potential transfers. Both agreed NA-H should have used the resident's gait belt. The administrator and DON agreed there was the potential for harm for an accidental fall due to staff not using the appropriate equipment. The administrator was unsure why the nurse aide care plans were not up to date or reflective of what resident's care was required but did acknowlege their current computer software was "not friendly to long term care (LTC) use" and was not able to be resident specific. Both agreed care plans failed to detail resident specific needs. Surveyor: 34083 R11's undated care plan failed to identify safety measures for behaviors of anxiety with agitation, attempted elopement, wandering and self-transfers with resulting falls. R11 also had a diagnosis of PTSD with delusions of still being in war and the care plan failed to include interventions to manage his issues. R11 had signed provider orders for Lorazepam for his anxiety, Oxycodone for pain, Insulin for diabetes,	F 656		

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F 656	Continued From page 18 and Tramadol for pain. His medications were not identified on the care plan with monitoring for potential side effects. R42's current undated, care plan identified R42 was admitted to the facility on 8/26/2019, and had diagnoses of at risk for aspiration, Alzheimer's disease with behavioral disturbance, delirium, high blood pressure (HTN), chronic obstructive pulmonary disease (COPD), Osteoarthritis, peripheral vascular disease (PVD), hypothyroidism. R42's care plan identified problems of Alzheimer's dementia, fall risk with a history of falls prior to admission which resulted in a left hip fracture with surgical repair, activity involvement, nutritional status with offer preferred supplement for weight loss and wound healing, and at risk for pain evidence by a history of venous stasis ulcers, and arthritis in her shoulders. The care plan also listed R42 was receiving hospice services. R42 had little to no specific person-centered goals or interventions identified on her care plan according to existing diagnoses or needs. R42 had also been identified as having issues with the potential for choking and there were no interventions or monitoring mentioned. R50's current undated, care plan identified R5 was admitted to the facility on 11/20/09 and had diagnoses of a Stage 3 pressure ulcer (PU) to his right buttock, neurogenic bladder, paraplegia, dyspnea, history of below the knee amputation, muscle spasms, hyponatremia, colostomy, chronic pain syndrome, and hypotension. R50's care plan identified problems with skin integrity, risk for skin breakdown due to	F 656		

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F 656	Continued From page 19 immobility, history of pressure ulcers, history of skin grafts, contractures, noncompliance with repositioning at times, urostomy and colostomy sites, nutritional status-with offered high protein snacks related to his wounds and needed encouragement to eat, at risk for pain but and listed on scheduled pain medication, but no non-pharmacological interventions listed, and psychosocial wellbeing/mood identified. Throughout R50's care plan, R50 had little to no specific person-centered goals or interventions identified according to his specific diagnoses or needs. R121's undated, care plan identified R121 was admitted to the facility on 11/25/19, and had diagnoses of malnutrition, hyperlipidemia, dementia, adjustment disorder with depressed mood, Parkinson's Disease, HTN, osteoarthritis. R121 had experienced an injury of unknown origin with bruising under his left arm pit that extended to his chest area and under his right upper arm. R121 was developing increased weakness and it was thought the bruising was a result of use of and EZ stand lift and not being able to support his weight on his legs. R121's current, undated care plan identified problems of communication ability/cognition, ADLs, bowel, and bladder incontinence, fall risk, psychosocial wellbeing/mood, chronic pain, and nutritional status. Throughout R121's care plan, R121 had little to no specific person-centered goals or interventions identified according to his specific diagnoses or needs as he continued to have physical decline. R122's, undated care plan identified R122 was admitted to the facility on 4/12/22 and discharged	F 656		

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F 656	Continued From page 20 on 7/20/22, following an extended hospitalization. R122 had diagnoses of self-neglect, insomnia, chronic heart failure, anxiety, hypotension, atrial fibrillation (a-fib- an irregular heart rthymn), physical deconditioning, lymphedema, left ventricular hypertrophy (LVH) (left side of heart not pumping effectively), Asthma, COPD, morbid obesity, hypothyroidism, HTN, and depressive disorder. R122's care plan identified problems of ADLs, bladder incontinence, communication ability, fall risk, acute/chronic pain, psychosocial wellbeing/mood activity involvement, and medication side effects. R122 had little to no specific person-centered goals or interventions identified on the care plan according to existing diagnoses or needs. R122 was also identified as having psychological issues and was seen by a provider, but the care plan made no mention of behavioral or psychological interventions. R127's undated care plan identified R127 was admitted to the facility on 2/18/20 and died on 8/23/22. R127's discharge summary listed diagnoses of postmenopausal vaginal bleeding, hospice care, chronic kidney disease stage IV, diabetes type 2; anemia, diabetic neuropathy, hypothyroidism, CAD, hypotension, mixed incontinence, chronic anticoagulation, HTN, memory deficit. R127's care plan listed problems of ADLs, bowel and bladder incontinence, communication/cognition ability, fall risk, activity involvement, anticoagulant therapy, blood sugar status, respiratory status, and hospice care. R127 had little to no specific person-centered goals or interventions identified on the care plan	F 656		

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F 656	Continued From page 21 according to existing diagnoses or needs Surveyor: 39988 R20's 9/12/22, significant change Minimum Data Set (MDS) assessment identified severe cognitive impairment with inattention and disorganized thinking. R20 had verbal, physical and other behaviors during the assessment period. R20 required extensive assist with cares, R20 took an antipsychotic 6, antianxiety 2, and pain medication 4 of the 7 look back period. R20's undated, care plan identified Communication deficit as evidenced by advanced dementia with moderate cognitive losses, problem understanding others, and was mostly non-verbal. The goal was to maintain communication and cognition. Interventions identified care conference as needed, family notification as needed, BIMS interview as needed, communication as needed, nurse observation as needed, notify provider of critical results as needed, and hearing aid/glasses's every 12 hours. The care plan further identified fall risk as evidenced by history of falls, impaired balance, hypertension medication, impaired mobility, and impaired cognition. The goal was to prevent falls and injury. Interventions included balance and functional range of motion as needed and fall risk assessment as need. Psychosocial well being and mood was identified as a problem as evidenced by withdrawal from care and activities, grief over loss of status, daily routine is very different from prior pattern in community, and strong identification with past. The goal was to establish own goals, strong identification with past, and maintain mood. Interventions included an individual abuse	F 656		

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F 656	Continued From page 22 prevention plan, alcoholic beverages as needed, insomnia assessment as needed, staff observation as needed, social service assessment as need, PTSD screen as needed, PHQ-9 as needed, Behavior/mood observation every 12 hours, elopement risk as needed, AIMS assessment as needed, and behavior/mood assessment every 12 hours. R20's care plan lacked individualized interventions for staff to follow to ensure communication to meet needs, to prevent falls, and to identify if R20 was displaying any target behaviors as there were none identified. Interview on 10/26/22 at 1:45 p.m., with registered nurse (RN)-A identified R20 had been seen by psych for medication adjustments related to his physical behaviors. She revealed side effects of medication were being monitored and agreed that the target behaviors were not identified on the care plan but staff charted any behaviors that occurred. Review of 10/21/22, Behavior health note by psychiatric provider identified R20 had diagnosis of vascular dementia with behavioral disturbance, psychotic disorder wit delusions and hallucinations. R20 behaviors had been physical aggression to staff, raising hands and shake fist at caregivers, shoved staff, poked staff in eye, punched staff in face, kicked at wife. None of this information had been identified on R20's care plan. R54's 8/20/22, significant change MDS assessment identified moderate cognitive impairment. R54 required extensive assist with cares and transfers. R54 had history of falls, took daily diuretic, and had occasional pain.	F 656		

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F 656	Continued From page 23 R54's undated, care plan identified fall risk as evidenced by history of falls, impaired balance, psychotropic drugs, hypertension medications, diuretic medication, impaired mobility, and impaired cognition. The goal was to prevent falls and injury. Interventions included balanced and functional range of motion as needed and fall risk assessment as needed. The care plan identified chronic pain as evidenced by peripheral vascular disease, and lymphedema. The goal was to be free from pain and residents to have acceptable level of pain. Interventions included pain interview as needed and pain assessment as needed. R54's care plan lacked individualized interventions to prevent falls and to minimize pain for staff to follow. R43's 9/21/22, annual MDS assessment identified severe cognitive impairment with inattention and disorganized thinking. R43 required extensive assist with cares and was identified to have had 2 or more falls. R43 took a daily antipsychotic, antidepressant, and a daily hypnotic. R43's undated, care plan identified a communication deficit as evidenced by Parkinson's dementia with moderate to severe cognitive losses's, was able to make self understood but sometimes talked nonsensical, his orientation fluctuated, he had problems understanding others, and memory impairments. The goal was to maintain communications and cognition. Interventions included care conference summary as needed, family notifications as needed, BIMS interview as needed, communication as needed, nurse observation as needed, notify provider with critical results as	F 656		

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F 656	Continued From page 24 needed, hearing aide and glasses's every 12 hours. The care plan identified elopement as a problem with wander guard placed related to ability to wander, cognitive loss and desire to go outside. The goal was R43 will not leave facility unattended. Interventions included wander guard alarm check daily using wander guard pocket reader and elopement risk as needed. R43's care plan lacked individualized interventions for staff to follow to ensure communication to meet needs and initialized interventions to prevent elopement. Surveyor: 44658 R4's care plan dated 10/24/22, indicated R4 had a concern for bladder and bowel due to frequent incontinence of urine. Interventions included recording R4's output and scanning R4's bladder as needed. R4 had a risk for falls related to a history of falls with an injury, impaired balance, the use of psychotropic and high blood pressure medications, and impaired mobility and cognition. Interventions included balance/functional range of motion (ROM) daily and keeping R4's bed at a level so R4 could sit on the edge of the bed at a 90-degree angle with her feet flat on the floor to allow for a safe transfer from bed. The care plan lacked interventions related to R4's fall while using the restroom unattended, R4 not activating her call light, and attempting to self-transfer. R57's quarterly Minimum Data Set (MDS) dated 10/5/22, indicated R57 had severe cognitive deficits. R57 required supervision of one staff for	F 656		

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F 656	Continued From page 25 eating and extensive assistance of two staff for all other activities of daily living (ADLs). R57 had diagnoses that included insomnia, Alzheimer's and dementia with behavioral disturbances, Multiple Sclerosis (MS), memory loss, and obstructive sleep apnea (OSA-sleep-related breathing disorder causing the airway to become obstructed and occasional to frequent cessation of breathing). R57's Care Area Assessment (CAA) dated 4/22/22, indicated R57 triggered for cognitive loss/dementia, due to Alzheimer's and dementia, instructing a continuation of the item on R57's care plan. R57 triggered for communication secondary to being hard of hearing and instructing a continuation of the item on the care plan. R57 also triggered for mood state due to a history of depression, instructing a continuation of the item on the care plan. R57's care plan dated 10/25/22, indicated R57 was at risk for a communication deficit related to hearing loss, difficulty making himself understood and understanding others and declining cognition. Interventions included notifying a provider with critical results as needed, MDS nursing observations as needed, completing a Brief Interview for Mental Status (BIMS) as needed, notifying family as needed, and completing a care conference summary as needed. The care plan lacked resident-centered interventions to assist, maintain, or improve R57's communication deficits. The care plan also indicated R57 was at risk for psychosocial well-being evidenced by withdrawal from activities, grief over loss of roles/status, daily routine very different from prior pattern in the community and having a strong identification with the past. Interventions included	F 656		

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F 656	Continued From page 26 visiting with R57 about past agricultural business and discussing his memory book and pictures. R57's care plan further indicated R57 had a deficit related to activities due to a lack of interest. Interventions included daily activity review, an activity evaluation, MDS preferences to be reviewed as needed, and a spiritual assessment to be completed. The care plan lacked indications of R57's preferences for activities or an individualized plan to increase R57's involvement in activities. R57 had respiratory concerns related to OSA and using a CPAP. Interventions included putting the CPAP on every night and cleaning it weekly. No other interventions or instructions regarding the use of the CPAP machine were indicated. R57's care plan also indicated R57 was at risk for psychosocial wellbeing. Interventions included monitoring R57 for side effects related to the use of Seroquel; however, R57 was no longer taking the antipsychotic medication. The care plan lacked evidence R57 had been evaluated for dementia to develop a resident-centered plan to decrease R57's repetitive behaviors and lacked indication that R57 was taking Depakote (an anti-convulsant used also as an antipsychotic) or interventions to monitor for side effects related to the medication. Review of the 3/23/22, Facility Wide Risk Assessment identified the facility provided person centered care. Staff were to find out the resident's likes and dislikes and what makes for a good day and incorporate that information into the care planning process and to to ensure staff had the information. Review of August 2020, Care Planning policy identified a person centered care plan would recognize what was important to the resident with	F 656		

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F 656	Continued From page 27 regard to daily routines and activities, what supports the resident required, and having an understanding of the resident' life prior to residing in the nursing home.	F 656		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Surveyor: 44658	F 657	The facility reviewed the Care Plan policy 11/16/22.	12/8/22

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F 657	Continued From page 28 Based on interview, and record review the facility failed to review and revise a care plan for 1 of 1 (R4) residents who had an unwitnessed fall after being left on the toilet and attempting to self-transfer. Findings include: Review of the 5/12/22, report to the State Agency (SA) indicated R4 was found laying on the floor outside her bathroom door with her clothing halfway up. Review of the 5/16/22, 5-day Investigation Report indicated R4 had not activated her call light for assistance prior to self-transferring from the bathroom. R4 was found on the floor outside the bathroom. R4 reported pain to her neck and pelvis and was transferred to the emergency department for evaluation. R4 did not sustain any fractures; however, was diagnosed with a urinary tract infection (UTI) and returned to the facility the same day. The report indicated R4 would continue to be an assist of one staff member and the intervention to prevent a reoccurrence was to keep R4's wheelchair close to her with the brake on in the event she attempts to self-transfer. R4's annual Minimum Data Set (MDS) dated 10/26/22, indicated R4 had intact cognition, was independent with eating but required extensive assistance of two staff for all other activities of daily living (ADLs). R4's diagnoses included falls, cervical muscle strain, anemia (low iron), emphysema (a lung disease resulting in shortness of breath), arthritis of the neck, elbow, shoulder, lumbar disc (lower back) disease, osteopenia (low bone density resulting in frail bones), ambulatory dysfunction, stroke, fracture	F 657	The staff were trained on the updated policy and processes on 11/30/22, 12/6/22, 12/7/22, 12/8/22. Meditech hands on training for all staff will be started on (insert date) and completed on (Insert date) and has been added to the new hire training for all staff. R4's care plan has been updated to reflect the interventions regarding her call light and fall reduction on The audits and topic has been added to the score card reviewed at the monthly quality meeting and the agenda items as well. Audit: 100% of charts will be audited 1 care plan per unit will be audited weekly x4; 1 care plan per unit monthly x 3 ; 1 care plan per unit quarterly.	

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F 657	Continued From page 29 of the pelvis, and amputation of the fifth toe. R4's Care Area Assessments (CAAs) dated 11/24/21, indicated R4 triggered for ADL function related to a decline in ADL function and falls. R4 also triggered for falls due to a fall history, requiring assistance with ADLs and balance. Risks included falls, pain, injury, and decline in overall condition. Interventions included a continuation of the concern on R4's care plan. R4's care plan dated 10/24/22, indicated R4 had a concern for bladder and bowel due to frequent incontinence of urine. Interventions included recording R4's output and scanning R4's bladder as needed. R4 had a risk for falls related to a history of falls with an injury, impaired balance, the use of psychotropic and high blood pressure medications, and impaired mobility and cognition. Interventions included balance/functional range of motion (ROM) daily and keeping R4's bed at a level so R4 could sit on the edge of the bed at a 90-degree angle with her feet flat on the floor to allow for a safe transfer from bed. The care plan lacked interventions related to R4's fall while using the restroom unattended, R4 not activating her call light, and attempting to self-transfer. R4's progress note dated 5/12/22, indicated R4 was found lying on her left side on the floor between her bedroom and bathroom doors with her pants and underwear around her ankles. R4 complained of lower back pain, tingling to both her hands, and refused to move her lower extremities. R4 was unable to tell staff what she was doing at the time of the fall; however, R4 was last seen on the toilet at 2:15 p.m. and was found on the floor at 2:25 p.m. R4's Care Assessments dated 5/12/22, indicated	F 657		

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F 657	Continued From page 30 R4 was at a high risk for falls. Interventions put in place to prevent future falls indicated no referrals made at the time. Post fall actions indicated to use the call light and post fall education included calling for assistance; however, the resident's readiness to learn was documented as cognitively unable. R4's Clinical Note dated 5/13/22, indicated R4 had a urinary analysis (UA) completed secondary to a fall the previous day. Per facility staff R4 was asymptomatic and was not complaining of urinary frequency, infrequency, or urgency and had no fever. An order for a urine culture (UC) was placed and due to R4's lack of symptoms, treatment for a UTI would be delayed pending the UC results. During an interview on 10/25/22, at 8:23 a.m. R4 stated her one concern was being left in the bathroom. R4 stated she had had multiple strokes and could fall easily because she got dizzy which made her scared to move. R4 stated she would pull the call light, but she felt the staff did not respond quick enough. R4 stated her doctor told her she was not to be left alone while in the bathroom, the facility, or outside due to safety concerns. R4 did not recall her previous fall; however, stated she had almost fallen before. During an interview on 10/27/22, licensed practical nurse (LPN)-B stated R4 didn't remember to use her call light and should not be left unattended in the bathroom; however, R4's care plan was not updated regarding falls because the fall was attributed to R4's UTI, and not due to staff or environmental factors. The facility Fall Prevention and Management	F 657		

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F 657	Continued From page 31 policy dated 5/2022, indicated staff were to assess and identify residents at risk for fall and take precautionary measures to prevent falls and fall related injuries. Clinical assessments of resident risk factors were used to create appropriate interventions. If a resident was determined to be at risk for falling, the nurse will incorporate the appropriate fall prevention interventions into the resident's plan of care. A gait belt was to be used with all assisted transfers and assisted ambulation. Fall preventions were to be customized to each resident's unique needs and risk factors. Resident falls will be documented, and the resident care plan will be updated with new interventions as necessary. Resident care sheets include interventions from the resident's care plan to address fall prevention. After a fall, licensed staff will review the resident's care plan and note the date and time of the fall on the plan of care, making necessary revisions to address risk factors related to the fall.	F 657		
F 688 SS=E	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility	F 688		12/8/22

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F 688	Continued From page 32 receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Surveyor: 38687 Based on observation, interview, and document review, the facility failed to ensure 4 of 4 residents (R3, R5, R51, R56, and R57) recieved restorative range of motion (ROM) therapy to prevent potential decline in ROM and/or contractures. Findings include: R3's 2/9/22 annual MDS identified she required extensive assist of 1 staff for ADL and had no impairment marked on the MDS to her upper or lower body, and used a walker or wheelchair for ambulation. R3's current, undated care plan identified R3 was admitted to the facility in July, 2017. R3's care plan identified problems noted for psychosocial well-being, was noted to require assistance of 2 staff with most Activities of Daily Living (ADL) status. There was no mention R3 had contractures of her left hand, not that she was to have worn a brace on her left hand to prevent further deterioration and contracture or required the splint to be refitted. Observation and interview on 10/24/22 at 7:10 p.m., with R3 identified she remarked she had a "frozen left ankle". She has rheumatoid arthritis (RA). The brace for her hand "doesnt fit... it squishes them together". She hadn't been refitted. She used to be an occupational therapist	F 688	The facility policy was reviewed and updated on 11/30/22. The staff were trained on the updated policy 11/30/22, 12/6/22, 12/7/22, 12/8/22 The nursing and therapy team met on 11/30/22 to review and determine which residents must have ROM exercises daily and updated their care plans, work lists and daily assignment sheets to reflect so. The activities department has added an exercise group which provides 8 opportunities a month for resident movement, that was started on 11/3/22. The supervisors will be doing observations and coaching with their teams on the identified residents to assure that it is being done and documented. Therapy will huddle with the team daily to discuss any ROM concerns and any additional residents they feel would benefit from ROM cares in their care plans. The following was done with the identified residents: R3 Residents care plan has been updated to include ROM exercised and use of her orthotics. R5 ROM exercises have been added to her care plan R56 training was completed on her orthotics and the care plan updated to reflect the ROM interventions and goals R51 care plan has been updated and	

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F 688	Continued From page 33 and was quite familiar with restorative therapy. She gets no ROM from staff. The facility cut thier restorative program and to her knowledge, they havent gotten anyone else and "apparently arent planning to". R3's fingers on her left hand were visibly contracted and her feet turned inward. Buried in the corner, under a piece of luggage were her orthotics. R5's 10/20/22, Significant Change Minimum Data Set (MDS) identified she had severely impaired cognition due to needed to be prompted to recall words, her inattention and ability to stay focused during the interview, and disorganized thinking. R5 required extensive assistance from 1 staff for bed mobility, transfer, dressing, eating, toilet use and personal hygiene. R5 was marked no impairment to her upper and lower extremities. R5 received no restorative therapy from a restorative program. R5's current, undated care plan identified R5 was admitted to the facility in November 2021 and had diagnoses of cancer, high blood pressure, GERD, diabetes, high cholesterol. thyroid disorder, anxiety disorder. R5's care plan identified problems noted for bladder incontinence, communication and cognitive concerns, was a fall risk, was on hospice, was on a constant carb diabetic diet, chronic pain, psychosocial well-being/mood, activities, medication side effects, and skin integrity. R5 had no mention Interview on 10/25/22 at 2:54 p.m., with R5 identified she doesnt get any ROM therapy from staff. She would be at risk for ROM decline. R56's 4/20/22, Significant Change MDS identified she had intact cognition, and was marked	F 688	interventions and goals placed for the ROM exercises. R51 Care plan has been reviewed and ROM goals and interventions placed. 11 additional residents have been identified to benefit from a program that includes ROM activities and their care plans have been updated. The audits have been added to the quality score card and also the agenda for discussion monthly at the quality meetings. Audits: 100% observation audits 2 audits per week x4 ; 4 audits per month x 3 ; 4 audits per quarter.	

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F 688	Continued From page 34 completely independent with all ADL, despite being a paraplegic. There was no restorative therapy noted on the assessment. R56's current, undated care plan identified R56 was admitted to the facility in March 2021 and had diagnoses of heart failure, neurogenic bladder, high cholesterol, paraplegia, MS, anxiety, depression, pressure ulcer to her left buttock-Stage III, and dysphagia (difficulty swallowing). She had identified problems of ADL status, catheter use, ostomy care, communication and cognitive ability, fall risk, nutritional status, chronic pain, psychosocial well-being, activity involvement, skin integrity. R56 had little to no specific person-centered goals or interventions identified on the care plan according to existing diagnoses or needs. Observation and interview on 10/25/22 at 9:42 a.m., with nurse aide (NA)-G immediately prior to R56's dressing change identified R56 was visibly severely contracted in upper and lower limbs due to her MS and paraplegia diagnoses. identified there are no specific staff for restorative any longer. That program was discontinued. All NAs were now responsible to do restorative ROM, but they "just dont have the time". When they are able to do ROM for residents, they are supposed to document in the electronic medical record when it's completed. No orthotics were identified having been applied. R56's Occupational Therapy (OT) progress notes identified on: 1) 8/11/22, OT put on R56's bilateral hand orthotics and educated the restorative aide (RA) on how to put them on. Staff left the orthotics on for 75 minutes and checked for	F 688		

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F 688	Continued From page 35 redness/discomfort. The RA was educated and shown how to perform passive ROM (PROM) (staff are required to perform due to residents' inability to move extremities). 2) 8/12/22, OT performed the PROM and put on R56's orthotics to her hands. Nursing staff were educated on proper methods doe donning and doffing (on and off) of the orthotics. 3) 8/15/22, OT noted they had washed, dried and applied lotion to R56's left elbow crease as it was "showing white maceration [skin breakdown due to moisture] and had a foul odor due to being in a chronically flexed position". OT provided gentle PROM to her bilateral upper extremities due to "significant tightness/contractures noted". R56 had pain in her left (L) wrist when the OT attempted to place her wrist in a neutral position. R56 had "significant wrist extension contracture which is currently unsupported". OT then adjusted her L elbow orthotic into a more flexed position to accommodate her current flexion contracture for better support. 4) 8/29/22, OT documented PROM was completed by OT to her upper body. R56 had facial grimacing during her should exercises specifically. R56's spouse was present with him reporting R56's right (R) ROM was "normal up until recently". OT noted contractures beginning at the R elbow. 5) 9/13/22, R56 reported she "doesn't go into her wheelchair much". R56 was in her bed in the supine (lying on back) position with her elbows in flexion and her left upper extremity supinated with contracture in her fingers. Communication was provided to nursing staff for potential of positioning side lying and in wheelchair to provide repositioning and stretching. R56's orthotics were placed in her lower drawer of her dresser "near her bed for ease, as they were observed by T to	F 688		

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F 688	Continued From page 36 be in her recliner with Hoer lift and tangled." 6) 9/14/22, OT completed a pictorial program with written instruction for staff to increase ease of donning splints and preventing further contracture development. 7) 9/16/22, R56 reported staff ae stretching her arms, but cannot recall if it occurs daily. 8) 9/19/22, OT provided PROM and again educated staff on how to apply R56's orthotics for 30 minutes and check for redness and pain. 9) OT once more educated staff on completing PROM prior to donning her orthotics. 10) 10/14/22, OT noted R56 reported staff were not putting on her orthotics nor were they doing PROM and said it had not been completed "in a long time". 11) 10/17/22, R56 had facial grimacing while OT provided PROM to her R shoulder. Ot once again stressed to staff the importance of providing PROM as she is completely dependent for all positioning and use of her extremities. There was no mention if OT's continued concerns were brought forth to management, or if management routinely audited OT notes for residents at risk to identify the lack of staff care with PROM. Interview on 10/26/22 at 1:50 p.m. identified R56 was once more observed without any orthotics applied and was lying in bed. R56 said she has them for her right elbow (she thinks) but was unsure if staff were applying them as ordered. R56 family member was also there and reported R56 rarely had her orthotics applied. Interview on 10/27/22 at 12:19 p.m., with the director of therapy (DT) identified R56 is receiving OT now and has been for a while. OT has been working with R56 to find the right hand splints for	F 688		

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F 688	Continued From page 37 her. R56 was on physical therapy (PT) from July to August 2022, but has since competed PT. After it was brought to the administrator's attention about residents not receiving restorative therapy from staff, OT was and has been currently training staff right now on her upper extremities. R56 "can't move and really needs staff to do everything for her". OT works upper and PT normally worked her lower extremities. Her upper body is maintaining, but her lower extremities have not been getting restorative PROM therapy at all and "is likely declining". R56 was to be screened next month to see if she has had any decline. Interview on 10/28/22 at 8:48 a.m., with the administrator identified the facility's restorative program was "cut" due to budgetary cuts. Upper management wanted staff NA's to do it, but she acknowledged they "don't have time". She agreed this had the potential for harm and was affecting resident care. Since becoming aware by surveyors during the survey process ROM was not being done, she was now going to have PT work with those residents who are affected and at risk for further decline. The administrator also agreed R56 and R3's orthotics were not being applied as ordered. Surveyor: 44658 R51's quarterly minimum data set (MDS) dated 9/28/22, indicated R51 had severe cognitive deficits and required extensive assistance of one staff for eating and extensive assistance of two staff for all other activities of daily living (ADLs). R51's diagnoses included constipation, disturbances of salivary secretion, anxiety, spinal stenosis, Parkinson's disease with dementia, and a fall resulting in a hip fracture.	F 688		

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F 688	Continued From page 38 During an interview on 10/24/22, at 7:26 a.m. family member (FM)-F stated R51 was receiving restorative therapy prior to the program being canceled a few months prior. R51 was supposed to do ROM exercises but since the staff had not been assisting him, FM-F had been trying to do the exercises with him. During an interview on 10/27/22, at 12:18 p.m. physical therapist (PT)-B stated she recommended passive ROM (PROM) exercises for R51 to keep his legs stretched out so he could continue to transfer with the EZ stand (a device that assists residents to stand up during transfers and requires only one staff to operate) and not downgrade to a Hoyer lift (a device that lifts a resident lying in a sling, requiring no effort from the resident and two staff to operate). However, PT-B also stated the nursing assistants (NAs) told her they did not have time to assist R51 with his PROM exercises. R51's PROM exercise log dated October 2022, indicated R51 received PROM exercises as follows: -10/3 -10/9 -10/10 -10/12 -10/17 -10/18 -10/22 -10/23 R51 did not receive PROM exercises for 15 out of 23 days. R57's quarterly MDS dated 10/5/22, indicated R57 had severe cognitive deficits and required	F 688		

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F 688	Continued From page 39 supervision with assistance of staff for eating and extensive assistance of two staff for all other ADLs. R57's diagnoses included a pressure injury on his coccyx (tailbone), fall resulting in pain to his left shoulder and a head abrasion, dementia with behavioral disturbance, major depression, constipation, spastic paraplegia due to multiple sclerosis (MS), ambulatory dysfunction, MS, and gait abnormality. R57's care plan dated 10/25/22, indicated R57 required assistance with some or all ADLs. Interventions included R57 participating in a restorative therapy program 4-6 times per week. R57 was also at risk for falls due to a history of falls, impaired balance, mobility, and cognition. Interventions included balance/functional ROM as needed. R57's CAAs dated 4/22/22, indicated R57 triggered for ADL functional/rehabilitation potential, falls, and pressure ulcers. R57's Restorative Nursing Program form dated 8/15/22, indicated PT-B recommended R57 complete or attempt knee extension stretches, hip adductor stretches, active leg kicks, and crunches while reaching, five days a week to maintain ROM of both his lower extremities for optimal positioning in his wheelchair. R57's Caregiver Education form dated 9/29/22, indicated PT-B recommended left arm PROM stretches in bed, wheelchair, or recliner to be completed daily. R57's Physical Therapy Discharge Summary dated 9/29/22, indicated R57 completed 2 out of 3 PT goals and had a follow-up maintenance program for upper extremity PROM. Discharge	F 688		

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F 688	Continued From page 40 recommendations included daily PROM to left upper extremity. No documentation was provided to indicate R57 received any ROM/PROM exercises after his discharge from therapy services on 9/29/22. R57's Care Conference Summary dated 10/12/22, indicated R57 was no longer receiving therapy services but family was interested in R57 being on a maintenance program to be able to keep the abilities he had. During an interview on 10:25/22, at 11:22 a.m. FM-E stated because of R57's MS, he got "really stiff." He was getting therapy for 15 minutes a few times a week before it was discontinued last month. During an interview on 10/26/22, at 2:02 p.m. PT-B and occupational therapist (OT)-C stated R57 was discharged from OT on 9/16/22, and from PT on 9/29/22 because his progress plateaued. The facility no longer had a restorative aid (RA), therefore, therapy printed range of motion (ROM) exercises for the nursing assistants (NAs) to complete with the residents; however, they did not believe the exercises were being done which caused residents' mobilities to decline and be referred back to therapy. PT-B stated residents weren't being walked and were struggling to participate in their surface-to-surface transfers. PT-B and OT-C stated it was a frustrating cycle. During an interview on 10/27/22, at 10:33 a.m. R57's FM-E stated she was unaware staff were supposed to continue providing ROM exercises for R57 after he had discharged from therapy.	F 688		

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F 688	Continued From page 41 FM-E further stated staff had not been doing exercises with R57, but she would like them to so R57 could maintain his mobility as long as possible. During an interview on 10/27/22, at 1:49 p.m. NA-F stated therapy would send a form to the NAs with instructions for ROM exercises to be completed with the residents after they were discharged from therapy. NA-F stated R57 was supposed to have ROM exercises completed; however, NA-F did not know how often. NA-F also stated she did not do ROM exercises with R57 when she transferred him out of bed and assisted him with his cares that morning. During an interview on 1/27/22, at 1:57 p.m. licensed practical nurse (LPN)-B stated she would submit a referral to therapy if a resident's activities of daily living (ADLs) and/or strength declined. LPN-B stated since the RA program ended, she noticed an increase in the number of residents whose mobility and strength were declining because the NAs often did not have time to complete the recommended ROM exercises with the residents. During an interview on 10/27/22, at 5:17 p.m. RN-F stated a form was sent to her and the NAs if a resident discharged from therapy services but would benefit from a maintenance exercise program. The staff should communicate during the morning huddle and verbal handoff report if a resident had a recommended exercise program. RN-F stated it had been tough to maintain resident abilities since the RA program ended. RN-F stated when a resident declined in ADLs and transfers, they may end up requiring a two staff assist instead of one which would increase	F 688		

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F 688	Continued From page 42 the NAs' workload and decrease resident independence. A resident would then be referred back to therapy and the cycle would continue. During an interview on 10/27/22, at 11:59 a.m. the director of therapy (DT) stated most residents were put on a restorative program after discharge from therapy to maintain their function; however, since the facility no longer had an RA, the NAs were supposed to complete ROM exercises with the residents. The DT stated a written recommendation for an exercise plan was sent to registered nurse (RN)-F who may add it to a resident's care plan, and another copy to the resident's unit for the NAs to review. Therapy would also screen the residents three months after discharge from therapy services to assess their progress. DT stated the failure to complete maintenance exercises resulted in residents being referred back to therapy due to a decline in their mobility and strength. R57 had been on and off therapy a few times since he had admitted to the facility in February 2022, and was discharged from therapy last month after plateauing. A recommendation for ROM exercises was sent to RN-F and the NAs so R57 could continue to maintain his mobility. During an interview on 10/27/22, at 3:17 p.m. the director of nursing (DON) stated it had been a challenge since the RA program ended in July and there were areas of improvement needed regarding the resident exercise program. The DON further stated the facility had a goal to include exercises as a resident activity; however, that had not been implemented. There was no policy specific to providing ROM supplied by the end of the survey.	F 688		

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F 689 SS=E	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Surveyor: 44658 Based on observation, interview, and record review the facility failed to ensure the environment was free from hazards when a staff's injectable mediation was found to be accessible to residents in an unlocked refrigerator 1 of 1 dayroom refridgerator. This had the potential to affect all 19 residents who resided on the unit. Further, the facility failed to safely transfer 1 of 1 resident (R31) using a gait belt and the assistance of 2 staff when R31 was transferred by 1 staff from her wheelchair to her recliner. FOOD and MEDICATION STORAGE During an observation on 10/26/22, at 9:05 a.m. a small refrigerator labeled "Staff Food + Drinks only!! Please initial and date items" was found unlocked and accessible to all residents, staff, and visitors, in the resident day room. A locking mechanism was on the outside of the refrigerator; however, the lock was affixed to a shelf inside the refrigerator without a key. The refrigerator was full of food and a red emergency Glucagon 1 milligram (mg) injection kit in a clear, plastic bag with a pharmacy label indicating it belonged to a facility staff member was on the top door-shelf.	F 689	The facility reviewed the food and medication storage policy on 11/30/22 The staff were trained in the food and medication storage policy on 11/30/22, 12/6/22, 12/7/22, 12/8/22. The staff mini refrigerators were removed from all living rooms in the facility immediately on 10/26/22 and relocated to a secured area off the units. The staff medication was also removed immediately and placed in a secured cooler on 10/26/22 and the employee coached on the requirements for personal medication The Safe Transfer policy was reviewed on 12/1/22. The staff were trained on the policy on 11/30/22, 12/6/22, 12/7/22, 12/8/22. An audit was completed of 100% of the current residents of who has the need for gait belts, this was completed on (insert date) Current gait belts have been numbered for the room they belongs to and placed in each of those resident's room.	12/8/22

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F 689	Continued From page 44 Two unidentified residents were watching TV in the dayroom and no staff were present. During an interview on 10/26/22, at 9:14 a.m. licensed practical nurse (LPN)-B stated the refrigerator should have been locked so residents and visitors weren't able to access the staff food. LPN-B also stated the staff emergency Glucagon kit should not have been in a refrigerator designated for food or unlocked allowing visitors and residents access to it. During an interview on 10/26/22, at 9:36 a.m. the director of nursing (DON) stated staff medication should not be stored in a refrigerator with food. The medication should have been stored in a locked refrigerator designated for medication and the staff refrigerator should have been locked to ensure residents don't have access to food items they should not have. The facility Falls and Accident policy dated 11/2021, defined accidents as any unexpected or unintentional incident, which results or may result in injury or illness to a resident and a hazard as elements of the resident environment that have the potential to cause injury or illness. Staff would ongoingly assess the physical environment regarding potential hazards, including access to sharps. Any deficiencies I the safety of the physical environment would be immediately addressed. Surveyor: 38687 TRANSFER R31's 9/7/22, quarterly Minimum Data Set (MDS) identified she had intact cognition with diagnoses of Parkinson's disease, glaucoma, retention of urine, constipation, and pain. R31 was to have	F 689	Additional gait belts have been purchased to have available to staff on each unit. Audits: 100% observation audits 2 observations per unit per week x4; 8 (2 per unit observations per month x 3; 8 observations quarterly.	

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F 689	Continued From page 45 had extensive assistance of 2 staff for transfers between surfaces and required the use of a wheelchair. Observation on 10/27/22 at approximately 9:45 a.m. identified R31 was being transferred with nurse aide (NA)-H identified she was in process of performing a pivot transfer to R31. NA-H was observed grabbing onto the back side of R31's elastic waistband pants, and pivoting R31 from her wheelchair to a chair without use of a gait belt. R31's current, undated care plan identified R31 was admitted to the facility in March 2022. R31 was at risk for falls as evidence by a history of falls, impaired balance, Parkinson's disease, urinary tract infections, and impaired mobility. There were no interventions identified on the care plan reflective of her MDS assessment. R31 had a problem noted with Activities of Daily Living (ADL) and required assistance with ADL's. R31 was noted to transfer/pivot with use of a gait belt and a walker. There was no mention R31 required 2 staff for safety. Review of the 6/24/22,current nurse aide (NA) care plan identified under the section "Care Plan/Special Needs/Special Diet" the only notation for NA staff was that she "likes makeup and recliner". Her ADL's were listed as "A1" (assistance of 1). There was no indication why the nurse aide care plans did not contain critical elements of resident care needed or why it had not been revised recently. Interview and observation on 10/27/22 at 10:00 a.m. with the administrator and director of nursing identified all residents were to have gait belts in	F 689		

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F 689	Continued From page 46 their rooms for potential transfers. Both agreed NA-H should have used the resident's gait belt. The administrator and DON agreed there was the potential for harm for an accidental fall due to staff not using the appropriate equipment. The administrator was unsure why the nurse aide care plans were not up to date or reflective of what resident's care was required. Review of the February 2019, Ambulation policy identified the purpose was to ensure the facility provided a safe transfer for residents when family members would accompany and ambulate with them. There was no mention of how staff were to safely transfer a resident.	F 689		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition	F 690		12/8/22

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F 690	Continued From page 47 demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Surveyor: 38687 Based on observation, interview, and document review, the facility failed to intervene for 1 of 1 resident (R51) with a strict bowel regimen and ensure catheter leg straps were used to prevent pain, discomfort, or potential infection or injury to 1 of 1 resident (R56). Findings include: BLADDER R56's 4/20/22, Significant Change MDS identified she had intact cognition, and was marked completely independent with all ADL despite being a paraplegic. There was no restorative therapy noted on the assessment. R56's current, undated care plan identified R56 was admitted to the facility in March 2021 and had diagnoses of heart failure, neurogenic bladder, high cholesterol, paraplegia, MS, anxiety, and depression. She had identified	F 690	The facility reviewed the policy on Urinary Incontinence Prevention /Management program and indwelling foley catheter management as well as Bowel Management LTC on 12/1/22. The staff were trained on both policies on 11/30/22, 12/6/22, 12/7/22, 12/8/22. The Resident care plans for both (R56) and (R51) were updated to reflect the needs to be addressed and what needs to be done. An audit of 100% of the current residents who have catheters was conducted to make sure the care plans were updated, and the correct equipment being used. We have determined that the policy and procedure was not being followed for the bowel management and the retraining and audits will ensure that the residents bowel management needs are addressed per the policy. Audits: 100% observation audits	

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F 690	Continued From page 48 problems of ADL status, catheter use, communication and cognitive ability, and had chronic pain. R56 was noted to have a suprapubic (tube placed in opening into bladder through stomach) catheter with interventions to clean and change the catheter bag monthly. The care plan also had a discrepancy and noted R56 was to have her Foley (tube inserted into urethra, then into the bladder) flushed twice per day. Staff were to place a pad under R56 if it leaked. There was also a notation to "cath secure change" however, there was no indication what that meant or how staff was to ensure her catheter remained secured to her leg. Observation and interview on 10/26/22 at 1:50 p.m., with R56 identified she was visibly grimacing and complained of having some "discomfort" today. R56's family member was present but went into the hall to find staff. R56 declined further interview. Interview on 10/26/22 at 1:54 p.m., with trained medication aide (TMA)-A identified R56 was upset because her catheter may have "fallen out" and staff were waiting on the nurse to assess her. R56 had a Foley catheter and was paralyzed and unable to move her lower body. Interview on 10/26/22 at 1:58 p.m., with licensed practical nurse (LPN)-B identified she was the only nurse on the floor that day. She was unaware R56's catheter had potentially "come out". LPN-B noted she would check on R56 right away. Further interview on 10/26/22 at 2:38 p.m., with TMA-A identified R56 was assessed by LPN-B. R56's catheter had not "come out" but was "just leaking".	F 690	2 observations of residents with catheters per week x 4; 4 observations per month x 3 ; 4 observations quarterly. 2 observations of residents with bowel management plans per week x 4; 4 observations per month x 3 ; 4 observations quarterly.	

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F 690	Continued From page 49 Further interview on 10/26/22 at 2:50 p.m., with LPN-B identified R56's catheter had not come out, but it was being pulled on via gravity, and that was causing her pain. Staff often failed to place a secure leg strap on all residents who had catheters. Using a leg strap to secure the catheter would offload the pressure caused by the bag being hung on the bed and getting heavy with captured urine. "This has been an ongoing issue". The facility was "trying to teach staff to make sure they provided appropriate cares, but in her opinion, it was unsuccessful. She has brought this up to management. All nurse aides (NAs) and nurses should know a Foley catheter was to be secured by a leg strap. LPN-B was unsure if this was care planned and staff educated to R56's care plan. "They should be looking at the electronic (EMR) care plan". R56's 6/24/22, NA care plan, made no mention R56 had a catheter. Interview on 10/26/22 at 4:06 p.m., with the infection preventionist (IP) identified she started mid November 2021. The IP was unaware of complications from R56 not having a leg strap on her catheter to secure it. The IP stated catheter infections were "always high" at the facility. The IP agreed staff failing to use appropriate catheter leg straps for residents led to tubes inadvertently slipping out and increased the rate of urinary tract infections (UTI). Interview on 10/28/22 at 11:19 a.m., with the administrator identified she agreed there was no clear direction on catheter care or ensuring R56 or other residents with catheters had notations to ensure catheters were secured properly. Care	F 690		

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F 690	Continued From page 50 plans were a common issue with the software the facility used, and not able to be modified easily. Review of the April 2022 Long Term Care Cleaning/Care of Catheter Bags policy identified staff were to keep the bag below the level of the bladder, monitor tubing for kinks. There was no mention in the policy staff should secure the catheter tubing with a leg strap to avoid complications such as pain or infection. Surveyor: 44658 BOWEL REGIMEN R51's quarterly Minimum Data Set (MDS) dated 9/28/22, indicated R51 had severe cognitive deficits and was unable to complete the Brief Interview for Mental Status (BIMS) assessment. R51 required extensive assistance of one staff for eating and extensive assistance of two staff for all other activities of daily living (ADLs). R51's MDS Section H-Bladder and Bowel, lacked indication R51 had incidents of constipation. R51's diagnoses included constipation, disturbances of salivary secretion, anxiety, spinal stenosis, Parkinson's disease with dementia, and a fall resulting in a hip fracture. R51's Care Area Assessment (CAA) dated 4/14/22, indicated R51 triggered for delirium and cognitive loss/dementia with risks including decreased cognition resulting in increased behaviors and an inability to make his needs known. R51's CAA did not indicate R51 had concerns regarding constipation or bowel incontinence. R51's care plan dated 10/25/22, indicated R51	F 690		

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F 690	Continued From page 51 had bowel and bladder incontinence. Interventions included recording R51's output every six hours. R57 also had concerns related to medication side effects that included constipation and fecal impaction. R51's physician orders dated 10/25/22, indicated R51 received bisacodyl 10 milligrams (mg) rectal suppository daily as needed for constipation, polyethylene glycol 3350 (Miralax) 8.5 grams every other day and Senna 8.6 mg (a stool softener) twice daily. Review of the facility Admission/Standing Orders dated 6/22, indicated polyethylene glycol 3350 17 mg orally as needed for constipation; Milk of Magnesium (MOM) 30 milliliters (ml) orally as needed for constipation if polyethylene glycol 3350 was not effective within 6 hours times one dose.; bisacodyl suppository (rectal) 10 mg could be given as needed daily for constipation if polyethylene glycol 3350 and Milk of Magnesia were not effective times one dose. If not effective, notify provider. R51's bowel continence log dated 9/1/22, to 10/27/22, indicated R51 went three or more days without a bowel movement from: -9/1/22, at 2:00 a.m. to 9/4/22, 8:00 a.m. -9/4/22, at 8:00 a.m. to 9/8/22, at 3:13 p.m. -9/12/22, at 8:00 a.m. to 9/16/22, at 6:04 a.m. -9/24/22, at 10:28 p.m. to 9/28/22, at 10:17 p.m. -9/30/22, at 2:57 p.m. to 10/4/22, at 10:01 p.m. -10/6/22, at 8:00 p.m. to 10/10/22, at 8:00 a.m. -10/10/22, at 8:00 a.m. to 10/13/22, at 8:00 a.m. -10/15/22, at 3:08 p.m. to 10/19/22, at 2:50 p.m. -10/19/22, at 2:50 p.m. to 10/23/22, at 8:00 p.m. -10/24/22, at 8:00 p.m. to at least 10/27/22, at 2:48 p.m.	F 690		

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F 690	Continued From page 52 R51's medication administration record (MAR) dated 9/1/22, thru 10/27/22, indicated R57 received a 10 milligram (mg) of bisacodyl (a suppository) on: -10/4/22 at 3:12 p.m. -10/13/22, at 7:25 a.m. -10/19/22, at 7:13 a.m. During an interview on 10/24/22, at 7:18 p.m. family member (FM)-F stated staff were to be monitoring R51's bowel movements daily. FM-F stated R51 should have been given a suppository on the morning of the third day of him not having a BM. However, because it was an "as needed" medication, the trained medical assistants (TMAs) would forget to tell the nurse and R51 wouldn't get the suppository when he should. FM-F stated R51 went four days without a BM last week and she had to tell the nursing staff to give him a suppository which made FM-F "so mad" because it increased R51's pain and wears him out for the whole day. During an observation on 10/26/22, from 7:26 a.m. R51 was overheard in his room, moaning, and saying "hello?" multiple times. During an interview on 10/27/22, at 2:08 p.m. licensed practical nurse (LPN)-B stated she had repeatedly informed staff to monitor R51's BMs and if he hadn't had one for two days, to give him prune juice or "something" to help him move his bowels. LPN-B stated the facility Standing House Orders (SHO) indicated a suppository should be given on the morning of the third day a resident had not had a BM. LPN-B stated R51 should have received a suppository the previous morning but did not get one until that day. LPN-B further	F 690		

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F 690	Continued From page 53 stated R51 would get worn out and moan a lot if staff waited until the fourth day to give the suppository. During an interview on 10/27/22, at 2:55 p.m. the director of nursing (DON) stated resident BMs should have been monitored daily and residents who had not had a BM for two days should be given a suppository on the morning of the third day to avoid obstruction, impaction, and pain. The DON further stated when R51 didn't get a suppository until the fourth day of not moving his bowels, he would have increased behaviors and fatigue. A facility policy on the treatment of constipation and bowel movement monitoring was requested but not received.	F 690		
F 695 SS=E	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Surveyor: 44658 Based on observation, interview, and record review the facility failed to ensure staff were appropriately trained and applied a continuous positive airway pressure (CPAP) machine with the	F 695	The facility reviewed the policy on O2 Equipment on 12/1/22. The facility policy on Liquid Oxygen Therapy was updated to speak to the changing of the o2 tubing on 12/1/22, The staff were trained on the policy and	12/8/22

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F 695	Continued From page 54 use of distilled water. The facility also failed to ensure there was a method to identify when O2 tubing needed to be replaced or changed for 3 of 3 (R15, R16, R27) residents. Furthermore, the facility failed to ensure caution signs were place on 3 of 3 (R15, R16, R27) resident doors to identify when oxygen was in use. Findings include: During an observation and interview on 10/25/22, at 11:16 a.m. R57's ResMed AirSense 10 CPAP machine was on his bedside table, the attached humidified water container was dry, and no distilled water was found in R57's room. R57's family member (FM)-E, who was in the room, verified there was no distilled water in R57's room, closet, or bathroom. During an observation and interview on 10/26/22, at 8:38 a.m. R57's CPAP machine was on his nightstand, the attached container for the humidified water was dry and no distilled water was found in his room. Trained medical assistant (TMA)-E stated the night nursing assistant (NA) would put the CPAP on R57 at night and the morning NA would take it off and clean it. TMA-E also stated she was told R57 woke up yelling during the previous night, so the staff removed the CPAP mask from his face. Review of the Resmed AirSense 10 user guide dated February 2021, (document.resmed.com) indicated adverse effects for the use of the CPAP were: Dryness of the nose, mouth, or throat Nosebleed Bloating	F 695	procedures of the O2 equipment 11/30/22, 12/6/22, 12/7/22, 12/8/22. The storage rooms on each floor have been stocked with par levels of distilled water on 12/1/22. Bags have been purchased for the O2 tubbing with dates to indicate the change dates on 12/1/22 Caution signs O2 being used signs have been placed outside 11 resident rooms who currently receives O2 treatments door on 12/8/22 The topic and audits have been added to the Quality Score card and the agenda for monthly quality meetings. Audits: 100% observations 2 observations of residents with CPAP, neb and/or oxygen per week x 4; 4 observations per month x 3; 4 observations quarterly.	

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F 695	Continued From page 55 Ear or sinus discomfort Eye irritation Skin rashes Instructions for use of the CPAP indicated to open the water tub and fill it with distilled water up to the maximum water level mark. Do not fill the water tub with hot water. Close the water tub and insert it into the side of the device. After stopping therapy, a Sleep Report would be generating including an indicator for the proper functioning of the humidifier. The humidifier moistens the air and is designed to make therapy more comfortable. Ensure the CPAP machine is lower than the patient's head to prevent the mask and air tubing from filling with water. R57's quarterly Minimum Data Set (MDS) dated 10/5/22, indicated R57 had severe cognitive deficits. R57 required supervision of one staff for eating and extensive assistance of two staff for all other activities of daily living (ADLs). R57 had diagnoses that included insomnia, Alzheimer's and dementia with behavioral disturbances, Multiple Sclerosis (MS), memory loss, and obstructive sleep apnea (OSA-sleep-related breathing disorder causing the airway to become obstructed and occasional to frequent cessation of breathing). R57's Care Area Assessment (CAA) dated 4/22/22, lacked indication R57 had a respiratory concern or used a CPAP machine. R57's care plan dated 10/25/22, indicated R57 required assistance with some or all ADLs and required the use of adaptive equipment. R57 had communication deficits related to hearing loss,	F 695		

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F 695	Continued From page 56 problems making himself understood and understanding others due to declining cognition. R57 also had respiratory concerns related to OSA and using a CPAP. Interventions included putting the CPAP on every night and cleaning it weekly. No other interventions or instructions for the application or use of the CPAP were indicated. During an interview on 10/26/22, at 10:04 a.m. TMA-F stated although she got R57 up that morning, she had not emptied or cleaned the water out of R57's CPAP machine. TMA-F then verified R57's CPAP machine did not have any water in the humidifier container. TMA-F also stated there should have been a bottle of distilled water in R57's room to use in his CPAP and did not know why it wasn't there. During an interview on 10/26/22, at 12:36 p.m. overnight NA-E stated she applied R57's CPAP in the evenings and that R57 did not need water in his CPAP machine. During an interview on 10/26/22, at 2:34 p.m. overnight NA-D stated R57 had not refused or resisted using his CPAP machine when she applied it to his face; however, NA-D would reposition R57's CPAP during the night if he knocked it off. NA-D further stated she had never put water in R57's CPAP machine because it was unnecessary. R15's quarterly MDS dated 8/17/22, indicated R15 had intact cognition, was independent for eating but required extensive assistance of two staff for all other ADLs. The MDS lacked indication that R15 was on oxygen therapy.	F 695		

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F 695	Continued From page 57 R15's diagnoses included congestive heart failure (CHF), shortness of breath, lower leg edema (water retention), obstructive sleep apnea (OSA), atrial fibrillation (an irregular heartbeat), and rhinitis (inflammation of the nasal passages). R15's physician orders dated 9/21/22, indicated R15 was on humidified oxygen therapy requiring the oxygen filter, tubing, and humidifier to be changed. During an observation on 10/25/22, at 12:03 p.m. R15 was in her room with 2 liters per minute (LPM) oxygen being delivered by nasal cannula from a large oxygen tank. The oxygen and nasal cannula tubing lacked a label to indicate when they had last been changed. Additionally, no caution or safety sign was posted outside R15's door to indicate oxygen was being used in the room. Documentation indicating R15's tubing and humidifier was being changed weekly was requested but not available. R16's quarterly MDS dated 8/17/22, indicated R16 had mild cognitive deficits, was independent for eating, required extensive assistance of one staff for all other ADLs and was on oxygen therapy. R16 had diagnoses that included aortic stenosis (hardening of the aortic heart vessel), chronic respiratory failure, chronic obstructive pulmonary disease (COPD), anxiety, heart failure, dementia, and oxygen dependence. R16's Oxygen Tubing Change History indicated R16's oxygen tubing had been changed as follows: -10/24/22	F 695		

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F 695	Continued From page 58 -10/3/22 -9/3/22 -8/27/22 -8/13/22 -8/6/22 -7/30/22 -7/23/22 -7/17/22 -7/2/22 R16's oxygen tubing was not changed seven out of the 17-week log. During an observation on 10/26/22, at 11:02 a.m. R16 was in a recliner in her room with 2 LPM humidified oxygen being delivered by nasal cannula from a large oxygen tank. A second large oxygen tank was also in the room, unused. The oxygen, and cannula tubing, and humidified water container lacked a label to indicate when they were last changed. There was also no caution or safety sign outside R16's door indicating oxygen was being used in the room. During an interview on 10/27/22, at 3:24 p.m. the director of nursing (DON) stated NAs put the CPAP masks on residents at night, then nursing staff should do hourly checks to ensure they were working properly. The DON stated R57's CPAP should have been filled with distilled water according to the manufacturer's recommendations to avoid dryness and/or night-time behaviors. The DON also stated staff should label the oxygen, and nasal cannula tubing, and water containers to indicate when they were last changed, and caution signs should be posted outside resident rooms when the residents were using oxygen. The DON further stated staff should document in a resident's chart, when they changed the tubing and water	F 695		

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F 695	Continued From page 59 containers to ensure they were changed weekly. A facility policy for CPAP machine application and use was requested but not provided. Surveyor: 39988 R27's 8/30/22, significant change Minimum Data Set (MDS) assessment identified R27 had difficulty staying focused, was easily distracted, and had a hard time keeping track of what was said. R27 required extensive assistance of 2 staff for all cares. R27 had chronic obstructive pulmonary disease (COPD), Alzheimer's disease, diabetes, and history of acute respiratory failure. R27 required oxygen therapy and was receiving hospice services. R27's current care plan identified respiratory status as active with a start date of 10/24/22, as evidenced by COPD. Maintain respiratory status, nebulizer tubing change every Monday at 8:00 a.m. Oxygen therapy to keep oxygen saturation above 90% titration between 1-4 liters via nasal cannula, wean as tolerated. Oxygen filter, clean and change per protocol, oxygen humidifier change per protocol, and oxygen tubing change per protocol all initiated on 7/29/22. The facility revised the care plan on 10/24/22, after surveyor inquired about how the facility tracked that tubing was being changed for the nebulizer and oxygen being used. Following revision the care plan still lacked evidence of a schedule for changing the oxygen tubing. R27's Active Medication List printed 10/25/22, identified Albuterol/ipratropium 3 milliliters (ML) inhalation nebulizer treatment every 6 hours scheduled.	F 695		

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F 695	Continued From page 60 Observation and interview on 10/25/22 at 10:03 a.m., R27 stated she has used oxygen for a long time. R27's oxygen tubing was undated. There was no sign on R27's door indicating she was on oxygen therapy. Observation on 10/26/22 at 9:35 a.m., R27's nebulizer treatment mask was still attached to the machine sitting on bedside table and the tubing was undated. Observation on 10/26/22 at 11:50 a.m., R27's nebulizer treatment mask was still attached to the machine on bedside table and tubing was undated. Interview on 10/26/22 at 11:05 with trained medication aide (TMA)-C revealed that the oxygen tubing and nebulizer tubing should be changed weekly and dated. She agreed with no date or charting that there would be no way to know when last changed. Interview on 10/27/22 at 1:00 p.m., with director of nursing (DON) confirmed she had entered the order to change oxygen and nebulizer tubing every 7 days. She confirmed that previous to today there would have been no way to know if the tubing had been getting changed as it was not being date or charted. She further confirmed that no one on oxygen had a sign outside of their room identifying that oxygen was in use and there should be. Review of the May 2022, Liquid Oxygen Therapy Use in LTC policy identified that cannula's and bubblers should be changed on a weekly basis, the same day of week. There was no mention of	F 695		

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F 695	Continued From page 61 changing the tubing for oxygen or nebulizer's in the policy.	F 695		
F 732 SS=F	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the	F 732		12/8/22

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F 732	Continued From page 62 posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Surveyor: 39988 Based on observation and interview the facility failed to ensure daily nurse staffing information was posted on each of the 2 floors of the facility in a visible prominent place readily accessible to visitor and resident within the nursing home. This had the potential to affect all 69 residents and visitors who wanted to review this information. Interview on 10/25/22 at 2:19 p.m., with trained medication aide (TMA)-D identified that there was no posting of staff on duty anyplace for residents or visitors to view. That information was only accessible on the computer. She was unaware if any paper form with that information was posted in the building. Interview on 10/25/22 at 2:20 with registered nurse (RN)-E identified that nurse staffing information was located on the computer and then on weekends it is on paper. She was unaware if any paper form was posted in the building that showed nurse staffing information. Observation on 10/25/22 at 2:32 p.m., daily nursing staff posting was found by the elevators to go down to the lower level hanging on the wall at wheelchair height below a poster along with several other papers which were all on hooks in a clear plastic protective sleeve. This location was straight down the hall from the entrance to the building located by a conference room. From the front door entrance both resident living	F 732	The facility updated the Staff Nurse Posting policy to reflect the updates on 12/1/22. The staff have been trained on the updated policy and where the report is located on 11/30/22, 12/6/22, 12/7/22, 12/8/22. The new location has been established and the hours posted on the ground floor by the elevator and the posting area has been moved upstairs to be located in the front lobby on 12/6/22. Families will be communicated to on the location of the nurse hours posting locations at the family council meeting on 12/15/22. Residents were communicated to on the location of the nurse hours posting at the resident council meeting on 12/8/22. We have added this audit and topic to be discussed at our monthly quality meetings and also our monthly resident council meetings. Audits: 100% observations 2 observations per week until 100% compliance. x 3 months then 10 observations quarterly.	

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F 732	Continued From page 63 quarters where located to the right of the main entrance and then divided into 2 hallways of resident rooms. The nursing staff posting was not visible to resident or visitors unless they went to the elevator and looked through the multiple items hanging on the wall. There was no posting of nurse staffing located in the lower level which also had 2 divided areas of resident rooms. Interview on 10/25/22 at 2:29 p.m., with administrator agreed that the staff posting was not placed on both floors of the building. Observation on 10/26/22 at 9:04 a.m., of the staff posting located by the first floor elevators was dated 10/25/22 from yesterday and not current. There were no other postings observed on either floor of the building. Observation on 10/27/22 at 9:19 a.m., unable to locate any nurse staff posting for the day on lower level. On first floor next to elevators is the staff posting in a clear plastic protective sleeve hanging on the wall at wheelchair height that has current date on it. Interview on 10/27/22 at 12:41 p.m.., with family member (FM)-C identified she was unaware of any type of information being posted in the building like that and stated that would be kind of nice to know. Interview on 10/27/22 at 12:43 p.m., with FM-D identified they had no idea that there was any type of information about how many staff were working and had never seen anything like that before. Interview on 10/27/22 at 3:52 p.m., with director	F 732		

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F 732	Continued From page 64 of nursing (DON) agreed that the staff posting was not visible and prominent to visitors or residents in its current location. She confirmed there had never been staff posting located on the lower level as it had only been placed by the elevators. She confirmed the current location was not by the entrance and agreed visitors and residents would not know where to even look for if they wanted to review. A policy for nursing staff posting was requested but not provided.	F 732		
F 744 SS=E	Treatment/Service for Dementia CFR(s): 483.40(b)(3) §483.40(b)(3) A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being. This REQUIREMENT is not met as evidenced by: Surveyor: 44658 Based on observation, interview, and record review the facility failed to develop and implement a person-centered dementia care and treatment plan for 1 of 1 (R57) residents with dementia. In addition, the facility failed to ensure 6 of 8 staff received specialized dementia training on how to care for residents with dementia. Findings include: R57's quarterly Minimum Data Set (MDS) dated 10/5/22, indicated R57 had severe cognitive deficits. R57 required supervision of one staff for eating and extensive assistance of two staff for all	F 744	The facility reviewed their policy on dementia training and updated it on 11/28/22. The facility reviewed the current training for staff and updated it to meet the required training items The staff have all received the new updated training and are completing that training. The resident R57 care plan was updated to include resident -centered interventions to aide in his communication deficits. The audits have been placed on our quality score card and the topic on the quality agenda for our monthly meetings. Audits:	12/8/22

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F 744	Continued From page 65 other activities of daily living (ADLs). R57 had diagnoses that included major depressive disorder, psychotic disorder due to another medical condition with delusions, agitation due to dementia, insomnia, Alzheimer's and vascular dementia with behavioral disturbances, and memory loss. R57's annual MDS dated 7/7/22, indicated in Section F-Preferences - Routine & Activities, an interview for daily activity preference should not be conducted. R57's preferences were assessed by the staff as follows: -Yes: Reading newspapers, books, and magazines, listening to music, being around animals such as pets, and spending time outdoors. -No: Keeping up with the news, doing things in groups, participating in favorite activities, spending time away from the facility, and religious activities/practices. R57's Care Area Assessment (CAA) dated 4/22/22, indicated R57 triggered for cognitive loss/Dementia and was at risk for cognitive decline, changes in mood and behaviors, and inability to make needs known. R57 also triggered for mood and was at risk for worsening signs and symptoms, isolation, and behaviors. R57's care plan dated 10/25/22, indicated R57 was at risk for a communication deficit related to hearing loss, difficulty making himself understood and understanding others and declining cognition. Interventions included notifying a provider with critical results as needed, MDS nursing observations as needed, completing a Brief Interview for Mental Status (BIMS) as needed,	F 744	100% observations 2 observations per unit per week x4; 8 units observations per month; 8 observations quarterly	

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F 744	Continued From page 66 notifying family as needed, and completing a care conference summary as needed. The care plan lacked resident-centered interventions to assist, maintain, or improve R57's communication deficits. The care plan also indicated R57 was at risk for psychosocial well being evidenced by withdrawal from activities, grief over loss of roles/status, daily routine very different from prior pattern in the community and having a strong identification with the past. Interventions included visiting with R57 about past agricultural business and discussing his memory book and pictures. R57's care plan further indicated R57 had a deficit related to activities due to a lack of interest. Interventions included daily activity review, an activity evaluation, MDS preferences to be reviewed as needed, and a spiritual assessment to be completed. The care plan lacked indications of R57's preferences for activities or an individualized plan to increase R57's involvement in activities. The care plan also lacked evidence R57 had been evaluated for dementia to develop a resident-centered plan to decrease R57's repetitive behaviors R57's Care Conference Summary dated 7/19/22, indicated R57 had multiple medication changes due to psychological adjustments. R57 would also refuse to attend activities or say he didn't "want to bother anyone." The summary indicated for staff to encourage R57 to attend more activities to keep R57 busy and keep his mind "off of things." R57's Care Conference Summary dated 10/12/22, indicated R57 attended a few activities but generally did not stay long unless it was a one-to-one interaction.	F 744		

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F 744	Continued From page 67 R57's Activity Attendance Review dated October 2022, indicated out of 27 days, R57 only watched TV for 15 days, watched TV/computer/social time and or reading for 10 days, played a card game 1 day, attended an outing 1 day and attended 2 church services. R57's Behavior/Mood Assessment dated October 2022, was as follows: -10/1/22, at 8:00 p.m. R57 was yelling and calling for help. Staff spoke to him, and he is now sleeping well. -10/2/22, at 8:00 p.m. R57 was yelling and calling for help. Staff spoke to him, and he is now sleeping well. -10/4/22, at 8:00 a.m. R57 hollered out one time. FM-E redirected and R57 has remained calm. -10/7/22, at 8:00 a.m. some yelling out -10/7/22, at 8:00 p.m. R57 was yelling "help me" when staff was in his room setting up medications. Staff tried unsuccessfully to calm R57. -10/10/22, at 8:00 a.m. hollering out around lunch and early afternoon. Gave R57 newspaper, drink, book and turned on the TV to redirect but was unsuccessful. R57 calmed down around 2:30 p.m. and was moved to a recliner to relax. -10/10/22, at 10:30 p.m. R57 was yelling and calling for "help." Staff spoke to resident who stated he was "fine." R57 slept well the rest of the night. -10/12/22, at 8:00 a.m. R57 yelled "help me, help me." -10/14/22, at 8:00 a.m. R57 yelled "help me, help me." Redirected and brought to different area, however, R57 did not stop hollering until FM-E came for lunch. -10/16/22, at 8:00 p.m. R57 was yelling and	F 744		

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F 744	Continued From page 68 calling out for help. Sometimes used abusive language; however, was okay. -10/17/22, at 8:00 p.m. R57 was yelling and calling for help. -10/18/22, at 8:00 a.m. R57 had yelled all afternoon, has had many medication changes after consult with provider. -10/19/22, at 8:00 a.m. R57 had been yelling since he woke up. Was calm when he had 1:1 care. -10/20/22, at 8:00 p.m. yelling help me, help me. -10/21/22, at 8:00 a.m. yelling help me, help me. -10/22/22, at 8:00 a.m. yelling, calling out. -10/22/22, at 8:00 p.m. R57 was yelling and appeared confused, calling for help and asking aides what they were doing. -10/23/22, at 8:00 p.m. yelling and calling for help. -10/24/22, at 8:00 p.m. yelling out and calling for help. -10/25/22, at 8:00 p.m. R57 was yelling and calling for help and asking what was being done. During an observation on 10/26/22, at 8:38 a.m. R57 was waking up and laying in bed as trained medical assistant (TMA)-E was preparing R57's medications in his room. TMA-E picked up the bed controller at the foot of R57's bed and began raising the head of the bed. R57 began yelling out "Wait! Stop!" but TMA-E continued to raise the head of the bed without slowing or stopping, telling R57, "It's fine". R57 responded "No it's not"! TMA-E then told R57 she needed to give him his medications. After assisting R57 with his medications, R57 began asking "What's going on?" repeatedly. TMA-E did not respond to R57 until after the third time, telling R57 he had an appointment, and the nursing assistants (NAs) would be coming in to get him up. R57 asked what the appointment was for, but TMA-E did not	F 744		

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F 744	Continued From page 69 respond and left the room. R57, still sitting straight up in bed, began saying "help me please," "what's going on?" and "nobody will talk to me" repeatedly. TMA-E was summoned back to the room but was unable to provide details regarding R57's appointment. TMA-E lowered the head of R57's bed then left the room. During an interview on 10/26/22, at 9:58 a.m. family member (FM)-E stated she felt the staff were ignoring R57 and his "dementia phase" was not being "delt with." FM-E would appreciate more attention to his dementia, stating when R57 was yelling he usually needed help with something or wanted something to do because R57 did not like to sit still. During an interview on 10/26/22, at 11:03 a.m. TMA-E stated dementia training was completed online but she could not recall interventions for residents with dementia except that a resident with dementia's thinking was their reality and "we just go with it". TMA-E stated they would give residents a newspaper or books to read but that most just watched TV. There were also puzzles in a cabinet that were brought out around the holidays for the residents to work on. TMA-E stated R57 yelled for help and would say no one was talking to him, "all day, every day," and "at some point you just leave him in a safe setting and leave him be." TMA-E stated although he can be pleasant to have a conversation with, R57 could also be rude and "it makes you not want to talk to him." TMA-E further stated the facility did not have the staff to sit and interact with him. During an interview on 10/26/22, at 1:29 p.m. licensed practical nurse (LPN)-B stated R57 liked to be involved in things and have one-to-one	F 744		

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F 744	Continued From page 70 attention, which the staff didn't have time to provide. The activities coordinator (AC) attempted to play cards with him the previous day but R57 kept yelling out. LPN-B stated the staff would have R57 sit out in the day room to take a nap which worked "pretty good." R57 also liked watching TV and reading magazines. LPN-B had looked through his memory book with him once which brought R57 joy because he would remember the photos. During an interview on 10/27/22, at 10:33 a.m. R57 stated he would get sad because he doesn't have enough interaction with people. He would prefer to talk to people instead of watch TV all day. R57 also stated there wasn't much for him to do. FM-E, who was visiting R57, stated R57 used to be a farmer and enjoyed being outdoors, watching people come and go, and building things like the birdhouse project the facility had organized previously. During an interview on 10/27/22, at 12:56 p.m. the AC stated because he recently started the position in May 2022, he had not had a chance to do an assessment on R57's activity preferences or spend one to one time with him, but the AC was aware R57 attended church services on Thursdays. The AC stated there was bingo every Monday and Wednesday, but R57 did not like to attend, and movie-night one Friday a month; however, R57's yelling would occasionally disturb the movie. The AC was aware R57 had a memory book and photo album in his room for staff to get to know R57 better and connect with him, but he had not looked at them or shared them with R57. The AC stated he played Uno (a card game) with R57 on Monday because FM-E stated R57 enjoyed the game; however, R57 did not appear	F 744		

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F 744	Continued From page 71 to remember how to play. The AC would occasionally sit with R57 when he would yell and R57 would be agreeable to the AC pushing him around the facility in his wheelchair. When AC asked R57 if he was aware he was yelling, R57 would say no. The AC further stated he "hadn't done a lot with the men" and was trying to find ideas because most of them did not like craft projects. During an interview on 10/27/22, at 3:03 p.m. the director of nursing (DON) stated R57's behaviors were mostly verbal outbursts. The DON stated she believed it had been hard for R57 to adjust to the facility because he had a private nurse at home and really embraced the one-to-one interaction. When staff talked to R57, he was "good", but would start yelling when staff walked away from him. There was no policy specific to behaviors and/or monitoring provided by the end of the survey.	F 744		
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	F 755		12/8/22

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F 755	Continued From page 72 biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Surveyor: 38687 Based on observation, interview and document review, the facility failed to administer medication according to manufacture's instructions and physician order for 1 of 25 observations. Additionally, the fcility failed to ensure the correct dose of Depakote (anti-siezure medication) was administered during a Gradual Dose Reduction (GDR) for 1 of 1 resident (R57). Findings include: Observation and interview on 10/25/22 at 5:00 p.m., with registered nurse (RN)- A as she prepared to administer R36's Novolog 70/30 Flex Pen insulin 30 units subcutaneous (SQ). RN-A was observed preparing to administer the insulin by cleansing the attachment site for the needle,	F 755	The facility reviewed the current Medication Administration policy and updates were made on 12/1/22. The staff were trained on the updated policy and procedures on11/30/22, 12/6/22, 12/7/22, 12/8/22. The Charge nurses will be expected to verify medication received matches what is in the order. Audits: 100% observation 2 observations per week x 4; 4 observations per month x 3; 4 observations per quarter.	

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F 755	Continued From page 73 attaching the needle to the pen and priming with 1 unit of insulin. RN-A dialed the pen to the 30 unit mark and administered the insulin to R36. She reported she always primed the insulin pen with one unit as that was what the facility policy identified. RN-A reported she had not read the insert provided with the insulin pens and was not aware of the instructions to prime with 2 units before administering the ordered insulin dose. Review of the manufacture's instructions for priming of the insulin Flex Pen identified following attachment of a new sterile needle, the pen was to be primed with 2 units of insulin before dialing the ordered insulin dose to be administered. Interview on 10/25/22 at 5:15 p.m., with licensed practical nurse (LPN)-B who was also the supervisor for the unit, reported she was not aware of the manufacture instruction to prime the Novolog Flex Pen with 2 units and waste prior to administration of the ordered dose. Interview on 10/28/22 at 9:30 a.m., with the director of nursing (DON) voiced her expectation that manufacture's recommendations be followed when priming and administering insulin with insulin pens. R57's quarterly Minimum Data Set (MDS) dated 10/5/22, indicated R57 had severe cognitive deficits. R57 had diagnoses that included major depressive disorder, psychotic disorder due to another medical condition with delusions, agitation due to dementia, insomnia, Alzheimer's and vascular dementia with behavioral disturbances, and memory loss. R57's physician orders dated 10/18/22, at 1:45	F 755		

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F 755	Continued From page 74 p.m. indicated R57 was to have a GDR of his Depakote as follows: Depakote Sprinkles 125 milligrams (mg) -Take 2 capsules (250 mg) 3 times per day (750 mg) for 3 days from 10/19/22, to 10/21/22. -Take 1 capsule (125 mg) 3 times per day (350 mg) for 3 days from 10/22/22, to 10/24/22. -Take 2 capsules (250 mg) 2 times per day (500 mg, an increase) for 3 days from 10/25/22, to 10/27/22. -Take 2 capsules (250 mg) 1 time per day (250 mg) daily for 3 days from 10/27/22, to 10/29/22, then discontinue. R57's physician orders dated 10/18/22, at 2:54 p.m. indicated R57's corrected GDR was as follows: -Take 2 capsules (250 mg) 3 times per day (750 mg) for 3 days from 10/19/22, to 10/21/22. -Take 1 capsule (125 mg) 3 times per day (350 mg) for 3 days from 10/22/22, to 10/24/22. -Take 2 capsules (125 mg) 2 times per day (250 mg, corrected) for 3 days from 10/25/22, to 10/27/22. -Take 2 capsules (125 mg) 1 time per day (125 mg, corrected) daily for 3 days from 10/27/22, to 10/29/22, then discontinue. R57's Orders with Administration record from 10/1/22, thru 10/27/22, indicated the original, incorrect gradual dose reduction order was entered into R57's electronic medical record (EMR); however, the pharmacy delivered R57's Depakote in accordance with the correct GDR order; therefore, R57 was administered incorrect doses and/or no doses of Depakote as indicated below:	F 755		

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F 755	Continued From page 75 -10/19/22, to 10/20/22, Depakote 250 mg three times per day. -10/21/22, to 10/23/22, Depakote 125 mg three times per day. -10/24/22, Depakote 125 mg twice. -10/25/22, Depakote 250 mg twice. -10/26/22, Depakote 125 mg once. -10/27/22, Depakote 125 mg once. During at interview on 10/26/22, at 1:29 p.m. licensed practical nurse (LPN)-B stated the provider had ordered a gradual dose reduction (GDR) for R57's Depakote; however, the pharmacy had been sending incorrect doses. LPN-B stated because the pharmacy did not send the correct dose, R57 did not receive his morning dose of 125 mg of Depakote prior to leaving for an appointment with his family member (FM)-E that day. LPN-B stated "poor" FM-E "is probably going crazy" due to R57's likely increases in behaviors. LPN-B further stated she told the prior evening staff to order more Depakote; however, it did not appear to have been done. LPN-B stated the order on 10/24/22, for 125 mg twice a day for a total of 250 mg was correct. LPN-B also stated the order on 10/25/22, for 250 mg twice a day for a total of 500 mg was also correct although R57 was supposed to be on a GDR. LPN-B further stated the staff who received R57's Depakote from the pharmacy should have verified the dose was correct against the order. Furthermore, the staff administering the medication should have verified the medication card dose matched the order prior to administering the medication, and any discrepancies should have been verified with the pharmacy. During an interview on 10/27/22, at 3:57 p.m. the pharmacist (PH) stated the pharmacy received	F 755		

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F 755	Continued From page 76 multiple prescriptions on 10/18/22, for R57's Depakote medication. At 1:54 p.m. an order was received indicating R57's GDR for his Depakote beginning on 10/19/22; however, there was a discrepancy. The order indicated the dose on 10/25/22, increased from R57's prescribed dose on 10/24/22, instead of decreasing. The PH contacted the provider and at 2:46 p.m. on 10/18/22, the pharmacy received a corrected order to indicate R57 should have received 125 mg of Depakote twice a day from 10/25/22, to 10/27/22. During an interview on 10/27/22, at 3:30 p.m. the director of nursing (DON) stated staff were expected to verify medication received from the pharmacy matches what is on the order. The DON also stated staff should verify they are administering the correct dose of a medication to a resident and clarify any discrepancies with the provider and/or pharmacist prior to administering it. Review of the May 2023 policy Medication Administration identified all medications were to be stored and administered according to manufacture's guidelines.	F 755		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.	F 761		12/8/22

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F 761	Continued From page 77 §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Surveyor: 34083 Based on observation and interview the facility failed to ensure medications were stored securely in 3 of 25 rooms on the Horizons unit, and in 2 of 12 rooms on the Transitions unit. Findings include: During an observation and interview on 10/26/22, at 10:04 a.m. R57's in-room medicine cabinet used to store R57's non-narcotic, facility medications, was found unlocked.. Family member (FM)-E and trained medical assistant (TMA)-F were present in the room. TMA-F stated the cabinet should have been locked. Observation on 10/28/22 at 8:06 a.m. with LPN-C on the Horizons unit identified Rooms 2, 18, and 33 were unsecured with the attached touch pad	F 761	The facility reviewed the Mediation Storage policy on 12/1/22. Trained the staff on the policy and also how to report a broken piece of equipment 11/30/22, 12/6/22, 12/7/22, 12/8/22. The broken lock was fixed immediately by the Maintenace team on 10/28/22. Audits: 100% observations 2 observations per unit x 4 ; 8 observations per month x 3; 8 observations per quarter.	

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F 761	Continued From page 78 lock mounted on the door of the cabinet. Rooms 2 and 33 were noted to not have the lock engaged, but room 18 the lock was nonfunctioning. Observation on 10/28/22 at 8:30 a.m., on the Transitions unit with RN-F identified Room 7 and 10 had in room medication cabinets that were not secured. Both RN-F and LPN-C confirmed that anyone entering the identified rooms could have had access to the medications stored in the cabinets and they should have been secured immediately following administration of any medications. Interview on 10/28/22 at 9:15 a.m. with RN-D the nursing supervisor, reported her expectation for in room medication cabinets be locked when medications were not being administered and if there was a problem with the locking mechanism it should be reported immediately to maintenance. Until the lock was repaired, she stated any medications were to be removed and stored in a secure location until the issue was resolved. Interview on 10/28/22 at 10:55 a.m., with the administrator reported she had not been made aware of an issue with the locking mechanism on room 18's medication storage cabinet and her expectation was for a work to be submitted immediately. She verbalized she should have been made aware of the concern immediately by staff and intervention implemented. A policy for in room medication storage was requested but not provided prior to exit.	F 761		

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F 812	Continued From page 79	F 812		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Surveyor: 44658 Based on observation, interview, and document review the facility failed to ensure potentially hazardous food was cooled properly in the refrigerator after being cooked and failed to ensure food was properly labeled and dated after being removed from their original packaging. In addition, the facility failed to ensure fans were positioned to avoid blowing from a dirty environment to a clean environment in the dish washing area of the main kitchen. These deficient practices had the potential to affect all 68 residents who ate from the main kitchen.	F 812	The facility reviewed the Cooling of Potentially Hazardous Foods policy and process on 11/30/22. Trained the dietary cooks on the policy updates on 12/1/22,12/2/22 and 12/6/22. The facility reviewed and updated the LTC Food Safety & Sanitation policy and process on 11/30/22. The staff have been trained on the updated policy and process on 12/6/22. New hire training module was created for the updated policies. Additional fan on the cart was removed on 10/25/22. The fan above the pots and pans sink was	12/8/22

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F 812	Continued From page 80 During the initial kitchen observation and interviews on 10/24/22, from 2:15 p.m. to 5:30 p.m. with the dietary director (DD), the following was observed: Main kitchen dry storage: -Dry, white rice in a large plastic bucket approximately 1/6th full, with no expiration date or fill date -Dry, wild rice in a large plastic bucket, full, with no expiration date or fill date -Multiple large cans of food approximately 6 pounds (lbs) 11 ounces (oz) including but not limited to pineapple tidbits, various tomatoes (diced, sliced), ketchup, and spaghetti sauce were removed from their original shipping box and stored on the shelf without an expiration date. -Chocolate sheet cake on cart covered with plastic wrap, expiration labeled "X 31" (no month). -An opened and used apple juice box (46 fluid oz) expiration labeled "X 30" (no month). Main kitchen refrigerator: -A tray of wrapped, half-sandwiches on a shelf contained: two egg salad, six turkey, and six ham sandwiches all labeled with an expiration of "X 29" (no month). -Three, uncovered trays of two-dozen, pasteurized eggs, lacked an expiration date. -Three, uncovered metal containers filled with frozen veggies, on a cart, lacked a label indicating when they were opened or intended to be used by. Main kitchen freezer:	F 812	removed on 12/6/22. Audits were completed of the food storage locations in the main kitchen and the four kitchen areas in the long term care units to check for expiration dates on food items were correctly labeled with the month/date/year completed on 12/7/22. Audit: 100% observations 2 observations per unit per week x 3; 4 observations per month; 4 observations per quarter.	

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F 812	Continued From page 81 -A clear, plastic bag containing approximately a dozen, frozen, red meat patties unlabeled with no expiration date. -Unknown, frozen, breaded food item in metal container with no lid, label, or expiration date. During an interview at approximately 3:00 p.m. the Cook (CK)-B stated the uncovered, breaded food item in a small metal container was frozen shrimp she had just put in there to defrost for the evening meal. CK-B asked this surveyor if they should be covered. CK-B also stated she assumed the meat patties were placed in the freezer that day but was not sure. Main kitchen cooler: -Five large turkey breasts, wrapped in foil then cut entirely lengthwise, exposing the meat, were on a cart in the back of the freezer, directly under the fan. Large, plastic ice packs had been folded in half and stuffed inside each turkey breast. During an observation and interview on 10/24/22, at 4:20 p.m. registered dietician (RD)-B temp'd the turkey breasts as follows: 75 degrees Fahrenheit 90 degrees Fahrenheit 80 degrees Fahrenheit 82 degrees Fahrenheit 80 degrees Fahrenheit During an interview on 10/24/22, at 4:35 p.m. CK-B stated she cooked the turkey breasts to 168 degrees Fahrenheit that afternoon, then put them in the cooler at 1:00 p.m. They would be sliced the next day, then served the day after that. CK-B stated the ice packs were placed in the turkey	F 812		

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F 812	Continued From page 82 breasts to speed the cooling process. CK-B further stated although the ServSafe food handler certification course she completed, advised cooling meat in cold water, CK-B found that unappetizing and refused to do it. Main kitchen: -Two large metal carts (approximately 18" wide by 24" deep by 30" high) on wheels were stored under an industrial sink. One contained, and was labeled "sugar," (white) the other contained, and was labeled "flour" (white). The carts lacked and expiration date or when they were last filled. -Multiple bulbs of garlic in an open plastic tub dated 6/3. Some of the bulbs were soft and/or a dark brown in color. During an interview at approximately 3:50 p.m. the DD stated she did not know how long garlic was good for and that she would probably toss them. The DD further stated there was no specific length of time for how long they would keep garlic. Main Kitchen Dish Washing area: -An industrial carpet and floor dryer/fan was placed on a cart between where the dirty pots and pans were cleaned in three metal sinks and where they were placed on shelves to dry after being sanitized. The fan was covered in dust and dirt and blowing air onto the clean pots and pans from approximately five feet away. Another wall mounted fan was in the ceiling corner above the dirty pots and pans area, also blowing in the direction of the clean drying racks. During an interview on 10/24/22, at approximately	F 812		

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F 812	Continued From page 83 5:30 p.m. dietary aid (DA)-A stated they used the industrial fan on the cart to help dry the clean pots and pans faster. The corner ceiling fan also helped dry the pots and pans as well as keep the staff cool. During an observation and interview on 10/24/22, at 5:05 p.m. in the first-floor kitchenette refrigerator, two open and uncovered trays containing 27 pasteurized eggs lacked a label to indicated when they were opened or when they would expire. DA-B stated she did not know when the eggs were put into the refrigerator or when they would expire. During an interview on 10/25/22, at 9:35 a.m. dietary director (DD) stated the cans of food should have been labeled with an expiration date after they were removed from their original shipping boxes. The DD also stated staff should be writing expiration dates with the month and day they expire to avoid confusion and serving expired food to residents. Cooked meat should be cooled according to the guidelines to lessen the possibility of bacterial growth and to ensure the residents don't get sick. The DD stated the sugar and flour in the metal carts were good for approximately eight to nine months and the carts would be washed prior to refilling them; however, there was no documentation to indicate when the sugar or flour was put into the carts and, therefore, the DD did not know when they would expire. The DD further stated fans blowing from a dirty area to a clean area would be a concern for cross contamination. The facility referenced the "Food Storage Guide. Answer the Question ...How long can I store before its quality deteriorates or it's no longer safe	F 812		

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F 812	Continued From page 84 to eat?" article by Julie Garden-Robinson. NDSU Extension Service; dated February 2012 as the facility policy on food storage. The article indicated white flour was to be stored in an airtight container in the refrigerator for 6-8 months. Shell eggs were to be stored covered for 3 weeks. The facility Chill Down Log undated, indicated if the initial food temperature was greater than 140 degrees Fahrenheit, check the food frequently until the food reaches 140 degrees Fahrenheit or less. After 2 hours of cooling, if the food temp is 41 degrees Fahrenheit or less, the cooling process was complete. If the food temp was between 42-70 degrees Fahrenheit, continue to cool the food and re-check the temperature after an additional 2 hours. However, if the food temperature is above 70 degrees Fahrenheit, the food must be discarded or properly reheated to 165 degrees Fahrenheit for 15 seconds then begin the cooling process again. No other facility policy on food storage or labeling was provided.	F 812		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program.	F 880		12/8/22

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F 880	Continued From page 85 The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and	F 880		

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F 880	Continued From page 86 (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Surveyor: 44658 Based on observation, interview, and document review, the facility failed to: 1) Ensure 1 of 1 resident (R33) was placed into transmission based precautions (TBP)and tested immediately after showing symptoms of COVID. This had the potential to affect 1 other resident (R8) who shared a table with R33 at each meal. 2) Ensure appropriate hand hygiene was maintained during 1 of 1 IV antibiotic administration. 3) Appropriately clean all 6 of 6 whirlpool tubs and appropriately launder and transport and store linen on the Meadows and Garden wings located on the 1st floor. 4) Implement appropriate infection control (IC) technique during 1 of 1 dressing change for R56. 5) Maintain 1 of 1 resident (R27) nebulizer machine in a sanitary manner. Findings include:	F 880	The facility policy on Transmission Based Precautions was reviewed on 12/1/22. The facility policy of hand hygiene was reviewed on 12/1/22. The facility policy on equipment cleaning in LTC was reviewed and updated on 12/2/22. The facility policy on infection control standard of precautions on 12/2/22. The facility policy and process on Laundry in LTC was reviewed and updated on 12/1/22. Training with staff on all infection prevention items was completed on 12-4-2022 and 12-8-2022. Training was also added to the new hire training materials. Processes developed per manufacturer infection for use on whirlpools that are in use. One whirlpool was taken out of service. New process developed for storage of	

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F 880	Continued From page 87 Transmission Based Precautions and Testing of COVID Symptomatic Residents R33's annual Minimum Data Set (MDS) dated 9/7/22, indicated R33 had intact cognition, was independent with eating, required extensive assistance of one staff for bed mobility and limited assistance with all other activities of daily living (ADLs). R33's diagnoses included prostate cancer, coronary artery disease, high blood pressure, and kidney disease. R33's Care Area Assessment (CAA) dated 9/7/22, indicated R33 triggered for communication, ADL function, falls, and pressure ulcers. R33's care plan dated 9/1/22, indicated R33 was at risk for communication related to new onset of cognitive losses resulting in poor recall and safety awareness. R33's progress note dated 10/26/22, at 7:59 a.m. indicated R33 had been having a cough and nasal congestion since receiving his immunizations six days prior. R33 stated he felt fine except for the infrequent cough he had. R33's SARS-CoV-2 (PCR) test dated 10/26/22, at 9:15 a.m. indicated R33 was positive for COVID-19. During an observation on 10/26/22, at 7:54 a.m. from approximately 40 feet down the hallway, outside the resident dining room, licensed practical nurse (LPN)-B was overheard asking R33 if his cough had improved since the previous day. R33 stated it was a "bad head cold" he couldn't get rid of and felt worse. LPN-B took	F 880	linen including ted hose. Along with new process and new policy implemented for laundry process to ensure cross contamination does not occur. Audits: COVID - 100% observations 2 observations per unit per week x 4' 8 observations per month x3; 8 observations quarterly Hand Hygiene- 100% observations 30 observations per month Tub Cleaning - 2 observations per unit per week x 4; 8 observations per month x 3; 8 observations quarterly. Laundry - 2 observations per unit per week x 4; 8 observations per month x 3; 8 observations quarterly.	

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F 880	Continued From page 88 R33's blood pressure, temperature and oxygen level and reported them as "fine", telling R33 she would inform the provider. R33 then self-propelled his wheelchair into the resident dining room, without a mask, where other residents were seated for breakfast. During an interview on 10/26/22, at 11:20 a.m. LPN-B stated she tested R33 for COVID-19 at 8:45 a.m. using a rapid antigen test that indicated R33 was positive for COVID-19. Thirty minutes later, LPN-B tested R33 for COVID-19 using a polymerase chain reaction (PCR) test which also indicated R33 was positive. LPN-B stated R33 received a COVID-19 booster and influenza vaccine on 10/20/22. On 10/22/22, R33 began having diarrhea, however, R33 had a history of diarrhea and therefore the staff did not believe it was a concern. On 10/24/22, R33 began having nasal congestion but he believed it was a result of being outside that day. On 10/25/22, LPN-B stated R33 developed a cough, and she should have quarantined him on transmission-based precautions (TBP) and tested him for COVID-19 at that time but did not. LPN-B stated she also failed to notify the provider of R33's new onset of symptoms until today, 10/26/22. LPN-B further stated she should have redirected R33 to his room, placed him on TBP, and tested him for COVID-19 instead of allowing him to eat breakfast with other residents in the dining room that morning. The facility COVID-19 Outbreak Guidelines policy dated 10/2022, indicated the facility should have a plan in place to identify a COVID-19 outbreak, and the process to prevent further transmission. A single new case of COVID-19 in any resident should be evaluated to determine if others in the	F 880		

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F 880	Continued From page 89 facility could have been exposed. No further documentation was provided regarding the facility process for identifying and responding to a resident with a new onset of COVID-19 symptoms. IV Antibiotic Therapy R64's quarterly Minimum Data Set (MDS) dated 10/12/22, indicated R64 had mild cognitive deficits, required supervision for eating and extensive assistance for all other activities of daily living (ADLs). R64 had diagnoses that included hypothyroidism (low functioning thyroid), heart failure, chronic obstructive pulmonary disease (COPD), Alzheimer's and dementia, malnutrition, a chronic non-pressure ulcer of the foot, and osteomyelitis of the foot (a bone infection). During an interview on 10/25/22, at 10:38 a.m. R64 stated she was receiving an antibiotic (Ceftriaxone 2 grams in 50 milliliters normal saline) intravenously (IV) for an infection in her foot that went into the bone. During an observation an interview on 10/26/22, at 8:28 a.m. licensed practical nurse (LPN)-A was observed attaching an intravenous (IV) antibiotic medication to an IV line in R64's right arm without wearing gloves. The medication pump alarmed with an error and LPN-A attempted to troubleshoot the occlusion by touching the pump machine, tubing and R64's arm and clothing without first performing hand hygiene. LPN-A stated she should have worn gloves to administer the IV medication, removed them, then performed hand hygiene prior to touching anything else to avoid cross contamination.	F 880		

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F 880	Continued From page 90 During an observation and interview on 10/26/22, at 7:15 a.m. multiple pairs of compression socks were observed hanging over hallway handrails in front of rooms 123, 128, 134, 137, and 138. Nursing assistant (NA)-Carla was then observed walking out of a resident room, approximately 50 feet down the hallway, holding dirty bed linen against her uniform, and without wearing gloves. NA- disposed of the dirty linen in a laundry bin and walked back towards the resident room without performing hand hygiene. NA- stated because there was only "one dirty spot" on the sheets, she didn't think contamination would be a concern. NA- further stated the overnight staff would hang the socks on the handrails to dry because there was not a "good" place to hang them in the resident rooms and there was more "air flow" in the hallways. There was no specific policy related to IV antibiotics provided by the end of the survey. Surveyor: 38687 WHIRLPOOL TUB CLEANING Observation and interview on 10/26/22 at 3:50 p.m., with bath aide (BA)-F identified BA-F was beginning her cleaning and disinfecting of the whirlpool tub. BA-F had scrubs on and applied no personal protective equipment (PPE) (gloves, gown and goggles) prior to beginning the process. The tub was an Apollo whirlpool tub with water jets. BA-F began her process by opening pouring MasterCare one-step disinfectant/cleaner straight in without using any measurement. BA-F then used a toilet brush (designated for this use) to clean any debris from the sides of the tub. BA-F then filled the tub with water passed the	F 880		

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F 880	Continued From page 91 level of the water jets and turned the jets on and washed the top of the whirlpool chair. The sides of the tub were visibly dry before 60 seconds had elapsed. BA-F allowed the whirlpool jets to run until it caused bubbles to fill the tub. BA-F then used the sprayer to rinse out the tub. The process took less than 8 minutes. BA-F was unaware of any instructions for use on how to appropriately clean and disinfect the tub by the manufacturer. She was taught this way, and taught others to clean and disinfect the tub using this method. BA-F was unaware she should wear PPE during the cleaning and disinfection process. Review of the Apollo Advantage Bathing System manual located at https://apollobath.com/wp-content/uploads/2021/09/CD0012-Advantage-Operation-Manual.pdf, identified use of other manufacturer's cleaners and disinfectants was not recommended and could compromise the overall process. The tub came with a hose and compartment for their cleaning and disinfecting processes. The manufacturer recommended use of Cid-A-L cleaner and disinfectant. Staff were to clean and disinfect the whirlpool tub using the following process for: Cleaning 1) Place the chair in the tub, release the carrier from the tub, and close the door. 2) Close the Tub Drain. Turn the Selector Knob to "TUB CLEANER" and the Control Knob to "On." 3) Turn the whirlpool on. After the Turbo Clean (Trademark) mixture has come out of the jets for about 30 seconds or when there is about 2 inches of cleaning solution in the foot well; turn the Selector Knob to "Rinse." 4) Lift seat bottom off chair, (pull up from back of	F 880		

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F 880	Continued From page 92 seat). Use the cleaning solution to scrub the tub, chair and underneath seat bottom. When clear water comes out of all the jets, turn the whirlpool off. 5) Turn the Control Knob to "Off" and open the Tub Drain. 6) Use the shower wand to rinse the tub and chair. Disinfection 1) Place the chair in the tub, release the carrier from the tub, and close the door. 2) Close the Tub Drain. Turn the Selector Knob to "DISINFECTANT" and the Control Knob to "On." 3) Turn the whirlpool on. When there is about 2 inches of disinfectant in the foot well, turn the whirlpool off. Turn the Control Knob to "Off." 4) Lift seat bottom off chair, (pull up from back of seat). Use the disinfecting solution to scrub the tub, chair and underneath seat bottom. 5) Leave wet for 10 minutes (wet contact time for all surfaces). Open the Tub Drain. 6) After 10 minutes, turn the Selector Knob to "Rinse" and the Control Knob to "On." Turn the whirlpool on. When clear water comes out of all the jets, turn the whirlpool off. Turn the Control Knob to "Off." 7) Use the shower wand to rinse the tub and chair. LAUNDRY Observations of laundry processes on the first floor identified on: 1) 10/24/22 at 2:25 p.m., of the laundry room in the Gardens wing identified the laundry room was small, had a washer and dryer located inside it with automated chemicals were tubed into the	F 880		

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F 880	Continued From page 93 washing machine. Empty laundry baskets were stacked on top of the dryer. There was no visible sorting area to separate dirty linen from clean linen, and no sorting table for folding clean linen. Linen left in this room was uncovered and exposed to potential air contaminates when the laundry area was not separated. 2) 10/25/22 at 8:11 a.m., a laundry basket full of resident clothing was sitting on the floor in the hallway, uncovered, in a laundry basket outside R32's room. 3) 10/25/22 at 8:21 a.m., R56's clothing was sitting in an open laundry basket clean, uncovered outside the room in the hallway. 4) 10/25/22 at 8:22 a.m., R32's and R56's clothing baskets remained uncovered in the hallway and were still there at 8:50 a.m. Further observation on 10/27/22 at 8:04 a.m., R39's bathroom was visible from the hall. On the floor in the bathroom sat the same white laundry baskets seen previously throughout the facility with clean laundry, now holding dirty laundry and sitting on the bathroom floor. Review of the February 2020, Laundry and Linen procedures policy identified PPE was to be worn by laundry personnel when handling soiled linen. Laundry and linen employees were to receive 1 on 1 training by the manager including infection prevention and appropriate linen handling. Collection carts for soiled linen were to be used by the facility. Clean linen was to be placed on a covered cart and stored in an enclosed linen cart which was to be wheeled in patient areas. There was to be a counter to fold clean linen. There was no mention of using routine laundry baskets to both hold dirty and clean linens or how staff would ensure those baskets were cleaned appropriately.	F 880		

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F 880	Continued From page 94 DRESSING CHANGE Observation on 10/25/22 at 9:42 a.m. with registered nurse (RN)-A performing a dressing change to R56's pressure ulcers with assistance from nurse aide (NA)-G identified R56 was paralyzed and was unable to move her arms and legs independently. NA-G rolled R56 towards her so RN-A could perform the dressing change. RN-A had sterile dressings on a barrier on R56's bedside table. RN-A washed, dried her hands, and applied clean gloves. R56 had multiple areas in varied stages of healing. RN-A measured each wound with different paper measuring tapes using the same gloves touching the different pressure ulcer areas. RN-A needed a Q-tip to measure depth of 1 area, and without removing gloves, she went to R56's closet, and retrieved a tub of clean dressing supplies with her soiled gloves, touching those clean supplies and returning them to the cupboard. After finishing measuring all of the wound/pressure ulcer areas, RN-A then set the contaminated wound measuring tapes on top of the sterile dressings she had on the bedside table, along with her contaminated pen she used to record those measurements on the measuring tapes. She then proceeded to grab the bottle of wound wash and sterile 4x4's with her soiled gloves, and washed each wound using the same contaminated 4x4 gauze pads, cross contaminating the wounds. RN-A then applied bordered foam dressing without removing her contaminated gloves or performing hand hygiene and donning new gloves, and proceeded to apply the once sterile dressings to R56's wounds. RN-A then removed her same contaminated gloves at the end of the procedure and washed her hands. RN-A was unable to be interviewed immediately	F 880		

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F 880	Continued From page 95 after the dressing change due to her needing to assist another resident immediately after. Interview on 10/26/22 at 4:06 p.m., with the infection preventionist (IP) identified she performed environmental audits 2 x per year with the adjoining hospital safety advisor. She was unaware laundry was being cleaned and stored in the manners described above. She agreed definite processes needed to be changed to ensure cross contamination did not occur and laundry was handled and transported appropriately. She also noted she always had high increases of UTI in the facility and not disinfecting the whirlpool tubs appropriately could lead to an increase in urinary tract infections (UTI). The IP agreed RN-A should have performed appropriate hand hygiene and glove changes between tasks. RN-A should have also not contaminated clean or sterile dressing supplies. This was a cause of concern and cross contamination of R56's wounds. There was no policy related to appropriate hand hygiene or glove use provided by the end of the survey. Surveyor: 39988 NEBULIZER R27's 8/30/22, significant change Minimum Data Set (MDS) assessment identified R27 had difficulty staying focused, was easily distracted, and had a hard time keeping track of what was said. R27 required extensive assistance of 2 staff for all cares. R27 had chronic obstructive pulmonary disease (COPD), Alzheimer's disease, diabetes, and history of acute respiratory failure.	F 880		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVERA MORNINGSIDE HEIGHTS CARE CENTER	300 SOUTH BRUCE STREET MARSHALL, MN 56258

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F 880	Continued From page 96 R27 required oxygen therapy and was receiving hospice services. R27's current care plan identified respiratory status as active with a start date of 10/24/22, as evidenced by COPD. Maintain respiratory status, nebulizer tubing change every Monday at 8:00 a.m. R27's Active Medication List printed 10/25/22, identified Albuterol/ipratropium 3 milliliters (ML) inhalation nebulizer treatment every 6 hours scheduled. Observation on 10/25/22 at 10:03 a.m., R27 nebulizer mask was still connected to the machine with some moisture noted inside mask, the mask was laying in a basket on top of some papers next to the nebulizer machine. Observation on 10/26/22 at 9:35 a.m., R27's nebulizer treatment mask was still attached to the machine sitting on bedside table. Observation on 10/26/22 at 11:50 a.m., R27's nebulizer treatment mask was still attached to the machine on bedside table. Interview on 10/26/22 at 11:05 with trained medication aide (TMA)-C revealed that the person working on the medication cart and assisting with the nebulizer treatment would be the person responsible for cleaning the nebulizer equipment. The medication staff should rinse the mask and port that the medication goes in and set it on a clean paper towel to dry after each administration.	F 880		

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F 880	Continued From page 97 Interview on 10/26/22 at 1:15 p.m., with registered nurse (RN)-D confirmed that the protocol was to clean and place the nebulizer supplies on a clean paper towel to dry after each use. Interview on 10/27/22 at 1:00 p.m., with director of nursing (DON) confirmed staff should be rinsing and leaving the nebulizer supplies on a clean paper towel to dry after each use along with replacing supply's weekly. Review of October 2022, Avera LTC Disinfection of Non-Critical Patient Care Equipment policy identified Nebulizer's supplies were to be rinsed, and set on clean paper towel and covered with another paper towel to dry in the residents room until the next treatment. Every 24 hours staff will disassemble all nebulizer equipment and wash with soap and rinse and air dry on a clean paper towel covered by another paper towel. Nebulizer supplies should be replaced weekly or more often based on manufacturer instructions for use.	F 880		

Minnesota Department of Health

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300 SOUTH BRUCE STREET
MARSHALL, MN 56258

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: Surveyor: 34083 On 10/24/22 through 110/28/22, a standard licensing survey was conducted completed at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found NOT in compliance with the MN State	2 000		

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2 000	Continued From page 1 Licensure. The following licensing orders were issued: 0302, 0565, 0620, 0895, 0910, 1095, 1100, 1375, 1580, 1610, and 1980. The following complaints were found to be SUBSTANTIATED: H5228035C (MN82447), H52285143C (MN85027), and H52285077C (MN86082), however, NO licensing orders were issued. The following complaint was found to be SUBSTANTIATED: H52285146C (MN87174), with a licensing order issued at 0565. The following complaints were found to be UNSUBSTANTIATED: H52285144C (MN83743) and H52285149C (MN86301) and H52285145C (MN83502). Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor ' s findings are the Suggested Method of Correction and Time Period for Correction. You have agreed to participate in the electronic	2 000		

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2 000	Continued From page 2 receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm. The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		
2 302	MN State Statute 144.6503 Alzheimer's disease or related disorder train ALZHEIMER'S DISEASE OR RELATED DISORDER TRAINING: MN St. Statute 144.6503 (a) If a nursing facility serves persons with Alzheimer's disease or related disorders, whether in a segregated or general unit, the facility's direct care staff and their supervisors must be trained in dementia care.	2 302		12/8/22

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2 302	Continued From page 3 (b) Areas of required training include: (1) an explanation of Alzheimer's disease and related disorders; (2) assistance with activities of daily living; (3) problem solving with challenging behaviors; and (4) communication skills. (c) The facility shall provide to consumers in written or electronic form a description of the training program, the categories of employees trained, the frequency of training, and the basic topics covered. (d) The facility shall document compliance with this section. This MN Requirement is not met as evidenced by: Surveyor: 39988 Based on interview and document review the facility failed to ensure 6 out of 8 staff reviewed (licensed practical nurse (LPN)A, nursing assistant (NA)-B, NA-C, NA-D, NA-E, and the administrator) received dementia or Alzheimer's training upon hire and annually per the facility policy. Findings include: During record review of Alzheimer's disease or related disorder training that encompassed explanation of Alzheimer's disease and related disorders, assistance with activities of daily living, problem solving with challenging behaviors, and communication skills identified the following: 1) LPN-A had only received training in dementia communication and working with difficult and	2 302	The facility reviewed their policy on dementia training and updated it on 11/28/22. The facility reviewed the current training for staff and updated it to meet the required training items The staff have all received the new updated training and are completing that training. The resident R57 care plan was updated to include resident -centered interventions to aide in his communication deficits. Audits: 100% observations 2 observations per unit per week x4; 8 units observations per month; 8 observations quarterly	

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2 302	Continued From page 4 combative people. LPN-A's training record lacked evidence of understanding dementia and assistance with activities of daily living. 2) NA-B had only received training in dementia communication and working with difficult and combative people. NA-B's training record lacked evidence of understanding dementia and assistance with activities of daily living. 3) NA-C had only received training in dementia communication and working with difficult and combative people. NA-C's training record lacked evidence of understanding dementia and assistance with activities of daily living. 4) NA-D had only received training in dementia communication and working with difficult and combative people. NA-D's training record lacked evidence of understanding dementia and assistance with activities of daily living. 5) NA-E had only received training in dementia communication. NA-E's training record lacked evidence of working with difficult and combative people, understanding dementia and assistance with activities of daily living. 6) The administrator had only received training in dementia communication. The administrator's training record lacked evidence of being trained in working with difficult and combative people, understanding dementia and assistance with activities of daily living. Interview on 10/27/22 at 3:38 p.m., with director of nursing (DON) confirmed all staff should be having Alzheimer's training upon hire and yearly. She revealed that the facility policy did not include all the training requirements. Her expectation would be that all staff working with residents should complete the required Alzheimer's training. Interview on 10/27/22 at 3:45 p.m. with administrator agreed that all staff had not	2 302		

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2 302	Continued From page 5 completed all the required components of Alzheimer's training. Review of the May 2022, Alzheimer's Disease/Staff Training policy identified the areas of training to include Alzheimer's Disease and related disorders, managing challenging behaviors, understanding abuse, communication with patients with dementia, and preventing abuse. The policy lacked identified training for assistance with activities of daily living. Review of the 3/23/22, Facility Wide Risk Assessment identified staff development training would include care and management of the resident with Alzheimer's or other dementia, providing services to individuals with cognitive impairment, and dementia management training. SUGGESTED METHOD OF CORRECTION: The DON or designee could enroll all direct care staff in the appropriate Alzheimer's training courses and notify them of a timeline for completion. The DON could ensure all direct care staff complete the missed courses via an audit, and could develop a regular audit of facility education course completion to be done following new staff orientation and throughout the year as appropriate. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 302		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident.	2 565		12/8/22

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2 565	Continued From page 6 This MN Requirement is not met as evidenced by: Surveyor: 44658 Based on interview and document review, the facility failed to ensure development of comprehensive care plans were developed and implemented for each resident, included measurable objectives and timeframe's to meet a resident's medical, nursing, and mental and psychosocial needs and include services to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being for 16 of 18 sampled residents (R3, R4, R5, R11, R20, R31, R41, R42, R43, R50, R54, R56, R57, R121, R122, and R127). Findings include: R5's current, undated care plan identified R5 was admitted to the facility in November, 2021 and had diagnoses of cancer, high blood pressure, GERD, diabetes, high cholesterol. thyroid disorder, anxiety disorder, . R5's care plan identified problems noted for bladder incontinence, communication and cognitive concerns, was a fall risk, was on hospice, was on a constant carb diabetic diet, chronic pain, psychosocial well-being/mood, activities, medication side effects, and skin integrity. R5 had little to no specific person-centered goals or interventions identified on the care plan according to existing diagnoses or needs. R5 recieved an anti-coagulant and the care plan made no mention of any bleeding precautions.	2 565	The facility reviewed the Care Plan policy 11/16/22. The staff were trained on the updated policy and processes on 11/30/22, 12/6/22, 12/7/22, 12/8/22. Meditech hands on training for all staff has been scheduled for ongoing training.and has been added to the new hire training for all staff. The care plans were audited for 100% of the facility. A plan has been developed to update each resident's care plan with person centered items. The following has been updated: R5 has had resident goals and interventions added to the care plan. Bleeding precautions were also added to the residents care plan. R3 has been updated with the residents' goals and interventions for side effects from psychotropic drug use and behavior interventions. The plan for restorative therapy to reduce the contractures has been noted in the care plan. R41 has had their care plan updated with resident centered goals and interventions that relate to their diagnoses. R56's Care plan has been updated to include the indication of the catheter to be secured to the resident's leg with a leg strap to keep the catheter in place. Person centered goals and interventions have been identified and updated in her R31 Care plan has been updated to direct staff to use a gait belt for all transfers with	

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2 565	Continued From page 7 R3's current, undated care plan identified R3 was admitted to the facility in July, 2017. R3's care plan identified problems noted for psychosocial well being, Activities of Daily Living (ADL) status, bowel and bladder incontinence, communication and cognitive ability, fall risk, oral and respiratory status, blood sugar status, nutrition, pain, activity involvement, was at risk for medication side effects, and skin integrity. R3 was at risk for side effects from psychotropic drug use related to behaviors, however no interventions were placed on the care plan specific to R3.R3 also had contractures and the need for restorative therapy was also not noted on the care plan. Throughout R3's care plan, R3 had little to no specific person-centered goals or interventions identified according to existing diagnoses or needs. R41's current, undated care plan identified R3 was admitted to the facility in October, 2021 with diagnoses of dementia, enlarged prostate, diabetes, glaucoma and was legally blind, high cholesterol, and a below the knee amputation. R14 had little to no specific person-centered goals or interventions identified on the care plan according to existing diagnoses or needs. R56's current, undated care plan identified R56 was admitted to the facility in March 2021 and had diagnoses of heart failure, neurogenic bladder, high cholesterol, paraplegia, MS, anxiety, depression, pressure ulcer to her left buttock- Stage III, and dysphagia. She had identified problems of ADL status, catheter use, ostomy care, communication and cognitive ability, fall risk, nutritional status, chronic pain, psychosocial well-being, activity involvement, skin integrity. R56 was noted to have a suprapubic (tube placed in opening into bladder through stomach) catheter with interventions to clean and	2 565	the resident. Goals and Interventions have been updated in the resdients care plan. choking. R50 non pharmacological interventions have been updated in the care plan as well as person centered goals R11 His care plan has been updated to address his agitation and PTSD and the interventions to handle his behaviors and diagnosis. His medications have been updated in his care plan along with monitoring for side effects. R42 Person centered goals have been placed in her care plan as well as interventions to address her potential for R121 care plan was reviewed, the resident has expired. R122 care plan was reviewed, the resident has discharged. R127 Care plan was reviewed, the resident has expired. R20 care plan has been updated to reflect his behaviors and interventions used by staff when those behaviors occur. R54 the care plan has been updated to reflect individualized interventions to prevent falls and minimize pain. R43 the care plan was updated to reflect interventions for staff to ensure communication to meet needs and prevent elopement. he enjoyed, medications have been update and all side effects as well. CPAP cares and interventions have also been updated in his care plan. R4 Care plan was updated to reflect interventions related to using her call light and using the bathroom unattended and fall reduction R57 care plan has been updated with	

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2 565	Continued From page 8 change the catheter bag monthly. The care plan also had a discrepancy and noted R56 was to have her Foley (tube inserted into urethra, then into the bladder) flushed twice per day. Staff were to place a pad under R56 if it leaked. There was also a notation to "cath secure change" however, there was no indication what that meant or how staff was to ensure her catheter remained secured to her leg. R56 had little to no specific person-centered goals or interventions identified on the care plan according to existing diagnoses or needs. R31's 9/7/22, quarterly Minimum Data Set (MDS) identified she had intact cognition with diagnoses of Parkinson's disease, glaucoma, retention of urine, constipation, and pain. R31 was to have had extensive assistance of 2 staff for transfers between surfaces and required the use of a wheelchair. Observation on 10/27/22 at approximately 9:45 a.m. identified R31 was being transferred with nurse aide (NA)-H identified she was in process of performing a pivot transfer to R31. NA-H was observed grabbing onto the back side of R31's elastic waistband pants, and pivoting R31 from her wheelchair to a chair without use of a gait belt. R31's current, undated care plan identified R31 was admitted to the facility in March 2022. R31 was at risk for falls as evidence by a history of falls, impaired balance, Parkinson's disease, urinary tract infections, and impaired mobility. There were no interventions identified on the care plan reflective of her MDS assessment. R31 had a problem noted with Activities of Daily Living (ADL) and required assistance with ADL's. R31 was noted to transfer/pivot with use of a gait belt	2 565	interventions to increased the resident activity involvement and what activities Audit: 100% of charts will be audited 1 care plan per unit will be audited weekly x4; 1 care plan per unit monthly x 3 ; 1 care plan per unit quarterly.	

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2 565	Continued From page 9 and a walker. There was no mention R31 required 2 staff for safety. Review of the 6/24/22,current nurse aide (NA) care plan identified under the section "Care Plan/Special Needs/Special Diet" the only notation for NA staff was that she "likes makeup and recliner". Her ADL's were listed as "A1" (assistance of 1). There was no indication why the nurse aide care plans did not contain critical elements of resident care needed or why it had not been revised recently. Interview and observation on 10/27/22 at 10:00 a.m. with the administrator and director of nursing identified all residents were to have gait belts in their rooms for potential transfers. Both agreed NA-H should have used the resident's gait belt. The administrator and DON agreed there was the potential for harm for an accidental fall due to staff not using the appropriate equipment. The administrator was unsure why the nurse aide care plans were not up to date or reflective of what resident's care was required but did acknowlege their current computer software was "not friendly to long term care (LTC) use" and was not able to be resident specific. Both agreed care plans failed to detail resident specific needs. R20's 9/12/22, significant change Minimum Data Set (MDS) assessment identified severe cognitive impairment with inattention and disorganized thinking. R20 had verbal, physical and other behaviors during the assessment period. R20 required extensive assist with cares, R20 took an antipsychotic 6, antianxiety 2, and pain medication 4 of the 7 look back period. R20's undated, care plan identified	2 565		

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STREET ADDRESS, CITY, STATE, ZIP CODE: 300 SOUTH BRUCE STREET MARSHALL, MN 56258

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2 565	Continued From page 10 Communication deficit as evidenced by advanced dementia with moderate cognitive losses, problem understanding others, and was mostly non-verbal. The goal was to maintain communication and cognition. Interventions identified care conference as needed, family notification as needed, BIMS interview as needed, communication as needed, nurse observation as needed, notify provider of critical results as needed, and hearing aid/glasses's every 12 hours. The care plan further identified fall risk as evidenced by history of falls, impaired balance, hypertension medication, impaired mobility, and impaired cognition. The goal was to prevent falls and injury. Interventions included balance and functional range of motion as needed and fall risk assessment as need. Psychosocial well being and mood was identified as a problem as evidenced by withdrawal from care and activities, grief over loss of status, daily routine is very different from prior pattern in community, and strong identification with past. The goal was to establish own goals, strong identification with past, and maintain mood. Interventions included an individual abuse prevention plan, alcoholic beverages as needed, insomnia assessment as needed, staff observation as needed, social service assessment as need, PTSD screen as needed, PHQ-9 as needed, Behavior/mood observation every 12 hours, elopement risk as needed, AIMS assessment as needed, and behavior/mood assessment every 12 hours. R20's care plan lacked individualized interventions for staff to follow to ensure communication to meet needs, to prevent falls, and to identify if R20 was displaying any target behaviors as there were none identified. Interview on 10/26/22 at 1:45 p.m., with	2 565		

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2 565	Continued From page 11 registered nurse (RN)-A identified R20 had been seen by psych for medication adjustments related to his physical behaviors. She revealed side effects of medication were being monitored and agreed that the target behaviors were not identified on the care plan but staff charted any behaviors that occurred. Review of 10/21/22, Behavior health note by psychiatric provider identified R20 had diagnosis of vascular dementia with behavioral disturbance, psychotic disorder wit delusions and hallucinations. R20 behaviors had been physical aggression to staff, raising hands and shake fist at caregivers, shoved staff, poked staff in eye, punched staff in face, kicked at wife. None of this information had been identified on R20's care plan. R54's 8/20/22, significant change MDS assessment identified moderate cognitive impairment. R54 required extensive assist with cares and transfers. R54 had history of falls, took daily diuretic, and had occasional pain. R54's undated, care plan identified fall risk as evidenced by history of falls, impaired balance, psychotropic drugs, hypertension medications, diuretic medication, impaired mobility, and impaired cognition. The goal was to prevent falls and injury. Interventions included balanced and functional range of motion as needed and fall risk assessment as needed. The care plan identified chronic pain as evidenced by peripheral vascular disease, and lymphedema. The goal was to be free from pain and residents to have acceptable level of pain. Interventions included pain interview as needed and pain assessment as needed. R54's care plan lacked individualized interventions to prevent falls and to minimize pain	2 565		

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2 565	Continued From page 12 for staff to follow. R43's 9/21/22, annual MDS assessment identified severe cognitive impairment with inattention and disorganized thinking. R43 required extensive assist with cares and was identified to have had 2 or more falls. R43 took a daily antipsychotic, antidepressant, and a daily hypnotic. R43's undated, care plan identified a communication deficit as evidenced by Parkinson's dementia with moderate to severe cognitive losses's, was able to make self understood but sometimes talked nonsensical, his orientation fluctuated, he had problems understanding others, and memory impairments. The goal was to maintain communications and cognition. Interventions included care conference summary as needed, family notifications as needed, BIMS interview as needed, communication as needed, nurse observation as needed, notify provider with critical results as needed, hearing aide and glasses's every 12 hours. The care plan identified elopement as a problem with wander guard placed related to ability to wander, cognitive loss and desire to go outside. The goal was R43 will not leave facility unattended. Interventions included wander guard alarm check daily using wander guard pocket reader and elopement risk as needed. R43's care plan lacked individualized interventions for staff to follow to ensure communication to meet needs and initialized interventions to prevent elopement. R4's care plan dated 10/24/22, indicated R4 had a concern for bladder and bowel due to frequent incontinence of urine. Interventions included recording R4's output and scanning R4's bladder	2 565		

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2 565	Continued From page 13 as needed. R4 had a risk for falls related to a history of falls with an injury, impaired balance, the use of psychotropic and high blood pressure medications, and impaired mobility and cognition. Interventions included balance/functional range of motion (ROM) daily and keeping R4's bed at a level so R4 could sit on the edge of the bed at a 90-degree angle with her feet flat on the floor to allow for a safe transfer from bed. The care plan lacked interventions related to R4's fall while using the restroom unattended, R4 not activating her call light, and attempting to self-transfer. R57's quarterly Minimum Data Set (MDS) dated 10/5/22, indicated R57 had severe cognitive deficits. R57 required supervision of one staff for eating and extensive assistance of two staff for all other activities of daily living (ADLs). R57 had diagnoses that included insomnia, Alzheimer's and dementia with behavioral disturbances, Multiple Sclerosis (MS), memory loss, and obstructive sleep apnea (OSA-sleep-related breathing disorder causing the airway to become obstructed and occasional to frequent cessation of breathing). R57's Care Area Assessment (CAA) dated 4/22/22, indicated R57 triggered for cognitive loss/dementia, due to Alzheimer's and dementia, instructing a continuation of the item on R57's care plan. R57 triggered for communication secondary to being hard of hearing and instructing a continuation of the item on the care plan. R57 also triggered for mood state due to a history of depression, instructing a continuation of the item on the care plan. R57's care plan dated 10/25/22, indicated R57 was at risk for a communication deficit related to hearing loss, difficulty making himself understood	2 565		

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2 565	Continued From page 14 and understanding others and declining cognition. Interventions included notifying a provider with critical results as needed, MDS nursing observations as needed, completing a Brief Interview for Mental Status (BIMS) as needed, notifying family as needed, and completing a care conference summary as needed. The care plan lacked resident-centered interventions to assist, maintain, or improve R57's communication deficits. The care plan also indicated R57 was at risk for psychosocial well-being evidenced by withdrawal from activities, grief over loss of roles/status, daily routine very different from prior pattern in the community and having a strong identification with the past. Interventions included visiting with R57 about past agricultural business and discussing his memory book and pictures. R57's care plan further indicated R57 had a deficit related to activities due to a lack of interest. Interventions included daily activity review, an activity evaluation, MDS preferences to be reviewed as needed, and a spiritual assessment to be completed. The care plan lacked indications of R57's preferences for activities or an individualized plan to increase R57's involvement in activities. R57 had respiratory concerns related to OSA and using a CPAP. Interventions included putting the CPAP on every night and cleaning it weekly. No other interventions or instructions regarding the use of the CPAP machine were indicated. R57's care plan also indicated R57 was at risk for psychosocial wellbeing. Interventions included monitoring R57 for side effects related to the use of Seroquel; however, R57 was no longer taking the antipsychotic medication. The care plan lacked evidence R57 had been evaluated for dementia to develop a resident-centered plan to decrease R57's repetitive behaviors and lacked indication that R57 was taking Depakote (an anti-convulsant used also as an antipsychotic) or	2 565		

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2 565	Continued From page 15 interventions to monitor for side effects related to the medication. Review of the 3/23/22, Facility Wide Risk Assessment identified the facility provided person centered care. Staff were to find out the resident's likes and dislikes and what makes for a good day and incorporate that information into the care planning process and to to ensure staff had the information. Review of August 2020, Care Planning policy identified a person centered care plan would recognize what was important to the resident with regard to daily routines and activities, what supports the resident required, and having an understanding of the resident' life prior to residing in the nursing home. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures related to ensuring the care plan for each individual resident is followed. The director of nursing or designee could develop a system to educate staff and develop a monitoring system to ensure staff are providing care as directed by the written plan of care. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 565		
2 620	MN Rule 4658.0445 Subp. 4 A-N Clinical Record; Admission Information Subp. 4. Admission information. Identification information must be collected and maintained for each resident upon admission and must include, at a minimum:	2 620		12/8/22

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2 620	Continued From page 16 A. the resident's legal name and preferred name; B. previous address; C. social security number; D. gender; E. marital status; F. date and place of birth; G. date and hour of admission; H. advance directives, & Do Not Resuscitate (DNR) & Do Not Intubate (DNI) status, if any; I. name, address, and telephone number of designated relative or significant other, if any; J. name, address, and telephone number of person to be notified in an emergency; legal representative, designated representative, or representative payee, if any; K. legal representative, designated representative, or representative payee, if any; L. religious affiliation, place of worship, and clergy member; M. hospital preference; and N. name of attending physician. This MN Requirement is not met as evidenced by: Surveyor: 38687 Based on interview and document review, the facility failed to ensure the accuracy of 1 of 1 resident (R41) medical record when R41 had conflicting end of life (code status) documentation. Findings include: R41's current, undated "electronic medical record	2 620	The facility reviewed and updated the policy to correct the concerns identified in the survey process on 11/1/22 The team was trained on the new policy and the updates on 11/30/22, 12/6/22, 12/7/22, 12/8/22. An audit was completed on 10/28/22 of a 100% of the current resident charts for their POLST documents and that the information matched. Any discrepancies were corrected in the	

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2 620	Continued From page 17 (EMR) identified R41 was marked as "full resuscitation" (wanting all lifesaving measures including cardio pulmonary resuscitation (CPR)). R41's October 2021, POLST (Physician Orders for Life Sustaining Treatment) form identified R41 wished to be a Do Not Resuscitate (DNR) with selective treatment of antibiotic use. Interview on 10/26/22 at 2:18 p.m., with the director of nursing (DON) identified she was unaware of the conflicting information of R41's code status. She stated "Full resuscitation may be the same as DNR with selective treatment. That could be just how they [staff] have to put that into the computer system". She was unsure if that would be considered conflicting information, but agreed both the POLST and EMR should match. She agreed R41 could potentially received CPR against his wishes in an emergent situation occurred. No policy relating to Advanced Directives was provided by the end of survey. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee should review policies and procedures for advanced directives, physician orders and/or a POLST to ensure records a re consistent and maintained accurate throughout the medical record upon admission, quarterly, and with any significant change such as the election of a hospice benefit. The DON should also ensure a process for inputting this changed data appropriately into the electronic medical record. Staff should be educated on the need to clarify discrepancies in advanced directives, POLST, and/or physician orders. The DON or designee should review the resident affected, and all other current residents	2 620	resident's charts to reflect the correct information The process changes are the following: The social worker is responsible for obtaining the POLST document upon admission or at the initial care conference. The POLST document will then be scanned into the resident's chart. The nursing supervisor will verify the code status and compare it to what is in the EMR system and update if necessary. The advance directive on the resident R41 was corrected to reflect the correct status in the EMR as the POLST 10/28/22 Audits: 100% of charts will be audited on admissions and readmissions. Audits will be completed monthly until 100% compliance is met. the frequency will be monthly x 3 months. then 20% of admissions and readmissions quarterly x3 quarters.	

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2 620	Continued From page 18 to ensure accuracy of code status and audit any newly admitted resident EMR. The results of those audits should go to the Quality Assurance Performance Improvement (QAPI) committee for a specific time until compliance is achieved and maintained to determine compliance or the need for further monitoring. TIME PERIOD FOR CORRECTION: Twenty One (21) days	2 620		
2 895	MN Rule 4658.0525 Subp. 2.B Rehab - Range of Motion Subp. 2. Range of motion. A supportive program that is directed toward prevention of deformities through positioning and range of motion must be implemented and maintained. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: B. a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and to prevent further decrease in range of motion. This MN Requirement is not met as evidenced by: Surveyor: 44658 Based on observation, interview, and document review, the facility failed to ensure 4 of 4 residents (R3, R5, R51, R56, and R57) recieved restorative range of motion (ROM) therapy to prevent potential decline in ROM and/or contractures.	2 895	The facility policy was reviewed and updated on 11/30/22. The staff were trained on the updated policy 11/30/22, 12/6/22, 12/7/22, 12/8/22 The nursing and therapy team met on 11/30/22 to review and determine which residents must have ROM exercises daily and updated their care plans, work lists	12/8/22

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2 895	Continued From page 19 Findings include: R3's 2/9/22 annual MDS identified she required extensive assist of 1 staff for ADL and had no impairment marked on the MDS to her upper or lower body, and used a walker or wheelchair for ambulation. R3's current, undated care plan identified R3 was admitted to the facility in July, 2017. R3's care plan identified problems noted for psychosocial well-being, was noted to require assistance of 2 staff with most Activities of Daily Living (ADL) status. There was no mention R3 had contractures of her left hand, not that she was to have worn a brace on her left hand to prevent further deterioration and contracture or required the splint to be refitted. Observation and interview on 10/24/22 at 7:10 p.m., with R3 identified she remarked she had a "frozen left ankle". She has rheumatoid arthritis (RA). The brace for her hand "doesnt fit... it squishes them together". She hadn't been refitted. She used to be an occupational therapist and was quite familiar with restorative therapy. She gets no ROM from staff. The facility cut thier restorative program and to her knowledge, they havent gotten anyone else and "apparently arent planning to". R3's fingers on her left hand were visibly contracted and her feet turned inward. Buried in the corner, under a piece of luggage were her orthotics. R5's 10/20/22, Significant Change Minimum Data Set (MDS) identified she had severely impaired cognition due to needed to be prompted to recall words, her inattention and ability to stay focused during the interview, and disorganized thinking.	2 895	and daily assignment sheets to reflect so. The activities department has added an exercise group which provides 8 opportunities a month for resident movement, that was started on 11/3/22 The following was done with the identified residents: R3 Residents care plan has been updated to include ROM exercised and use of her orthotics. R5 ROM exercises have been added to her care plan R56 training was completed on her orthotics and the care plan updated to reflect the ROM interventions and goals R51 care plan has been updated and interventions and goals placed for the ROM exercises. R51 Care plan has been reviewed and ROM goals and interventions placed. 11 additional residents have been identified to benefit from a program that includes ROM activities and their care plans have been updated. Audits: 100% observation audits 2 audits per week x4 ; 4 audits per month x 3 ; 4 audits per quarter.	

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2 895	Continued From page 20 R5 required extensive assistance from 1 staff for bed mobility, transfer, dressing, eating, toilet use and personal hygiene. R5 was marked no impairment to her upper and lower extremities. R5 received no restorative therapy from a restorative program. R5's current, undated care plan identified R5 was admitted to the facility in November 2021 and had diagnoses of cancer, high blood pressure, GERD, diabetes, high cholesterol. thyroid disorder, anxiety disorder. R5's care plan identified problems noted for bladder incontinence, communication and cognitive concerns, was a fall risk, was on hospice, was on a constant carb diabetic diet, chronic pain, psychosocial well-being/mood, activities, medication side effects, and skin integrity. R5 had no mention Interview on 10/25/22 at 2:54 p.m., with R5 identified she doesnt get any ROM therapy from staff. She would be at risk for ROM decline. R56's 4/20/22, Significant Change MDS identified she had intact cognition, and was marked completely independent with all ADL, despite being a paraplegic. There was no restorative therapy noted on the assessment. R56's current, undated care plan identified R56 was admitted to the facility in March 2021 and had diagnoses of heart failure, neurogenic bladder, high cholesterol, paraplegia, MS, anxiety, depression, pressure ulcer to her left buttock-Stage III, and dysphagia (difficulty swallowing). She had identified problems of ADL status, catheter use, ostomy care, communication and cognitive ability, fall risk, nutritional status, chronic pain, psychosocial well-being, activity involvement, skin integrity. R56 had little to no	2 895		

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2 895	Continued From page 21 specific person-centered goals or interventions identified on the care plan according to existing diagnoses or needs. Observation and interview on 10/25/22 at 9:42 a.m., with nurse aide (NA)-G immediately prior to R56's dressing change identified R56 was visibly severely contracted in upper and lower limbs due to her MS and paraplegia diagnoses. identified there are no specific staff for restorative any longer. That program was discontinued. All NAs were now responsible to do restorative ROM, but they "just dont have the time". When they are able to do ROM for residents, they are supposed to document in the electronic medical record when it's completed. No orthotics were identified having been applied. R56's Occupational Therapy (OT) progress notes identified on: 1) 8/11/22, OT put on R56's bilateral hand orthotics and educated the restorative aide (RA) on how to put them on. Staff left the orthotics on for 75 minutes and checked for redness/discomfort. The RA was educated and shown how to perform passive ROM (PROM) (staff are required to perform due to residents' inability to move extremities). 2) 8/12/22, OT performed the PROM and put on R56's orthotics to her hands. Nursing staff were educated on proper methods doe donning and doffing (on and off) of the orthotics. 3) 8/15/22, OT noted they had washed, dried and applied lotion to R56's left elbow crease as it was "showing white maceration [skin breakdown due to moisture] and had a foul odor due to being in a chronically flexed position". OT provided gentle PROM to her bilateral upper extremities due to "significant tightness/contractures noted". R56 had pain in her left (L) wrist when the OT	2 895		

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2 895	Continued From page 22 attempted to place her wrist in a neutral position. R56 had "significant wrist extension contracture which is currently unsupported". OT then adjusted her L elbow orthotic into a more flexed position to accommodate her current flexion contracture for better support. 4) 8/29/22, OT documented PROM was completed by OT to her upper body. R56 had facial grimacing during her should exercises specifically. R56's spouse was present with him reporting R56's right (R) ROM was "normal up until recently". OT noted contractures beginning at the R elbow. 5) 9/13/22, R56 reported she "doesn't go into her wheelchair much". R56 was in her bed in the supine (lying on back) position with her elbows in flexion and her left upper extremity supinated with contracture in her fingers. Communication was provided to nursing staff for potential of positioning side lying and in wheelchair to provide repositioning and stretching. R56's orthotics were placed in her lower drawer of her dresser "near her bed for ease, as they were observed by T to be in her recliner with Hoer lift and tangled." 6) 9/14/22, OT completed a pictorial program with written instruction for staff to increase ease of donning splints and preventing further contracture development. 7) 9/16/22, R56 reported staff ae stretching her arms, but cannot recall if it occurs daily. 8) 9/19/22, OT provided PROM and again educated staff on how to apply R56's orthotics for 30 minutes and check for redness and pain. 9) OT once more educated staff on completing PROM prior to donning her orthotics. 10) 10/14/22, OT noted R56 reported staff were not putting on her orthotics nor were they doing PROM and said it had not been completed "in a long time". 11) 10/17/22, R56 had facial grimacing while OT	2 895		

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	00343		C 10/28/2022

NAME OF PROVIDER OR SUPPLIER: AVERA MORNINGSIDE HEIGHTS CARE CENTE

STREET ADDRESS, CITY, STATE, ZIP CODE: 300 SOUTH BRUCE STREET MARSHALL, MN 56258

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2 895	Continued From page 23 provided PROM to her R shoulder. Ot once again stressed to staff the importance of providing PROM as she is completely dependent for all positioning and use of her extremities. There was no mention if OT's continued concerns were brought forth to management, or if management routinely audited OT notes for residents at risk to identify the lack of staff care with PROM. Interview on 10/26/22 at 1:50 p.m. identified R56 was once more observed without any orthotics applied and was lying in bed. R56 said she has them for her right elbow (she thinks) but was unsure if staff were applying them as ordered. R56 family member was also there and reported R56 rarely had her orthotics applied. Interview on 10/27/22 at 12:19 p.m., with the director of therapy (DT) identified R56 is receiving OT now and has been for a while. OT has been working with R56 to find the right hand splints for her. R56 was on physical therapy (PT) from July to August 2022, but has since competed PT. After it was brought to the administrator's attention about residents not receiving restorative therapy from staff, OT was and has been currently training staff right now on her upper extremities. R56 "can't move and really needs staff to do everything for her". OT works upper and PT normally worked her lower extremities. Her upper body is maintaining, but her lower extremities have not been getting restorative PROM therapy at all and "is likely declining". R56 was to be screened next month to see if she has had any decline. Interview on 10/28/22 at 8:48 a.m., with the administrator identified the facility's restorative program was "cut" due to budgetary cuts. Upper	2 895		

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2 895	Continued From page 24 management wanted staff NA's to do it, but she acknowledged they "don't have time". She agreed this had the potential for harm and was affecting resident care. Since becoming aware by surveyors during the survey process ROM was not being done, she was now going to have PT work with those residents who are affected and at risk for further decline. The administrator also agreed R56 and R3's orthotics were not being applied as ordered. R51's quarterly minimum data set (MDS) dated 9/28/22, indicated R51 had severe cognitive deficits and required extensive assistance of one staff for eating and extensive assistance of two staff for all other activities of daily living (ADLs). R51's diagnoses included constipation, disturbances of salivary secretion, anxiety, spinal stenosis, Parkinson's disease with dementia, and a fall resulting in a hip fracture. During an interview on 10/24/22, at 7:26 a.m. family member (FM)-F stated R51 was receiving restorative therapy prior to the program being canceled a few months prior. R51 was supposed to do ROM exercises but since the staff had not been assisting him, FM-F had been trying to do the exercises with him. During an interview on 10/27/22, at 12:18 p.m. physical therapist (PT)-B stated she recommended passive ROM (PROM) exercises for R51 to keep his legs stretched out so he could continue to transfer with the EZ stand (a device that assists residents to stand up during transfers and requires only one staff to operate) and not downgrade to a Hoyer lift (a device that lifts a resident lying in a sling, requiring no effort from the resident and two staff to operate). However,	2 895		

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2 895	Continued From page 25 PT-B also stated the nursing assistants (NAs) told her they did not have time to assist R51 with his PROM exercises. R51's PROM exercise log dated October 2022, indicated R51 received PROM exercises as follows: -10/3 -10/9 -10/10 -10/12 -10/17 -10/18 -10/22 -10/23 R51 did not receive PROM exercises for 15 out of 23 days. R57's quarterly MDS dated 10/5/22, indicated R57 had severe cognitive deficits and required supervision with assistance of staff for eating and extensive assistance of two staff for all other ADLs. R57's diagnoses included a pressure injury on his coccyx (tailbone), fall resulting in pain to his left shoulder and a head abrasion, dementia with behavioral disturbance, major depression, constipation, spastic paraplegia due to multiple sclerosis (MS), ambulatory dysfunction, MS, and gait abnormality. R57's care plan dated 10/25/22, indicated R57 required assistance with some or all ADLs. Interventions included R57 participating in a restorative therapy program 4-6 times per week. R57 was also at risk for falls due to a history of falls, impaired balance, mobility, and cognition. Interventions included balance/functional ROM as needed. R57's CAAs dated 4/22/22, indicated R57 triggered for ADL functional/rehabilitation	2 895		

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2 895	Continued From page 26 potential, falls, and pressure ulcers. R57's Restorative Nursing Program form dated 8/15/22, indicated PT-B recommended R57 complete or attempt knee extension stretches, hip adductor stretches, active leg kicks, and crunches while reaching, five days a week to maintain ROM of both his lower extremities for optimal positioning in his wheelchair. R57's Caregiver Education form dated 9/29/22, indicated PT-B recommended left arm PROM stretches in bed, wheelchair, or recliner to be completed daily. R57's Physical Therapy Discharge Summary dated 9/29/22, indicated R57 completed 2 out of 3 PT goals and had a follow-up maintenance program for upper extremity PROM. Discharge recommendations included daily PROM to left upper extremity. No documentation was provided to indicate R57 received any ROM/PROM exercises after his discharge from therapy services on 9/29/22. R57's Care Conference Summary dated 10/12/22, indicated R57 was no longer receiving therapy services but family was interested in R57 being on a maintenance program to be able to keep the abilities he had. During an interview on 10:25/22, at 11:22 a.m. FM-E stated because of R57's MS, he got "really stiff." He was getting therapy for 15 minutes a few times a week before it was discontinued last month. During an interview on 10/26/22, at 2:02 p.m. PT-B and occupational therapist (OT)-C stated	2 895		

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2 895	Continued From page 27 R57 was discharged from OT on 9/16/22, and from PT on 9/29/22 because his progress plateaued. The facility no longer had a restorative aid (RA), therefore, therapy printed range of motion (ROM) exercises for the nursing assistants (NAs) to complete with the residents; however, they did not believe the exercises were being done which caused residents' mobilities to decline and be referred back to therapy. PT-B stated residents weren't being walked and were struggling to participate in their surface-to-surface transfers. PT-B and OT-C stated it was a frustrating cycle. During an interview on 10/27/22, at 10:33 a.m. R57's FM-E stated she was unaware staff were supposed to continue providing ROM exercises for R57 after he had discharged from therapy. FM-E further stated staff had not been doing exercises with R57, but she would like them to so R57 could maintain his mobility as long as possible. During an interview on 10/27/22, at 1:49 p.m. NA-F stated therapy would send a form to the NAs with instructions for ROM exercises to be completed with the residents after they were discharged from therapy. NA-F stated R57 was supposed to have ROM exercises completed; however, NA-F did not know how often. NA-F also stated she did not do ROM exercises with R57 when she transferred him out of bed and assisted him with his cares that morning. During an interview on 1/27/22, at 1:57 p.m. licensed practical nurse (LPN)-B stated she would submit a referral to therapy if a resident's activities of daily living (ADLs) and/or strength declined. LPN-B stated since the RA program ended, she noticed an increase in the number of	2 895		

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2 895	Continued From page 28 residents whose mobility and strength were declining because the NAs often did not have time to complete the recommended ROM exercises with the residents. During an interview on 10/27/22, at 5:17 p.m. RN-F stated a form was sent to her and the NAs if a resident discharged from therapy services but would benefit from a maintenance exercise program. The staff should communicate during the morning huddle and verbal handoff report if a resident had a recommended exercise program. RN-F stated it had been tough to maintain resident abilities since the RA program ended. RN-F stated when a resident declined in ADLs and transfers, they may end up requiring a two staff assist instead of one which would increase the NAs' workload and decrease resident independence. A resident would then be referred back to therapy and the cycle would continue. During an interview on 10/27/22, at 11:59 a.m. the director of therapy (DT) stated most residents were put on a restorative program after discharge from therapy to maintain their function; however, since the facility no longer had an RA, the NAs were supposed to complete ROM exercises with the residents. The DT stated a written recommendation for an exercise plan was sent to registered nurse (RN)-F who may add it to a resident's care plan, and another copy to the resident's unit for the NAs to review. Therapy would also screen the residents three months after discharge from therapy services to assess their progress. DT stated the failure to complete maintenance exercises resulted in residents being referred back to therapy due to a decline in their mobility and strength. R57 had been on and off therapy a few times since he had admitted to the facility in February 2022 and was discharged	2 895		

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2 895	Continued From page 29 from therapy last month after plateauing. A recommendation for ROM exercises was sent to RN-F and the NAs so R57 could continue to maintain his mobility. During an interview on 10/27/22, at 3:17 p.m. the director of nursing (DON) stated it had been a challenge since the RA program ended in July and there were areas of improvement needed regarding the resident exercise program. The DON further stated the facility had a goal to include exercises as a resident activity; however, that had not been implemented. There was no policy specific to providing ROM supplied by the end of the survey. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review all residents at risk for limited range of motion to assure they are receiving the necessary treatment/services to prevent further limitation in range of motion. The director of nursing or designee, could conduct random audits of the delivery of care to ensure appropriate care and services are implemented. The results of the audits could be brought to the quality assurance committee for review. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 895		
2 910	MN Rule 4658.0525 Subp. 5 A.B Rehab - Incontinence Subp. 5. Incontinence. A nursing home must have a continuous program of bowel and bladder management to reduce incontinence and the unnecessary use of catheters. Based on the	2 910		12/8/22

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2 910	Continued From page 30 comprehensive resident assessment, a nursing home must ensure that: A. a resident who enters a nursing home without an indwelling catheter is not catheterized unless the resident's clinical condition indicates that catheterization was necessary; and B. a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This MN Requirement is not met as evidenced by: Surveyor: 38687 Based on observation, interview, and document review, the facility failed to intervene for 1 of 1 resident (R51) with a strict bowel regimen and ensure catheter leg straps were used to prevent pain, discomfort, or potential infection or injury to 1 of 1 resident (R56). Findings include: BLADDER R56's 4/20/22, Significant Change MDS identified she had intact cognition, and was marked completely independent with all ADL despite being a paraplegic. There was no restorative therapy noted on the assessment. R56's current, undated care plan identified R56 was admitted to the facility in March 2021 and had diagnoses of heart failure, neurogenic bladder, high cholesterol, paraplegia, MS, anxiety, and depression. She had identified problems of ADL status, catheter use,	2 910	The facility reviewed the policy on Urinary Incontinence Prevention /Management program and indwelling foley catheter management as well as Bowel Management LTC on 12/1/22. The staff were trained on both policies on 11/30/22, 12/6/22, 12/7/22, 12/8/22. The Resident care plans for both (R56) and (R51) were updated to reflect the needs to be addressed and what needs to be done. An audit of 100% of the current residents who have catheters was conducted to make sure the care plans were updated, and the correct equipment being used. Audits: 100% observation audits 2 observations of residents with catheters per week x 4; 4 observations per month x 3 ; 4 observations quarterly.	

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2 910	Continued From page 31 communication and cognitive ability, and had chronic pain. R56 was noted to have a suprapubic (tube placed in opening into bladder through stomach) catheter with interventions to clean and change the catheter bag monthly. The care plan also had a discrepancy and noted R56 was to have her Foley (tube inserted into urethra, then into the bladder) flushed twice per day. Staff were to place a pad under R56 if it leaked. There was also a notation to "cath secure change" however, there was no indication what that meant or how staff was to ensure her catheter remained secured to her leg. Observation and interview on 10/26/22 at 1:50 p.m., with R56 identified she was visibly grimacing and complained of having some "discomfort" today. R56's family member was present but went into the hall to find staff. R56 declined further interview. Interview on 10/26/22 at 1:54 p.m., with trained medication aide (TMA)-A identified R56 was upset because her catheter may have "fallen out" and staff were waiting on the nurse to assess her. R56 had a Foley catheter and was paralyzed and unable to move her lower body. Interview on 10/26/22 at 1:58 p.m., with licensed practical nurse (LPN)-B identified she was the only nurse on the floor that day. She was unaware R56's catheter had potentially "come out". LPN-B noted she would check on R56 right away. Further interview on 10/26/22 at 2:38 p.m., with TMA-A identified R56 was assessed by LPN-B. R56's catheter had not "come out" but was "just leaking". Further interview on 10/26/22 at 2:50 p.m., with	2 910		

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2 910	Continued From page 32 LPN-B identified R56's catheter had not come out, but it was being pulled on via gravity, and that was causing her pain. Staff often failed to place a secure leg strap on all residents who had catheters. Using a leg strap to secure the catheter would offload the pressure caused by the bag being hung on the bed and getting heavy with captured urine. "This has been an ongoing issue". The facility was "trying to teach staff to make sure they provided appropriate cares, but in her opinion, it was unsuccessful. She has brought this up to management. All nurse aides (NAs) and nurses should know a Foley catheter was to be secured by a leg strap. LPN-B was unsure if this was care planned and staff educated to R56's care plan. "They should be looking at the electronic (EMR) care plan". R56's 6/24/22, NA care plan, made no mention R56 had a catheter. Interview on 10/26/22 at 4:06 p.m., with the infection preventionist (IP) identified she started mid November 2021. The IP was unaware of complications from R56 not having a leg strap on her catheter to secure it. The IP stated catheter infections were "always high" at the facility. The IP agreed staff failing to use appropriate catheter leg straps for residents led to tubes inadvertently slipping out and increased the rate of urinary tract infections (UTI). Interview on 10/28/22 at 11:19 a.m., with the administrator identified she agreed there was no clear direction on catheter care or ensuring R56 or other residents with catheters had notations to ensure catheters were secured properly. Care plans were a common issue with the software the facility used, and not able to be modified easily.	2 910		

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2 910	Continued From page 33 Review of the April 2022 Long Term Care Cleaning/Care of Catheter Bags policy identified staff were to keep the bag below the level of the bladder, monitor tubing for kinks. There was no mention in the policy staff should secure the catheter tubing with a leg strap to avoid complications such as pain or infection. BOWEL REGIMEN R51's quarterly Minimum Data Set (MDS) dated 9/28/22, indicated R51 had severe cognitive deficits and was unable to complete the Brief Interview for Mental Status (BIMS) assessment. R51 required extensive assistance of one staff for eating and extensive assistance of two staff for all other activities of daily living (ADLs). R51's MDS Section H-Bladder and Bowel, lacked indication R51 had incidents of constipation. R51's diagnoses included constipation, disturbances of salivary secretion, anxiety, spinal stenosis, Parkinson's disease with dementia, and a fall resulting in a hip fracture. R51's Care Area Assessment (CAA) dated 4/14/22, indicated R51 triggered for delirium and cognitive loss/dementia with risks including decreased cognition resulting in increased behaviors and an inability to make his needs known. R51's CAA did not indicate R51 had concerns regarding constipation or bowel incontinence. R51's care plan dated 10/25/22, indicated R51 had bowel and bladder incontinence. Interventions included recording R51's output every six hours. R57 also had concerns related to medication side effects that included constipation and fecal impaction.	2 910		

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2 910	Continued From page 34 R51's physician orders dated 10/25/22, indicated R51 received bisacodyl 10 milligrams (mg) rectal suppository daily as needed for constipation, polyethylene glycol 3350 (Miralax) 8.5 grams every other day and Senna 8.6 mg (a stool softener) twice daily. Review of the facility Admission/Standing Orders dated 6/22, indicated polyethylene glycol 3350 17 mg orally as needed for constipation; Milk of Magnesium (MOM) 30 milliliters (ml) orally as needed for constipation if polyethylene glycol 3350 was not effective within 6 hours times one dose.; bisacodyl suppository (rectal) 10 mg could be given as needed daily for constipation if polyethylene glycol 3350 and Milk of Magnesia were not effective times one dose. If not effective, notify provider. R51's bowel continence log dated 9/1/22, to 10/27/22, indicated R51 went three or more days without a bowel movement from: -9/1/22, at 2:00 a.m. to 9/4/22, 8:00 a.m. -9/4/22, at 8:00 a.m. to 9/8/22, at 3:13 p.m. -9/12/22, at 8:00 a.m. to 9/16/22, at 6:04 a.m. -9/24/22, at 10:28 p.m. to 9/28/22, at 10:17 p.m. -9/30/22, at 2:57 p.m. to 10/4/22, at 10:01 p.m. -10/6/22, at 8:00 p.m. to 10/10/22, at 8:00 a.m. -10/10/22, at 8:00 a.m. to 10/13/22, at 8:00 a.m. -10/15/22, at 3:08 p.m. to 10/19/22, at 2:50 p.m. -10/19/22, at 2:50 p.m. to 10/23/22, at 8:00 p.m. -10/24/22, at 8:00 p.m. to at least 10/27/22, at 2:48 p.m. R51's medication administration record (MAR) dated 9/1/22, thru 10/27/22, indicated R57 received a 10 milligram (mg) of bisacodyl (a suppository) on: -10/4/22 at 3:12 p.m. -10/13/22, at 7:25 a.m.	2 910		

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	00343	A. BUILDING: _____ B. WING _____	C 10/28/2022

NAME OF PROVIDER OR SUPPLIER
AVERA MORNINGSIDE HEIGHTS CARE CENTE

STREET ADDRESS, CITY, STATE, ZIP CODE
300 SOUTH BRUCE STREET
MARSHALL, MN 56258

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2 910	Continued From page 35 -10/19/22, at 7:13 a.m. During an interview on 10/24/22, at 7:18 p.m. family member (FM)-F stated staff were to be monitoring R51's bowel movements daily. FM-F stated R51 should have been given a suppository on the morning of the third day of him not having a BM. However, because it was an "as needed" medication, the trained medical assistants (TMAs) would forget to tell the nurse and R51 wouldn't get the suppository when he should. FM-F stated R51 went four days without a BM last week and she had to tell the nursing staff to give him a suppository which made FM-F "so mad" because it increased R51's pain and wears him out for the whole day. During an observation on 10/26/22, from 7:26 a.m. R51 was overheard in his room, moaning, and saying "hello?" multiple times. During an interview on 10/27/22, at 2:08 p.m. licensed practical nurse (LPN)-B stated she had repeatedly informed staff to monitor R51's BMs and if he hadn't had one for two days, to give him prune juice or "something" to help him move his bowels. LPN-B stated the facility Standing House Orders (SHO) indicated a suppository should be given on the morning of the third day a resident had not had a BM. LPN-B stated R51 should have received a suppository the previous morning but did not get one until that day. LPN-B further stated R51 would get worn out and moan a lot if staff waited until the fourth day to give the suppository. During an interview on 10/27/22, at 2:55 p.m. the director of nursing (DON) stated resident BMs should have been monitored daily and residents who had not had a BM for two days should be	2 910		

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2 910	Continued From page 36 given a suppository on the morning of the third day to avoid obstruction, impaction, and pain. The DON further stated when R51 didn't get a suppository until the fourth day of not moving his bowels, he would have increased behaviors and fatigue. A facility policy on the treatment of constipation and bowel movement monitoring was requested but not received. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review all physician orders for residents with catheters and/or specific bowel treatments to ensure cares are performed as ordered. The director of nursing or designee, could conduct routine audits to ensure appropriate care and services were implemented as ordered. The results of those audits should be taken to the QAPI committee for a determined amount of time to ensure compliance or the need for further monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	2 910		
21095	MN Rule 4658.0650 Subp. 4 Food Supplies; Storage of Nonperishable food Subp. 4. Storage of nonperishable food. Containers of nonperishable food must be stored a minimum of six inches above the floor in a manner that protects the food from splash and other contamination, and that permits easy cleaning of the storage area. Containers may be stored on equipment such as dollies, racks, or pallets, provided the equipment is easily movable and constructed to allow for easy cleaning. Nonperishable food and containers of	21095		12/8/22

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21095	Continued From page 37 nonperishable food must not be stored under exposed or unprotected sewer lines or similar sources of potential contamination. The storage of nonperishable food in toilet rooms or vestibules is prohibited. This MN Requirement is not met as evidenced by: Surveyor: 44658 Based on observation, interview, and document review the facility failed to ensure potentially hazardous food was cooled properly in the refrigerator after being cooked and failed to ensure food was properly labeled and dated after being removed from their original packaging. These deficient practices had the potential to affect all 68 residents who ate from the main kitchen. During the initial kitchen observation and interviews on 10/24/22, from 2:15 p.m. to 5:30 p.m. with the dietary director (DD), the following was observed: Main kitchen dry storage: -Dry, white rice in a large plastic bucket approximately 1/6th full, with no expiration date or fill date -Dry, wild rice in a large plastic bucket, full, with no expiration date or fill date -Multiple large cans of food approximately 6 pounds (lbs) 11 ounces (oz) including but not limited to pineapple tidbits, various tomatoes (diced, sliced), ketchup, and spaghetti sauce were removed from their original shipping box and stored on the shelf without an expiration date.	21095	The facility reviewed the Cooling of Potentially Hazardous Foods policy and process on 11/30/22. Trained the dietary cooks on the policy updates on 12/1/22,12/2/22 and 12/6/22. The facility reviewed and updated the LTC Food Safety & Sanitation policy and process on 11/30/22. The staff have been trained on the updated policy and process on 12/6/22. New hire training module was created for the updated policies. Additional fan on the cart was removed on 10/25/22. The fan above the pots and pans sink was removed on 12/6/22. Audits were completed of the food storage locations in the main kitchen and the four kitchen areas in the long term care units to check for expiration dates on food items were correctly labeled with the month/date/year completed on 12/7/22. Audit: 100% observations 2 observations per unit per week x 3; 4 observations per month; 4 observations per quarter.	

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21095	Continued From page 38 -Chocolate sheet cake on cart covered with plastic wrap, expiration labeled "X 31" (no month). -An opened and used apple juice box (46 fluid oz) expiration labeled "X 30" (no month). Main kitchen refrigerator: -A tray of wrapped, half-sandwiches on a shelf contained: two egg salad, six turkey, and six ham sandwiches all labeled with an expiration of "X 29" (no month). -Three, uncovered trays of two-dozen, pasteurized eggs, lacked an expiration date. -Three, uncovered metal containers filled with frozen veggies, on a cart, lacked a label indicating when they were opened or intended to be used by. Main kitchen freezer: -A clear, plastic bag containing approximately a dozen, frozen, red meat patties unlabeled with no expiration date. -Unknown, frozen, breaded food item in metal container with no lid, label, or expiration date. During an interview at approximately 3:00 p.m. the Cook (CK)-B stated the uncovered, breaded food item in a small metal container was frozen shrimp she had just put in there to defrost for the evening meal. CK-B asked this surveyor if they should be covered. CK-B also stated she assumed the meat patties were placed in the freezer that day but was not sure. Main kitchen cooler: -Five large turkey breasts, wrapped in foil then cut entirely lengthwise, exposing the meat, were	21095		

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21095	Continued From page 39 on a cart in the back of the freezer, directly under the fan. Large, plastic ice packs had been folded in half and stuffed inside each turkey breast. During an observation and interview on 10/24/22, at 4:20 p.m. registered dietician (RD)-B temp'd the turkey breasts as follows: 75 degrees Fahrenheit 90 degrees Fahrenheit 80 degrees Fahrenheit 82 degrees Fahrenheit 80 degrees Fahrenheit During an interview on 10/24/22, at 4:35 p.m. CK-B stated she cooked the turkey breasts to 168 degrees Fahrenheit that afternoon, then put them in the cooler at 1:00 p.m. They would be sliced the next day, then served the day after that. CK-B stated the ice packs were placed in the turkey breasts to speed the cooling process. CK-B further stated although the ServSafe food handler certification course she completed, advised cooling meat in cold water, CK-B found that unappetizing and refused to do it. Main kitchen: -Two large metal carts (approximately 18" wide by 24" deep by 30" high) on wheels were stored under an industrial sink. One contained, and was labeled "sugar," (white) the other contained, and was labeled "flour" (white). The carts lacked and expiration date or when they were last filled. -Multiple bulbs of garlic in an open plastic tub dated 6/3. Some of the bulbs were soft and/or a dark brown in color. During an interview at approximately 3:50 p.m. the DD stated she did not know how long garlic was good for and that she would probably toss	21095		

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21095	Continued From page 40 them. The DD further stated there was no specific length of time for how long they would keep garlic. Main Kitchen Dish Washing area: -An industrial carpet and floor dryer/fan was placed on a cart between where the dirty pots and pans were cleaned in three metal sinks and where they were placed on shelves to dry after being sanitized. The fan was covered in dust and dirt and blowing air onto the clean pots and pans from approximately five feet away. Another wall mounted fan was in the ceiling corner above the dirty pots and pans area, also blowing in the direction of the clean drying racks. During an interview on 10/24/22, at approximately 5:30 p.m. dietary aid (DA)-A stated they used the industrial fan on the cart to help dry the clean pots and pans faster. The corner ceiling fan also helped dry the pots and pans as well as keep the staff cool. During an observation and interview on 10/24/22, at 5:05 p.m. in the first-floor kitchenette refrigerator, two open and uncovered trays containing 27 pasteurized eggs lacked a label to indicated when they were opened or when they would expire. DA-B stated she did not know when the eggs were put into the refrigerator or when they would expire. During an interview on 10/25/22, at 9:35 a.m. dietary director (DD) stated the cans of food should have been labeled with an expiration date after they were removed from their original shipping boxes. The DD also stated staff should be writing expiration dates with the month and day they expire to avoid confusion and serving	21095		

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21095	Continued From page 41 expired food to residents. Cooked meat should be cooled according to the guidelines to lessen the possibility of bacterial growth and to ensure the residents don't get sick. The DD stated the sugar and flour in the metal carts were good for approximately eight to nine months and the carts would be washed prior to refilling them; however, there was no documentation to indicate when the sugar or flour was put into the carts and, therefore, the DD did not know when they would expire. The DD further stated fans blowing from a dirty area to a clean area would be a concern for cross contamination. The facility referenced the "Food Storage Guide. Answer the Question ...How long can I store before its quality deteriorates or it's no longer safe to eat?" article by Julie Garden-Robinson. NDSU Extension Service; dated February 2012 as the facility policy on food storage. The article indicated white flour was to be stored in an airtight container in the refrigerator for 6-8 months. Shell eggs were to be stored covered for 3 weeks. The facility Chill Down Log undated, indicated if the initial food temperature was greater than 140 degrees Fahrenheit, check the food frequently until the food reaches 140 degrees Fahrenheit or less. After 2 hours of cooling, if the food temp is 41 degrees Fahrenheit or less, the cooling process was complete. If the food temp was between 42-70 degrees Fahrenheit, continue to cool the food and re-check the temperature after an additional 2 hours. However, if the food temperature is above 70 degrees Fahrenheit, the food must be discarded or properly reheated to 165 degrees Fahrenheit for 15 seconds then begin the cooling process again.	21095		

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21095	Continued From page 42 No other facility policy on food storage or labeling was provided. SUGGESTED METHOD OF CORRECTION: The dietary manager (DM) and registered dietician (RD) could re-educate dietary staff on the policies and procedures related to labeling and storage of foods. The DM could conduct random audits to ensure compliance and the RD should oversee the completion of those audits. The DM or RD should bring the results of those audit results to the Quality Assurance Performance Improvement (QAPI) committee for review. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21095		
21100	MN Rule 4658.0650 Subp. 5 Food Supplies; Storage of Perishable food Subp. 5. Storage of perishable food. All perishable food must be stored off the floor on washable, corrosion-resistant shelving under sanitary conditions, and at temperatures which will protect against spoilage. This MN Requirement is not met as evidenced by: Surveyor: 44658 Based on observation, interview, and document review the facility failed to ensure potentially hazardous food was cooled properly in the refrigerator after being cooked and failed to ensure food was properly labeled and dated after being removed from their original packaging. These deficient practices had the potential to affect all 68 residents who ate from the main	21100	The facility reviewed and updated the LTC Food Safety & Sanitation policy and process on 11/30/22. The staff have been trained on the updated policy and process on 12/6/22. New hire training module was created for the updated policies. Additional fan on the cart was removed on 10/25/22. The fan above the pots and pans sink was	12/8/22

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21100	Continued From page 43 kitchen. During the initial kitchen observation and interviews on 10/24/22, from 2:15 p.m. to 5:30 p.m. with the dietary director (DD), the following was observed: Main kitchen dry storage: -Dry, white rice in a large plastic bucket approximately 1/6th full, with no expiration date or fill date -Dry, wild rice in a large plastic bucket, full, with no expiration date or fill date -Multiple large cans of food approximately 6 pounds (lbs) 11 ounces (oz) including but not limited to pineapple tidbits, various tomatoes (diced, sliced), ketchup, and spaghetti sauce were removed from their original shipping box and stored on the shelf without an expiration date. -Chocolate sheet cake on cart covered with plastic wrap, expiration labeled "X 31" (no month). -An opened and used apple juice box (46 fluid oz) expiration labeled "X 30" (no month). Main kitchen refrigerator: -A tray of wrapped, half-sandwiches on a shelf contained: two egg salad, six turkey, and six ham sandwiches all labeled with an expiration of "X 29" (no month). -Three, uncovered trays of two-dozen, pasteurized eggs, lacked an expiration date. -Three, uncovered metal containers filled with frozen veggies, on a cart, lacked a label indicating when they were opened or intended to be used by.	21100	removed on 12/6/22. Audits were completed of the food storage locations in the main kitchen and the four kitchen areas in the long term care units to check for expiration dates on food items were correctly labeled with the month/date/year completed on 12/7/22. Audit: 100% observations 2 observations per unit per week x 3; 4 observations per month; 4 observations per quarter.	

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21100	Continued From page 44 Main kitchen freezer: -A clear, plastic bag containing approximately a dozen, frozen, red meat patties unlabeled with no expiration date. -Unknown, frozen, breaded food item in metal container with no lid, label, or expiration date. During an interview at approximately 3:00 p.m. the Cook (CK)-B stated the uncovered, breaded food item in a small metal container was frozen shrimp she had just put in there to defrost for the evening meal. CK-B asked this surveyor if they should be covered. CK-B also stated she assumed the meat patties were placed in the freezer that day but was not sure. Main kitchen cooler: -Five large turkey breasts, wrapped in foil then cut entirely lengthwise, exposing the meat, were on a cart in the back of the freezer, directly under the fan. Large, plastic ice packs had been folded in half and stuffed inside each turkey breast. During an observation and interview on 10/24/22, at 4:20 p.m. registered dietician (RD)-B temp'd the turkey breasts as follows: 75 degrees Fahrenheit 90 degrees Fahrenheit 80 degrees Fahrenheit 82 degrees Fahrenheit 80 degrees Fahrenheit During an interview on 10/24/22, at 4:35 p.m. CK-B stated she cooked the turkey breasts to 168 degrees Fahrenheit that afternoon, then put them in the cooler at 1:00 p.m. They would be sliced the next day, then served the day after that. CK-B stated the ice packs were placed in the turkey	21100		

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21100	Continued From page 45 breasts to speed the cooling process. CK-B further stated although the ServSafe food handler certification course she completed, advised cooling meat in cold water, CK-B found that unappetizing and refused to do it. Main kitchen: -Two large metal carts (approximately 18" wide by 24" deep by 30" high) on wheels were stored under an industrial sink. One contained, and was labeled "sugar," (white) the other contained, and was labeled "flour" (white). The carts lacked and expiration date or when they were last filled. -Multiple bulbs of garlic in an open plastic tub dated 6/3. Some of the bulbs were soft and/or a dark brown in color. During an interview at approximately 3:50 p.m. the DD stated she did not know how long garlic was good for and that she would probably toss them. The DD further stated there was no specific length of time for how long they would keep garlic. Main Kitchen Dish Washing area: -An industrial carpet and floor dryer/fan was placed on a cart between where the dirty pots and pans were cleaned in three metal sinks and where they were placed on shelves to dry after being sanitized. The fan was covered in dust and dirt and blowing air onto the clean pots and pans from approximately five feet away. Another wall mounted fan was in the ceiling corner above the dirty pots and pans area, also blowing in the direction of the clean drying racks. During an interview on 10/24/22, at approximately 5:30 p.m. dietary aid (DA)-A stated they used the	21100		

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21100	Continued From page 46 industrial fan on the cart to help dry the clean pots and pans faster. The corner ceiling fan also helped dry the pots and pans as well as keep the staff cool. During an observation and interview on 10/24/22, at 5:05 p.m. in the first-floor kitchenette refrigerator, two open and uncovered trays containing 27 pasteurized eggs lacked a label to indicated when they were opened or when they would expire. DA-B stated she did not know when the eggs were put into the refrigerator or when they would expire. During an interview on 10/25/22, at 9:35 a.m. dietary director (DD) stated the cans of food should have been labeled with an expiration date after they were removed from their original shipping boxes. The DD also stated staff should be writing expiration dates with the month and day they expire to avoid confusion and serving expired food to residents. Cooked meat should be cooled according to the guidelines to lessen the possibility of bacterial growth and to ensure the residents don't get sick. The DD stated the sugar and flour in the metal carts were good for approximately eight to nine months and the carts would be washed prior to refilling them; however, there was no documentation to indicate when the sugar or flour was put into the carts and, therefore, the DD did not know when they would expire. The DD further stated fans blowing from a dirty area to a clean area would be a concern for cross contamination. The facility referenced the "Food Storage Guide. Answer the Question ...How long can I store before its quality deteriorates or it's no longer safe to eat?" article by Julie Garden-Robinson. NDSU Extension Service; dated February 2012 as the	21100		

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	00343		C 10/28/2022

NAME OF PROVIDER OR SUPPLIER: AVERA MORNINGSIDE HEIGHTS CARE CENTE

STREET ADDRESS, CITY, STATE, ZIP CODE: 300 SOUTH BRUCE STREET MARSHALL, MN 56258

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21100	Continued From page 47 facility policy on food storage. The article indicated white flour was to be stored in an airtight container in the refrigerator for 6-8 months. Shell eggs were to be stored covered for 3 weeks. The facility Chill Down Log undated, indicated if the initial food temperature was greater than 140 degrees Fahrenheit, check the food frequently until the food reaches 140 degrees Fahrenheit or less. After 2 hours of cooling, if the food temp is 41 degrees Fahrenheit or less, the cooling process was complete. If the food temp was between 42-70 degrees Fahrenheit, continue to cool the food and re-check the temperature after an additional 2 hours. However, if the food temperature is above 70 degrees Fahrenheit, the food must be discarded or properly reheated to 165 degrees Fahrenheit for 15 seconds then begin the cooling process again. No other facility policy on food storage or labeling was provided. SUGGESTED METHOD OF CORRECTION: The dietary manager (DM) and registered dietician (RD) could re-educate dietary staff on the policies and procedures related to labeling and storage of foods. The DM could conduct random audits to ensure compliance and the RD should oversee the completion of those audits. The DM or RD should bring the results of those audit results to the Quality Assurance Performance Improvement (QAPI) committee for review. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21100		

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21375	Continued From page 48	21375		
21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment. This MN Requirement is not met as evidenced by: Surveyor: 38687 Based on observation, interview, and document review, the facility failed to: 1) Ensure 1 of 1 resident (R33) was placed into transmission based precautions (TBP)and tested immediately after showing symptoms of COVID. This had the potential to affect 1 other resident (R8) who shared a table with R33 at each meal. 2) Ensure appropriate hand hygiene was maintained during 1 of 1 IV antibiotic administration. 3) Appropriately clean all 6 of 6 whirlpool tubs and appropriately launder and transport and store linen on the Meadows and Garden wings located on the 1st floor. 4) Implement appropriate infection control (IC) technique during 1 of 1 dressing change for R56. 5) Maintain 1 of 1 resident (R27) nebulizer machine in a sanitary manner. Findings include: Transmission Based Precautions and Testing of COVID Symptomatic Residents R33's annual Minimum Data Set (MDS) dated 9/7/22, indicated R33 had intact cognition, was independent with eating, required extensive	21375	The facility policy on Transmission Based Precautions was reviewed on 12/1/22. The facility policy of hand hygiene was reviewed on 12/1/22. The facility policy on equipment cleaning in LTC was reviewed and updated on 12/2/22. The facility policy on infection control standard of precautions on 12/2/22. The facility policy and process on Laundry in LTC was reviewed and updated on 12/1/22. Training with staff on all infection prevention items was completed on 12-4-2022 and 12-8-2022. Training was also added to the new hire training materials. Processes developed per manufacturer infection for use on whirlpools that are in use. One whirlpool was taken out of service. New process developed for storage of linen including ted hose. Along with new process and new policy implemented for laundry process to ensure cross contamination does not occur. Audits: COVID - 100% observations 2 observations per unit per week x 4' 8	12/8/22

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21375	Continued From page 49 assistance of one staff for bed mobility and limited assistance with all other activities of daily living (ADLs). R33's diagnoses included prostate cancer, coronary artery disease, high blood pressure, and kidney disease. R33's Care Area Assessment (CAA) dated 9/7/22, indicated R33 triggered for communication, ADL function, falls, and pressure ulcers. R33's care plan dated 9/1/22, indicated R33 was at risk for communication related to new onset of cognitive losses resulting in poor recall and safety awareness. R33's progress note dated 10/26/22, at 7:59 a.m. indicated R33 had been having a cough and nasal congestion since receiving his immunizations six days prior. R33 stated he felt fine except for the infrequent cough he had. R33's SARS-CoV-2 (PCR) test dated 10/26/22, at 9:15 a.m. indicated R33 was positive for COVID-19. During an observation on 10/26/22, at 7:54 a.m. from approximately 40 feet down the hallway, outside the resident dining room, licensed practical nurse (LPN)-B was overheard asking R33 if his cough had improved since the previous day. R33 stated it was a "bad head cold" he couldn't get rid of and felt worse. LPN-B took R33's blood pressure, temperature and oxygen level and reported them as "fine", telling R33 she would inform the provider. R33 then self-propelled his wheelchair into the resident dining room, without a mask, where other residents were seated for breakfast. During an interview on 10/26/22, at 11:20 a.m.	21375	observations per month x3; 8 observations quarterly Hand Hygiene- 100% observations 30 observations per month Tub Cleaning - 2 observations per unit per week x 4; 8 observations per month x 3; 8 observations quarterly. Laundry - 2 observations per unit per week x 4; 8 observations per month x 3; 8 observations quarterly.	

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21375	Continued From page 50 LPN-B stated she tested R33 for COVID-19 at 8:45 a.m. using a rapid antigen test that indicated R33 was positive for COVID-19. Thirty minutes later, LPN-B tested R33 for COVID-19 using a polymerase chain reaction (PCR) test which also indicated R33 was positive. LPN-B stated R33 received a COVID-19 booster and influenza vaccine on 10/20/22. On 10/22/22, R33 began having diarrhea, however, R33 had a history of diarrhea and therefore the staff did not believe it was a concern. On 10/24/22, R33 began having nasal congestion but he believed it was a result of being outside that day. On 10/25/22, LPN-B stated R33 developed a cough, and she should have quarantined him on transmission-based precautions (TBP) and tested him for COVID-19 at that time but did not. LPN-B stated she also failed to notify the provider of R33's new onset of symptoms until today, 10/26/22. LPN-B further stated she should have redirected R33 to his room, placed him on TBP, and tested him for COVID-19 instead of allowing him to eat breakfast with other residents in the dining room that morning. The facility COVID-19 Outbreak Guidelines policy dated 10/2022, indicated the facility should have a plan in place to identify a COVID-19 outbreak, and the process to prevent further transmission. A single new case of COVID-19 in any resident should be evaluated to determine if others in the facility could have been exposed. No further documentation was provided regarding the facility process for identifying and responding to a resident with a new onset of COVID-19 symptoms. IV Antibiotic Therapy	21375		

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21375	Continued From page 51 R64's quarterly Minimum Data Set (MDS) dated 10/12/22, indicated R64 had mild cognitive deficits, required supervision for eating and extensive assistance for all other activities of daily living (ADLs). R64 had diagnoses that included hypothyroidism (low functioning thyroid), heart failure, chronic obstructive pulmonary disease (COPD), Alzheimer's and dementia, malnutrition, a chronic non-pressure ulcer of the foot, and osteomyelitis of the foot (a bone infection). During an interview on 10/25/22, at 10:38 a.m. R64 stated she was receiving an antibiotic (Ceftriaxone 2 grams in 50 milliliters normal saline) intravenously (IV) for an infection in her foot that went into the bone. During an observation an interview on 10/26/22, at 8:28 a.m. licensed practical nurse (LPN)-A was observed attaching an intravenous (IV) antibiotic medication to an IV line in R64's right arm without wearing gloves. The medication pump alarmed with an error and LPN-A attempted to troubleshoot the occlusion by touching the pump machine, tubing and R64's arm and clothing without first performing hand hygiene. LPN-A stated she should have worn gloves to administer the IV medication, removed them, then performed hand hygiene prior to touching anything else to avoid cross contamination. During an observation and interview on 10/26/22, at 7:15 a.m. multiple pairs of compression socks were observed hanging over hallway handrails in front of rooms 123, 128, 134, 137, and 138. Nursing assistant (NA)-Carla was then observed walking out of a resident room, approximately 50 feet down the hallway, holding dirty bed linen against her uniform, and without wearing gloves. NA- disposed of the dirty linen in a laundry bin	21375		

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21375	Continued From page 52 and walked back towards the resident room without performing hand hygiene. NA- stated because there was only "one dirty spot" on the sheets, she didn't think contamination would be a concern. NA- further stated the overnight staff would hang the socks on the handrails to dry because there was not a "good" place to hang them in the resident rooms and there was more "air flow" in the hallways. WHIRLPOOL TUB CLEANING Observation and interview on 10/26/22 at 3:50 p.m., with bath aide (BA)-F identified BA-F was beginning her cleaning and disinfecting of the whirlpool tub. BA-F had scrubs on and applied no personal protective equipment (PPE) (gloves, gown and goggles) prior to beginning the process. The tub was an Apollo whirlpool tub with water jets. BA-F began her process by opening pouring MasterCare one-step disinfectant/cleaner straight in without using any measurement. BA-F then used a toilet brush (designated for this use) to clean any debris from the sides of the tub. BA-F then filled the tub with water passed the level of the water jets and turned the jets on and washed the top of the whirlpool chair. The sides of the tub were visibly dry before 60 seconds had elapsed. BA-F allowed the whirlpool jets to run until it caused bubbles to fill the tub. BA-F then used the sprayer to rinse out the tub. The process took less than 8 minutes. BA-F was unaware of any instructions for use on how to appropriately clean and disinfect the tub by the manufacturer. She was taught this way, and taught others to clean and disinfect the tub using this method. BA-F was unaware she should wear PPE during the cleaning and disinfection process.	21375		

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21375	Continued From page 53 Review of the Apollo Advantage Bathing System manual located at https://apollobath.com/wp-content/uploads/2021/09/CD0012-Advantage-Operation-Manual.pdf, identified use of other manufacturer's cleaners and disinfectants was not recommended and could compromise the overall process. The tub came with a hose and compartment for their cleaning and disinfecting processes. The manufacturer recommended use of Cid-A-L cleaner and disinfectant. Staff were to clean and disinfect the whirlpool tub using the following process for: Cleaning 1) Place the chair in the tub, release the carrier from the tub, and close the door. 2) Close the Tub Drain. Turn the Selector Knob to "TUB CLEANER" and the Control Knob to "On." 3) Turn the whirlpool on. After the Turbo Clean (Trademark) mixture has come out of the jets for about 30 seconds or when there is about 2 inches of cleaning solution in the foot well; turn the Selector Knob to "Rinse." 4) Lift seat bottom off chair, (pull up from back of seat). Use the cleaning solution to scrub the tub, chair and underneath seat bottom. When clear water comes out of all the jets, turn the whirlpool off. 5) Turn the Control Knob to "Off" and open the Tub Drain. 6) Use the shower wand to rinse the tub and chair. Disinfection 1) Place the chair in the tub, release the carrier from the tub, and close the door. 2) Close the Tub Drain. Turn the Selector Knob to "DISINFECTANT" and the Control Knob to "On." 3) Turn the whirlpool on. When there is about 2	21375		

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21375	Continued From page 54 inches of disinfectant in the foot well, turn the whirlpool off. Turn the Control Knob to "Off." 4) Lift seat bottom off chair, (pull up from back of seat). Use the disinfecting solution to scrub the tub, chair and underneath seat bottom. 5) Leave wet for 10 minutes (wet contact time for all surfaces). Open the Tub Drain. 6) After 10 minutes, turn the Selector Knob to "Rinse" and the Control Knob to "On." Turn the whirlpool on. When clear water comes out of all the jets, turn the whirlpool off. Turn the Control Knob to "Off." 7) Use the shower wand to rinse the tub and chair. LAUNDRY Observations of laundry processes on the first floor identified on: 1) 10/24/22 at 2:25 p.m., of the laundry room in the Gardens wing identified the laundry room was small, had a washer and dryer located inside it with automated chemicals were tubed into the washing machine. Empty laundry baskets were stacked on top of the dryer. There was no visible sorting area to separate dirty linen from clean linen, and no sorting table for folding clean linen. Linen left in this room was uncovered and exposed to potential air contaminates when the laundry area was not separated. 2) 10/25/22 at 8:11 a.m., a laundry basket full of resident clothing was sitting on the floor in the hallway, uncovered, in a laundry basket outside R32's room. 3) 10/25/22 at 8:21 a.m., R56's clothing was sitting in an open laundry basket clean, uncovered outside the room in the hallway. 4) 10/25/22 at 8:22 a.m., R32's and R56's clothing baskets remained uncovered in the	21375		

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21375	Continued From page 55 hallway and were still there at 8:50 a.m. Further observation on 10/27/22 at 8:04 a.m., R39's bathroom was visible from the hall. On the floor in the bathroom sat the same white laundry baskets seen previously throughout the facility with clean laundry, now holding dirty laundry and sitting on the bathroom floor. Review of the February 2020, Laundry and Linen procedures policy identified PPE was to be worn by laundry personnel when handling soiled linen. Laundry and linen employees were to receive 1 on 1 training by the manager including infection prevention and appropriate linen handling. Collection carts for soiled linen were to be used by the facility. Clean linen was to be placed on a covered cart and stored in an enclosed linen cart which was to be wheeled in patient areas. There was to be a counter to fold clean linen. There was no mention of using routine laundry baskets to both hold dirty and clean linens or how staff would ensure those baskets were cleaned appropriately. DRESSING CHANGE Observation on 10/25/22 at 9:42 a.m. with registered nurse (RN)-A performing a dressing change to R56's pressure ulcers with assistance from nurse aide (NA)-G identified R56 was paralyzed and was unable to move her arms and legs independently. NA-G rolled R56 towards her so RN-A could perform the dressing change. RN-A had sterile dressings on a barrier on R56's bedside table. RN-A washed, dried her hands, and applied clean gloves. R56 had multiple areas in varied stages of healing. RN-A measured each wound with different paper measuring tapes using the same gloves touching the different pressure ulcer areas. RN-A needed a Q-tip to measure	21375		

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21375	Continued From page 56 depth of 1 area, and without removing gloves, she went to R56's closet, and retrieved a tub of clean dressing supplies with her soiled gloves, touching those clean supplies and returning them to the cupboard. After finishing measuring all of the wound/pressure ulcer areas, RN-A then set the contaminated wound measuring tapes on top of the sterile dressings she had on the bedside table, along with her contaminated pen she used to record those measurements on the measuring tapes. She then proceeded to grab the bottle of wound wash and sterile 4x4's with her soiled gloves and washed each wound using the same contaminated 4x4 gauze pads, cross contaminating the wounds. RN-A then applied bordered foam dressing without removing her contaminated gloves or performing hand hygiene and donning new gloves and proceeded to apply the once sterile dressings to R56's wounds. RN-A then removed her same contaminated gloves at the end of the procedure and washed her hands. RN-A was unable to be interviewed immediately after the dressing change due to her needing to assist another resident immediately after. Interview on 10/26/22 at 4:06 p.m., with the infection preventionist (IP) identified she performed environmental audits 2 x per year with the adjoining hospital safety advisor. She was unaware laundry was being cleaned and stored in the manners described above. She agreed definite processes needed to be changed to ensure cross contamination did not occur and laundry was handled and transported appropriately. She also noted she always had high increases of UTI in the facility and not disinfecting the whirlpool tubs appropriately could lead to an increase in urinary tract infections (UTI). The IP agreed RN-A should have performed appropriate hand hygiene and glove	21375		

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21375	Continued From page 57 changes between tasks. RN-A should have also not contaminated clean or sterile dressing supplies. This was a cause of concern and cross contamination of R56's wounds. There was no policy related to appropriate hand hygiene or glove use provided by the end of the survey. NEBULIZER R27's 8/30/22, significant change Minimum Data Set (MDS) assessment identified R27 had difficulty staying focused, was easily distracted, and had a hard time keeping track of what was said. R27 required extensive assistance of 2 staff for all cares. R27 had chronic obstructive pulmonary disease (COPD), Alzheimer's disease, diabetes, and history of acute respiratory failure. R27 required oxygen therapy and was receiving hospice services. R27's current care plan identified respiratory status as active with a start date of 10/24/22, as evidenced by COPD. Maintain respiratory status, nebulizer tubing changes every Monday at 8:00 a.m. R27's Active Medication List printed 10/25/22, identified Albuterol/ipratropium 3 milliliters (ML) inhalation nebulizer treatment every 6 hours scheduled. Observation on 10/25/22 at 10:03 a.m., R27 nebulizer mask was still connected to the machine with some moisture noted inside mask, the mask was laying in a basket on top of some papers next to the nebulizer machine.	21375		

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21375	Continued From page 58 Observation on 10/26/22 at 9:35 a.m., R27's nebulizer treatment mask was still attached to the machine sitting on bedside table. Observation on 10/26/22 at 11:50 a.m., R27's nebulizer treatment mask was still attached to the machine on bedside table. Interview on 10/26/22 at 11:05 with trained medication aide (TMA)-C revealed that the person working on the medication cart and assisting with the nebulizer treatment would be the person responsible for cleaning the nebulizer equipment. The medication staff should rinse the mask and port that the medication goes in and set it on a clean paper towel to dry after each administration. Interview on 10/26/22 at 1:15 p.m., with registered nurse (RN)-D confirmed that the protocol was to clean and place the nebulizer supplies on a clean paper towel to dry after each use. Interview on 10/27/22 at 1:00 p.m., with director of nursing (DON) confirmed staff should be rinsing and leaving the nebulizer supplies on a clean paper towel to dry after each use along with replacing supply's weekly. Review of October 2022, Avera LTC Disinfection of Non-Critical Patient Care Equipment policy identified Nebulizer's supplies were to be rinsed and set on clean paper towel and covered with another paper towel to dry in the resident's room until the next treatment. Every 24 hours staff will disassemble all nebulizer equipment and wash with soap and rinse and air dry on a clean paper towel covered by another paper towel. Nebulizer	21375		

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	00343		C 10/28/2022

NAME OF PROVIDER OR SUPPLIER: AVERA MORNINGSIDE HEIGHTS CARE CENTE

STREET ADDRESS, CITY, STATE, ZIP CODE: 300 SOUTH BRUCE STREET MARSHALL, MN 56258

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21375	Continued From page 59 supplies should be replaced weekly or more often based on manufacturer instructions for use. SUGGESTED METHODS OF CORRECTION The ICP or designee could review facility policies/procedures regarding appropriate infection control technique during dressing changes. The ICP or designee could provide staff education regarding the policies and educate staff on appropriate IC technique while performing dressing changes. The ICP or designee should complete timely audits to ensure policies are being followed to ensure on-going competence. The ICP, or designee should take education verifications and the audits to the Quality Assurance Performance Improvement (QAPI) committee to determine compliance or the need for continued monitoring. The DON (Director of Nursing) or designee should review/revise facility policies to ensure appropriate screening, notification of signs and symptoms of illness, daily cumulative tracking and trending of all illnesses in the facility, immediate implementation of droplet precautions, and appropriate use of PPE are implemented to mitigate potential COVID-19 transmission. The DON or designee could educate all staff on existing or revised policies and perform ongoing continuous audits to ensure compliance. The results of those audits should be taken to QAPI to determine compliance. The DON (Director of Nursing) or designee should review/revise facility policies to ensure they contain all components of an infection control program to mitigate transmission of potential infections. The DON or designee could educate all staff on existing or revised policies and perform audits to ensure the policies are	21375		

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21375	Continued From page 60 being followed. The results of those audits should be taken to Quality Assurance Performance Improvement committee to determine compliance and the need for further monitoring. Time Period for Correction: Twenty-one (21) days.	21375		
21580	MN Rule 4658.1325 Subp. 7 Administration of Medications; Requirements Subp. 7. Administration requirements. The administration of medications must include the complete procedure of checking the resident's record, transferring individual doses of the medication from the resident's prescription container, and distributing the medication to the resident. This MN Requirement is not met as evidenced by: Surveyor: 38687 Based on observation, interview and document review, the facility failed to administer medication according to manufacture's instructions and physician order for 1 of 25 observations. Additionally, the fcility failed to ensure the correct dose of Depakote (anti-siezure medication) was administered during a Gradual Dose Reduction (GDR) for 1 of 1 resident (R57). Findings include: Observation and interview on 10/25/22 at 5:00 p.m., with registered nurse (RN)- A as she prepared to administer R36's Novolog 70/30 Flex	21580	The facility reviewed the current Medication Administration policy and updates were made on 12/1/22. The staff were trained on the updated policy and procedures on11/30/22, 12/6/22, 12/7/22, 12/8/22. The Charge nurses will be expected to verify medication received matches what is in the order. Audits: 100% observation 2 observations per week x 4; 4 observations per month x 3; 4 observations per quarter.	12/8/22

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21580	Continued From page 61 Pen insulin 30 units subcutaneous (SQ). RN-A was observed preparing to administer the insulin by cleansing the attachment site for the needle, attaching the needle to the pen and priming with 1 unit of insulin. RN-A dialed the pen to the 30 unit mark and administered the insulin to R36. She reported she always primed the insulin pen with one unit as that was what the facility policy identified. RN-A reported she had not read the insert provided with the insulin pens and was not aware of the instructions to prime with 2 units before administering the ordered insulin dose. Review of the manufacture's instructions for priming of the insulin Flex Pen identified following attachment of a new sterile needle, the pen was to be primed with 2 units of insulin before dialing the ordered insulin dose to be administered. Interview on 10/25/22 at 5:15 p.m., with licensed practical nurse (LPN)-B who was also the supervisor for the unit, reported she was not aware of the manufacture instruction to prime the Novolog Flex Pen with 2 units and waste prior to administration of the ordered dose. Interview on 10/28/22 at 9:30 a.m., with the director of nursing (DON) voiced her expectation that manufacture's recommendations be followed when priming and administering insulin with insulin pens. R57's quarterly Minimum Data Set (MDS) dated 10/5/22, indicated R57 had severe cognitive deficits. R57 had diagnoses that included major depressive disorder, psychotic disorder due to another medical condition with delusions, agitation due to dementia, insomnia, Alzheimer's and vascular dementia with behavioral disturbances, and memory loss.	21580		

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21580	Continued From page 62 R57's physician orders dated 10/18/22, at 1:45 p.m. indicated R57 was to have a GDR of his Depakote as follows: Depakote Sprinkles 125 milligrams (mg) -Take 2 capsules (250 mg) 3 times per day (750 mg) for 3 days from 10/19/22, to 10/21/22. -Take 1 capsule (125 mg) 3 times per day (350 mg) for 3 days from 10/22/22, to 10/24/22. -Take 2 capsules (250 mg) 2 times per day (500 mg, an increase) for 3 days from 10/25/22, to 10/27/22. -Take 2 capsules (250 mg) 1 time per day (250 mg) daily for 3 days from 10/27/22, to 10/29/22, then discontinue. R57's physician orders dated 10/18/22, at 2:54 p.m. indicated R57's corrected GDR was as follows: -Take 2 capsules (250 mg) 3 times per day (750 mg) for 3 days from 10/19/22, to 10/21/22. -Take 1 capsule (125 mg) 3 times per day (350 mg) for 3 days from 10/22/22, to 10/24/22. -Take 2 capsules (125 mg) 2 times per day (250 mg, corrected) for 3 days from 10/25/22, to 10/27/22. -Take 2 capsules (125 mg) 1 time per day (125 mg, corrected) daily for 3 days from 10/27/22, to 10/29/22, then discontinue. R57's Orders with Administration record from 10/1/22, thru 10/27/22, indicated the original, incorrect gradual dose reduction order was entered into R57's electronic medical record (EMR); however, the pharmacy delivered R57's Depakote in accordance with the correct GDR order; therefore, R57 was administered incorrect doses and/or no doses of Depakote as indicated below:	21580		

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21580	Continued From page 63 -10/19/22, to 10/20/22, Depakote 250 mg three times per day. -10/21/22, to 10/23/22, Depakote 125 mg three times per day. -10/24/22, Depakote 125 mg twice. -10/25/22, Depakote 250 mg twice. -10/26/22, Depakote 125 mg once. -10/27/22, Depakote 125 mg once. During at interview on 10/26/22, at 1:29 p.m. licensed practical nurse (LPN)-B stated the provider had ordered a gradual dose reduction (GDR) for R57's Depakote; however, the pharmacy had been sending incorrect doses. LPN-B stated because the pharmacy did not send the correct dose, R57 did not receive his morning dose of 125 mg of Depakote prior to leaving for an appointment with his family member (FM)-E that day. LPN-B stated "poor" FM-E "is probably going crazy" due to R57's likely increases in behaviors. LPN-B further stated she told the prior evening staff to order more Depakote; however, it did not appear to have been done. LPN-B stated the order on 10/24/22, for 125 mg twice a day for a total of 250 mg was correct. LPN-B also stated the order on 10/25/22, for 250 mg twice a day for a total of 500 mg was also correct although R57 was supposed to be on a GDR. LPN-B further stated the staff who received R57's Depakote from the pharmacy should have verified the dose was correct against the order. Furthermore, the staff administering the medication should have verified the medication card dose matched the order prior to administering the medication, and any discrepancies should have been verified with the pharmacy. During an interview on 10/27/22, at 3:57 p.m. the pharmacist (PH) stated the pharmacy received	21580		

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21580	Continued From page 64 multiple prescriptions on 10/18/22, for R57's Depakote medication. At 1:54 p.m. an order was received indicating R57's GDR for his Depakote beginning on 10/19/22; however, there was a discrepancy. The order indicated the dose on 10/25/22, increased from R57's prescribed dose on 10/24/22, instead of decreasing. The PH contacted the provider and at 2:46 p.m. on 10/18/22, the pharmacy received a corrected order to indicate R57 should have received 125 mg of Depakote twice a day from 10/25/22, to 10/27/22. During an interview on 10/27/22, at 3:30 p.m. the director of nursing (DON) stated staff were expected to verify medication received from the pharmacy matches what is on the order. The DON also stated staff should verify they are administering the correct dose of a medication to a resident and clarify any discrepancies with the provider and/or pharmacist prior to administering it. Review of the May 2023 policy Medication Administration identified all medications were to be stored and administered according to manufacture's guidelines. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures for medication administration. The director of nursing or designee could develop a system to educate staff and develop a monitoring system to ensure medication were correctly administered. The quality assurance committee could monitor these measures to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) days	21580		

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21610	MN Rule 4658.1340 Subp. 1 Medicine Cabinet and Preparation Area;Storage Subpart 1. Storage of drugs. A nursing home must store all drugs in locked compartments under proper temperature controls, and permit only authorized nursing personnel to have access to the keys. This MN Requirement is not met as evidenced by: Surveyor: 44658 Based on observation and interview the facility failed to ensure medications were stored securely in 3 of 25 rooms on the Horizons unit, and in 2 of 12 rooms on the Transitions unit. Findings include: During an observation and interview on 10/26/22, at 10:04 a.m. R57's in-room medicine cabinet used to store R57's non-narcotic, facility medications, was found unlocked.. Family member (FM)-E and trained medical assistant (TMA)-F were present in the room. TMA-F stated the cabinet should have been locked. Observation on 10/28/22 at 8:06 a.m. with LPN-C on the Horizons unit identified Rooms 2, 18, and 33 were unsecured with the attached touch pad lock mounted on the door of the cabinet. Rooms 2 and 33 were noted to not have the lock engaged, but room 18 the lock was nonfunctioning. Observation on 10/28/22 at 8:30 a.m., on the Transitions unit with RN-F identified Room 7 and 10 had in room medication cabinets that were not secured.	21610	The facility reviewed the Mediation Storage policy on 12/1/22. Trained the staff on the policy and also how to report a broken piece of equipment 11/30/22, 12/6/22, 12/7/22, 12/8/22. The broken lock was fixed immediately by the Maintenance team on 10/28/22. Audits: 100% observations 2 observations per unit x 4 ; 8 observations per month x 3; 8 observations per quarter.	12/8/22

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21610	Continued From page 66 Both RN-F and LPN-C confirmed that anyone entering the identified rooms could have had access to the medications stored in the cabinets and they should have been secured immediately following administration of any medications. Interview on 10/28/22 at 9:15 a.m. with RN-D the nursing supervisor, reported her expectation for in room medication cabinets be locked when medications were not being administered and if there was a problem with the locking mechanism it should be reported immediately to maintenance. Until the lock was repaired, she stated any medications were to be removed and stored in a secure location until the issue was resolved. Interview on 10/28/22 at 10:55 a.m., with the administrator reported she had not been made aware of an issue with the locking mechanism on room 18's medication storage cabinet and her expectation was for a work to be submitted immediately. She verbalized she should have been made aware of the concern immediately by staff and intervention implemented. A policy for in room medication storage was requested but not provided prior to exit. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON) and consulting pharmacist could review and revise policies and procedures for proper storage of medications. Nursing staff could be educated as necessary to the importance of properly securing medications. The DON or designee, along with the pharmacist, could conduct audits on a regular basis to ensure compliance.	21610		

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21610	Continued From page 67 TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21610		
21980	MN St. Statute 626.557 Subd. 3 Reporting - Maltreatment of Vulnerable Adults Subd. 3. Timing of report. (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless: (1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, clause (4). (b) A person not required to report under the provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point. (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency. (e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause	21980		12/8/22

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21980	Continued From page 68 (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead agency shall consider this information when making an initial disposition of the report under subdivision 9c. This MN Requirement is not met as evidenced by: Surveyor: 44658 Based on interview and record review, the facility failed to develop and/or implement policies and procedures for ensuring the reporting of a reasonable suspicion of crime in accordance with section 1150B of the Act related to misappropriation of property to the State Agency (SA) no later than 24 hours when 1 of 1 resident (R4) alleged she was missing $200.00 from her billfold. Findings include: R4's annual Minimum Data Set (MDS) dated 10/26/22, indicated R4 had intact cognition, was independent with eating but required extensive assistance of two staff for all other activities of daily living (ADLs). R4's diagnoses included stroke, and depression. R4's care plan dated 10/24/22, indicated R4 was	21980	The vulnerable adult policy and process was reviewed on 11/11/22. The vulnerable adult policy and process was trained with staff on 11/30/22, 12/6/22, 12/7/22, 12/8/22. The investigation was submitted to MDH on 10/26/22 and the police were called and arrived for the investigation on 10/26/22 and opened case # 22-16559. Family was contacted and reported that the resident attended a recent wedding and gave her grandkids money at the wedding. The Marshall police department was contacted on 12/1/22 and they have not closed the case yet. Audit: Observation audits will be completed of the daily taped report. 5x/weeks x 4; 2x/week x 4; 1x/week x4; 2x/month x3.	

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21980	Continued From page 69 at risk for psychosocial wellbeing and mood related to depression, loss of independence, and a change in her daily routine. Interventions included monitoring R4 and performing assessments as needed. R4's care plan also indication R4 had no current communication concerns and was able to make her needs known. During an interview on 10/25/22, at 8:35 a.m. R4 stated she put money she received from family and friends into her billfold, wrapped it in a red towel, and put it in a drawer. R4 stated a couple of weeks ago she discovered $200.00 was missing from her wallet. R4 reported the missing money to licensed practical nurse (LPN)-B, however, no one ever came and spoke to her which upset R4. R4 stated she did not fill out a form regarding the missing money and was not aware there was a grievance process. During an interview on 10/26/22, at 2:50 p.m. LPN-B stated R4 told her she was missing $200.00 about a month ago. LPN-B stated she looked around R4's room but didn't find any money and was unaware of a billfold or red towel. LPN-B spoke to R4's family member who told LPN-B they did not know of anyone giving R4 any money or that R4 had any money, therefore, LPN-B did not fill out a Quality Measure (QM-grievance form) or contact the administrator per the facility policy. During an interview on 10/26/22, at 3:07 p.m. the director of nursing (DON) stated she was unaware R4 was missing money and would have expected a QM form to be filled out and the policy followed regarding misappropriation of money when R4 first reported she was missing $200.00.	21980		

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21980	Continued From page 70 The facility Vulnerable Adult Abuse Prevention Plan dated 9/2022, indicated misappropriation of resident property was the deliberate misplacement, or wrongful, temporary or permanent use of a resident's belongings or money with the resident's consent. The facility will respond to all incidents of abuse and/or neglect by conducting an investigation to determine why abuse, neglect, or misappropriation occurred and what changes are needed to prevent further occurrences. All alleged violations involving abuse, neglect or misappropriation are to be reported immediately, but not later than 2 hours if the allegation involves abuse or resulted in serious bodily injury; or not later than 24 hours if the events did not involve abuse and do not result in serious bodily injury. Staff must report to the administrator. Staff were to investigate incidents and all persons on/in the area of the incident were to be interviewed. SUGGESTED METHOD OF CORRECTION: The administrator or designee could develop/revise policies or procedures to ensure timely reporting of all allegations of abuse, neglect, oir misappropriation of property are within appropriate timeframes for reporting. The facility should re-educate staff to policies and procedures, and audit all complaints of alleged abuse or neglect in a measurable and specific way. The results of those audits should be taken to the Quality Assurance Performance Improvement (QAPI) committee to determine the need for further monitoring or compliance. Those audits should be ongoing and random after compliance is determined by QAPI to ensure compliance is being maintained. TIME PERIOD FOR CORRECTION: 21 DAYS	21980		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING **02 - NEW BUILDING AND RENOVATED EXISTING BLD** B. WING _____	(X3) DATE SURVEY COMPLETED
	245228		**10/25/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVERA MORNINGSIDE HEIGHTS CARE CENTER	**300 SOUTH BRUCE STREET** **MARSHALL, MN 56258**

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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 10/25/2022. At the time of this survey, Avera Morningside Heights Care Center 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		12/08/2022

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

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K 000	Continued From page 1 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. Avera Marshall Regional Medical Center Nursing Home was constructed as follows: The original building was constructed in 1963, it is two-stories in height, has no basement, is fully fire sprinkler protected and was determined to be of Type II(111) construction; The 2004 Addition is two-stories in height, has no basement, is fully fire sprinkler protected and was determined to be of Type II(111) construction. The nursing home is separated from an attached	K 000		

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K 000	Continued From page 2 hospital by 2-hour fire rated wall assemblies. The building has a fire alarm system with smoke detection in the corridors, which is monitored for automatic fire department notification. Additionally, all Resident Rooms are equipped with automatic smoke detection. The facility has a capacity of 76 beds and had a census of 70 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 345 SS=F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to test and inspect the fire alarm system per NFPA 101 (2012 edition), Life Safety Code, section 9.6.1.5 and NFPA 72 (2010 edition), National Fire Alarm and Signaling Code, Table 14.3.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 10/25/2022 between 10:00 AM to 12:00 PM,	K 345	The Facility reviewed the policy on the testing and Maintenance of the fire alarm system. The testing /inspection of the fire alarm system in LTC was conducted on 10/31/22 and 11/1/22. The testing documentation will be kept in the facilities Life Safety documentation binder. A reminder call to the testing vendor will be made 6 weeks prior to the test date. This date was added to the department	12/8/22

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K 345	Continued From page 3 during documentation review, it was revealed after a review of inspection records that the annual fire alarm inspection last occurred on 01/13/2021. An interview with the Maintenance Director verified this finding at the time of discovery.	K 345	calendar of all LTC maintenance staff as well as the vendors calendar on 12/6/22 for the next testing date as well as dates going forward. This was confirmed with the vendor is was completed for correction on 12/7/22. Operations Manager will be responsible for the corrective action and the monitoring of the corrective action items.	