



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
October 3, 2024

Administrator
The Estates At Greeley LLC
313 South Greeley Street
Stillwater, MN 55082

RE: CCN: 245342
Cycle Start Date: August 7, 2024

Dear Administrator:

On September 24, 2024, the Minnesota Departments of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

A handwritten signature in black ink, appearing to read 'Melissa Poepping'.

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



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October 3, 2024

Administrator
The Estates At Greeley LLC
313 South Greeley Street
Stillwater, MN 55082

Re: Reinspection Results
Event ID: JBMP12

Dear Administrator:

On September 24, 2024 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 August 7, 2024. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in black ink, appearing to read 'M. Poepping'.

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



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
August 19, 2024

Administrator
The Estates At Greeley LLC
313 South Greeley Street
Stillwater, MN 55082

RE: CCN: 245342
Cycle Start Date: August 7, 2024

Dear Administrator:

On August 7, 2024, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

The Estates At Greeley LLC

August 19, 2024

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

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

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

DEPARTMENT CONTACT

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

Renee McClellan, Regional Operations Supervisor
Metro A District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
625 Robert Street N
P.O. Box 64975
Saint Paul, Minnesota 55164-0975
Email: renee.mcclellan@state.mn.us
Office: 651-201-4391 Mobile: 651-328-9282

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

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

If substantial compliance with the regulations is not verified by November 7, 2024 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by February 7, 2025 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

INFORMAL DISPUTE RESOLUTION (IDR) / 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/lrc_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

The Estates At Greeley LLC

August 19, 2024

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dates specified for compliance or the imposition of remedies.

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

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

Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in black ink, appearing to read "M. Poepping". The signature is fluid and cursive, with a large initial "M" and a long, sweeping underline.

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



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Electronically delivered
August 19, 2024

Administrator
The Estates At Greeley LLC
313 South Greeley Street
Stillwater, MN 55082

Re: State Nursing Home Licensing Orders
Event ID: JBMP11

Dear Administrator:

The above facility was surveyed on August 5, 2024 through August 7, 2024 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

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

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

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

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

Renee McClellan, Regional Operations Supervisor
Metro A District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
625 Robert Street N
P.O. Box 64975
Saint Paul, Minnesota 55164-0975
Email: renee.mcclellan@state.mn.us
Office: 651-201-4391 Mobile: 651-328-9282

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.



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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245342	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/07/2024
NAME OF PROVIDER OR SUPPLIER THE ESTATES AT GREELEY LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 313 SOUTH GREELEY STREET STILLWATER, MN 55082		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
E 000	Initial Comments On 8/5/24-8/7/24, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73 was conducted during a standard recertification survey. The facility was in compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000			
F 000	INITIAL COMMENTS On 8/5/24-8/7/24, a standard recertification survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities. Your 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. 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 604 SS=D	Right to be Free from Physical Restraints CFR(s): 483.10(e)(1), 483.12(a)(2) §483.10(e) Respect and Dignity.	F 604			9/13/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		09/03/2024

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245342	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/07/2024
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F 604	Continued From page 1 The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(2) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure residents were free from physical restraints for 1 of 1 resident (R37). Findings include: R37's Optional State Assessment (OSA) dated 7/10/24, indicated R37 had severe cognitive impairment, did not have	F 604	1.) A detailed description of the corrective action taken or planned to correct the deficiency.¿ Provide all staff education on the use of Restraints. Education will provide different scenarios and examples of what classifies and what does not.		

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F 604	Continued From page 2 behaviors, required extensive assistance with bed mobility, transfers, and toileting. R37's quarterly Minimum Data Set (MDS) dated 7/10/24, indicated R37 continuously had inattention, disorganized thinking, and an altered level of consciousness that fluctuated. Additionally, R37 rejected care 1 to 3 days, wandered 1 to 3 days, was frequently incontinent of bowel and bladder, had two or more falls with no injury, two or more falls with injury except major injury, was on hospice, and did not use restraints. R37's Medical Diagnosis form indicated the following diagnoses: Alzheimer's disease with late onset, traumatic subdural hemorrhage with loss of consciousness, fracture of unspecified part of neck of right femur, muscle weakness, anxiety disorder, age-related osteoporosis without current pathological fracture, and history of falling. R37's physician's orders were reviewed and lacked orders for a restraint. R37's care plan dated 1/23/24, indicated R37 was at risk for falling, had an altered cognition, and communication, and had an alteration in mood and behavior due to loss of independence and become anxious when R37 was not in her room, and interventions included to provide cues, reorientation, and supervision as needed, anticipate and meet resident's needs, speak to resident in simple to understand terms, repeat as needed. R37's care plan dated 1/29/24, indicated R37 got antsy around meal times and wheeled self around asking staff where she ate and word searches	F 604	2.) Address the measures that will be put in place to ensure the deficiency does not reoccur.¿ Perform Audits 1Xs a week Xs each shift Xs 4 months. 3.) Indicate how to facility plans to monitor future performance to ensure solutions are sustained.¿ The Executive Quality Improvement Committee will review the audit tools and results to determine trends and/ or issues that may need further interventions. The results will determine the ongoing frequency of future audits. 4.) Identify who is responsible for corrective actions and monitoring of compliance.¿ The Director of Nursing or desginee 5.) The actual or proposed date for completion of the remedy.¿¿ 9/13		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245342	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/07/2024
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F 604	Continued From page 3 helped calm R37. R37's care plan dated 2/21/24, indicated R37 was at risk for elopement due to Alzheimer's disease. The care plan lacked interventions R37's wheelchair should be locked when at the dining room table. A form, West CNA (certified nursing assistant) Report Sheet indicated R37 transferred with assist of 1 with a walker, was continent of bowel, had mixed continence of bladder, and self-transfers and was at risk for falls. The form lacked information on specific fall interventions. R37's nursing progress notes dated 6/16/24, indicated R37 frequently self-transferred. During interview on 8/6/24 at 12:58 p.m., hospice registered nurse (RN)-D stated R37 has needed increased cares and was in her own world, oriented to self, and was nonsensical. Additionally, R37 has had several falls and did not know to ask for help and was impulsive and much more forgetful and stated R37's falls went in spurts. During interview and observation on 8/7/24 between 8:03 a.m., and 8:11 a.m., housekeeper (H)-A brought R37 up to the table in the dining room and locked R37's wheelchair after setting her up at the table and left the area. H-A stated she brought R37 out to the dining room so she could sweep R37's room and verified she locked the brakes and stated she always locked the brakes of the wheelchair so R37 can't try to get up. R37 was trying to pick up her crossword puzzle and H-A assisted in picking it up for R37.	F 604			

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F 604	Continued From page 4 During interview on 8/7/24 at 8:14 a.m., licensed practical nurse (LPN)-A stated they did not lock wheelchairs because it was considered a restraint if they can't unlock it and stated it didn't matter if R37's wheelchair was locked and stated R37 was at a very high risk for falling. During interview on 8/7/24 at 8:21 a.m., registered nurse (RN)-E stated R37 was at risk for falling and stated locking the wheelchair would be considered a restraint and could cause more of a safety issue because R37 was not able to move and not able to back up. During interview on 8/7/24 at 9:22 a.m., the director of nursing (DON) stated housekeeping would need education and further stated housekeeping did not have access to the care plan and stated R37 could unlock the chair. During interview on 8/7/24 at 10:27 a.m., nursing assistant (NA)-D stated they had a sheet that indicated the cares a resident required and stated she could look at the documentation in the electronic medical record (EMR). NA-D stated R37 could propel her wheelchair and further stated R37 would not be able to think to know how to unlock and lock her wheelchair and stated R37's wheelchair had been locked before such as in the bathroom and when R37 first sits down in the chair and NA-D stated R37 thinks the wheelchair is stuck and does not know how to unlock it. An email sent on 8/7/24 at 1:02 p.m., from the DON indicated the facility did not have a policy on restraints because they did not use restraints.	F 604			

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F 686 F 686 SS=D	Continued From page 5 Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation interview and record review the facility failed to ensure skin assessments were completed under a removable device for R16 and failed to ensure interventions were implemented for R20 who both were reviewed and at risk for pressure injury. Findings include: R16's admission Minimum Data Set (MDS) dated 6/10/24, indicated R16 was cognitively intact and had diagnoses of left ankle fracture, lung disease, and schizoaffective disorder. R16's MDS further indicated R16 required assistance with mobility, was at risk for pressure injury and required pressure reliving devices for the chair and bed. R16's orthopedic consultation/clinic referral form dated 7/31/24, indicated R16 had a cam boot (removable splint) for the left lower extremity to	F 686 F 686			9/13/24

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F 686	Continued From page 6 wear while weightbearing. R16's provider order dated 6/6/24, indicated R16's left leg splint was to remain clean, dry, and intact until next clinic visit. R16's provider and nursing orders lacked indication they had been updated following R16's orthopedic appointment on 7/31/24. R16's nursing progress note dated 7/31/24 at 4:55 p.m., indicated R16's left lower extremity cast was removed and replaced with a cam boot (removable splint). R16's progress notes dated 7/31/24-8/6/24, lacked indication R16's cam boot was removed for skin assessment. R16's weekly skin assessment dated 8/6/24, indicated R16 had lower extremity edema and intact skin. The skin assessment lacked indication R16 had healing surgical incisions, peeling skin on the left foot, or R16's cam boot was removed for assessment. R16's care plan dated 6/7/24, indicated R16 was at risk for alteration in skin integrity related to decreased mobility, assistance required with activities of daily living (ADL), transfers, and left ankle surgery to repair a fracture. Interventions included monitor for skin breakdown and for signs or symptoms of infection. R16's care plan revised after survey entrance on 8/7/24, indicated R16's cam boot could be removed when in bed and had to be in place when R16 was out of bed or ambulating.	F 686	day rotating through all 3 shifts 2xweek x 1 week, then 1x a day rotating through all 3 shifts weekly x 4 months. 3.) Indicate how to facility plans to monitor future performance to ensure solutions are sustained. The Executive Quality Improvement Committee will review the audit tools and results to determine trends and/ or issues that may need further interventions. The results will determine the ongoing frequency of future audits. 4.) Identify who is responsible for corrective actions and monitoring of compliance. Director of Nursing or designee 5.) The actual or proposed date for completion of the remedy. 9/13		

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F 686	Continued From page 7 When interviewed on 8/5/24 at 2:25 p.m., R16 was sitting in the wheelchair and had the cam boot on the left ankle. R16 stated they had broken their ankle and had surgery to fix it. R16 had not been aware of any skin problems from the boot and further stated nurses do not remove the boot or look at skin or the incision. R16 stated the cam boot could be taken off when in bed but never was. When interviewed on 8/7/24 at 10:19 a.m., nursing assistant (NA)-E stated they were not aware of R16's boot ever being removed. "It was always on". When interviewed on 8/7/24 at 9:03 a.m., RN-A stated skin assessments were completed once a week on bath day. If a new skin issue was noted the nurse would open a skin management note and notification goes to the provider and Director of Nursing (DON). RN-A stated for surgical wound or treatments, the surgical providers will determine the treatment needed. When there is a removable splint there were orders to remove it for skin checks at least once a day. RN-A acknowledged R16's orders stated to leave splint dry and intact until follow up and acknowledged the orthopedic order to wear cam boot when weight bearing. RN-A stated he hadn't cared for R16 since the cast was removed and would need to follow up on the orders as they were conflicting. An observation on 8/7/24 at 9:43 a.m. registered nurse (RN)-A had clarified orders and entered R16's room to assess R16's skin under the cam boot. R16 was seated in the wheelchair with the left leg resting on an elevated wheelchair leg. RN-A unstrapped and removed the cam boot.	F 686			

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F 686	Continued From page 8 The top half of the boot was removed and showed R16 had a sock that went just above their ankle. RN-A lifted R16's leg and first removed the sock and placed it on the floor, then removed the bottom part of the boot. R16 set his leg back down on the wheelchair leg rest. There was a strong odor coming from R16's foot. R16's foot was swollen. There was indentation from R16's sock just above the ankle. R16's surgical incision was located on the outside of the left ankle had no drainage and was almost completely healed. There was some betadine surgical scrub still on R16's heel and ankle area. R16's foot bottom was very cracked and very dry, and the sides of the foot had large amounts of dry dead skin peeling off. R16's skin was otherwise intact. RN-A used their gloved hand to brush some of the flaky skin off R16's foot. RN-A had obtained a washcloth and water and proceeded to wash R16's ankle area and foot paying close attention to the areas of flaky skin and in between toes. R16 apologized about the smell and stated "this was the first time the boot was taken off". After washing, RN-A then applied lotion. R16's cam boot was noted to have skin flakes inside of the boot. With a cleaning wipe, RN-A held the boot over the garbage to wipe out the skin that had flaked off into the boot when R16's sock was removed. RN-A then placed a clean sock on R16's foot and placed the cam boot back on. A follow up interview on 8/7/2, at 11:00 a.m., RN-A verified the very dry and flaky skin R16 had on the left ankle/foot. RN-A stated R16's orders were updated to clarify what was needed and R16's provider had been notified and ordered additional treatment for R16's skin and edema. When interviewed on 8/7/24 at 11:40 a.m., the	F 686			

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F 686	Continued From page 9 DON stated when residents come back from appointments orders were provided either electronically or written. The orders were placed by either the health unit coordinator or the nurse depending on the time of day. DON verified R16's orders and expected them to have been updated upon return from the clinic. DON further stated R16's cam boot should have been removed with CMS checks as it was a closed boot and expected staff to follow up on any skin concerns. When interviewed on 8/7/24 at 1:18 p.m., RN-C verified they supported wound rounds and documentation. RN-C stated when a resident required a removable device there should be orders directing staff to remove it at least daily to perform a skin assessment. This was important to ensure skin breakdown was not occurring from pressure in the splint or device. Furthermore, if provider orders were contraindicating to this the nurse should call and clarify. R20 R20's quarterly MDS dated 7/26/24, indicated R20 was cognitively intact and had diagnoses of Parkinson's disease, diabetes, and peripheral vascular disease. Furthermore, R20 was at risk of pressure injury and had no suspected deep tissue injury (DTI) or other skin concerns. R20 required a pressure reducing device for the chair and bed. R20's care plan dated 1/26/24, indicated R20 was at risk for skin alteration related to decline in condition, falls, decreased mobility and Parkinson's disease. Interventions included to monitor skin integrity daily during cares and	F 686			

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F 686	Continued From page 10 provide a pressure distribution mattress and cushion. A facility document titled West NA Report Sheet no date, lacked indication R20 was at risk for skin alterations or required additional interventions. R20's provider and nursing orders dated 6/27/24, indicated R20 required wound care monitoring and skin prep application to left heel twice a day. R20 also required blue boots on while in bed, feet reclined/elevated while in recliner at all times due to DTI (deep tissue injury). R20's electronic medical record lacked evidence R20 had a skin and wound evaluation for the DTI. An observation on 8/7/24 at 7:32 a.m., NA-F entered R20's room to assist with morning cares. R20 was laying in bed. NA-F removed R20's blue heel protection boots. R20's heels were intact. NA-F helped to sit up and placed shoes on R20 and assisted to the bathroom. After the bathroom, NA-F assisted R20to their recliner to sit and moved R20's bedside table over in front of them. NA-F provided R20 with their dentures and a washcloth to wash their face. Once completed, NA-F left R20's room without asking, encouraging, or assisting R20 to elevate their legs in the recliner. When interviewed on 8/7/24 at 7:53 a.m., NA-F stated R20 usually was up in their chair most of the day and wasn't sure if R20 liked their legs elevated in the recliner. NA-F further stated R20 was not at risk for pressure injuries and was not aware of any interventions other than the blue heel boots that were in place to protect R20 from skin injury. NA-F stated any interventions were	F 686			

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F 686	Continued From page 11 known by the care sheet. NA-F verified the care sheet did not list interventions R20 required. When interviewed on 8/7/24 at 11:09 a.m., licensed practical nurse (LPN)-A stated if a skin concern was noted RN-C was notified for orders and a progress note was documented. LPN-A verified R20 had a heel that was pink, but soft and boggy. LPN-A had not been working and had not seen it the past couple of days and was unsure if it had changed. LPN-A stated when R20 gets in to the recliner staff should request and encourage him to elevate legs to minimize pressure and prevent swelling. When interviewed on 8/7/24 at 11:40 a.m., the DON expected staff to complete a progress note or skin note when a skin concern was noted. Anything that is then identified was followed up by RN-C for review. Furthermore, NA staff knew what interventions were in place from their task sheets. DON stated R20 was able to put his feet down when wanted and staff needed to encourage R20 to elevate when in the recliner. If the staff were the ones placing R20 in the recliner they were expected to encourage and ask R20 to elevate their feet. When interviewed on 8/7/24 at 1:18 p.m., RN-C stated hospice reported R20's DTI and were managing it. All the monitoring was done through hospice. RN-C further stated they usually would also follow but had not been since hospice was. RN-C acknowledged they never assessed the DTI and should have looked at it and documented it. A facility policy titled Skin Assessment and Wound Management revised 3/20/24, directed	F 686			

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F 686	Continued From page 12 staff to complete a weekly skin assessment and implement appropriate interventions. Furthermore, the policy directed staff to initiate a skin wound evaluation when new skin problems were identified and update resident care lists and care plan.	F 686			
F 687 SS=D	Foot Care CFR(s): 483.25(b)(2)(i)(ii) §483.25(b)(2) Foot care. To ensure that residents receive proper treatment and care to maintain mobility and good foot health, the facility must: (i) Provide foot care and treatment, in accordance with professional standards of practice, including to prevent complications from the resident's medical condition(s) and (ii) If necessary, assist the resident in making appointments with a qualified person, and arranging for transportation to and from such appointments. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure podiatry services were obtained for 1 of 1 resident (R16) reviewed for foot care. Findings include: R16's admission Minimum Data Set (MDS) dated 6/10/24, indicated R16 was cognitively intact and had diagnoses of left ankle fracture, lung disease, and schizoaffective disorder. R16's MDS further indicated R16 required substantial assistance for personal cares and was dependent on staff for bathing and dressing the lower body and feet.	F 687			9/13/24
			1.) A detailed description of the corrective action taken or planned to correct the deficiency. Effectuated resident was added to the podiatry patient list for the following month. 2.) Address the measures that will be put in place to ensure the deficiency does not reoccur. Ancillary Referral Form Initiated. If a staff member determines a referral is needed for an in-house or outside source, the staff		

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F 687	Continued From page 13 R16's weekly skin inspection dated 6/14/24, indicated R16 had overgrown toenails however trimming was not necessary. R16's weekly skin inspection dated 6/21/24, indicated R16's toenails were not trimmed and R16 required podiatry to cut toenails due to thickness. R16's weekly skin inspection dated 6/28/24, indicated R16 required a podiatrist for toenail clipping. R16's weekly skin inspection dated 7/19/24, indicated R16 required podiatry to cut toenails due to thickness. R16's care plan dated 6/7/24, indicated R16 had a self-care deficit related to ankle fracture and required assistance with personal hygiene. R16's medical record lacked indication R16 had been seen or referred for podiatry services. An observation on 8/7/24 at 9:43 a.m. registered nurse (RN)-A entered R16's room to assess R16's skin. R16 was seated in the wheelchair with the left leg resting on an elevated wheelchair leg. R16's left leg was in a cam boot (removable splint). RN-A removed the boot and R16's sock that was in place under the boot. R16's foot was extremely dry with peeling skin on bottom and sides of feet. R16's toenails were yellowed and thick. R16's toenails were slightly curled over the top of R16's toes. When interviewed on 8/7/24 at 11:00 a.m., RN-A was not sure of the process to obtain podiatry services for residents when needed and referred	F 687	will complete a Ancillary Referral Form. This form will be completed and handed in to management. Management will then address the referral with the provider and IDT and proper follow-up will be provided. Leadership will perform audits of Weekly Skin Assessments and Progress notes to ensure referral form was completed by requesting staff. Weekly Review with the in-house provider scheduler to ensure all referrals are listed. 1 Xs a week for 6 months. 3.) Indicate how to facility plans to monitor future performance to ensure solutions are sustained. The Executive Quality Improvement Committee will review the audit tools and results to determine trends and/ or issues that may need further interventions. The results will determine the ongoing frequency of future audits. 4.) Identify who is responsible for corrective actions and monitoring of compliance. Director or Nursing, Nurse Manager, or designee 5.) The actual or proposed date for completion of the remedy. 9/13		

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F 687	Continued From page 14 to RN-B. RN-B stated if nurses were unable to provide toenail care for residents, they would be placed on the list to be seen by podiatry. Podiatry services were offered about every 2-3 months. If the need was urgent, a consult order for an outside provider was obtained. RN-B stated RN-C reviewed weekly skin notes and alerted the admission coordinator (AC) who had the list or would work on an outside appointment. When interviewed on 8/7/24 at 11:11 a.m., the AC stated in house podiatry services were offered every 2-3 moths. AC stated they had a list of residents who need to be seen but if the need was more urgent, an order would be obtained for an outside referral. AC stated the last time podiatry was here was 7/11/24 and was scheduled to be onsite next on 9/12/24. AC verified R16 had not been placed on the list to be seen and would add them. When interviewed on 8/7/14 at 11:40 a.m., the Director of Nursing (DON) stated AC had the list and was responsible to update it when notified of residents needing podiatry services. Since R16 was a short-term resident admitted for therapy services for the broken ankle they may not have the chance to see podiatry and then a referral would be made at discharge. DON expected residents who required services by podiatry to be on the list and seen when podiatry was in house. When interviewed on 8/7/24 at 1:39 p.m., RN-B stated they review any weekly skin assessments that were completed the previous day to ensure they were completed and to identify new skin concerns. RN-B further stated any nail care concerns for podiatry was usually addressed by the bedside nurse and if needed the bedside	F 687			

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F 687	Continued From page 15 nurse would get them onto the podiatry list to be seen.	F 687			
F 689 SS=D	The facility admission agreement no date, indicated specail services available at the facility included podiatry services. 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: Based on observation, interview, and document review, the facility failed to ensure 1 of 1 resident (R37) with repeated falls had implemented interventions to promote safety and reduce the risk of falls and the facility failed to ensure R37 was free from physical restraints. Findings include: R37's Optional State Assessment (OSA) dated 7/10/24, indicated R37 had severe cognitive impairment, did not have behaviors, required extensive assistance with bed mobility, transfers, and toileting. R37's quarterly Minimum Data Set (MDS) dated 7/10/24, indicated R37 continuously had inattention, disorganized thinking, and an altered level of consciousness that fluctuated.	F 689			9/13/24
			1.) A detailed description of the corrective action taken or planned to correct the deficiency.¿ Sign posted in resident's room at exit to remind staff to implemente or remove interventions as necessary. 2.) Address the measures that will be put in place to ensure the deficiency does not reoccur.¿ All Residents with action interventions to promote safety will be posted to the Resident Care Board. ¿ 3.) Indicate how to facility plans to monitor future performance to ensure solutions are sustained.¿ ¿Audits Xs 3 shifts Xs 1 time a week Xs 4 months. The Executive Quality Improvement Committee will review the audit tools and		

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F 689	Continued From page 16 Additionally, R37 rejected care 1 to 3 days, wandered 1 to 3 days, was frequently incontinent of bowel and bladder, had two or more falls with no injury, two or more falls with injury except major injury, was on hospice, and did not use restraints. R37's Medical Diagnosis form indicated the following diagnoses: Alzheimer's disease with late onset, traumatic subdural hemorrhage with loss of consciousness, fracture of unspecified part of neck of right femur, muscle weakness, anxiety disorder, age-related osteoporosis without current pathological fracture, and history of falling. Refer to F604, based on observation, interview, and document review, the facility failed to ensure residents were free from physical restraints for 1 of 1 resident (R37). R37's care plan dated 1/23/24, indicated R37 was at risk for falling due to history of closed right hip fracture, late onset Alzheimer's dementia, osteoporosis, diabetes mellitus type two, and anxiety. R37's goal was to be safe and free from falls and had the following interventions: 2/20/24, ensure the TV remote is within reach while in the room 3/16/24, encourage resident to be in common areas for safety 4/12/24, call light reminder signage posted on the wall in the room 6/5/24, stop sign and wait for assistance posted on resident's bathroom door. 6/13/24, night light to room 6/17/24, floor mat next to bed only while patient is in bed, otherwise please remove mat from the floor. 6/27/24, ensure gripper socks are on at all times	F 689	results;to determine trends and/ or issues that may need further interventions. The results will determine the ongoing frequency of future audits.; 4.) Identify who is responsible for corrective actions and monitoring of compliance.; Director of Nursing, Administrator or desginee 5.) The actual or proposed date for completion of the remedy.;; 9/13		

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F 689	Continued From page 17 6/27/24, toileting schedule offer toileting upon rising, before and after meals, before bedtime, start of nights, midnight, and 4-5 a.m., and as needed. 7/31/24, offer snack between lunch and dinner. 8/6/24, soft touch call light The care plan lacked interventions R37's wheelchair should be locked when at the dining room table. A form, West CNA (certified nursing assistant) Report Sheet indicated R37 transferred with assist of 1 with a walker, was continent of bowel, had mixed continence of bladder, self-transferred, and was at risk for falls. The form lacked information on specific fall interventions. R37's physician's orders dated 6/9/24, indicated staff were to stay in the bathroom with R37 during toileting until R37 was finished and assisted bath the R37's wheelchair. After toileting, staff to bring R37 into the TV lounge or dining room to be monitored by staff. R37's medication administration record (MAR) and treatment administration record (TAR) dated August 2024, indicated R37 was to have a floor mat next to the bed every shift for fall intervention that started on 6/14/24, and was discontinued on 8/6/24. R37's progress note dated 4/11/24 at 10:37 a.m., indicated R37 had an unwitnessed fall at 9:00 p.m., R37 was trying to shut the door to her room and tripped on the mat next to the bed and the floor mat was removed. R37's progress note dated 6/5/24 at 10:04 a.m.,	F 689			

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F 689	Continued From page 18 indicated R37 fell at 9:35 a.m., while ambulating to the bathroom. R37's progress note dated 6/8/24 at 6:10 p.m., indicated R37 was ambulating in her bathroom and fell bumping her head on the wheelchair wheel of another resident. R37's progress note dated 6/10/24 at 6:26 a.m., indicated R37 was found sitting on the floor next to her bed. R37's progress note dated 6/14/24 at 3:46 p.m., indicated R37 had an unwitnessed fall at 2:30. R37's progress note dated 6/25/24 at 4:07 a.m., indicated the nursing assistant (NA) entered R37's room at 12:10 a.m., and found R37 had slid off the bed that was in the low position and was sitting on the floor mat and planned to continue with toileting plan. R37's progress note dated 6/25/24 at 3:53 p.m., indicated R37 was found sitting on the floor in the hall with her back against the wall. R37's progress note dated 7/7/24 at 10:13 p.m., indicated staff noted R37 sitting on the floor at 9:00 p.m., and had her gown and socks on and R37 stated she slid out of bed. R37's progress note dated 7/26/24 at 10:37 p.m., indicated R37 was found on the floor and was unsteady with a transfer. R37's progress note dated 8/6/24 at 10:11 p.m., indicated R37 was calling for help at 3:00 p.m., and was noted to be sitting on the floor next to her bed with the wheelchair in fron of her and the	F 689			

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F 689	Continued From page 19 plan was to keep the bed at normal height when R37 was out of bed and inquire about new shoes and torn shoes would be removed. R37's Incident Review and Analysis form dated 4/11/24 at 10:39 a.m., indicated R37 fell while ambulating on 4/10/24 at 9:00 p.m. and tripped on her floor mat and the floor mat was immediately removed. R37's Incident Review and Analysis form dated 6/5/24 at 11:36 a.m., indicated R37 fell on 6/5/24 at 9:35 a.m., while ambulating to the bathroom and a stop sign and ask for assistance with bathroom transfer sign was placed on R37's bathroom door and staff were educated on following the toileting schedule. R37's Incident Review and Analysis form dated 6/12/24 at 1:20 p.m., indicated R37 was found on the floor on 6/8/24 at 6:10 p.m. and staff were educated on best practices to stay with resident until toileting was finished. R37's Incident Review and Analysis form dated 6/13/24 at 11:05 a.m., indicated R37 was found on the floor on 6/12/24 at 9:46 p.m. R37 was closing the room door after toileting and laying down in bed. An intervention added included a night light was added to the room. R37's Incident Review and Analysis form dated 6/17/24 at 9:41 a.m., indicated R37 was found on the floor on 6/14/24 at 2:30 p.m., R37 was unsure what she was doing and was checked for incontinence, was not incontinent and was toileted and assisted to bed. An intervention implemented was to have the floor mat next to the bed only while R37 was in bed, otherwise the	F 689			

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F 689	Continued From page 20 floor mat was to be removed from the floor. R37's Incident Review and Analysis form dated 6/27/24 at 2:52 p.m., indicated R37 was found sitting in the hallway on 6/25/24 at 4:06 p.m., and a hospice evaluation was requested along with offering activity and encourage R37 to be in common areas. R37's Incident Review and Analysis form dated 7/9/24 at 12:40 p.m., indicated R37 slid out of her bed on 7/7/24 at 9:52 p.m., and glow tape was added to the call light. R37's Incident Review and Analysis form dated 7/30/24 at 10:29 a.m., indicated R37 was found on the floor on 7/26/24 at 4:25 p.m., and was self-transferring. Interventions included to offer a snack between lunch and dinner. R37's Incident Review and Analysis form dated 8/7/24 at 9:12 a.m., indicated R37 was found on the floor on 8/6/24 at 3:00 p.m., and was self-transferring to her bed from the wheelchair. An intervention included to keep the bed in the standard position when R37 was out of bed. During observation on 8/5/24 at 1:15 p.m to 1:16 p.m., an un-named staff person brought R37 into her room in R37 was in her wheelchair with the back of the wheelchair facing the nightstand. R37 had a mat located on the floor and the bed was positioned in the low position almost to the floor. During observation on 8/6/24 at 11:38 a.m., R37 was in her room working on a crossword and the mat was not located on the floor.	F 689			

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F 689	Continued From page 21 During interview and observation on 8/7/24 between 8:03 a.m., and 8:11 a.m., housekeeper (H)-A brought R37 up to the table in the dining room and locked R37's wheelchair after setting her up at the table and left the area. H-A stated she brought R37 out to the dining room so she could sweep R37's room and verified she locked the brakes and stated she always locked the brakes of the wheelchair so R37 can't try to get up. R37 was trying to pick up her crossword puzzle and H-A assisted in picking it up for R37. See also F604. During observation on 8/7/24 at 8:13 a.m., R37's fall mat was located on the floor in R37's room and R37 was in the dining room. During interview and observation on 8/7/24 at 8:14 a.m., licensed practical nurse (LPN)-A verified the mat was on the floor by R37's bed and stated the mat was not a hindrance for R37 and added it was there because R37 tries to get in and out of bed constantly and the mat was kept there to prevent R37 from falling. LPN-A further stated wheelchairs were not locked because it was considered a restraint and stated it did not matter if R37's wheelchair was locked and added R37 was at a very high risk for falling. During interview on 8/7/24 at 8:21 a.m., registered nurse (RN)-E stated R37 was at risk for falling and stated fall interventions included a soft touch call light and a floor mat while in bed, a toileting schedule and keep R37 in high traffic areas. RN-E further stated locking the wheelchair would be considered a restraint and could cause more of a safety risk because R37 was not able to move and not able to back up.	F 689			

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F 689	Continued From page 22 During interview on 8/7/24 at 9:22 a.m., the director of nursing (DON) stated they always try to follow the care plan and planned to talk with the aides to see why the mat was on the floor and further, housekeeping did not have access to the care plan and stated R37 could unlock the chair and stated it would be important to provide education to housekeeping. During interview on 8/7/24 between 10:27 a.m., and 10:37 a.m., nursing assistant (NA)-D stated they had a sheet that indicated the cares a resident required and stated she could look at the documentation in the electronic medical record (EMR). NA-D stated R37 could propel her wheelchair and further stated R37 would not be able to think to know how to unlock and lock her wheelchair and stated R37's wheelchair had been locked before such as in the bathroom and when R37 first sits down in the chair and NA-D stated R37 thinks the wheelchair is stuck and does not know how to unlock it. NA-D further stated R37's mat was supposed to be on the floor at all times and verified the mat was on the floor and R37 was in the wheelchair. At 10:37 a.m., NA-D viewed the West CNA Report sheet form and verified the form lacked fall prevention interventions including whether the mat was supposed to be off the floor when R37 was in the chair. During interview on 8/7/24 at 10:43 a.m., the DON was notified R37 was in her room and the mat was located on the floor and staff were going down to R37's room to follow up. An email sent on 8/7/24 at 1:02 p.m., from the DON indicated the facility did not have a policy on restraints because they did not use restraints.	F 689			

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F 689	Continued From page 23	F 689			
F 732 SS=C	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.	F 732			9/13/24

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F 732	Continued From page 24 §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 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: Based on observation, interview, and document review, the facility failed to ensure complete required nurse staffing information was posted and was timely on a daily basis. This had the potential to affect all 48 residents, staff, and visitors who could wish to review this information. Findings include: On 8/6/24 at 1:57 p.m., form, Estates at Greeley, dated 8/6/24, was located next to the adminstartor's office. The form identified an area to document the census, however, the census number was undocumented. Additionally, the form identified some staff and their titles, but did not identify all staff and their titles and lacked information on the total number and actual hours worked by registered nurses (RNs), licensed practical nurses (LPNs), and nursing assistants (NAs). During interview on 8/6/24 at 2:00 p.m., the administrator verified the form, Estates at Greeley, was the staff posting and stated it usually included the census and verified the	F 732	1.) A detailed description of the corrective action taken or planned to correct the deficiency. Nursing staffing data with break down of hours per department and position were posted. 2.) Address the measures that will be put in place to ensure the deficiency does not reoccur. The scheduler or designee, will post all required staffing data daily to ensure information is available to the public. 3.) Indicate how to facility plans to monitor future performance to ensure solutions are sustained. The scheduler or designee, will post all required staffing data daily to ensure information is available to the public. The Admin or designee will audit the daily nurse staffing forms to ensure that nursing hours reported are accurate with the actual hours worked by nursing staff. The audit will be completed for 5 days per		

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F 732	Continued From page 25 census was not added on the form and proceeded to write the census number on the form. When asked about the total hours worked, the administrator stated after the shift was worked it was broken down on how many hours were worked. During interview on 8/7/24 at 9:34 a.m., the director of nursing (DON), verified staff posting forms reviewed from 7/26/24, through 8/6/24, lacked tallied hours. Further, the DON stated she corrected the posting for 8/7/24, and going forward to include the tally for the total number and actual hours worked. A policy was requested, but not received.	F 732	week for one month and 2 days per week each month thereafter. The Executive Quality Improvement Committee will review the audit tools to determine trends and/ or issues that may need further interventions. The results will determine the ongoing frequency of future audits. 4.) Identify who is responsible for corrective actions and monitoring of compliance. The Administrator or designee 5.) The actual or proposed date for completion of the remedy. 9/13		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a	F 758			9/13/24

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F 758	Continued From page 26 specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure gradual dose reductions (GDR) were attempted, or an adequate medical justification for the use of psychotropic medications for 2 of 5 residents (R19, R14) reviewed for unnecessary medications. Findings include:	F 758	1.) A detailed description of the corrective action taken or planned to correct the deficiency. Reviewed effected resident's GDR recommendations and modified by provider. 2.) Address the measures that will be put in place to ensure the deficiency does not		

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F 758	Continued From page 27 R19's quarterly Minimum Data Set (MDS) dated 5/29/24, indicated moderate cognitive impairment, did not have hallucinations, delusions, physical behaviors. R19 had verbal behavioral symptoms 1 to 3 days and did not have other behavioral symptoms and did not reject cares. Further, R19 took antipsychotic and antidepressant medications, a gradual dose reduction had not been attempted and had not been documented by a physician as clinically contraindicated. R19's Medical Diagnosis form indicated the following diagnoses: Parkinson's disease, dementia in other diseases classified elsewhere without behavioral disturbance, history of falling, and insomnia. R19 had the following physician order: 4/28/23, trazodone 150 milligrams (MG) by mouth daily for insomnia at bedtime. R19's medication administration record (MAR) dated August 2024, indicated give trazodone 150 mg by mouth one time a day for insomnia at bedtime and side effects included sedation, orthostatic hypotension (a form of low blood pressure that happens from standing up from sitting or lying down), anticholinergic symptoms, extra pyramidal symptoms and if observed document in a progress note. R19's care plan dated 5/9/23, indicated R19 had the potential for psychotropic drug ADR (adverse drug reaction) related to daily use of psychotropic medication and interventions included: administer medication as ordered monitoring for ADR's.	F 758	reoccur. A House-wide audit is being performed to ensure all Residents' GDR recommendations have been addressed within guidelines. Moving forward, the IDT Team will meet monthly with Consulting Pharmacist to review all GDR recommendations submitted. 3.) Indicate how to facility plans to monitor future performance to ensure solutions are sustained. The Executive Quality Improvement Committee will review the audit tools and results to determine trends and/ or issues that may need further interventions. The results will determine the ongoing frequency of future audits. The Consulting Pharmacist will continue to review the compliance of returned Medication Recommendations. 4.) Identify who is responsible for corrective actions and monitoring of compliance. Director of Nursing or designee 5.) The actual or proposed date for completion of the remedy. 9/13		

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F 758	Continued From page 28 Report suspected ADR's to nursing, physician, physician assistant (PA). Medications are reviewed by physician, PA, and pharmacist, update physician, PA regarding efficiency of medications and or ADR's as needed. R19's care plan dated 12/5/23, indicated R19 had a potential for alteration in sleep due to a diagnosis of insomnia and interventions included medication for sleep per physician order and provide with a quiet environment to sleep. R19's Consultant Pharmacist Recommendation to Physician form dated 4/14/24, indicated R19 took trazodone 150 mg at bedtime since 4/28/24, (the order was from 4/28/23), for insomnia. Within the first year in which a resident is admitted on a psychotropic medication or after the prescribing practitioner has initiated a psychotropic medication, the facility must attempt a GDR in two separate quarters (with at least one month between the attempts), unless clinically contraindicated. After the first year, a GDR must be attempted annually, unless clinically contraindicated. R19 was due for a dose reduction assessment and the pharmacist inquired if during the next visit if the physician could review whether R19 continued to be on the lowest effective dose of their regimen and if a dose reduction was contraindicated to document the clinical rationale. Under the heading, Physician/Prescriber Response, indicated "Patient refuses" and was signed on 4/15/24. The form lacked any clinical rationale or justification for continued use. During observation on 8/6/24 at 2:29 p.m., R19 was observed to be in bed snoring.	F 758			

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F 758	Continued From page 29 During interview on 8/7/24 at 9:55 a.m., the director of nursing (DON) stated the pharmacist consultant sends the pharmacy recommendation electronically to the team and the provider reviews them and they act on the revisions and the physician signs them and the physician should write a rationale as to why they disagree. The DON stated they liked to have a conversation about the consultant pharmacist recommendation and stated patient refused was not a good reason for a rationale and stated the nurse practitioner signed the form. During interview on 8/7/24 at 10:58 a.m., the consultant pharmacist (CP) stated typically they needed clinical documentation for a rationale for a GDR not completed such as the resident is stable and stated if a resident refused or the power of attorney refused, the pharmacist stated she thought the provider would respect the resident or POA's decision if they did not want a GDR and stated she would accept a refusal and stated she did not look to see if someone was capable of making their own decisions and stated it would be the provider's determination. A policy, Gradual Dose Reduction (GDR), dated 12/2019, indicated the facilities goal was to monitor ongoing use of psychotropic medications and other medications that impact brain activity that are ordered in place of a psychotropic medication. Gradual dose reductions and or documentation of contraindications per current documentation of contraindications per current pharmacy and federal guidelines. Within the 1st year the facility must attempt a GDR in two separate quarters with at least one month between the attempts unless clinically contraindicated. Clinically contraindicated	F 758			

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F 758	Continued From page 30 means: the continued use is in accordance with relevant current standards or practice and the physician has documented the clinical rationale for why any attempted dose reduction would be likely to impair the resident's function or cause psychiatric instability by exacerbating an underlying medical or psychiatric disorder; or the resident's target symptoms returned or worsened after the most recent attempt at tapering the dose within the facility and the physician has documented the clinical rationale for why any additional attempted dose reduction at that time would be likely to impair the resident's function or cause psychiatric instability by exacerbating an underlying medical or psychiatric disorder. R14's quarterly Minimum Data Set (MDS) dated 7/19/24, indicated intact cognition and a diagnosis of major depressive disorder. It further indicated R14 received an antidepressant on a routine basis. R14's physician's orders dated 2/8/23, indicated escitalopram oxalate tablet 10 milligrams (mg). Give 5 mg by mouth one time a day related to major depressive disorder, single episode, mild. If the following symptoms are observed, document in the progress notes: sedation, orthostatic hypotension, anticholinergic, and extra pyramidal. R14's care plan dated 7/24/24, indicated R14 had a potential for psychotropic drug adverse reactions related to daily use of antidepressant medications. Side effects may include: sedation, orthostatic hypotension, anticholinergic, and extra pyramidal symptoms. If observed document in	F 758			

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F 758	Continued From page 31 progress notes with an intervention for the medications to be reviewed by medical doctor (MD) and Pharmacist. R14's consultant pharmacy recommendation dated 6/19/2024, indicated R14 was currently receiving escitalopram 10 mg daily for major depressive disorder since the last gradual dose reduction (GDR) in February 2023. Per state operation manual (SOM) guidelines, an attempt to taper the medication must be done every year, unless clinically contraindicated. R14 was due for a dose reduction assessment. "During your next visit could you please review whether resident continues on the lowest effective doses of his regimen. If a dose reduction is contraindicated, please document clinical rationale below." The recommendation was signed by the nurse practioner (NP) on 7/2/24 with a handwritten notation indicating "pt [patient] POA [Power of Attorney] refused and lacked clincial rationale and was not noted to be clinically contraindicated. During interview on 8/7/24 at 9:55 a.m., the director of nursing (DON) stated the pharmacist consultant sends the pharmacy recommendation electronically to the team and the provider reviews them and they act on the revisions and the physician signs them and the physician should write a rationale as to why they disagree. The DON stated they liked to have a conversation about the consultant pharmacist recommendation and stated patient refused was not a good reason for a rationale and stated the nurse practitioner signed the form. During interview on 8/7/24 at 10:58 a.m., the consultant pharmacist (CP) stated typically they needed clinical documentation for a rationale for	F 758			

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F 758	Continued From page 32 a GDR not completed such as the resident is stable and stated if a resident refused or the power of attorney refused, the pharmacist stated she thought the provider would respect the resident or POA's decision if they did not want a GDR and stated she would accept a refusal and stated she did not look to see if someone was capable of making their own decisions and stated it would be the provider's determination. On 8/7/24 at 12:06 p.m., the survey called and left a message for the medical director (MD) but did not receive a call back. A policy, Gradual Dose Reduction (GDR), dated 12/2019, indicated the facilities goal was to monitor ongoing use of psychotropic medications and other medications that impact brain activity that are ordered in place of a psychotropic medication. Gradual dose reductions and or documentation of contraindications per current documentation of contraindications per current pharmacy and federal guidelines. Within the 1st year the facility must attempt a GDR in two separate quarters with at least one month between the attempts unless clinically contraindicated. Clinically contraindicated means: the continued use is in accordance with relevant current standards or practice and the physician has documented the clinical rationale for why any attempted dose reduction would be likely to impair the resident's function or cause psychiatric instability by exacerbating an underlying medical or psychiatric disorder; or the resident's target symptoms returned or worsened after the most recent attempt at tapering the dose within the facility and the physician has documented the clinical rationale for why any additional attempted dose reduction at that time	F 758			

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F 758	Continued From page 33	F 758			
F 803 SS=D	would be likely to impair the resident's function or cause psychiatric instability by exacerbating an underlying medical or psychiatric disorder. Menus Meet Resident Nds/Prep in Adv/Followed CFR(s): 483.60(c)(1)-(7) §483.60(c) Menus and nutritional adequacy. Menus must- §483.60(c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.; §483.60(c)(2) Be prepared in advance; §483.60(c)(3) Be followed; §483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups; §483.60(c)(5) Be updated periodically; §483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and §483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to provide menu's and alternate food choices to 2 of 2 residents (R14, R98) reviewed for food.	F 803			9/13/24
			1.) A detailed description of the corrective action taken or planned to correct the deficiency.¿ Effected residents were provided with		

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F 803	Continued From page 34 R14's quarterly Minimum Data Set (MDS) dated 7/19/24, indicated intact cognition and diagnoses of congestive heart disease (CHF), type II diabetes. and required setup/clean up assistance with eating. R14's physician's orders dated 6/30/24, indicated a consistent carbohydrate diet, regular texture, regular (thin) consistency, no added salt. Offer assistance cutting foods, related to type II diabetes mellitus. R14's care plan dated 7/24/24, indicated a potential for alteration in nutrition related to diabetes mellitus type II (DMII), obesity, and history of COVID 19, iron deficiency anemia, depression, dementia, dysphagia, and hypertension (HTN) with an intervention to offer substitute for dislikes or when not eating. During interview on 8/5/24 at 1:35 p.m., R14 stated he never knows what he's going to get to eat for each meal and he hadn't received a menu. He also stated staff do not come in and ask him what he would like to eat before each meal, therefore he doesn't feel he get's a choice stating "I just have to eat what they give me." During a follow up interview on 8/7/24 at 8:40 a.m., the surveyor showed R14 the weekly menu and a Bistro (alternate) menu. He stated he had never been given a menu up until a week ago and he had to ask for it. He further stated he had never been given or seen the alternate menu and didn't know he had a choice of those items. R98's admission Minimal Data Set (MDS) report dated 8/2/24, indicated intact cognition,	F 803	monthly menu and A La Cart (alternative meal) request forms. Effected residents were verbally educated on how to request an alternative meal if they do not prefer the menu item. 2.) Address the measures that will be put in place to ensure the deficiency does not reoccur.¿ New Admissions will receive the monthly menu and A La Cart request form within 72¿ hours of admission. A La Cart request forms will be provided as needed. Monthly menu and A La Cart request form will also be posted on facility communication board. 3.) Indicate how to facility plans to monitor future performance to ensure solutions are sustained.¿ Audits will be done 1X week to ensure delivery of menu for 6 months. The Administrator will present the findings to the Registered Dietician and the QAPI Committee for any recommendations x 3 months and will include the plan as part of the 2024-2025 Facility QAPI Plan. Menu options and satisfaction will also be reviewed bi-monthly in resident council. 4.) Identify who is responsible for corrective actions and monitoring of compliance.¿ Culinary Director or designee 5.) The actual or proposed date for completion of the remedy.¿¿ 9/13		

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F 803	Continued From page 35 diagnoses of R98's of enterocolitis due to c-diff, sepsis, urinary tract infection (UTI), and was independent with eating. R98's physician's orders dated 8/1/24, indicated a 2 gram (gm) sodium diet, regular texture, regular (thin) consistency. R98's care plan dated 8/2/24, indicated R98 had a potential alteration in nutrition related to C-Diff, sepsis, urinary tract infection (UTI), DMII, depression, HLD, and HTN. Decreased sodium/saturated fat needs related to HTN, HLD as evidenced by therapeutic diet order. Diet: 2 grams (gm) no added salt diet, regular texture, regular (thin) consistency. It further indicated an intervention to offer a substitute for dislikes or when not eating. During interview on 08/05/24, at 5:40 p.m. R98 stated she didn't know what she was going to get to eat each meal until it showed up in her room and there were a lot of things she didn't like. She further stated she hadn't received a menu and didn't know their were alternative menu items she could choose from. During a follow up interview on 8/7/24 at 8:43 a.m., surveyor showed R98 the weekly menu and the alternate menu, in which she stated she'd never been given one and she didn't know their were alternate food items she could choose from, she just eats what she get's and theirs been things she didn't want to eat, for example "the green beans had all kinds of other stuff in them and I couldn't eat it." During interview on 8/6/24 at 8:37 a.m., the cook (C)-A stated the resident's know what they are	F 803			

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F 803	Continued From page 36 having for each meal because the menu was posted on each end of the the dining halls. Also during activities often times the resident's will ask what was on the menu for that day. When a resident was admitted they received a menu. Staff do not go in the resident's room and ask what they would like for each meal. The resident's don't get two choices "It's more of a fixed menu. I think they get menu's or they can ask if they want to get a menu." During interview on 8/6/24 at 12:02 p.m., the dietary manager stated their menu was a 5 week fixed menu which only included one food option unless they're serving fish or pork. They also provide a Bistro menu which lists alternative options the residents can choose from. The Bistro menu was not passed out to residents or posted on the wall with the weekly menu but was located in a hanging file on the wall next to the kitchen. The kitchen manager further stated he feels the dietary staff would make the residents anything they wanted even if it wasn't listed on the menu. During interview on 8/7/24 at 8:28 a.m., nursing assistant (NA)-E stated each resident get's a weekly menu and an alternate menu every week so they can choose what they would like to eat. During interview on 8/7/24 at 8:48 a.m. NA-G stated residents know what they are going to eat each day by looking at the menu's that are posted at the end of the each hallway. NA-G further stated the residents can ask for a menu or ask a staff member what the meal was going to be. It was the responsiblity of the resident to ask for a menu or tell a staff member if they don't like what was being served.	F 803			

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F 803	Continued From page 37 During interview on 8/7/24 at 8:53 a.m., registered nurse (RN)-A stated the nursing assistants were responsible for passing out menu's to the residents but anyone can do it. RN-A stated he didn't know if staff passed out the Bistro (alternate) menu to residents or not or if it was posted. During interview on 8/7/24 at 9:53 a.m., licensed practical nurse (LPN)-C stated staff provide menu's to the residents who are "conscious" and those that aren't don't receive menu's because "it doesn't matter." They don't pass out the alternate menu because if the resident wants something different they will ask for i The facility's policy regarding menus dated 10/2017 indicated, menus are developed and prepared to meet resident choices including religious, cultural and ethnic needs while following established national guidelines for nutritional adequacy. Menus for regular and therapeutic diets are written at least two (2) weeks in advance, and are dated and posted in the kitchen at least one (1) week in advance. Copies of menus are posted in at least two (2) resident areas, in positions and in print large enough for residents to read them.	F 803			
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.	F 880			9/13/24

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F 880	Continued From page 38 §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (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	F 880			

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F 880	Continued From page 39 disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure transmission-based precautions (TBP) were utilized for 1 of 1 residents (R98) who required contact precautions for clostridium difficile (C. diff, a highly contagious infection). Furthermore, the facility failed to ensure enhanced barrier precautions (EBP) and appropriate hand hygiene was used for 1 of 1 residents (R20) observed during personal cares. Findings include: R98's admission Minimum Data Set (MDS) report dated 8/2/24, indicated intact cognition and a diagnoses of enterocolitis due to c-diff, sepsis, and urinary tract infection (UTI). R98's physician's orders lacked indication R98	F 880	1.) A detailed description of the corrective action taken or planned to correct the deficiency.¿ Staff member was immediately educated of proper guidelines and utilization of PPE. 2.) Address the measures that will be put in place to ensure the deficiency does not reoccur.¿ All Staff were re-educated on requirements and proper utilization of PPE. 3.) Indicate how to facility plans to monitor future performance to ensure solutions are sustained.¿ Perform Audits 5Xs a week across random shifts for 1 month and bi-weekly		

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F 880	Continued From page 40 required contact precautions. R98's care plan dated 8/2/24, lacked indication R98 required contact precautions. R98's progress note dated 8/6/24, indicated R98 was receiving Vancomycin oral solution 250 mg/5 milliliters (ml) and had one large loose stool. During observation on 8/6/24 at 2:31 p.m., R98's room had a sign on the door indicating contact precautions: everyone must clean hands before entering and leaving the room. Providers and staff: put on gloves and a gown before room entry, discard before exiting. R98 was sitting in her wheelchair in the dining room with certified occupational therapy assistant (COTA)-A. After a few minutes COTA-A assisted R98 to stand up and was walking behind R98 in the hallway holding onto her gait belt with one hand and pulling the wheelchair behind her with the other. They stopped at her room and went inside. COTA-A removed R98's gait belt and assisted her to sit down in her recliner. Then she picked up two water pitchers and exited the room, walked down the hallway to the water cooler in the common/television area, filled up the water pitchers, and brought them back to R98's room. Then exited the room. COTA-A was not wearing a gown or gloves during this process and did not wash or sanitize her hands upon entering/exiting the room. During interview on 8/6/24 at 2:34 p.m., COTA-A stated R98 was on contact precautions for C-diff, verified not donning appropriate personal protective equipment (PPE), and stated another therapist (unknown) said a gown and gloves only needed to be worn if they were performing cares.	F 880	thereafter. The Executive Quality Improvement Committee will review the audit tools and results, to determine trends and/ or issues that may need further interventions. The results will determine the ongoing frequency of future audits. 4.) Identify who is responsible for corrective actions and monitoring of compliance. Infection Control Preventionalist or designee 5.) The actual or proposed date for completion of the remedy. 9/13		

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F 880	Continued From page 41 During interview on 8/6/27 at 3:00 p.m., licensed practical nurse (LPN)-B stated staff working with residents who are on contact precautions should wear gloves and a gown upon entering the room and performing cares. They should also be washing their hands with soap and water as opposed to hand sanitizer. During interview on 8/7/24 at 9:55 a.m., the director of nursing (DON) stated staff working with residents on contact precautions (specifically R98) should be wearing a gowns, gloves, and washing their hands with soap and water, when entering the room to provide cares. The DON further stated therapy was considered to be providing cares and if staff don't wear the appropriate PPE, C-diff can spread very easily throughout the facility. R20's quarterly MDS dated 7/26/24, indicated R20 was cognitively intact and had diagnoses of Parkinson's disease, diabetes, and peripheral vascular disease. R20's provider and nursing orders lacked indication R20 required EBP. R20's care plan dated 1/26/24, lacked indication R20 required EBP. A facility document titled West NA Report Sheet no date, lacked indication R20 required EBP. An observation on 8/5/24 at 12:48 p.m., R20 was sitting in their room in a wheelchair. Their door	F 880			

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F 880	Continued From page 42 was open and on the outside of the door was a sign. The sign directed staff to gown and glove when providing close contact cares. Upon R20's door was also a hanging storage rack that had gowns and gloves. An observation on 8/7/24 at 7:32 a.m., NA-F entered R20's room to assist with morning cares. NA-F performed hand hygiene before entering R20's room and then obtained gloves from the bathroom. NA-F did not place a gown on. NA-F took a urinal half filled with urine from R20's table and went into the bathroom to empty. The urinal was brought back to the beside and placed on the floor near R20's bed. Without removing gloves or performing hand hygiene, NA-F went over to R20's door and obtained a transfer belt. NA-F returned to R20's bed and grabbed the bed control to lift the bed up. R20's blue boots were removed, and compression socks placed. R20's bed was lowered and NA-F assisted R20 to sit up. Once at the end of the bed, R20 was assisted to put on their slippers and NA-F placed the transfer belt around R20. With assistance, R20 was walked into the bathroom and to stand in front of the toilet. NA-F assisted with R20's pants and removed R20's brief soiled with urine and placed in the garbage. R20 then sat on the toilet. NA-F removed gloves and without hand hygiene donned new gloves and shut the door slightly and straightened R20's bed. R20 was done and NA-F went in to assist R20 to stand and provided personal cleaning for R20. Without removing gloves or performing hand hygiene, NA-F assisted with placing a clean brief and pulled up R20's pants. R20 was assisted out of the bathroom to sit in their recliner. NA-F then obtained a washcloth and wet down with warm water. The washcloth was given to R20 to wash	F 880			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/20/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245342	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/07/2024
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F 880	Continued From page 43 his face. NA-F then removed gloves and without performing hand hygiene NA-F donned new gloves and assisted R20 with a clean shirt. R20 asked for dentures and NA-F took the white denture container, brought them to the sink and took the dentures out of the case to rinse before handing to R20 to place in mouth. After R20 was done, NA-F removed gloves and tied up R20;s soiled garbage. NA-F left room and brought soiled bag to soiled utility room garbage. NA-F then washed hands. When interviewed on 8/7/24 at 7:53 a.m., NA-F verified they did not change gloves after emptying the urinal and assisting with personal cares for R20. NA-F further verified hand hygiene was not completed after glove removal. NA-F further stated they usually keep hand sanitizer in their pockets however the shirt they were wearing did not have pockets to keep sanitizer handy. NA-F verified R20 had enhanced barrier sign or the hanging container of gowns and gloves. NA-F stated they should have been in a gown and gloves when providing cares. When interviewed on 8/7/24 at 11:40 a.m., the Director of Nursing (DON) expected staff to remove gloves and perform hand hygiene when moving from unclean to clean areas. DON further stated staff were expected to wear gown and gloves when assisting with cares for residents on EBP. When interviewed on 8/7/24 at 1:18 p.m., the infection preventionist (IP) expected staff to follow any precautions that were posted outside of the rooms. IP stated R98 had admitted with C. Diff and was going to remain on precautions until the antibiotic was completed. IP stated staff were	F 880			

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F 880	Continued From page 44 instructed that if they are only dropping something off and not having hands on contact with the environment or resident, gowning and gloves was not needed. Any staff who had contact with the environment or hands on with the resident were expected to gown and glove. IP reviewed the contact isolation sign that was posted on R98's door and verified it said all staff who enter were required to gown and glove. IP wasn't sure about why the contact isolation sign said only staff were required to gown and glove and did not instruct hand washing with soap and water. IP stated the facility had another sign for enteric precautions that instructed all who enter gown, gloves and wash hands with soap and water to due to how easily C. Diff was spread. IP further stated hand sanitizer was not enough. IP stated the enteric precautions sign should be in place for residents with C. Diff. Residents who require EBP are identified with signage on the doors. Staff were expected to wear gown and gloves with any hands-on resident cares such as toileting or transferring. Furthermore, IP expected staff to perform hand hygiene after any glove removal and when moving from dirty tasks to clean tasks. This was important to minimize risk of infections. A facility policy titled Transmission-Based Precautions revised 7/2023, directed staff to use TBP for residents who are known to be infected with an infectious agent. Contact precautions was used when the infection was spread directly person to person or indirect contact with the resident or environment. Appropriate PPE included gown and gloving upon entering the room or making direct contact with the resident or environment. Upon exiting the room, hand hygiene was required. The facility policy lacked direction on enteric precautions or when hand	F 880			

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F 880	Continued From page 45 washing with soap and water required. A facility policy titled Handwashing Policy revised 2/2024, directed proper hand washing should be used to protect the spread of infection. Hand washing shall be completed after changing incontinent products. Furthermore, hand hygiene was required after glove removal and before glove donning. A facility policy titled Enhanced Barrier Precautions dated directed staff to initiate EBP for residents with residents wth wounds and PPE should be worn during high contact resident care activities such as dressing, transferring and hygiene.	F 880			

Minnesota Department of Health

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2 000	Initial Comments *****ATTENTION***** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 8/5/24-8/7/24, a licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT IN compliance with the MN State Licensure.	2 000			

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Electronically Signed

TITLE

(X6) DATE

09/03/24

Minnesota Department of Health

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2 000	Continued From page 1 Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled " ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin <https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html> The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. 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.	2 000			

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2 000	Continued From page 2 THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000			
2 505	MN Rule 4658.0300 Subp. 1 A-E Use of Restraints Subpart 1. Definitions. For purposes of this part, the following terms have the meanings given. A. "Physical restraints" means any manual method or physical or mechanical device, material, or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body. Physical restraints include, but are not limited to, leg restraints, arm restraints, hand mitts, soft ties or vests, and wheelchair safety bars. Physical restraints also include practices which meet the definition of a restraint, such as tucking in a sheet so tightly that a resident confined to bed cannot move; bed rails; chairs that prevent rising; or placing a resident in a wheelchair so close to a wall that the wall prevents the resident from rising. Bed rails are considered a restraint if they restrict freedom of movement. If the bed rail is used solely to assist the resident in turning or to help the resident get out of bed, then the bed rail is not used as a restraint. Wrist bands or devices on clothing that trigger electronic alarms to warn staff that a resident is leaving a room or area do not, in and of themselves, restrict freedom of movement and should not be considered restraints. B. "Chemical restraints" means any psychopharmacologic drug that is used for discipline or convenience and is not required to	2 505			9/13/24

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2 505	Continued From page 3 treat medical symptoms. C. "Discipline" means any action taken by the nursing home for the purpose of punishing or penalizing a resident. D. "Convenience" means any action taken solely to control resident behavior or maintain a resident with a lesser amount of effort that is not in the resident's best interest. E. "Emergency measures" means the immediate action necessary to alleviate an unexpected situation or sudden occurrence of a serious and urgent nature. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure residents were free from physical restraints for 1 of 1 resident (R37). Findings include: R37's Optional State Assessment (OSA) dated 7/10/24, indicated R37 had severe cognitive impairment, did not have behaviors, required extensive assistance with bed mobility, transfers, and toileting. R37's quarterly Minimum Data Set (MDS) dated 7/10/24, indicated R37 continuously had inattention, disorganized thinking, and an altered level of consciousness that fluctuated. Additionally, R37 rejected care 1 to 3 days, wandered 1 to 3 days, was frequently incontinent of bowel and bladder, had two or more falls with no injury, two or more falls with injury except major injury, was on hospice, and did not use restraints. R37's Medical Diagnosis form indicated the following diagnoses: Alzheimer's disease with late	2 505	Corrected		

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2 505	Continued From page 4 onset, traumatic subdural hemorrhage with loss of consciousness, fracture of unspecified part of neck of right femur, muscle weakness, anxiety disorder, age-related osteoporosis without current pathological fracture, and history of falling. R37's physician's orders were reviewed and lacked orders for a restraint. R37's care plan dated 1/23/24, indicated R37 was at risk for falling, had an altered cognition, and communication, and had an alteration in mood and behavior due to loss of independence and become anxious when R37 was not in her room, and interventions included to provide cues, reorientation, and supervision as needed, anticipate and meet resident's needs, speak to resident in simple to understand terms, repeat as needed. R37's care plan dated 1/29/24, indicated R37 got antsy around meal times and wheeled self around asking staff where she ate and word searches helped calm R37. R37's care plan dated 2/21/24, indicated R37 was at risk for elopement due to Alzheimer's disease. The care plan lacked interventions R37's wheelchair should be locked when at the dining room table. A form, West CNA (certified nursing assistant) Report Sheet indicated R37 transferred with assist of 1 with a walker, was continent of bowel, had mixed continence of bladder, and self-transfers and was at risk for falls. The form lacked information on specific fall interventions. R37's nursing progress notes dated 6/16/24,	2 505			

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2 505	Continued From page 5 indicated R37 frequently self-transferred. During interview on 8/6/24 at 12:58 p.m., hospice registered nurse (RN)-D stated R37 has needed increased cares and was in her own world, oriented to self, and was nonsensical. Additionally, R37 has had several falls and did not know to ask for help and was impulsive and much more forgetful and stated R37's falls went in spurts. During interview and observation on 8/7/24 between 8:03 a.m., and 8:11 a.m., housekeeper (H)-A brought R37 up to the table in the dining room and locked R37's wheelchair after setting her up at the table and left the area. H-A stated she brought R37 out to the dining room so she could sweep R37's room and verified she locked the brakes and stated she always locked the brakes of the wheelchair so R37 can't try to get up. R37 was trying to pick up her crossword puzzle and H-A assisted in picking it up for R37. During interview on 8/7/24 at 8:14 a.m., licensed practical nurse (LPN)-A stated they did not lock wheelchairs because it was considered a restraint if they can't unlock it and stated it didn't matter if R37's wheelchair was locked and stated R37 was at a very high risk for falling. During interview on 8/7/24 at 8:21 a.m., registered nurse (RN)-E stated R37 was at risk for falling and stated locking the wheelchair would be considered a restraint and could cause more of a safety issue because R37 was not able to move and not able to back up. During interview on 8/7/24 at 9:22 a.m., the director of nursing (DON) stated housekeeping would need education and further stated	2 505			

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2 505	Continued From page 6 housekeeping did not have access to the care plan and stated R37 could unlock the chair. During interview on 8/7/24 at 10:27 a.m., nursing assistant (NA)-D stated they had a sheet that indicated the cares a resident required and stated she could look at the documentation in the electronic medical record (EMR). NA-D stated R37 could propel her wheelchair and further stated R37 would not be able to think to know how to unlock and lock her wheelchair and stated R37's wheelchair had been locked before such as in the bathroom and when R37 first sits down in the chair and NA-D stated R37 thinks the wheelchair is stuck and does not know how to unlock it. An email sent on 8/7/24 at 1:02 p.m., from the DON indicated the facility did not have a policy on restraints because they did not use restraints. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review or revise policies, provide education for staff regarding physical restraint use. The Quality and Assessment Assurance (QAA) committee could do random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 505			
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in	2 830			9/13/24

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2 830	Continued From page 7 the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure 1 of 1 resident (R37) with repeated falls had implemented interventions to promote safety and reduce the risk of falls and the facility failed to ensure R37 was free from physical restraints. Findings include: R37's Optional State Assessment (OSA) dated 7/10/24, indicated R37 had severe cognitive impairment, did not have behaviors, required extensive assistance with bed mobility, transfers, and toileting. R37's quarterly Minimum Data Set (MDS) dated 7/10/24, indicated R37 continuously had inattention, disorganized thinking, and an altered level of consciousness that fluctuated. Additionally, R37 rejected care 1 to 3 days, wandered 1 to 3 days, was frequently incontinent of bowel and bladder, had two or more falls with no injury, two or more falls with injury except major injury, was on hospice, and did not use restraints. R37's Medical Diagnosis form indicated the	2 830	Corrected		

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2 830	Continued From page 8 following diagnoses: Alzheimer's disease with late onset, traumatic subdural hemorrhage with loss of consciousness, fracture of unspecified part of neck of right femur, muscle weakness, anxiety disorder, age-related osteoporosis without current pathological fracture, and history of falling. Refer to F604, based on observation, interview, and document review, the facility failed to ensure residents were free from physical restraints for 1 of 1 resident (R37). R37's care plan dated 1/23/24, indicated R37 was at risk for falling due to history of closed right hip fracture, late onset Alzheimer's dementia, osteoporosis, diabetes mellitus type two, and anxiety. R37's goal was to be safe and free from falls and had the following interventions: 2/20/24, ensure the TV remote is within reach while in the room 3/16/24, encourage resident to be in common areas for safety 4/12/24, call light reminder signage posted on the wall in the room 6/5/24, stop sign and wait for assistance posted on resident's bathroom door. 6/13/24, night light to room 6/17/24, floor mat next to bed only while patient is in bed, otherwise please remove mat from the floor. 6/27/24, ensure gripper socks are on at all times 6/27/24, toileting schedule offer toileting upon rising, before and after meals, before bedtime, start of nights, midnight, and 4-5 a.m., and as needed. 7/31/24, offer snack between lunch and dinner. 8/6/24, soft touch call light The care plan lacked interventions R37's wheelchair should be locked when at the dining	2 830			

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2 830	Continued From page 9 room table. A form, West CNA (certified nursing assistant) Report Sheet indicated R37 transferred with assist of 1 with a walker, was continent of bowel, had mixed continence of bladder, self-transferred, and was at risk for falls. The form lacked information on specific fall interventions. R37's physician's orders dated 6/9/24, indicated staff were to stay in the bathroom with R37 during toileting until R37 was finished and assisted bath the R37's wheelchair. After toileting, staff to bring R37 into the TV lounge or dining room to be monitored by staff. R37's medication administration record (MAR) and treatment administration record (TAR) dated August 2024, indicated R37 was to have a floor mat next to the bed every shift for fall intervention that started on 6/14/24, and was discontinued on 8/6/24. R37's progress note dated 4/11/24 at 10:37 a.m., indicated R37 had an unwitnessed fall at 9:00 p.m., R37 was trying to shut the door to her room and tripped on the mat next to the bed and the floor mat was removed. R37's progress note dated 6/5/24 at 10:04 a.m., indicated R37 fell at 9:35 a.m., while ambulating to the bathroom. R37's progress note dated 6/8/24 at 6:10 p.m., indicated R37 was ambulating in her bathroom and fell bumping her head on the wheelchair wheel of another resident. R37's progress note dated 6/10/24 at 6:26 a.m., indicated R37 was found sitting on the floor next	2 830			

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2 830	Continued From page 10 to her bed. R37's progress note dated 6/14/24 at 3:46 p.m., indicated R37 had an unwitnessed fall at 2:30. R37's progress note dated 6/25/24 at 4:07 a.m., indicated the nursing assistant (NA) entered R37's room at 12:10 a.m., and found R37 had slid off the bed that was in the low position and was sitting on the floor mat and planned to continue with toileting plan. R37's progress note dated 6/25/24 at 3:53 p.m., indicated R37 was found sitting on the floor in the hall with her back against the wall. R37's progress note dated 7/7/24 at 10:13 p.m., indicated staff noted R37 sitting on the floor at 9:00 p.m., and had her gown and socks on and R37 stated she slid out of bed. R37's progress note dated 7/26/24 at 10:37 p.m., indicated R37 was found on the floor and was unsteady with a transfer. R37's progress note dated 8/6/24 at 10:11 p.m., indicated R37 was calling for help at 3:00 p.m., and was noted to be sitting on the floor next to her bed with the wheelchair in fron of her and the plan was to keep the bed at normal height when R37 was out of bed and inquire about new shoes and torn shoes would be removed. R37's Incident Review and Analysis form dated 4/11/24 at 10:39 a.m., indicated R37 fell while ambulating on 4/10/24 at 9:00 p.m. and tripped on her floor mat and the floor mat was immediately removed. R37's Incident Review and Analysis form dated	2 830			

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2 830	Continued From page 11 6/5/24 at 11:36 a.m., indicated R37 fell on 6/5/24 at 9:35 a.m., while ambulating to the bathroom and a stop sign and ask for assistance with bathroom transfer sign was placed on R37's bathroom door and staff were educated on following the toileting schedule. R37's Incident Review and Analysis form dated 6/12/24 at 1:20 p.m., indicated R37 was found on the floor on 6/8/24 at 6:10 p.m. and staff were educated on best practices to stay with resident until toileting was finished. R37's Incident Review and Analysis form dated 6/13/24 at 11:05 a.m., indicated R37 was found on the floor on 6/12/24 at 9:46 p.m. R37 was closing the room door after toileting and laying down in bed. An intervention added included a night light was added to the room. R37's Incident Review and Analysis form dated 6/17/24 at 9:41 a.m., indicated R37 was found on the floor on 6/14/24 at 2:30 p.m., R37 was unsure what she was doing and was checked for incontinence, was not incontinent and was toileted and assisted to bed. An intervention implemented was to have the floor mat next to the bed only while R37 was in bed, otherwise the floor mat was to be removed from the floor. R37's Incident Review and Analysis form dated 6/27/24 at 2:52 p.m., indicated R37 was found sitting in the hallway on 6/25/24 at 4:06 p.m., and a hospice evaluation was requested along with offering activity and encourage R37 to be in common areas. R37's Incident Review and Analysis form dated 7/9/24 at 12:40 p.m., indicated R37 slid out of her bed on 7/7/24 at 9:52 p.m., and glow tape was	2 830			

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2 830	Continued From page 12 added to the call light. R37's Incident Review and Analysis form dated 7/30/24 at 10:29 a.m., indicated R37 was found on the floor on 7/26/24 at 4:25 p.m., and was self-transferring. Interventions included to offer a snack between lunch and dinner. R37's Incident Review and Analysis form dated 8/7/24 at 9:12 a.m., indicated R37 was found on the floor on 8/6/24 at 3:00 p.m., and was self-transferring to her bed from the wheelchair. An intervention included to keep the bed in the standard position when R37 was out of bed. During observation on 8/5/24 at 1:15 p.m to 1:16 p.m., an un-named staff person brought R37 into her room in R37 was in her wheelchair with the back of the wheelchair facing the nightstand. R37 had a mat located on the floor and the bed was positioned in the low position almost to the floor. During observation on 8/6/24 at 11:38 a.m., R37 was in her room working on a crossword and the mat was not located on the floor. During interview and observation on 8/7/24 between 8:03 a.m., and 8:11 a.m., housekeeper (H)-A brought R37 up to the table in the dining room and locked R37's wheelchair after setting her up at the table and left the area. H-A stated she brought R37 out to the dining room so she could sweep R37's room and verified she locked the brakes and stated she always locked the brakes of the wheelchair so R37 can't try to get up. R37 was trying to pick up her crossword puzzle and H-A assisted in picking it up for R37. See also F604.	2 830			

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2 830	Continued From page 13 During observation on 8/7/24 at 8:13 a.m., R37's fall mat was located on the floor in R37's room and R37 was in the dining room. During interview and observation on 8/7/24 at 8:14 a.m., licensed practical nurse (LPN)-A verified the mat was on the floor by R37's bed and stated the mat was not a hindrance for R37 and added it was there because R37 tries to get in and out of bed constantly and the mat was kept there to prevent R37 from falling. LPN-A further stated wheelchairs were not locked because it was considered a restraint and stated it did not matter if R37's wheelchair was locked and added R37 was at a very high risk for falling. During interview on 8/7/24 at 8:21 a.m., registered nurse (RN)-E stated R37 was at risk for falling and stated fall interventions included a soft touch call light and a floor mat while in bed, a toileting schedule and keep R37 in high traffic areas. RN-E further stated locking the wheelchair would be considered a restraint and could cause more of a safety risk because R37 was not able to move and not able to back up. During interview on 8/7/24 at 9:22 a.m., the director of nursing (DON) stated they always try to follow the care plan and planned to talk with the aides to see why the mat was on the floor and further, housekeeping did not have access to the care plan and stated R37 could unlock the chair and stated it would be important to provide education to housekeeping. During interview on 8/7/24 between 10:27 a.m., and 10:37 a.m., nursing assistant (NA)-D stated they had a sheet that indicated the cares a resident required and stated she could look at the documentation in the electronic medical record	2 830			

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2 830	Continued From page 14 (EMR). NA-D stated R37 could propel her wheelchair and further stated R37 would not be able to think to know how to unlock and lock her wheelchair and stated R37's wheelchair had been locked before such as in the bathroom and when R37 first sits down in the chair and NA-D stated R37 thinks the wheelchair is stuck and does not know how to unlock it. NA-D further stated R37's mat was supposed to be on the floor at all times and verified the mat was on the floor and R37 was in the wheelchair. At 10:37 a.m., NA-D viewed the West CNA Report sheet form and verified the form lacked fall prevention interventions including whether the mat was supposed to be off the floor when R37 was in the chair. During interview on 8/7/24 at 10:43 a.m., the DON was notified R37 was in her room and the mat was located on the floor and staff were going down to R37's room to follow up. An email sent on 8/7/24 at 1:02 p.m., from the DON indicated the facility did not have a policy on restraints because they did not use restraints. A policy, Fall Prevention and Management revised 2/2024, indicated the purpose of the protocol was to identify residents at risk for falls, implement fall prevention interventions, provide guidelines for assessing a resident after a fall and to assist staff in identifying causes of the fall. After an observed or probable fall staff will clarify the details of the fall, when the fall occurred, where, and what the individual was trying to do at the time the fall occurred. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON), or designee, could	2 830			

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2 830	Continued From page 15 review applicable policies and procedures to ensure accuracy, educate floor staff on expectations in accordance with those policies for the various care areas identified, and then audit to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: 21 Days	2 830	Corrected.		9/13/24
2 860	MN Rule 4658.0520 Subp. 2 F. Adequate and Proper Nursing Care; Hands-Feet Subp. 2. Criteria for determining adequate and proper care. The criteria for determining adequate and proper care include: E. per care and attention to hands and feet. Fingernails and toenails must be kept clean and trimmed. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure podiatry services were obtained for 1 of 1 resident (R16) reviewed for foot care. Findings include: R16's admission Minimum Data Set (MDS) dated 6/10/24, indicated R16 was cognitively intact and had diagnoses of left ankle fracture, lung disease, and schizoaffective disorder. R16's MDS further indicated R16 required substantial assistance for personal cares and was dependent on staff for bathing and dressing the lower body and feet. R16's weekly skin inspection dated 6/14/24, indicated R16 had overgrown toenails however trimming was not necessary.	2 860			

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2 860	Continued From page 16 R16's weekly skin inspection dated 6/21/24, indicated R16's toenails were not trimmed and R16 required podiatry to cut toenails due to thickness. R16's weekly skin inspection dated 6/28/24, indicated R16 required a podiatrist for toenail clipping. R16's weekly skin inspection dated 7/19/24, indicated R16 required podiatry to cut toenails due to thickness. R16's care plan dated 6/7/24, indicated R16 had a self-care deficit related to ankle fracture and required assistance with personal hygiene. R16's medical record lacked indication R16 had been seen or referred for podiatry services. An observation on 8/7/24 at 9:43 a.m. registered nurse (RN)-A entered R16's room to assess R16's skin. R16 was seated in the wheelchair with the left leg resting on an elevated wheelchair leg. R16's left leg was in a cam boot (removable splint). RN-A removed the boot and R16's sock that was in place under the boot. R16's foot was extremely dry with peeling skin on bottom and sides of feet. R16's toenails were yellowed and thick. R16's toenails were slightly curled over the top of R16's toes. When interviewed on 8/7/24 at 11:00 a.m., RN-A was not sure of the process to obtain podiatry services for residents when needed and referred to RN-B. RN-B stated if nurses were unable to provide toenail care for residents, they would be placed on the list to be seen by podiatry. Podiatry services were offered about every 2-3 months. If	2 860			

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2 860	Continued From page 17 the need was urgent, a consult order for an outside provider was obtained. RN-B stated RN-C reviewed weekly skin notes and alerted the admission coordinator (AC) who had the list or would work on an outside appointment. When interviewed on 8/7/24 at 11:11 a.m., the AC stated in house podiatry services were offered every 2-3 moths. AC stated they had a list of residents who need to be seen but if the need was more urgent, an order would be obtained for an outside referral. AC stated the last time podiatry was here was 7/11/24 and was scheduled to be onsite next on 9/12/24. AC verified R16 had not been placed on the list to be seen and would add them. When interviewed on 8/7/14 at 11:40 a.m., the Director of Nursing (DON) stated AC had the list and was responsible to update it when notified of residents needing podiatry services. Since R16 was a short-term resident admitted for therapy services for the broken ankle they may not have the chance to see podiatry and then a referral would be made at discharge. DON expected residents who required services by podiatry to be on the list and seen when podiatry was in house. When interviewed on 8/7/24 at 1:39 p.m., RN-B stated they review any weekly skin assessments that were completed the previous day to ensure they were completed and to identify new skin concerns. RN-B further stated any nail care concerns for podiatry was usually addressed by the bedside nurse and if needed the bedside nurse would get them onto the podiatry list to be seen. The facility admission agreement no date, indicated specail services available at the facility	2 860			

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2 860	Continued From page 18 included podiatry services. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON), or designee, could assess residents foot care needs and/or resident preferences for foot care and revise care plan based on the assessment and/or resident choice; then designate staff members to ensure podiatry appointment and transportation arrangements are made in a timely manner after assessment identified the concern; then develop an auditing system to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 860			
2 900	MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. This MN Requirement is not met as evidenced	2 900			9/13/24

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2 900	Continued From page 19 by: Based on observation interview and record review the facility failed to ensure skin assessments were completed under a removable device for R16 and failed to ensure interventions were implemented for R20 who both were reviewed and at risk for pressure injury. Findings include: R16's admission Minimum Data Set (MDS) dated 6/10/24, indicated R16 was cognitively intact and had diagnoses of left ankle fracture, lung disease, and schizoaffective disorder. R16's MDS further indicated R16 required assistance with mobility, was at risk for pressure injury and required pressure reliving devices for the chair and bed. R16's orthopedic consultation/clinic referral form dated 7/31/24, indicated R16 had a cam boot (removable splint) for the left lower extremity to wear while weightbearing. R16's provider order dated 6/6/24, indicated R16's left leg splint was to remain clean, dry, and intact until next clinic visit. R16's provider and nursing orders lacked indication they had been updated following R16's orthopedic appointment on 7/31/24. R16's nursing progress note dated 7/31/24 at 4:55 p.m., indicated R16's left lower extremity cast was removed and replaced with a cam boot (removable splint). R16's progress notes dated 7/31/24-8/6/24, lacked indication R16's cam boot was removed for skin assessment.	2 900	Corrected.		

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2 900	Continued From page 20 R16's weekly skin assessment dated 8/6/24, indicated R16 had lower extremity edema and intact skin. The skin assessment lacked indication R16 had healing surgical incisions, peeling skin on the left foot, or R16's cam boot was removed for assessment. R16's care plan dated 6/7/24, indicated R16 was at risk for alteration in skin integrity related to decreased mobility, assistance required with activities of daily living (ADL), transfers, and left ankle surgery to repair a fracture. Interventions included monitor for skin breakdown and for signs or symptoms of infection. R16's care plan revised after survey entrance on 8/7/24, indicated R16's cam boot could be removed when in bed and had to be in place when R16 was out of bed or ambulating. When interviewed on 8/5/24 at 2:25 p.m., R16 was sitting in the wheelchair and had the cam boot on the left ankle. R16 stated they had broken their ankle and had surgery to fix it. R16 had not been aware of any skin problems from the boot and further stated nurses do not remove the boot or look at skin or the incision. R16 stated the cam boot could be taken off when in bed but never was. When interviewed on 8/7/24 at 10:19 a.m., nursing assistant (NA)-E stated they were not aware of R16's boot ever being removed. "It was always on". When interviewed on 8/7/24 at 9:03 a.m., RN-A stated skin assessments were completed once a week on bath day. If a new skin issue was noted the nurse would open a skin management note and notification goes to the provider and Director	2 900			

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2 900	Continued From page 21 of Nursing (DON). RN-A stated for surgical wound or treatments, the surgical providers will determine the treatment needed. When there is a removable splint there were orders to remove it for skin checks at least once a day. RN-A acknowledged R16's orders stated to leave splint dry and intact until follow up and acknowledged the orthopedic order to wear cam boot when weight bearing. RN-A stated he hadn't cared for R16 since the cast was removed and would need to follow up on the orders as they were conflicting. An observation on 8/7/24 at 9:43 a.m. registered nurse (RN)-A had clarified orders and entered R16's room to assess R16's skin under the cam boot. R16 was seated in the wheelchair with the left leg resting on an elevated wheelchair leg. RN-A unstrapped and removed the cam boot. The top half of the boot was removed and showed R16 had a sock that went just above their ankle. RN-A lifted R16's leg and first removed the sock and placed it on the floor, then removed the bottom part of the boot. R16 set his leg back down on the wheelchair leg rest. There was a strong odor coming from R16's foot. R16's foot was swollen. There was indentation from R16's sock just above the ankle. R16's surgical incision was located on the outside of the left ankle had no drainage and was almost completely healed. There was some betadine surgical scrub still on R16's heel and ankle area. R16's foot bottom was very cracked and very dry, and the sides of the foot had large amounts of dry dead skin peeling off. R16's skin was otherwise intact. RN-A used their gloved hand to brush some of the flaky skin off R16's foot. RN-A had obtained a washcloth and water and proceeded to wash R16's ankle area and foot paying close attention to the areas of flaky skin and in between toes.	2 900			

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2 900	Continued From page 22 R16 apologized about the smell and stated "this was the first time the boot was taken off". After washing, RN-A then applied lotion. R16's cam boot was noted to have skin flakes inside of the boot. With a cleaning wipe, RN-A held the boot over the garbage to wipe out the skin that had flaked off into the boot when R16's sock was removed. RN-A then placed a clean sock on R16's foot and placed the cam boot back on. A follow up interview on 8/7/2, at 11:00 a.m., RN-A verified the very dry and flaky skin R16 had on the left ankle/foot. RN-A stated R16's orders were updated to clarify what was needed and R16's provider had been notified and ordered additional treatment for R16's skin and edema. When interviewed on 8/7/24 at 11:40 a.m., the DON stated when residents come back from appointments orders were provided either electronically or written. The orders were placed by either the health unit coordinator or the nurse depending on the time of day. DON verified R16's orders and expected them to have been updated upon return from the clinic. DON further stated R16's cam boot should have been removed with CMS checks as it was a closed boot and expected staff to follow up on any skin concerns. When interviewed on 8/7/24 at 1:18 p.m., RN-C verified they supported wound rounds and documentation. RN-C stated when a resident required a removable device there should be orders directing staff to remove it at least daily to perform a skin assessment. This was important to ensure skin breakdown was not occurring from pressure in the splint or device. Furthermore, if provider orders were contraindicating to this the nurse should call and clarify.	2 900			

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2 900	Continued From page 23 R20 R20's quarterly MDS dated 7/26/24, indicated R20 was cognitively intact and had diagnoses of Parkinson's disease, diabetes, and peripheral vascular disease. Furthermore, R20 was at risk of pressure injury and had no suspected deep tissue injury (DTI) or other skin concerns. R20 required a pressure reducing device for the chair and bed. R20's care plan dated 1/26/24, indicated R20 was at risk for skin alteration related to decline in condition, falls, decreased mobility and Parkinson's disease. Interventions included to monitor skin integrity daily during cares and provide a pressure distribution mattress and cushion. A facility document titled West NA Report Sheet no date, lacked indication R20 was at risk for skin alterations or required additional interventions. R20's provider and nursing orders dated 6/27/24, indicated R20 required wound care monitoring and skin prep application to left heel twice a day. R20 also required blue boots on while in bed, feet reclined/elevated while in recliner at all times due to DTI (deep tissue injury). R20's electronic medical record lacked evidence R20 had a skin and wound evaluation for the DTI. An observation on 8/7/24 at 7:32 a.m., NA-F entered R20's room to assist with morning cares. R20 was laying in bed. NA-F removed R20's blue heel protection boots. R20's heels were intact. NA-F helped to sit up and placed shoes on R20 and assisted to the bathroom. After the	2 900			

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2 900	Continued From page 24 bathroom, NA-F assisted R20to their recliner to sit and moved R20's bedside table over in front of them. NA-F provided R20 with their dentures and a washcloth to wash their face. Once completed, NA-F left R20's room without asking, encouraging, or assisting R20 to elevate their legs in the recliner. When interviewed on 8/7/24 at 7:53 a.m., NA-F stated R20 usually was up in their chair most of the day and wasn't sure if R20 liked their legs elevated in the recliner. NA-F further stated R20 was not at risk for pressure injuries and was not aware of any interventions other than the blue heel boots that were in place to protect R20 from skin injury. NA-F stated any interventions were known by the care sheet. NA-F verified the care sheet did not list interventions R20 required. When interviewed on 8/7/24 at 11:09 a.m., licensed practical nurse (LPN)-A stated if a skin concern was noted RN-C was notified for orders and a progress note was documented. LPN-A verified R20 had a heel that was pink, but soft and boggy. LPN-A had not been working and had not seen it the past couple of days and was unsure if it had changed. LPN-A stated when R20 gets in to the recliner staff should request and encourage him to elevate legs to minimize pressure and prevent swelling. When interviewed on 8/7/24 at 11:40 a.m., the DON expected staff to complete a progress note or skin note when a skin concern was noted. Anything that is then identified was followed up by RN-C for review. Furthermore, NA staff knew what interventions were in place from their task sheets. DON stated R20 was able to put his feet down when wanted and staff needed to encourage R20 to elevate when in the recliner. If	2 900			

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2 900	Continued From page 25 the staff were the ones placing R20 in the recliner they were expected to encourage and ask R20 to elevate their feet. When interviewed on 8/7/24 at 1:18 p.m., RN-C stated hospice reported R20's DTI and were managing it. All the monitoring was done through hospice. RN-C further stated they usually would also follow but had not been since hospice was. RN-C acknowledged they never assessed the DTI and should have looked at it and documented it. A facility policy titled Skin Assessment and Wound Management revised 3/20/24, directed staff to complete a weekly skin assessment and implement appropriate interventions. Furhtermore, the policy directed staff to initiate a skin wound evaluation when new skin problems were identified and update resident care lists and care plan. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could review all residents at risk for pressure ulcers to assure they are receiving the necessary interventions and monitoring to prevent pressure ulcers from developing and to promote healing of pressure ulcers. Audits can be conducted to ensure appropriate care and services are implemented. The DON or designee should bring all audit information to the Quality Assurance Performance Improvement (QAPI) committee to determine compliance or the need for further monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 900			

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21050	Continued From page 26	21050			
21050	MN Rule 4658.0625 Subp. 1 Menus; Meal Planning Subpart 1. Menu planning. All menus must be planned in advance, dated, and followed. Any changes in the meals actually served must be of equal nutritional value. The general menu for a seven-day period must be posted prior to the start of that seven-day period at a location readily accessible to residents, and any changes to the general menu must be noted on that posted menu. All menus and any changes for the current and following seven-day periods must be posted in the dietary area. Records of menus and of foods purchased must be filed for six months. A variety of foods must be provided. A file of tested recipes adjusted to a yield appropriate for the size of the home must be maintained. This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to provide menu's and alternate food choices to 2 of 2 residents (R14, R98) reviewed for food. R14's quarterly Minimum Data Set (MDS) dated 7/19/24, indicated intact cognition and diagnoses of congestive heart disease (CHF), type II diabetes. and required setup/clean up assistance with eating. R14's physician's orders dated 6/30/24, indicated a consistent carbohydrate diet, regular texture, regular (thin) consistency, no added salt. Offer assistance cutting foods, related to type II diabetes mellitus.	21050	Corrected.		9/13/24

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21050	Continued From page 27 R14's care plan dated 7/24/24, indicated a potential for alteration in nutrition related to diabetes mellitus type II (DMII), obesity, and history of COVID 19, iron deficiency anemia, depression, dementia, dysphagia, and hypertension (HTN) with an intervention to offer substitute for dislikes or when not eating. During interview on 8/5/24 at 1:35 p.m., R14 stated he never knows what he's going to get to eat for each meal and he hadn't received a menu. He also stated staff do not come in and ask him what he would like to eat before each meal, therefore he doesn't feel he get's a choice stating "I just have to eat what they give me." During a follow up interview on 8/7/24 at 8:40 a.m., the surveyor showed R14 the weekly menu and a Bistro (alternate) menu. He stated he had never been given a menu up until a week ago and he had to ask for it. He further stated he had never been given or seen the alternate menu and didn't know he had a choice of those items. R98's admission Minimal Data Set (MDS) report dated 8/2/24, indicated intact cognition, diagnoses of R98's of enterocolitis due to c-diff, sepsis, urinary tract infection (UTI), and was independent with eating. R98's physician's orders dated 8/1/24, indicated a 2 gram (gm) sodium diet, regular texture, regular (thin) consistency. R98's care plan dated 8/2/24, indicated R98 had a potential alteration in nutrition related to C-Diff, sepsis, urinary tract infection (UTI), DMII, depression, HLD, and HTN. Decreased sodium/saturated fat needs related to HTN, HLD as evidenced by therapeutic diet order. Diet: 2	21050			

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21050	Continued From page 28 grams (gm) no added salt diet, regular texture, regular (thin) consistency. It further indicated an intervention to offer a substitute for dislikes or when not eating. During interview on 08/05/24, at 5:40 p.m. R98 stated she didn't know what she was going to get to eat each meal until it showed up in her room and there were a lot of things she didn't like. She further stated she hadn't received a menu and didn't know their were alternative menu items she could choose from. During a follow up interview on 8/7/24 at 8:43 a.m., surveyor showed R98 the weekly menu and the alternate menu, in which she stated she'd never been given one and she didn't know their were alternate food items she could choose from, she just eats what she get's and theirs been things she didn't want to eat, for example "the green beans had all kinds of other stuff in them and I couldn't eat it." During interview on 8/6/24 at 8:37 a.m., the cook (C)-A stated the resident's know what they are having for each meal because the menu was posted on each end of the the dining halls. Also during activities often times the resident's will ask what was on the menu for that day. When a resident was admitted they received a menu. Staff do not go in the resident's room and ask what they would like for each meal. The resident's don't get two choices "It's more of a fixed menu. I think they get menu's or they can ask if they want to get a menu." During interview on 8/6/24 at 12:02 p.m., the dietary manager stated their menu was a 5 week fixed menu which only included one food option unless they're serving fish or pork. They also	21050			

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21050	Continued From page 29 provide a Bistro menu which lists alternative options the residents can choose from. The Bistro menu was not passed out to residents or posted on the wall with the weekly menu but was located in a hanging file on the wall next to the kitchen. The kitchen manager further stated he feels the dietary staff would make the residents anything they wanted even if it wasn't listed on the menu. During interview on 8/7/24 at 8:28 a.m., nursing assistant (NA)-E stated each resident get's a weekly menu and an alternate menu every week so they can choose what they would like to eat. During interview on 8/7/24 at 8:48 a.m. NA-G stated residents know what they are going to eat each day by looking at the menu's that are posted at the end of the each hallway. NA-G further stated the residents can ask for a menu or ask a staff member what the meal was going to be. It was the responsibility of the resident to ask for a menu or tell a staff member if they don't like what was being served. During interview on 8/7/24 at 8:53 a.m., registered nurse (RN)-A stated the nursing assistants were responsible for passing out menu's to the residents but anyone can do it. RN-A stated he didn't know if staff passed out the Bistro (alternate) menu to residents or not or if it was posted. During interview on 8/7/24 at 9:53 a.m., licensed practical nurse (LPN)-C stated staff provide menu's to the residents who are "conscious" and those that aren't don't receive menu's because "it doesn't matter." They don't pass out the alternate menu because if the resident wants something different they will ask for i	21050			

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21050	Continued From page 30 The facility's policy regarding menus dated 10/2017 indicated, menus are developed and prepared to meet resident choices including religious, cultural and ethnic needs while following established national guidelines for nutritional adequacy. Menus for regular and therapeutic diets are written at least two (2) weeks in advance, and are dated and posted in the kitchen at least one (1) week in advance. Copies of menus are posted in at least two (2) resident areas, in positions and in print large enough for residents to read them. SUGGESTED METHOD OF CORRECTION: The administrator or designee could ensure standard and alternate menus are approved by the registered or licensed dietitian periodically or as often as changed/needed, to accurately reflect the nutritional needs of the residents of the facility. The facility could update/create policies and procedures, and educate staff on these changes. The administrator or designee could perform audits periodically, determined by QAPI, to ensure all menus have been approved by the facility's registered or licensed dietitian. The facility could report audit findings to QAPI for further recommendations to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21050			
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	21375			9/13/24

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21375	Continued From page 31 sanitary environment. This MN Requirement is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure transmission-based precautions (TBP) were utilized for 1 of 1 residents (R98) who required contact precautions for clostridium difficile (C. diff, a highly contagious infection). Furthermore, the facility failed to ensure enhanced barrier precautions (EBP) and appropriate hand hygiene was used for 1 of 1 residents (R20) observed during personal cares. Findings include: R98's admission Minimum Data Set (MDS) report dated 8/2/24, indicated intact cognition and a diagnoses of enterocolitis due to c-diff, sepsis, and urinary tract infection (UTI). R98's physician's orders lacked indication R98 required contact precautions. R98's care plan dated 8/2/24, lacked indication R98 required contact precautions. R98's progress note dated 8/6/24, indicated R98 was receiving Vancomycin oral solution 250 mg/5 milliliters (ml) and had one large loose stool. During observation on 8/6/24 at 2:31 p.m., R98's room had a sign on the door indicating contact precautions: everyone must clean hands before entering and leaving the room. Providers and staff: put on gloves and a gown before room entry, discard before exiting. R98 was sitting in her wheelchair in the dining room with certified	21375	Corrected.		

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21375	Continued From page 32 occupational therapy assistant (COTA)-A. After a few minutes COTA-A assisted R98 to stand up and was walking behind R98 in the hallway holding onto her gait belt with one hand and pulling the wheelchair behind her with the other. They stopped at her room and went inside. COTA-A removed R98's gait belt and assisted her to sit down in her recliner. Then she picked up two water pitchers and exited the room, walked down the hallway to the water cooler in the common/television area, filled up the water pitchers, and brought them back to R98's room. Then exited the room. COTA-A was not wearing a gown or gloves during this process and did not wash or sanitize her hands upon entering/exiting the room. During interview on 8/6/24 at 2:34 p.m., COTA-A stated R98 was on contact precautions for C-diff, verified not donning appropriate personal protective equipment (PPE), and stated another therapist (unknown) said a gown and gloves only needed to be worn if they were performing cares. During interview on 8/6/27 at 3:00 p.m., licensed practical nurse (LPN)-B stated staff working with residents who are on contact precautions should wear gloves and a gown upon entering the room and performing cares. They should also be washing their hands with soap and water as opposed to hand sanitizer. During interview on 8/7/24 at 9:55 a.m., the director of nursing (DON) stated staff working with residents on contact precautions (specifically R98) should be wearing a gowns, gloves, and washing their hands with soap and water, when entering the room to provide cares. The DON further stated therapy was considered to be providing cares and if staff don't wear the	21375			

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21375	Continued From page 33 appropriate PPE, C-diff can spread very easily throughout the facility. R20's quarterly MDS dated 7/26/24, indicated R20 was cognitively intact and had diagnoses of Parkinson's disease, diabetes, and peripheral vascular disease. R20's provider and nursing orders lacked indication R20 required EBP. R20's care plan dated 1/26/24, lacked indication R20 required EBP. A facility document titled West NA Report Sheet no date, lacked indication R20 required EBP. An observation on 8/5/24 at 12:48 p.m., R20 was sitting in their room in a wheelchair. Their door was open and on the outside of the door was a sign. The sign directed staff to gown and glove when providing close contact cares. Upon R20's door was also a hanging storage rack that had gowns and gloves. An observation on 8/7/24 at 7:32 a.m., NA-F entered R20's room to assist with morning cares. NA-F performed hand hygiene before entering R20's room and then obtained gloves from the bathroom. NA-F did not place a gown on. NA-F took a urinal half filled with urine from R20's table and went into the bathroom to empty. The urinal was brought back to the beside and placed on the floor near R20's bed. Without removing gloves or performing hand hygiene, NA-F went over to R20's door and obtained a transfer belt. NA-F returned to R20's bed and grabbed the bed control to lift the bed up. R20's blue boots were removed, and compression socks placed. R20's bed was lowered and NA-F assisted R20 to sit	21375			

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21375	Continued From page 34 up. Once at the end of the bed, R20 was assisted to put on their slippers and NA-F placed the transfer belt around R20. With assistance, R20 was walked into the bathroom and to stand in front of the toilet. NA-F assisted with R20's pants and removed R20's brief soiled with urine and placed in the garbage. R20 then sat on the toilet. NA-F removed gloves and without hand hygiene donned new gloves and shut the door slightly and straightened R20's bed. R20 was done and NA-F went in to assist R20 to stand and provided personal cleaning for R20. Without removing gloves or performing hand hygiene, NA-F assisted with placing a clean brief and pulled up R20's pants. R20 was assisted out of the bathroom to sit in their recliner. NA-F then obtained a washcloth and wet down with warm water. The washcloth was given to R20 to wash his face. NA-F then removed gloves and without performing hand hygiene NA-F donned new gloves and assisted R20 with a clean shirt. R20 asked for dentures and NA-F took the white denture container, brought them to the sink and took the dentures out of the case to rinse before handing to R20 to place in mouth. After R20 was done, NA-F removed gloves and tied up R20;s soiled garbage. NA-F left room and brought soiled bag to soiled utility room garbage. NA-F then washed hands. When interviewed on 8/7/24 at 7:53 a.m., NA-F verified they did not change gloves after emptying the urinal and assisting with personal cares for R20. NA-F further verified hand hygiene was not completed after glove removal. NA-F further stated they usually keep hand sanitizer in their pockets however the shirt they were wearing did not have pockets to keep sanitizer handy. NA-F verified R20 had enhanced barrier sign or the hanging container of gowns and gloves. NA-F	21375			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00947	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/07/2024
NAME OF PROVIDER OR SUPPLIER THE ESTATES AT GREELEY LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 313 SOUTH GREELEY STREET STILLWATER, MN 55082		
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21375	Continued From page 35 stated they should have been in a gown and gloves when providing cares. When interviewed on 8/7/24 at 11:40 a.m., the Director of Nursing (DON) expected staff to remove gloves and perform hand hygiene when moving from unclean to clean areas. DON further stated staff were expected to wear gown and gloves when assisting with cares for residents on EBP. When interviewed on 8/7/24 at 1:18 p.m., the infection preventionist (IP) expected staff to follow any precautions that were posted outside of the rooms. IP stated R98 had admitted with C. Diff and was going to remain on precautions until the antibiotic was completed. IP stated staff were instructed that if they are only dropping something off and not having hands on contact with the environment or resident, gowning and gloves was not needed. Any staff who had contact with the environment or hands on with the resident were expected to gown and glove. IP reviewed the contact isolation sign that was posted on R98's door and verified it said all staff who enter were required to gown and glove. IP wasn't sure about why the contact isolation sign said only staff were required to gown and glove and did not instruct hand washing with soap and water. IP stated the facility had another sign for enteric precautions that instructed all who enter gown, gloves and wash hands with soap and water to due to how easily C. Diff was spread. IP further stated hand sanitizer was not enough. IP stated the enteric precautions sign should be in place for residents with C. Diff. Residents who require EBP are identified with signage on the doors. Staff were expected to wear gown and gloves with any hands-on resident cares such as toileting or transferring. Furthermore, IP expected staff to	21375			

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21375	Continued From page 36 perform hand hygiene after any glove removal and when moving from dirty tasks to clean tasks. This was important to minimize risk of infections. A facility policy titled Transmission-Based Precautions revised 7/2023, directed staff to use TBP for residents who are known to be infected with an infectious agent. Contact precautions was used when the infection was spread directly person to person or indirect contact with the resident or environment. Appropriate PPE included gown and gloving upon entering the room or making direct contact with the resident or environment. Upon exiting the room, hand hygiene was required. The facility policy lacked direction on enteric precautions or when hand washing with soap and water required. A facility policy titled Handwashing Policy revised 2/2024, directed proper hand washing should be used to protect the spread of infection. Hand washing shall be completed after changing incontinent products. Furthermore, hand hygiene was required after glove removal and before glove donning. A facility policy titled Enhanced Barrier Precautions dated directed staff to initiate EBP for residents with residents with wounds and PPE should be worn during high contact resident care activities such as dressing, transferring and hygiene. SUGGESTED METHOD OF CORRECTION: The DON or designee could train staff and perform audits to ensure hand hygiene, TBP, and infection control techniques are being followed. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	21375			

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21426	MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure tuberculosis (TB) screening and testing via two-step tuberculin skin testing (TST), chest x-ray, or TB blood test was completed according to the Centers for Disease Control & Prevention (CDC) guidelines for 2 of 5 staff [nursing assistant (NA)-A, NA-B], and failed to provide initial TB-related education for 1 of 5 staff (NA-C) reviewed for TB screening, testing, and training. Findings include:	21426	Corrected.		9/13/24

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21426	Continued From page 38 The facility unlabeled staff listing (undated) included the following employment start dates: NA-A - 6/4/24 NA-B - 6/10/24 NA-C - 7/10/24 NA-A's Mantoux/PPD Test Result Form dated 7/27/24, included one TST administered on 7/25/23, however, lacked evidence of TB baseline screening including history and symptoms, and lacked a two-step TST within 90 days of employment, chest x-ray results, or TB blood test documentation to rule out TB. NA-B's TB Baseline Tool for Health Care Worker (undated) lacked documentation of TB history and symptoms, and indicated they had a negative TB blood test, however NA-B's blood test documentation lacked a staff name, date, and any other identifying information. NA-C's education Certificates of Completion dated 7/17/24 - 7/23/24, lacked evidence of initial TB education upon hire. The facility staff schedules for the week of 7/29/24 - 8/5/24, included NA-A worked two shifts, and NA-B worked six shifts during that time period. During interview on 8/6/24 at 10:21 a.m., infection preventionist (IP) stated staff were required to have TB screening and TB blood test results, chest x-ray results, or the first step of a two-step TST completed prior to working with residents on the floor. They indicated if they did not have evidence from prior employment, human resources coordinated the testing and the staff nurses completed it, however if they already had	21426			

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21426	Continued From page 39 evidence of any testing within the past year, including TST, it would be sufficient, and no further testing was required. IP was unaware the TST must be completed within 90-days prior to hire. During interview on 8/6/24 at 10:31 a.m., director of nursing (DON) stated they expected staff to have completed the first TST (unless they had a previous blood test or chest x-ray) and TB education during orientation and prior to starting to work with residents to help identify and prevent possible spread of TB. The Facility TB Risk Assessment Worksheet for Health Care Settings Licensed By MDH (Minnesota Department of Health) dated 7/29/24, lacked a response to the question, "Is baseline TB screening of all health care personnel performed at the time of hire as required". The Worksheet included nursing staff were included in the baseline TB screening program, and TB training was provided to all health care personnel at the time of hire and annually. The Tuberculosis Screening and Prevention - Employees policy dated 7/31/23, included employees will be screened using an indivual risk assessment and symptom evaluation upon hire. TB testing may be completed with a blood test or two-step TST. Annual TB education is provided to all health care workers. SUGGESTED METHOD OF CORRECTION: The infection preventionist (IP), director of nursing (DON) and/or designee should review policies and procedures related to the screening and testing for tuberculosis for employees (staff). Facility staff could be educated on the TB regulations, symptom screening, and the two-step	21426			

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21426	Continued From page 40 Mantoux process. The IP, DON and/or designee could audit staff new hires as well as current staff records to ensure compliance. The IP, DON and/or designee could take those findings/education to the Quality Assurance Performance Improvement (QAPI) committee for a determined amount of time until the QAPI committee determines successful compliance or the need for ongoing monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21426			

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted on August 7,2024, by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, The Estates Greeley LLC, 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

Electronically Signed

TITLE

(X6) DATE

08/28/2024

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

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K 000	Continued From page 1 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. Greeley Healthcare Center is a 1-story building with a partial basement. The building was constructed at 3 different times. The original building was constructed in 1964 and was determined to be of Type II (111) construction. In 1988, an addition was constructed to the west side of the building that was determined to be of Type II(111)construction. In 1997, an addition was constructed to the north and south sides of the	K 000			

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K 000	Continued From page 2 building that was determined to be of Type V(111)construction. Because the original building and the additions meet the construction type allowed for existing buildings, the facility was surveyed as one building as Type V(111) construction. The facility has a capacity of 64 beds and had a census of 50 at the time of the survey.	K 000			
K 345 SS=F	The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by: 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 the transmission of the fire alarm signal per NFPA 101 (2012 edition), Life Safety Code sections 9.6.1.3, 9.6.1.5, NFPA 70, and NFPA 72. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 08/07/2024, between 8:00 AM and 10:00 AM, it was revealed by a review of available	K 345	K345 Fire Alarm System – Testing and Maintenance 1.) A detailed description of the corrective action taken or planned to correct the deficiency. Facility request documentation from fire alarm company. 2.) Address the measures that will be put in place to ensure the deficiency does not reoccur. A system for tracking was in place, but the	9/10/24	

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K 345	Continued From page 3 documentation that the annual fire alarm testing report didn't include testing of the dialer (DACT) to ensure notification of emergency services within 90 seconds. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 345	facility failed to request the documentation of these records. The facility will initiate a hard copy log to record these dates and times for future reference. 3.) Indicate how to facility plans to monitor future performance to ensure solutions are sustained. Audits will be done weekly for the first 4 weeks and monthly thereafter. The facility will determine the ongoing frequency of audits based off the results. 4.) Identify who is responsible for corrective actions and monitoring of compliance. Maintenance Director, Maintenance Assistant or designee 5.) The actual or proposed date for completion of the remedy. 9/10 K353 Sprinkler System – Maintenance and Testing 1.) A detailed description of the corrective action taken or planned to correct the deficiency. High storage located in noted areas removed. 2.) Address the measures that will be put in place to ensure the deficiency does not reoccur. Red lines have been painted on the wall to indicate high storage level with text saying, “no storage above this line”. 3.) Indicate how to facility plans to monitor future performance to ensure solutions are		

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K 345	Continued From page 4	K 345	sustained. Audits will be done weekly for the first 4 weeks and monthly thereafter. The facility will determine the ongoing frequency of audits based off the results. 4.) Identify who is responsible for corrective actions and monitoring of compliance. Maintenance Director, Assistant or designee. 5.) The actual or proposed date for completion of the remedy. 9/10 K920 Electrical Equipment – Power Cords and Extension Cords 1.) A detailed description of the corrective action taken or planned to correct the deficiency. Remove power strips from all areas of building. 2.) Address the measures that will be put in place to ensure the deficiency does not reoccur. 3.) Indicate how to facility plans to monitor future performance to ensure solutions are sustained. Audits will be done once a week for 4 weeks and once a month thereafter. 4.) Identify who is responsible for corrective actions and monitoring of compliance. Maintenance Direct, Maintenance Assistant or Designee. 5.) The actual or proposed date for completion of the remedy. 9/10		
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101	K 353			9/10/24

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K 353	Continued From page 5 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain spacing between storage and the sprinkler system per NFPA 101 (2012 edition), Life Safety Code, Section 9.7.5, NFPA 25 (2011 edition), Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, Section 5.2.1.2, and NFPA 13 (2010 edition), Standard for the Installation of Sprinkler Systems, Sections 8.6.5.3.2 and 8.15.9. This deficient finding could a widespread impact on the residents within the facility. Findings include: On 08/07/2024, between 8:00 AM and 10:00 AM, it was revealed by observation that in the South Wing Janitor's Closte and in the Storage Room	K 353	1.) A detailed description of the corrective action taken or planned to correct the deficiency. High storage in noted areas have been removed. 2.) Address the measures that will be put in place to ensure the deficiency does not reoccur. Red lines have been painted on the wall to indicate high storage level with text saying, "no storage above this line". High storage audits will be done weekly for the first 4 weeks and monthly thereafter.		

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K 353	Continued From page 6 where the water main shut off is located, items were being stored within 18" of the sprinkler system. An interview with the Maintenance Director verified this deficient findings at the time of discovery.	K 353	3.) Indicate how to facility plans to monitor future performance to ensure solutions are sustained. High storage audit results will be reviewed in monthly safety meeting and QAPI with IDT team. Audit results will determine the ongoing frequency of these audits. 4.) Identify who is responsible for corrective actions and monitoring of compliance. Maintenance Director, Assistant or designee. 5.) The actual or proposed date for completion of the remedy.		
K 920 SS=E	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assemblies that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are	K 920	9/10		9/10/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245342	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 08/07/2024
NAME OF PROVIDER OR SUPPLIER THE ESTATES AT GREELEY LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 313 SOUTH GREELEY STREET STILLWATER, MN 55082		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
K 920	Continued From page 7 used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the usage of electrical adaptive devices NFPA 99 (2012 edition), Health Care Facilities Code, sections 10.5.2.3.1 and 10.2.4.2.1, NFPA 101 (2012 edition), Life Safety Code, section 9.1.2, NFPA 70, (2011 edition), National Electrical Code, sections 400.8, and UL 1363. These deficient findings could have a patterned impact on the residents within the facility. Findings include: On 08/07/2024, between 8:00 AM and 10:00 AM, it was revealed by observation that there were several power strips being used within the facility that were not properly rated for a healthcare setting. One power strip was located in the Janitos closet and two additional power strips were located in the Rehab area. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 920	K920 Electrical Equipment ☐ Power Cords and Extension Cords 1.) A detailed description of the corrective action taken or planned to correct the deficiency. Remove power strips from all areas of building. 2.) Address the measures that will be put in place to ensure the deficiency does not reoccur. Education on power strip use and safety will be provided to all-staff. 3.) Indicate how to facility plans to monitor future performance to ensure solutions are sustained. Power strip audits will be completed once a week for four weeks and once a month thereafter. Audits will be done once a week for 4 weeks and once a month thereafter. Results will be reviewed and revised as needed with Quality Ass 4.) Identify who is responsible for corrective		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245342	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 08/07/2024
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K 920	Continued From page 8	K 920	actions and monitoring of compliance. Maintenance Direct, Maintenance Assistant or Designee. 5.) The actual or proposed date for completion of the remedy. 9/10		