Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
September 11, 2023

Administrator
Hilltop Healthcare Rehabilitation and Skilled Nursing
2501 Rice Lake Road
Duluth, MN 55811

RE: CCN: 245366
Cycle Start Date: June 12, 2023

Dear Administrator:

On August 2, 2023, the Minnesota Department(s) 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.

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

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July 11, 2023

Administrator
Hilltop Healthcare Rehabilitation and Skilled Nursing
2501 Rice Lake Road
Duluth, MN 55811

RE: CCN: 245366
Cycle Start Date: June 12, 2023

Dear Administrator:

On June 12, 2023, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Jennifer Kolsrud Brown, RN, Unit Supervisor
Rochester District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904-5506
Email: jennifer.kolsrud@state.mn.us
Office: (507) 206-2727 Mobile: (507) 461-9125

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 September 12, 2023 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by December 12, 2023 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

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

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

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

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

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245366	A. BUILDING _____ B. WING _____	C 06/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLTOP HEALTHCARE REHABILITATION AND SKILLED NURS	2501 RICE LAKE ROAD DULUTH, MN 55811

(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 6/5/23 to 6/12/23, a survey for compliance with Appendix Z, Emergency Preparedness Requirements for Long Term Care facilities, §483.73(b)(6) was conducted during a standard recertification survey. The facility was NOT in compliance. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulation has been attained.	E 000		
E 037 SS=C	EP Training Program CFR(s): 483.73(d)(1) §403.748(d)(1), §416.54(d)(1), §418.113(d)(1), §441.184(d)(1), §460.84(d)(1), §482.15(d)(1), §483.73(d)(1), §483.475(d)(1), §484.102(d)(1), §485.68(d)(1), §485.542(d)(1), §485.625(d)(1), §485.727(d)(1), §485.920(d)(1), §486.360(d)(1), §491.12(d)(1). *[For RNCHIs at §403.748, ASCs at §416.54, Hospitals at §482.15, ICF/IIDs at §483.475, HHAs at §484.102, REHs at §485.542, "Organizations" under §485.727, OPOs at §486.360, RHC/FQHCs at §491.12:] (1) Training program. The [facility] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing	E 037		7/26/23

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

Electronically Signed | 07/20/2023

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

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E 037	Continued From page 1 staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the [facility] must conduct training on the updated policies and procedures. *[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles. (ii) Demonstrate staff knowledge of emergency procedures. (iii) Provide emergency preparedness training at least every 2 years. (iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others. (v) Maintain documentation of all emergency preparedness training. (vi) If the emergency preparedness policies and procedures are significantly updated, the hospice must conduct training on the updated policies and procedures.	E 037		

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E 037	Continued From page 2 *[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) After initial training, provide emergency preparedness training every 2 years. (iii) Demonstrate staff knowledge of emergency procedures. (iv) Maintain documentation of all emergency preparedness training. (v) If the emergency preparedness policies and procedures are significantly updated, the PRTF must conduct training on the updated policies and procedures. *[For PACE at §460.84(d):] (1) The PACE organization must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, contractors, participants, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Demonstrate staff knowledge of emergency procedures, including informing participants of what to do, where to go, and whom to contact in case of an emergency. (iv) Maintain documentation of all training. (v) If the emergency preparedness policies and procedures are significantly updated, the PACE must conduct training on the updated policies and procedures. *[For LTC Facilities at §483.73(d):] (1) Training	E 037		

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E 037	Continued From page 3 Program. The LTC facility must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. *[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following: (i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment. (v) If the emergency preparedness policies and procedures are significantly updated, the CORF must conduct training on the updated policies and procedures. *[For CAHs at §485.625(d):] (1) Training program.	E 037		

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E 037	Continued From page 4 The CAH must do all of the following: (i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the CAH must conduct training on the updated policies and procedures. *[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least every 2 years. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide staff emergency preparedness (EP) training at least annually to all existing and new staff according to the facility's Emergency Preparedness Plan (EPP). This had	E 037	E037 EP Training Program Immediate Corrective action: Educational slides added to orientation. Identification of other residents:	

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E 037	Continued From page 5 the potential to affect all residents, staff, and visitors at the facility. Findings include: The facility EPP was reviewed and lacked documentation of annual and new hire EP training for staff. During an interview on 6/12/23 at 3:45 p.m., the acting administrator stated she was sure they had completed training in the past year but would need to look for it. The acting administrator had been in her position for less than a week at the time of survey. Requested documentation for staff training was not received.	E 037	All residents could be affected by EP training program. Corrective Action: IDT has been educated on EP training program All Staff educated on EP training program. EP educational relias added to all employees online education. Monitoring/Audits: DON/Designee shall audit 5 staff on Emergency Preparedness training 5 days a week X 1 week, then 2 times a week X 2 weeks then monthly X 2 months. Audit results will be discussed in QAPI.	
E 039 SS=C	EP Testing Requirements CFR(s): 483.73(d)(2) §416.54(d)(2), §418.113(d)(2), §441.184(d)(2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2), §483.475(d)(2), §484.102(d)(2), §485.68(d)(2), §485.542(d)(2), §485.625(d)(2), §485.727(d)(2), §485.920(d)(2), §491.12(d)(2), §494.62(d)(2). *[For ASCs at §416.54, CORFs at §485.68, REHs at §485.542, OPO, "Organizations" under §485.727, CMHCs at §485.920, RHCs/FQHCs at §491.12, and ESRD Facilities at §494.62]: (2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following: (i) Participate in a full-scale exercise that is community-based every 2 years; or	E 039		7/24/23

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E 039	Continued From page 6 (A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or (B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event. (ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed. *[For Hospices at 418.113(d):] (2) Testing for hospices that provide care in the patient's home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the following: (i) Participate in a full-scale exercise that is community based every 2 years; or (A) When a community based exercise is not	E 039		

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E 039	Continued From page 7 accessible, conduct an individual facility based functional exercise every 2 years; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full scale community-based exercise or individual facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (3) Testing for hospices that provide inpatient care directly. The hospice must conduct exercises to test the emergency plan twice per year. The hospice must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual facility-based functional exercise; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospice is exempt from engaging in its next required full-scale community	E 039		

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E 039	Continued From page 8 based or facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop led by a facilitator that includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the hospice's emergency plan, as needed. *[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):] (2) Testing. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the [PRTF, Hospital, CAH] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event.	E 039		

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HILLTOP HEALTHCARE REHABILITATION AND SKILLED NURS	2501 RICE LAKE ROAD DULUTH, MN 55811

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E 039	Continued From page 9 (ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the [facility's] emergency plan, as needed. *[For PACE at §460.84(d):] (2) Testing. The PACE organization must conduct exercises to test the emergency plan at least annually. The PACE organization must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the PACE experiences an actual natural or man-made emergency that requires activation of the emergency plan, the PACE is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years opposite the year the full-scale or functional	E 039		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLTOP HEALTHCARE REHABILITATION AND SKILLED NURS	2501 RICE LAKE ROAD DULUTH, MN 55811

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E 039	Continued From page 10 exercise under paragraph (d)(2)(i) of this section is conducted that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the PACE's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the PACE's emergency plan, as needed. *[For LTC Facilities at §483.73(d):] (2) The [LTC facility] must conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The [LTC facility, ICF/IID] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. (B) If the [LTC facility] facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required a full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following:	E 039		

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E 039	Continued From page 11 (A) A second full-scale exercise that is community-based or an individual, facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [LTC facility] facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [LTC facility] facility's emergency plan, as needed. *[For ICF/IIDs at §483.475(d)]: (2) Testing. The ICF/IID must conduct exercises to test the emergency plan at least twice per year. The ICF/IID must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or. (B) If the ICF/IID experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID is exempt from engaging in its next required full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by	E 039		

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E 039	Continued From page 12 a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the ICF/IID's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID's emergency plan, as needed. *[For HHAs at §484.102] (d)(2) Testing. The HHA must conduct exercises to test the emergency plan at least annually. The HHA must do the following: (i) Participate in a full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise every 2 years; or. (B) If the HHA experiences an actual natural or man-made emergency that requires activation of the emergency plan, the HHA is exempt from engaging in its next required full-scale community-based or individual, facility based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group	E 039		

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E 039	Continued From page 13 discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the HHA's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the HHA's emergency plan, as needed. *[For OPOs at §486.360] (d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following: (i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. If the OPO experiences an actual natural or man-made emergency that requires activation of the emergency plan, the OPO is exempt from engaging in its next required testing exercise following the onset of the emergency event. (ii) Analyze the OPO's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. *[RNCHIs at §403.748]: (d)(2) Testing. The RNHCI must conduct exercises to test the emergency plan. The RNHCI must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated,	E 039		

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E 039	Continued From page 14 clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the RNHCI's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the RNHCI's emergency plan, as needed. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure two emergency preparedness (EP) exercises, including two full-scale community-based exercises, or one community-based exercise and a tabletop exercise, or had activated their plan as a result of an actual event, were completed annually to test their EP program. This had the potential to affect residents, visitors, and staff at the facility. During an interview on 6/12/23 at 3:45 p.m., the acting administrator stated she was not sure where the documentation was for their EP exercises and would need to look for it. Requested documentation for emergency exercises was not received.	E 039	E039: EP Testing Requirements Immediate Corrective action: Table-Top completed with IDT team. Identification of other residents: All residents could be affected by EP training program. Corrective Action: IDT has been educated on E039 A emergency preparedness drill has been scheduled. EP educational relias added to all employees online education. Monitoring/Audits: DON/Designee shall audit Emergency Preparedness Testing Q6 months X 1 Year. Audit results will be discussed in QAPI.	
E 041 SS=C	Hospital CAH and LTC Emergency Power CFR(s): 483.73(e) §482.15(e) Condition for Participation: (e) Emergency and standby power systems. The hospital must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section and in the	E 041		7/21/23

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E 041	Continued From page 15 policies and procedures plan set forth in paragraphs (b)(1)(i) and (ii) of this section. §483.73(e), §485.625(e), §485.542(e) (e) Emergency and standby power systems. The [LTC facility CAH and REH] must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section. §482.15(e)(1), §483.73(e)(1), §485.542(e)(1), §485.625(e)(1) Emergency generator location. The generator must be located in accordance with the location requirements found in the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5, and TIA 12-6), Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4), and NFPA 110, when a new structure is built or when an existing structure or building is renovated. 482.15(e)(2), §483.73(e)(2), §485.625(e)(2), §485.542(e)(2) Emergency generator inspection and testing. The [hospital, CAH and LTC facility] must implement the emergency power system inspection, testing, and [maintenance] requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code. 482.15(e)(3), §483.73(e)(3), §485.625(e)(3),§485.542(e)(2) Emergency generator fuel. [Hospitals, CAHs and LTC facilities] that maintain an onsite fuel source to power emergency generators must have a plan for how it will keep emergency power systems	E 041		

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E 041	Continued From page 16 operational during the emergency, unless it evacuates. *[For hospitals at §482.15(h), LTC at §483.73(g), REHs at §485.542(g), and and CAHs §485.625(g):] The standards incorporated by reference in this section are approved for incorporation by reference by the Director of the Office of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may obtain the material from the sources listed below. You may inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the Federal Register to announce the changes. (1) National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169, www.nfpa.org, 1.617.770.3000. (i) NFPA 99, Health Care Facilities Code, 2012 edition, issued August 11, 2011. (ii) Technical interim amendment (TIA) 12-2 to NFPA 99, issued August 11, 2011. (iii) TIA 12-3 to NFPA 99, issued August 9, 2012. (iv) TIA 12-4 to NFPA 99, issued March 7, 2013. (v) TIA 12-5 to NFPA 99, issued August 1, 2013. (vi) TIA 12-6 to NFPA 99, issued March 3, 2014. (vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011.	E 041		

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E 041	Continued From page 17 (viii) TIA 12-1 to NFPA 101, issued August 11, 2011. (ix) TIA 12-2 to NFPA 101, issued October 30, 2012. (x) TIA 12-3 to NFPA 101, issued October 22, 2013. (xi) TIA 12-4 to NFPA 101, issued October 22, 2013. (xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009.. This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to test and inspect the generator per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.4.4.1.1.4, and NFPA 110 (2010 edition), Standard for Emergency and Standby Power Systems, section 8.4.1 and 8.4.2. These deficient findings could have a widespread impact on the residents within the facility. Findings include: During an interview and observation on 6/06/23, between 11:45 a.m. and 3:45pm, Maintenance Director and Acting Facility Administrator verified documentation of the emergency generator maintenance and testing weekly and monthly generator inspections were not performed from 6/06/22 to 6/06/23. In addition, available documentation of the emergency generator maintenance and annual generator inspections was not performed as well as the emergency generator maintenance that a 36 month 4-hour load-bank test had been preformed.	E 041	E0041 - SS=F - Hospital CAH and LTC Emergency Power Corrective Action: The Maintenance Director or designee will complete weekly generator non-load tests following the required procedure. All required documentation recorded in inspections binder. Maintenance Director or designee will complete monthly generator load tests following the required procedure. All required documentation recorded in inspections binder. Maintenance Director or designee contacted external company for generator contract. Requested and received contract paperwork. Scheduled 4-hour load bank test with external company. Scheduled annual service with external company.	

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E 041	Continued From page 18	E 041	System Change: These inspections has been added to the TELS system and it will monitor and alert when due. All inspections automatically scheduled. The Maintenance Director or designee will be alerted through TELS and verify completion and accuracy. • Weekly Non-load Test • Monthly Load Test Monitoring: Audit generator test weekly X 2 months. All issues will be reported to administrator immediately for follow up and brought to QAPI committee at least quarterly.	
F 000	INITIAL COMMENTS On 6/5/23 to 6/12/23, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. In addition to the recertification survey, the following complaints were reviewed The following complaints were reviewed with no deficiency issued. H53662610C (MN00093646) H53662606C (MN00092643) H53662608C (MN00092556) H53662615C (MN00083781) H53662613C (MN00092770) H53662605C (MN00092529) H53662609C (MN00093046)	F 000		

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F 000	Continued From page 19 H5366291C (MN00082294) H5366290C (MN00081819) The following complaints were reviewed with deficiency. H53662614C (MN00084347) with a deficiency issued at (755) H53662607C (MN00093661) with a deficiency issued at (755) The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F 000		
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: The facility failed to perform a self-administration of medication assessment and obtain provider order to have medication left in room for 1 of 1 (R40) residents reviewed for self-administration of medication.	F 554	F554: Resident Self Admin Medications Immediate Corrective action: Nurse responsible for leaving item in room was educated. Item was removed from resident 40 room.	7/24/23

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F 554	Continued From page 20 R40's significant change Minimum Data Set (MDS) assessment dated 5/14/23, indicated R40 had moderate cognitive impairment. Diagnoses included cancer, depression, dementia and schizophrenia. The Care Area Assessment Summary (CAA)-Focus areas to provide specialized, resident specific care, included cognitive loss/dementia, visual function and psychotropic drug use. R40's care plan dated 2/24/23 indicated cognitive impairment and behaviors. During an observation on 6/5/23 at 3:43 p.m., of R40's bedside table included a bottle of nystatin powder (used to treat fungal skin infections) and a second bottle in R40's restroom. A follow up observation on 6/6/23 at 2:28 p.m., remained the nystatin powder R40's bedside table and the second bottle restroom. During an interview on 6/6/23 at 3:48 p.m., trained medication aide (TMA)-D stated R40 is cognitively impaired and medication would not be left at the bedside. TMA-D entered R40's room and acknowledged nystatin powder had been left at the bedside and in the bathroom and should not have been. During an interview on 6/6/23 at 3:53 p.m., registered nurse (RN)-H stated if medications were to be left at resident bedside there needed to be a self administration of medication assessment and a provider order to leave at bedside. RN-H stated R40 was cognitively impaired and would not have medications left at bedside.	F 554	Identification of other residents: All residents could be affected by self-administration of medications. Corrective Action: IDT team has been educated on the self-administration of medications policy. IDT team has been educated on the medication administration policy. Nursing staff (RN/LPN/TMA) have been educated on the self-administration of medications policy prior to the start of their next shift. Nursing staff (RN/LPN/TMA) have been educated on the medication administration policy prior to the start of their next shift. Monitoring/Audits: DON/Designee shall audit 5 medication passes 5 days a week X 1 week, then 2 times a week X 2 weeks then monthly X 2 months. DON/Designee shall audit 5 residents with SAMS orders that a self-administration policy is completed 5 days a week X 1 week, then 2 times a week X 2 weeks then monthly X 2 months.	

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F 554	Continued From page 21 During an interview on 6/6/23 at 4:01 p.m., registered nurse (RN)-I stated that R40 was cognitively impaired and should not have medications left at bedside. During an interview on 6/06/23 at 4:15 p.m., the director of nursing (DON) stated and expectation the nurse would observe the medications given to R40 and then would return the medications to the medication cart. Facility policy Self-Administration of Medication indicated a resident could self administer medication if the self administration of medications assessment determined that self-administration is clinically appropriate. The facility policy of leaving medications at bedside was requested but not provided.	F 554		
F 557 SS=D	Respect, Dignity/Right to have Prsnl Property CFR(s): 483.10(e)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(2) The right to retain and use personal possessions, including furnishings, and clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to maintain respect and dignity for personal possessions for 2 of 2 resident's (R23, R94) reviewed who had their room searched and items removed without consent.	F 557	F557: Respect, Dignity/Right to personal privacy Immediate Corrective action: Nurse responsible for removing item was	7/24/23

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLTOP HEALTHCARE REHABILITATION AND SKILLED NURS	2501 RICE LAKE ROAD DULUTH, MN 55811

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 557	Continued From page 22 Findings include: R15's quarterly Minimum Data Set (MDS) assessment dated 5/10/23 indicated R15 was cognitively intact with diagnoses of hypertension, obesity, major depression, edema, and obstructive sleep apnea. R94's significant change MDS assessment dated 3/17/23 indicated R94 was cognitively intact with diagnoses of renal insufficiency, diabetes Mellitus, hypertension, coronary artery disease and anemia. During an interview on 6/7/23 at 11:23 a.m., R15 stated she was upset after hearing from her roommate staff had gone into their room, searched drawers and removed items while R15 attended a doctor's appointment on 6/6/23. R15 added staff had to have gone through drawers to find the over-the-counter medications. R15 said staff should not go behind residents' backs and go through personal stuff in resident rooms without consent. R15 asked licensed practical nurse (LPN)-D and was told the items were removed from the rooms because the state department said we couldn't have those things in the room without a doctor's order. R15 indicated a wait time of six weeks for the pharmacy to send her nystatin powder. R15 said she understood, but staff should not be going through resident belongings without being present. R15 also indicated she should have been told what wasn't allowed in the room before it was ordered and paid for. R15 said the Biofreeze was brand new. During the interview on 6/7/23 at 11:23 a.m. R94 stated she had items taken from the room and	F 557	immediately educated. Residents immediately affected were provided with replacement items. Identification of other residents: All residents could be affected Respect, Dignity/right to personal privacy. Corrective Action: IDT team educated on Room search policy. All staff have been educated on the Room search policy prior to start of next shift. Monitoring/Audits: DON/Designee shall audit 5 residents 5 days a week X 1 week, then 2 times a week X 2 weeks then monthly X 2 months.	

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F 557	Continued From page 23 nobody let her know they were taking the items out of the room. R94 has used Vicks for 50 years. During a follow up interview on 6/8/23 at 1:41 p.m., R15 stated her personal space was violated when staff took things out of her room and indicated she would like to be reimbursed for the items taken. During a follow-up interview on 6/8/23 at 1:54 p.m., R94 said they were in the building, and nobody came and got R94 or asked about removing items from the room. R94 stated she did not know what had happened to her stuff. R94 stated she felt like she had been violated. During an interview on 6/8/23 at 1:59 p.m., licensed practical nurse (LPN)-D stated the director of nursing (DON) had given the directive to make sure there were not any medicated creams or powders in resident rooms. LPN-D explained 3 staff had gone through all resident rooms on her unit. LPN-D indicated if the resident was on the floor or in their room they were notified, but if not, her and her staff removed all creams and powders from the rooms without residents being notified. LPN-D stated they had obtained orders for one resident to use Vicks vapor rub and Tums; otherwise everything that was not ordered by a provider and or labeled correctly was thrown away. LPN-D stated in retrospect things should have been handled differently. Residents should have been notified and items should not have gone in the garbage before the residents had an opportunity to send them out of the facility. During an interview on 6/8/23 at 3:43 p.m., the	F 557		

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F 557	Continued From page 24 DON stated because a Nystatin powder had been found in a room of a resident that did not have orders to self-administer medications (SAM) she had told unit leadership a facility audit needed to be done. They were told medicated items needed to be removed from rooms if a resident didn't have a SAM order in place. During an audit it would be expected Vicks and Bio Freeze would be removed from rooms if there was not a SAM order in place for the items. The DON stated it would be an expectation that staff would explain to residents why things needed to be taken out of their room based on policy and regulations. The DON explained residents can have these items, however orders and assessments have to be completed and in place first. The DON stated during an audit residents should be informed and approached when there is a need to remove a medication item from their room however if there was a risk to resident safety, then an item could be removed without notification to the resident. The DON stated she had spoken with LPN-D regarding this, and indicated the only directive she had given LPN-D, was to make sure there were not any mediation without a SAM order left in rooms. The DON stated in this instance, she felt resident rights had been violated because residents were not informed or given the opportunity to be present in the room when their belongings were gone through, and medication items were removed. Residents should have been informed and given the opportunity to be present. Facility policy Room Search dated 6/8/22, included: the facility shall notify a resident and or request of a non-urgent room search being conducted.	F 557		

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F 558	Continued From page 25	F 558		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure staff were educated and training for the use of specialized equipment for 1 of 1 resident (R89) reviewed. Findings include: R89's Admission Record dated 6/9/23, indicated R89 had diagnoses which included depression, heart failure (a condition in which the heart doesn't pump as well as it should), and paraplegia (paralysis of the legs and lower body, typically caused by spinal injury or disease). R89's 5-day Minimum Date Set (MDS) assessment dated 3/6/23, indicated R89 was cognitively intact, had some verbal and physical behaviors, and was always incontinent of bowel and bladder. R89's care plan dated 2/27/21, indicated R89 was at risk for complications with deficits with activities of daily living related to current medical and physical status. One goal was to remain clean, dry and skin intact. Interventions included nights to sign notebook in room and to put time you were in for check and change during the night. Only needed to be done if PureWick (a female	F 558	F558: Reasonable accommodations Immediate Corrective action: DON / ADON were immediately educated and created policy/procedure for Purewick External Catheter. Skin Assessment completed on affected resident to ensure no skin breakdown from potential improper use. Identification of other residents: All residents could be affected by reasonable accommodation. Corrective Action: IDT team has been educated on the purewick policy. Nursing staff (RN/LPN/TMA/CNA/Temp aide) have been educated on the purewick policy prior to the start of their next shift. Monitoring/Audits: DON/Designee shall audit Purewick competancy 5 days a week X 1 week, then 2 times a week X 2 weeks then monthly X 2 months.	7/24/23

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F 558	Continued From page 26	F 558		

external urine collection system that works outside the body) was not in place. Toilet use intervention indicated PureWick was to be used at night.

During an interview on 6/5/23 at 12:37 p.m., R89 stated she frequently would wake up in the morning soaked with urine from the back of her head down. R89 stated no one would wake her at night and no one except one nurse knew how to use the PureWick so she was frequently "soaking" wet in the morning.

During an interview on 6/9/23 at 12:41 p.m., trained medication aide (TMA)-B stated R89 would only allow certain staff to do things for her. TMA-B stated the PureWick would be set up by the nurse on the evening shift. TMA-B stated if R89 wouldn't allow staff to set up the PureWick she would need to be checked and changed every four hours through the night.

During an interview on 6/9/23 at 1:04 p.m., licensed practical nurse (LPN)-A stated directions on how to set up the PureWick were in the medication room. LPN-A verified there had not been any training or in-services on the PureWick for staff. LPN-A verified the nurse who R89 referenced only worked part time and if R89 would not allow staff to set up the PureWick, R89 would need to be checked and changed every four hours through the night.

During an interview on 6/9/23 at 2:39 p.m., the director of nursing verified staff had not been trained on setting up the PureWick machine.

During an interview on 6/9/23 at 3:13 p.m. registered nurse (RN)-H stated she had never

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F 558	Continued From page 27 used the PureWick or been trained on how to set it up.	F 558		
F 567 SS=E	Protection/Management of Personal Funds CFR(s): 483.10(f)(10(i)(ii) §483.10(f)(10) The resident has a right to manage his or her financial affairs. This includes the right to know, in advance, what charges a facility may impose against a resident's personal funds. (i) The facility must not require residents to deposit their personal funds with the facility. If a resident chooses to deposit personal funds with the facility, upon written authorization of a resident, the facility must act as a fiduciary of the resident's funds and hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in this section. (ii) Deposit of Funds. (A) In general: Except as set out in paragraph (f)(l0)(ii)(B) of this section, the facility must deposit any residents' personal funds in excess of $100 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain a resident's personal funds that do not exceed $100 in a non-interest bearing account, interest-bearing account, or petty cash fund. (B) Residents whose care is funded by Medicaid: The facility must deposit the residents' personal funds in excess of $50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that	F 567		7/26/23

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F 567	Continued From page 28 account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain personal funds that do not exceed $50 in a noninterest bearing account, interest-bearing account, or petty cash fund. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure residents had access to their personal funds upon request for 4 of 9 residents (R51, R7, R62, R79) reviewed for personal funds. This had the potential to effect 71 residents who utilized a personal funds account at the facility. Findings include: R51's quarterly Minimum Data Set (MDS) assessment dated 4/30/23 indicated R51 was cognitively intact. R7's quarterly MDS assessment dated 2/28/23 indicated R7 was severely cognitively impaired. R62's quarterly MDS assessment dated 6/2/23 indicated R62 had moderate cognitive impairment. R79's annual MDS assessment dated 2/25/23 indicated R79 was cognitively intact. During an interview on 6/5/23 at 1:07 p.m., R79 stated he could only get money from his account Monday through Friday from 8-4, and he could not get money on the weekend if he wanted it. During an interview on 6/5/23 at 2:17 p.m., R51 stated, residents could not always get money on the weekend from their resident accounts.	F 567	F567: Protection/Management of personal funds Immediate Corrective action: Residents affected by F567 were educated/informed about after hours banking. Identification of other residents: All residents could be affected by Protection/Management of personal funds. Corrective Action: IDT team has been educated on the Management/Personal funds Policy. All staff have been educated on the Management/Personal funds Policy. A after hours cash box was created with a log of residents balances with directions for staff to have cash available for residents 24 hours a day, 7 days a week. Monitoring/Audits: DON/Designee shall audit/interview 5 residents 5 days a week X 1 week, then 2 times a week X 2 weeks then monthly X 2 months. Audit results will be discussed in QAPI.	

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F 567	Continued From page 29 During an interview on 6/5/23 at 3:28 p.m., R62 stated they could not get money on weekends. During an interview on 6/5/23 at 6:13 p.m., R7 stated they could not get money from a personal account on the weekend. During an interview on 6/12/23 at 9:24 a.m., the activities director (AD) stated residents could get cash at the reception desk from the receptionist during business hours 8:00 a.m. to 4:30 p.m., but if they really needed to, residents could get money outside of business hours. The AD stated she would talk to the business office or administrator if a resident needed help getting money outside of business hours. During an interview on 6/12/23 at 9:30 a.m., nursing assistant (NA)-E stated if a resident wanted money, NA-E would contact the business office or receptionist-D at the front desk. NA-E was not sure, but stated thought there was a receptionist that could get money for residents on the weekend. During an interview on 6/12/23 at 9:39 a.m., registered nurse (RN)-B stated during regular hours residents can get money from their account from receptionist-D but RN-B stated did not know if residents could get money on weekends and holidays. During an interview on 6/12/23 at 9:44 a.m., NA-F stated residents can get money from their account from the reception desk Monday through Friday anytime they wanted from 8 a.m. to 4 p.m. if the receptionist is there. NA-F stated she thought there was a receptionist on the weekends	F 567		

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F 567	Continued From page 30 that could get money for residents and that she thought the supervisor may also have access to resident money after hours if there was an emergent need for money, but probably not if they just wanted money for a pack of cigarettes or something like that. During an interview on 6/12/23 at 11:40 a.m., receptionist-D stated the facility kept $1000.00 dollars in the petty cash and when it got down to $300.00 to $400.00 a check request was sent to corporate to replenish the cash box back up to $1000.00. Receptionist-D stated residents could get money between 8 a.m. and 4 p.m. when she was at work. After 4 p.m. the facility kept $50.00 on the Spruce unit for residents, but typically residents just waited until the next day to get money when she was back. Receptionist-D explained the $50.00 on the Spruce unit was also used for weekend cash requests so if a resident wanted more than $50.00, they would have to wait until the next week day because the petty cash only contained $50.00. During an interview on 6/12/23 at 12:51 p.m., the director of nursing (DON) stated the facility kept $500.00 dollars in petty cash for residents with personal facility accounts. The DON stated money was no longer kept on the Spruce unit for after hours, but residents could get money at the receptionist desk from 8 a.m. to 8 p.m. and after 8 p.m. she or the business office manager (BOM) would get funds for residents if requested and if neither of them were in the building the supervisor would contact them at home to return to work to get funds for a resident. During a follow-up interview on 6/12/23 at 1:40 p.m. receptionist-D confirmed $50.00 was not	F 567		

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F 567	Continued From page 31 currently being sent to the Spruce unit for after hours, and stated instead, petty cash was being kept in the business office. During an interview on 6/12/23 at 1:49 p.m., the BOM stated after hours petty cash was no longer on the Spruce unit, instead it was kept in the business office. The BOM stated residents knew they could get money at the reception desk or from her when she was at work. The BOM explained after hours and on weekends, only the BOM, DON, or administrator could access money, so in the event a resident requested funds after hours or on the weekend the supervisor would have to call the BOM or the administrator in to get the money for a resident request. The BOM stated staff are educated on hire that residents have 24 hour access to their funds and stated she believed staff knew residents could get money through reception during the week, but indicated she was not certain staff knew how to assist residents to get money during the weekend and off hours. The BOM stated we probably need to do some education with staff, so they know to call. The facility authorization residents sign when opening a "personal needs account" at the facility included bullet point: if the main office is closed, you or your appointed representative can receive funds from the nurse in charge.	F 567		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.	F 578		7/24/23

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F 578	Continued From page 32 §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the resident's wishes for	F 578	F578: Request/Refuse/Discontinue treatment.	

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F 578	Continued From page 33 advance directives were consistent in the medical record for 1 of 1 resident (R11). This practice had the potential to affect 41 residents reviewed for advance directives who may have received the incorrect wish for code status. Findings include: R11's quarterly Minimum Data Set (MDS) assessment dated 4/20/23, indicated R11 had severe cognitive impairment. Diagnoses included acute and chronic respiratory failure with hypoxia, kidney failure, hallucinations unspecified, epilepsy, degenerative disease of nervous system and methicillin resistant staphylococcus aureus infection. R11's most recent care conference documentation dated 5/25/23 indicated R11 had stated he wanted CPR. R11's electronic medical record orders indicated a DNR [do not resuscitate] had been ordered by provider on 5/31/23. The revision was noted by licensed practical nurse (LPN)-D. R11's provider orders for life-sustaining treatment (POLST) form dated 10/3/22 indicated R11 wanted cardiopulmonary resuscitation (CPR) initiated in the event he became pulseless and stopped breathing. R11's POLST dated 6/1/23 signed by FM-A changed code status to DNR, although documentation was not faxed to the facility until 6/7/23. When interviewed on 6/5/23 at 8:02 p.m., registered nurse RN-C stated the first place to	F 578	Immediate Corrective action: All POLST were audited to identify any errors POLST changed Identification of other residents: All residents could be affected by Request/Refuse/Discontinue treatment. Corrective Action: IDT team has been educated on Advanced Directives Policy Nursing staff (RN/LPN/TMA/CNA/Temp aide) have been educated on the Advanced Directive Policy prior to the start of their next shift. Monitoring/Audits: DON/Designee shall audit POLST for accuracy on 5 residents 5 days a week X 1 week, then 2 times a week X 2 weeks then monthly X 2 months. Audit results will be discussed in QAPI.	

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F 578	Continued From page 34 look for a code status was the POLST in the front of the chart, but one could also look at the electronic medical record (EMR) banner and indicated if there was a discrepancy, would initiate CPR. When interviewed on 6/5/23 at 8:02 p.m., trained medication aide (TMA)-A stated residents' code status was located on the POLST located at the top of the paper chart. TMA-A stated follow the paper chart POLST. TMA-A pulled R11's paper chart and confirmed R11's most recent POLST dated 10/2/22 indicated code status: CPR. When interviewed on 6/5/23 at 8:08 p.m., RN-E stated we would look at the POLST in the computer to determine a resident's code status. When interviewed on 6/5/23 at 8:09 p.m., RN-F stated to find a code status, would first look in the front of the paper chart at the POLST, and if there was any kind of discrepancy, would go by the most recent POLST. When interviewed on 6/7/23 at 2:06 p.m., LPN-D stated R11 was a DNR and staff can verify code status by reviewing the POLST in the resident's chart. LPN-D reviewed R11's chart and confirmed the banner read DNR. LPN-D stated the banner was a quick way to determine a resident's code status. LPN-D confirmed the discrepancy on the POLST in the EMR which read R11's code status was to perform CPR. LPN-D stated the process for when a code status changed with hospice they would get orders, orders would get checked and processed, once processed, the order would go into a bin for nurses to do a second check. Once the nurse completed the second check, the documents would go into another bin to get	F 578		

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F 578	Continued From page 35 scanned into the EMR. LPN-D stated staff are supposed to check the bins. LPN-D indicated staff have been taught to go by the POLST in chart, so in this case, staff would have to go by the POLST in the chart. LPN-D stated because there was an order in the record by the provider it was likely there was paperwork for R11's code status. LPN-D looked in the order/document bins and did not find an updated POLST. During an interview on 6/7/23 at 2:19 p.m., FM-A stated R11 did not want tubes down the throat, but R11 was not going to say he did not want CPR. FM-A stated she had talked to hospice about R11 wanting CPR and stated she was not aware R11 had said he wanted to be changed to DNR status. During an interview on 6/7/23 at 2:21 p.m. with FM-A present, R11 stated he did not know if he wanted to change his code status; "I don't know what I want, I don't know, it is a hard decision." When interviewed on 6/7/23 at approximately 3:00 p.m., the director of nursing (DON) stated normally when a resident is admitted to hospice, hospice would provide a copy of the POLST to the facility to be placed in the facility charts before leaving. The DON stated the order gets put in when the POLST is in hand and indicated it was unclear if LPN-D had the POLST in hand when the DNR order was entered. The DON stated the facility had not heard from R11's family that R11 would not want to be a DNR. During a phone interview on 6/8/23 at 11:49 a.m., FM-A stated LPN-D had called her and asked about the DNR status for R11. FM-A stated she	F 578		

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F 578	Continued From page 36 had talked with family, and they had decided R11's status should be changed to DNR because he had been rapidly declining. FM-A stated she had wanted R11 to say he wanted to change to DNR, but he didn't say that as you saw yesterday. Our family thought the change would be best. FM-A stated she did not know where hospice had got the idea R11 wanted to be DNR, when he was admitted to hospice, it had been decided R11 would have CPR and no tubes. Yesterday we decided R11 would be a DNR, so it doesn't really matter what hospice had before. When interviewed on 6/8/23 at 2:07 p.m. hospice RN-H stated when the team enters a facility to admit a resident into hospice, they would leave copies of the POLST not signed by the provider and preliminary admit documents at the facility and then we would fax a POLST and all documents once everything was completed and required provider and family signatures had been obtained.	F 578		
F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the	F 583		7/24/23

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F 583	Continued From page 37 residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on interview and observation the facility failed to provide adequate privacy for 1 of 1 resident (R334) reviewed for resident rights. Findings include: R334's quarterly Minimum Data Set (MDS) assessment dated 4/10/23 indicated intact cognition. R334 preferences under Section F includes, very important to resident to be able to use the phone in private. During an interview and observation on 6/05/23 at 6:37 p.m., R334 stated she doesn't feel like she has privacy. This is a shared room, there is a metal pole extending from the wall at the head of the bed, at a height of about six feet. The curtain	F 583	F583: Personal privacy/confidentiality of records. Immediate Corrective action: Resident no longer resides at the facility. Identification of other residents: All residents could be affected by Personal privacy/Confidentiality of records. Corrective Action: IDT team has been educated on Privacy and Confidentiality All staff have been educated on the resident privacy/confidentiality of records prior to the start of their next shift.	

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F 583	Continued From page 38 can extend almost all the way to the foot of the bed. The curtain rod is several feet down from the ceiling as the room has high ceilings. R334's roommate has her husband here often and she asks them to go elsewhere, or R334 has to leave the room. During an interview on 6/09/2023 3:05 p.m., administrator reviewed the curtains in R334's room and was not sure of the purpose or how long they have been there. During an interview on 6/09/2023 2:52 p.m., the director of nursing indicated the rods extend so the curtain goes to the end of the bed not sure how long these have been in place.	F 583	Verified curtains extend to end of bed. Monitoring/Audits: DON/Designee shall audit/interview 5 residents on personal privacy and confidentiality 5 days a week X 1 week, then 2 times a week X 2 weeks then monthly X 2 months. Audit results will be discussed in QAPI.	
F 585 SS=D	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available	F 585		7/24/23

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F 585	Continued From page 39 to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to	F 585		

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F 585	Continued From page 40 prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to investigate a report of missing items reported to staff by the resident for 1 of 1 (R40) residents reviewed for grievances.	F 585	F585: Grievances Immediate Corrective action: Resident/Resident representative offered a new wheelchair.	

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F 585	Continued From page 41 R40's significant change Minimum Data Set (MDS) assessment dated 5/14/23, indicated R40 had moderate cognitive impairment. Diagnoses included cancer, depression, dementia and schizophrenia.R40 could walk short distances with a walker but was dependent on a wheelchair for mobility. R40's resident admission belonging checklist dated 2/3/23 indicated R40 had her own wheelchair when she was admitted. During an interview on 6/05/23 at 8:54 a.m., family member (FM)-J stated the facility had called about cushions in R40's room. At this time it was revealed R40's wheelchair was missing. FM-J said they reported it to the nurse manager of the unit and to occupational therapy. During an interview on 6/7/23 at 10:41 a.m. registered occupational therapist (OTR)-K stated when R40's initial evaluation was completed there was special order cushions for a wheel chair in R40's. The wheelchair R40 was in at the time was a facility owned wheelchair. OTR-K phoned FM-J about the cushions and had determined R40 had her own wheelchair when she was admitted to the facility. OTR-K notified her supervisor R40 was missing a wheelchair. OTR-K did not fill out the grievance form. During an interview on 6/07/23 at 1:22 p.m. licensed social worker (LSW)-A stated if an item was reported missing, the staff would fill out the grievance form (including therapy staff), and give it to the director of nursing (DON). After the grievance form was given to the DON and completed it would come to social services to be filed in the grievance log. LSW-A stated she	F 585	Identification of other residents: All residents could be affected by the grievance process. Corrective Action: IDT team has been educated on the grievance policy. All staff have been educated on the grievance policy. Monitoring/Audits: DON/Designee shall audit all grievances 5 days a week X 1 week, then 2 times a week X 2 weeks then monthly X 2 months. Audit results will be discussed in QAPI.	

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F 585	Continued From page 42 started 4/23, and was not aware R40 had a missing wheelchair. LSW-A reviewed the grievance log book and acknowledge the reported missing wheelchair was not in the log from 2/23. During an interview on 6/8/23 at 9:17 a.m. the director of therapy (DOT)-L stated she had been made aware R40's missing wheelchair in an email from the nurse manager of R40's unit. DOT-L said OTR-K also updated her of the missing wheelchair identified after the evaluation on 2/24/23. DOT-L notified the nurse manager, therapy staff was not aware what happened to R40's personal wheelchair. During an interview on 6/8/23 at 1:04 p.m., with the administrator, the director of nursing (DON) and the assistant director of nursing (ADON), the ADON stated she remembered filling out R40's belonging worksheet on admission and R40 did have her own personal wheelchair. The administrator, DON and ADON all stated they were not aware that R40 had a missing wheelchair. The administrator and the DON both stated the expectation that staff, including therapy would fill out the grievance report and give it to the DON so the grievance could be investigated and remedied. Facility policy Grievance Process-Hilltop Healthcare dated 1/24/23, indicated grievance forms needed to be filled out and turned into the executive director, or designee, promptly so an investigation can begin right away.	F 585		
F 657 SS=E	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii)	F 657		7/24/23

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F 657	Continued From page 43 §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure care conferences were completed quarterly and or in a timely manner for 3 of 6 residents (R63, R51, R40). Findings include: R63's quarterly Minimum Data Set (MDS) assessment dated 5/23/23, indicated R63 was	F 657	F657: Care plan timing and revision. Immediate Corrective action: Residents affected by F657 were offered a care conference. Identification of other residents: All residents could be affected by Care plan timing and revision. An audit of all residents currently in house to identify missed care conferences was	

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F 657	Continued From page 44 cognitively intact and had no behaviors or rejection of cares. R63's admission record, indicated diagnoses which included depression, delusional disorder, alcohol dependence with persisting amnesic (the loss of memories) disorder, adult failure to thrive, mixed receptive expressive language disorder (a communication disorder in which both the receptive and expressive areas of communication may be affected in any degree, from mild to severe), and encephalopathy (a broad term for any brain disease that alters brain function). R63's care plan dated 8/5/20, indicated R63 was agitated about not going home, was delusional, and had a history of making false accusations. In addition, R63's care plan included long term placement with potential for discharge to a group home, assisted living facility, or adult foster care. During an initial interview on 06/05/23 at 2:02 p.m., R63 stated she was not being offered care conferences. A care conference summary dated 6/1/23, indicated R63 was invited to her care conference and attended. A care conference summary dated 3/8/23, indicated R63 was not in attendance at her care conference but her guardian attended. A care conference summary dated 10/24/22, indicated R63 was not in attendance at her care conference but family was. An interdisciplinary progress note dated 8/25/22, indicated the interdisciplinary team "met and	F 657	completed. Corrective Action: IDT team has been educated on Care plan/ Reviews/conferences policy. RN/LPN's have been educated on the Care plan/ Reviews/conferences policy. Monitoring/Audits: DON/Designee shall audit care conferences 5 residents 5 days a week X 1 week, then 2 times a week X 2 weeks then monthly X 2 months. Audit results will be discussed in QAPI.	

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F 657	Continued From page 45 discussed" R63's care, it was not clear if R63 or her guardian attended. A care conference dated 1/20/22, indicated R63 was not in attendance at her care conference but her guardian attended. During an interview on 6/9/23 at 11:15 a.m., social worker (SW)-A verified R63 was not being scheduled care conferences quarterly and care conferences should be scheduled quarterly and as needed even if the resident declined to attend. During an interview on 6/9/23 at 1:11 p.m., licensed practical nurse (LPN)-A verified R63 had not been having care conferences quarterly. LPN-A stated R63 and her guardian were having care conferences scheduled separately but they still should have been completed at least quarterly. During an interview on 6/9/23 at 2:16 p.m., the director of nursing (DON) verified care conferences should be done at least every three months and as needed. The DON verified R63 did not have a care conference every three months. The DON stated it was beneficial to involve the resident and their family in their plan of care.	F 657		
	51 R51's quarterly Minimum Data Set (MDS) assessment dated 4/20/23 indicated R51 was cognitively intact. R51 diagnoses included anemia heart failure, orthostatic hypotension, end stage			

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F 657	Continued From page 46 renal disease, viral hepatitis, respiratory failure, diabetes, and HIV. When interviewed 6/07/23 at 1:40 p.m., R51 stated she has not been invited to attend any kind of meeting about her care at the facility. R51's documented care conferences: 5/11/23 R51 did not attend 2/2/23: R51 did not attend; nurse and social worker attended. 9/14/22: R51 did not attend; nurse only attended. 2/17/22: R51 not present; nurse and social services attended. When interviewed on 6/9/23 at 2:05 p.m., licensed practical nurse (LPN)-D stated care conferences are done quarterly and as needed. The social worker (SW) oversees inviting everyone and sends out invites. When interviewed on 6/9/23 at 2:17 p.m., the SW stated the Minimum Data Set (MDS) coordinator puts out a schedule of when care conferences should be done in conjunction with quarterly and significant change MDS assessments. SW stated she will also schedule if a resident or family requests a conference. SW schedules in outlook and invite appropriate staff. Residents get a written invite and family are invited by phone and/or email. Typically, conferences are scheduled a week in advance. Most residents are going to the conferences. R40 R40's significant change Minimum Data Set (MDS) assessment dated 5/14/23, indicated R40	F 657		

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F 657	Continued From page 47 had moderated cognitive impairment. Diagnoses included cancer, depression, dementia and schizophrenia. R40's care plan dated 2/24/23, indicated R40 had cognitive impairment and behaviors. R40's Census report undated, indicated R40 was out of the facility due to hospitalization from 4/18/23 to 4/20/23. Review of R40's progress notes and care conference notes since 2/23/23, indicated on 2/23/23, a care conference occurred on that date. During an interview on 6/5/23 at 3: 48 p.m. family member (FM)-J stated care conferences were not being done at the facility that she was aware of. During an interview on 6/7/23 at 1:22 p.m. licensed social worker (LSW)-A stated care conferences were done within twenty one (21) days after admission and every ninety (90) days after that. She stated if a resident went to the hospital and readmitted, then the care conference cycle started over with the first care conference 21 days after readmission. The care conference notes would be documented in the care conference form and also in the progress notes. LSW-A stated she could not remember if they did a care conference after R40 returned from the hospital on 4/20/23. She LSW-A reviewed R40's care conference notes and progress notes and acknowledged there was no documentation that indicated a care conference occurred for R40. She stated she must have forgot to do one after R40 returned from the hospital. LSW-A stated it was important to do care conferences as scheduled so staff could find out what the	F 657		

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F 657	Continued From page 48 resident was wanting in their care and make the care resident specific. During an interview with the administrator and the director of nursing (DON) on 6/8/23 at 1:04 p.m. they both acknowledged an expectation that all resident care plans would be done as required so the facility could include the resident and their family in the decision making process while in the facility. The facility policy Care Plan - Reviews/Conferences dated 6/8/22, directed care conferences would be conducted at least quarterly and as needed. The policy indicated the care conferences provided an in-depth review of the resident's plan of care and provided an opportunity for the resident and the family to discuss care and offer input. Care Plans would be changed after care conferences so they could include the resident and family wishes.	F 657		
F 659 SS=D	Qualified Persons CFR(s): 483.21(b)(3)(ii) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (ii) Be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure qualified persons completed the minimum data set (MDS) for 2 of 2 residents (R51, R85) reviewed for MDS completion.	F 659	F659: Qualified Persons Immediate Corrective action: Residents affected by F659 MDS were re-submitted and assessed for accuracy.	7/24/23

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F 659	Continued From page 49 Findings include: R51's quarterly minimum data set (MDS) assessment dated 4/20/23 indicated R51 was cognitively intact. R51 diagnoses included: anemia heart failure, orthostatic hypotension, end stage renal disease, viral hepatitis, respiratory failure, and diabetes. A facility personnel file document from The Minnesota Department of Nursing showed that RN-J had been issued a temporary permit to practice as an RN in the state of Minnesota. The permit was issued on 7/13/22 and expired on 9/11/22. R51's significant change MDS dated 11/4/22, was signed by RN-J, who did not have a current Minnesota nursing license at the time the MDS was completed. R85's quarterly minimum data set (MDS) dated 2/22/23 indicated R85 was moderately cognitively intact and had diagnoses of left femur fracture, muscle weakness, and cerebral infarction. R85's quarterly MDS was signed by RN-J, who did not have a valid Minnesota nursing license at the time the MDS was completed. During an interview on 6/09/23 at 2:42 p.m., the administrator confirmed registered nurse (RN)-J did not have a valid Minnesota nursing license at the time of MDS completion for R85 on 2/22/23. The administrator stated the facility was not aware RN-J did not have a valid nursing license. During an interview on 06/09/23 at 2:52 p.m., the	F 659	Identification of other residents: All residents could be affected by Qualified persons. An audit of all residents back to expiration date of temporary RN were audited and submitted for correction. Corrective Action: IDT team has been educated on Qualified Persons. Monitoring/Audits: DON/Designee shall audit MDS submissions 5 days a week X 1 week, then 2 times a week X 2 weeks then monthly X 2 months. Audit results will be discussed in QAPI.	

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F 659	Continued From page 50 director of nursing (DON) confirmed registered nurse (RN)-J signed the completion of the MDS for R85 on 2/22/23 but did not have a valid Minnesota nursing license at the time. The DON stated she was not aware RN-J did not have a valid nursing license. The MDS is part of the federally mandated resident assessment instrument (RAI) process for clinical assessment of all residents in Medicare and Medicaid certified nursing homes. The RAI process has multiple regulatory requirements, the federal regulations indicated at 42 CFR 483.35(e) ... must provide an RN to conduct or coordinate the assessment and sign off the assessment as complete.	F 659		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to offer oral cares for 1 of 3 residents (R44) reviewed for personal cares. Findings include: R44's Admission Record, indicated diagnoses which included, multiple sclerosis (a disease in which the immune system eats away at the protective covering of nerves resulting in a disruption of communication between the brain and the body), dementia, anxiety, depression, and epilepsy.	F 677	F677: ADL care provided for dependent residents. Immediate Corrective action: Residents affected by F677 were assessed. Identification of other residents: All residents could be affected by ADL care provided for dependent residents. Corrective Action: IDT team has been educated on ADL care provided for dependent residents.	7/24/23

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F 677	Continued From page 51 R44's quarterly Minimum Data Set (MDS) assessment dated 6/1/23, indicated R44 was severely cognitively impaired, and required extensive assistance with activities of daily living. R44's care plan dated 5/21/19, identified a deficit with activities of daily living related to her multiple sclerosis, depression, anxiety, and epilepsy. Staff were directed to brush dentures and apply paste, as allows. During an observation on 6/7/23 at 7:49 a.m., nursing assistants (NA)-B and NA-D entered R44's room after performing hand hygiene, putting on gloves and isolation gowns to get R44 ready for the day. NA-B filled a wash basin with warm water. Both NA's talked with R44 telling her what they would be doing. A new shirt and clean brief were placed. R44 was positioned on her back and a pillow was placed on her left side. NA-B cleaned up supplies and put them away. NA-D gathered linens and garbage to remove from the room. NA-B placed R44's call light in her reach. Both removed their gloves, removed their isolation gowns, and washed their hands. Neither offered to comb R44's hair or perform oral cares. -at 9:08 a.m., NA-B brought R44 her breakfast tray, placed a cover up on R44's chest, performed hand hygiene and assisted her with eating. -at 9:26 a.m., NA-B finished assisting R44 with eating. R44's bed was placed in the low position, she remained on her back, no offer for oral care was made. -at 10:50 a.m., NA-B confirmed he did not offer	F 677	Nursing staff have been educated on ADL. Monitoring/Audits: DON/Designee shall audit 5 residents ADL's 5 days a week X 1 week, then 2 times a week X 2 weeks then monthly X 2 months. Audit results will be discussed in QAPI.	

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F 677	Continued From page 52 any oral care. NA-B stated R44 would not wear her dentures but her mouth should have been "swabbed". -at 10:54 a.m., licensed practical nurse (LPN)-A verified oral care should have been performed after meals. On 6/9/23 at 12:30 p.m., NA-C stated oral care should be completed after each meal and in the morning. NA-C stated R44 needed to have swabs used for oral care. On 6/9/23 at 2:14 p.m., the director of nursing (DON) verified oral care should be completed morning and evening, staff should complete oral care for residents who are unable to do this on their own. The facility policy Activities of Daily Living dated 6/8/22, directed staff to assist residents with their activities of daily living who were unable to complete on their own. The policy identified oral care as an activity of daily living.	F 677		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by:	F 684		7/24/23

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F 684	Continued From page 53 Based on observation, interview, and document review the facility failed to have a process to verify and follow up on needed equipment and appointment and for monitoring and treating constipation for 2 of 2 residents (R104, R26) reviewed. Findings include: R104's quarterly Minimum Data Set (MDS) assessment dated 4/27/23 indicated R104 was cognitively intact. Diagnoses included: obstructive pulmonary disease, primary hypertension, anemia stable, chronic kidney disease, artificial heart valve, congestive heart failure, atrial fibrillation, type 2 diabetes, and obstructive sleep apnea. During an interview on 6/8/23 at 3:21 p.m., R104 stated he had a sleep study two or three months ago and was told he needed to have a c-pap [continuous positive pressure] machine but so far didn't have it, and nobody had talked to him about it. R104 stated he also needed a colonoscopy, but it hadn't been done. R104 pointed to papers with a scheduled colonoscopy on 6/6/23 at 7:30 a.m. R104 stated nobody had said anything to him about his colonoscopy either and now it was two days past his appointment. R104's documents dated 3/9/23 gave instructions for pre-colonoscopy diet and prep. R104's after visit summary dated 4/17/23 sleep study for R104 to wear c-pap every night and call for follow-up after using the c-pap for 31-90 days. The visit summary also listed a Colonoscopy appointment scheduled for 6/6/23. When interviewed on 6/9/23 at 1:58 p.m.,	F 684	F684: Quality of Care Immediate Corrective action: Resident affected by F684 appointments were re-scheduled. Resident affected by F684 equipment was received. Resident affected by F684 bowel regimen was followed up on. Identification of other residents: All residents could be affected by Quality of Care. Corrective Action: IDT has been educated on appointment protocol. Nursing staff have been educated on the appointment protocol. IDT has been educated on the standing orders regarding bowel/constipation. Nursing staff have been educated on standing orders regarding bowel/constipation. Monitoring/Audits: DON/Designee shall audit 5 residents appointments 5 days a week X 1 week, then 2 times a week X 2 weeks then monthly X 2 months. DON/Designee shall audit 5 residents bowel 5 days a week X 1 week, then 2 times a week X 2 weeks then monthly X 2 months. Audit results will be discussed in QAPI.	

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F 684	Continued From page 54 licensed practical nurse (LPN)-D stated she became aware of R104 missed appointment when after received a text on 6/3/23 at 8:59 a.m., indicating the medication and diet orders had not been processed for R104's colonoscopy. This resulted in canceling the colonoscopy and transportation. LPN-D indicated the process is to check the orders to be processed every day. When interviewed on 6/9/23 at 3:37 p.m., LPN-D stated she recalled there was a problem with getting R104's c-pap related to insurance but was not sure where it was in the process now. When interviewed on 6/9/23 at 3:47 p.m., the director of nursing (DON) stated getting a c-pap for a resident was a quick process. The DON reviewed e-mails and stated it looked like there was an issue with getting R104's c-pap related to medical supply company having a problem with 104's insurance. The DON stated the facility was responsible for acquiring medical equipment, and back in April there should have been follow-up done until R104 received his c-pap. During an interview on 6/12/23 at 1:07p.m., provider stated R104's colonoscopy had been on the books since April, so it was unacceptable for R104 to miss the diagnostic appointment because orders were not processed. The provider stated he had not been consulted on 6/3/23 when it became known R104 had not started the diet prep for the colonoscopy. R104 needed the colonoscopy because he had anemia indicating blood loss and had blood in his stool. The colonoscopy does need to be rescheduled, but not emergently. R104's anemia is stable right now so he likely has been having slow bleeding, and if that were to change, R104 would be sent to	F 684		

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F 684	Continued From page 55 the emergency room. During a phone interview on 6/14/23 at 9:13 a.m., sleep study registered nurse (RN)-D stated during the study R104 had 12 to 13 breathing events per hour which meant R104 had mild to moderate apnea. RN-D explained during an event the brain and organs like the heart don't get enough oxygen so it is recommended anyone with more than 5 events should be prescribed a c-pap. In addition, a c-pap can help to prevent significant problems in the future like myocardial infarct (heart attack), stroke, heart arrythmias, high blood pressure and heart failure. Most people feel better once they get used to sleeping with a c-pap. RN-D confirmed R104 should have had his c-pap by now because it was sent a medical supply company back in April for mask fitting. R26 R26's quarterly Minimum Data Set (MDS) assessment, dated 4/30/23, indicated moderately impaired cognition and diagnoses of diabetes mellitus, dementia, and constipation. Furthermore, R26 needed extensive assistance for transfer, toilet use, and personal hygiene. R26's care plan, dated 1/8/21, indicated bowel and bladder deficits related to medical and physical status, medications and diagnoses that can affect bowel status. R26's goal was to have a bowel movement every one to three days through next review date. Interventions included medications as ordered, monitor bowel movements, document results, and follow bowel protocol. During an interview on 6/05/23 at 7:20 p.m., R26	F 684		

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F 684	Continued From page 56 stated she had lots of trouble with constipation but wasn't sure what they did about it. R26's provider orders, indicated: -Docusate sodium capsule 100 mg by mouth daily as needed (PRN) for constipation -Senna S Tablet 8.6-50 mg by mouth daily at bedtime for constipation R26's bowel tracking record indicated no bowel movements were recorded from 5/18/23 to 5/22/23 and from 5/24/23 to 5/28/23. R26's progress notes and medication administration record (MAR) lacked evidence of a nursing assessment or PRN medication administration for constipation from 5/18/23 to 5/28/23. During an interview on 6/09/23 at 10:37 a.m., trained medication aid (TMA)-C stated she believed R26 would show up on a report in the electronic health record if there were residents who had not had a bowel movement charted in 72 hours. TMA-C further stated she would check if charting was accurate and then work through the resident's orders to see what they can have for constipation. During an interview on 6/09/23 at 10:39 a.m., licensed practical nurse (LPN)-D stated she would first see if charting was completed. LPN-D stated she would assess the resident for signs and symptoms of constipation before looking at giving PRN medication. LPN-D would expect a nurse to talk with the resident about signs and symptoms of constipation and chart it.	F 684		

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F 684	Continued From page 57 During an interview on 6/12/23 at 10:52 a.m., the director of nursing (DON) stated she would expect nursing staff to follow up with a resident who had an alert in the electronic health record for no bowel movement and follow standing orders from there. A facility policy, titled Bowel and Bladder Management and dated 6/8/22, indicated a process for assessing, intervening, and managing bowel and bladder incontinence. It did not address constipation protocols.	F 684		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide timely repositioning to reduce/prevent the risk of worsening pressure ulcers for 1 of 5 residents (R22) reviewed for pressure ulcers. Findings include:	F 686	F686: Treatment/Services to prevent/heal pressure ulcer. Immediate Corrective action: Resident affected by F686 was assessed for any skin breakdown. Identification of other residents:	7/24/23

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	245366	A. BUILDING _____ B. WING _____	C 06/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLTOP HEALTHCARE REHABILITATION AND SKILLED NURS	2501 RICE LAKE ROAD DULUTH, MN 55811

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 58 R22's Admission Record, indicated diagnoses of dementia, anxiety, blindness of one eye, low vision of other eye, muscle weakness, and age-related physical debility. R22's significant change MDS dated 4/27/23, indicated R22 was significantly cognitively impaired, had highly impaired vision, required limited assistance with transfers and with toilet use. In addition, R22's MDS indicated she was always incontinent of bowel and bladder and was at risk for pressure ulcer. R22's care plan dated 1/3/23, indicated R22 was at risk for complications related to current/medical status. Interventions included incontinence care with incontinent brief changes and reposition every two hours in bed and chair and as needed. R22's care plan also indicated she was at risk for complications related to current medical/physical status. Interventions included to toilet upon rising, between meals, at bedtime, and as needed. R22's Active Order, directed staff to rotate resident every two hours to relieve pressure from left buttock. On 6/8/23 at 8:45 a.m., a continuous observation was started, R22 was seated in her wheelchair in the small dining room of the nurses station. R22 stated she was waiting for breakfast. On 6/8/23 at 9:05 a.m., trained medication aide (TMA)- B greeted her stated she had her medications, sat down next to her and gave them to R22. R22 was asked if she wanted to go the main dining room, she replied, "not really" and remained seated in the small dining room	F 686	All residents could be affected by Treatment/services to prevent/heal pressure ulcer. Corrective Action: IDT has been educated on ADL policy. Nursing staff have been educated on the ADL policy. Monitoring/Audits: DON/Designee shall audit ADL/repositioning on 5 residents 5 days a week X 1 week, then 2 times a week X 2 weeks then monthly X 2 months. Audit results will be discussed in QAPI.	

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F 686	Continued From page 59 watching the television. On 6/8/23 at 9:15 a.m., R22 was served her breakfast. On 6/8/23 at 9:37 a.m., activities aide (AA)-A stopped to tell her about the activities, stated he would come back and take her to the exercise activity. On 6/8/23 at 10:13 a.m., TMA-B brought R22 from the dining area directly to the exercise activity. On 6/8/23 at 10:45 a.m., AA-A brought R22 back to the nurses station and asked if she needed to wear her oxygen. No offer was made to bring R22 to the bathroom. On 6/8/23 at 10:48 a.m., AA-A brought R22 outside to the courtyard. R22 was wearing a ball cap, sunglasses, and a light jacket. On 6/8/23 at 11:01 a.m., AA-A brought her back inside and placed R22 at a table in the large dining room. At 11:08 a.m., Surveyor intervened and updated nursing assistant (NA)-D R22 may need to go to the bathroom, NA-D verified R22's brief was wet. R22 voided a small amount and had a small bowel movement. When NA-D asked R22 if she wanted to sit on the toilet longer, she declined and said it hurt too much to sit on the toilet. No redness or open areas were noted. During an interview on 6/8/23 at 11:03 a.m., NA-D verified R22 had last been toileted at 8:30 a.m. when she got her up for the day and should have	F 686		

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F 686	Continued From page 60 been offered repositioning and check and change every two hours. During an interview on 6/9/23 at 12:45 p.m., trained medication aide (TMA)-B stated dependent residents should be checked and changed and repositioned every two hours. During an interview on 6/9/23 at 2:14 p.m., the director of nursing (DON) stated dependent residents should be checked and changed and repositioned every two hours to prevent skin breakdown. In addition the DON stated staff should follow the resident's care plan. The facility policy Bowel and Bladder Management dated 6/8/22, indicated residents with bowel and bladder incontinence would receive appropriate treatment and services to achieve or maintain as much normal elimination function as possible. A policy on repositioning was requested but not provided.	F 686		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed reassess and to provide a safe smoking experience to continue for 1of 1	F 689	F689: Free of accident hazards/supervision/devices Immediate Corrective action:	7/24/23

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F 689	Continued From page 61 resident (R16) reviewed for smoking. Findings include: R16's quarterly Minimum Data Set (MDS) assessment, dated 5/25/23, indicated R16 was cognitively intact and had diagnoses of bipolar 2 disorder, paranoid schizophrenia, muscle weakness, nicotine dependence, mild cognitive impairment, and degeneration of the nervous system due to alcohol. R16 required limited assistance with bed mobility, transfers, and extensive assist with dressing, hygiene, and toilet use. R16's provider orders indicated R16 had smoking privileges. Staff were to hold cigarettes at the nurse's station and distribute, along with a lighter, when R16 asked. Furthermore, R16 was to turn lighter in when finished smoking. R16's care plan indicated a problem statement for non-compliance with smoking stipulations for refusing to allow staff to lock up smoking supplies. Interventions included educating and reminding R16 of potential negative outcomes related to his choices. Furthermore, nursing staff were to store the large bag of tobacco and distribute it as needed for R16 to roll cigarettes. R16 may have cigarettes on his person and nursing staff would encourage him to wear a smoking apron. R16's progress notes indicated an incident on 5/20/23 where R16 was witnessed falling asleep while smoking. R16's smoking assessment dated 5/23/23 indicated resident may smoke independently or	F 689	Resident affected by F689 was reassessed for smoking. Identification of other residents: All residents who smoke were reassessed and educated on the policy of smoking. Corrective Action: IDT has been educated on the smoking policy. All staff have been educated on the smoking policy. Monitoring/Audits: DON/Designee shall audit 5 residents 5 days a week X 1 week, then 2 times a week X 2 weeks then monthly X 2 months. Audit results will be discussed in QAPI.	

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F 689	Continued From page 62 with set up and may smoke unsupervised in designated smoking areas. Resident must request smoking materials from staff per policy. The following observations of R16 smoking and smoking paraphernalia were made: 6/06/23 3:15 p.m., in R16's room: loose tobacco and rolling papers covered bedside table, R16 not in room 6/06/23 3:24 p.m., smoking in outdoor courtyard area without a smoking apron 6/07/23 10:27 a.m., smoking in outdoor courtyard area without a smoking apron 6/07/23 2:18 p.m., outside courtyard smoking area, smoking without an apron 6/08/23 8:38 a.m. loose tobacco, rolling device, rolled cigarettes, and rolling papers covered bedside table. R16 was laying on the bed sleeping During an interview on 6/07/23 at 2:26 p.m., licensed practical nurse (LPN)-A confirmed she performed the most recent smoking evaluation, dated 5/23/23, for R16 because it was due for a quarterly assessment. LPN-A stated smoking evaluations are done quarterly and when there is a concern. As part of the assessment LPN-A watches the resident light, smoke, ash and extinguish the cigarette. Reviewing progress notes was not something LPN-A did for this assessment. When asked about a note dated 5/20/23 where it was charted R16 was witnessed sleeping while smoking. LPN-A stated R16 was known to fall asleep in his wheelchair but did not fall asleep while LPN-A was observing R16 for the assessment. LPN-A confirmed the outcome of the 5/23/23 assessment was that R16 was safe to smoke unsupervised and without a smoking	F 689		

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F 689	Continued From page 63 apron. During an observation and interview on 6/09/23 at 1 p.m., R16 was noted to be wearing a button-up flannel shirt with an approximately dime-size hole with charred-looking edges on the lower right front portion of the shirt. R16 does not know how or when these holes got there. During an interview on 6/09/23 at 1:45 p.m., LPN-A stated she did not know when the hole may have occurred in R16 flannel shirt or it may be an old shirt. LPN-A stated she would do another smoking assessment on R16 but added he will find a way to smoke whether or not they say it is and R16 will go off the property to smoke. During an interview on 6/09/23 at 2:13 p.m., nursing assistant (NA)-B stated most of R16's clothes had holes in them, "he is a smoker". NA-B could not say he had seen R16 falling asleep while smoking. During an interview on 6/12/23 at 10:52 a.m., the director of nursing (DON) stated they have tried to get R16 to wear a smoking apron, but he won't do it. When they have removed smoking privileges in the past, R16 went off the property to smoke. They have offered education and help with smoking cessation, but R16 declines. The DON felt R16 was as safe as he was going to be. An undated facility policy titled Smoking Policy, identified the purpose of the policy was to provide a safe smoking program that respects the rights and dignity of all residents. Residents who smoke will be assessed by nursing staff for safety with smoking at time of admission, quarterly, and with a change in condition. The assessment will	F 689		

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F 689	Continued From page 64 include physical, cognitive, mood, and behavior that may affect their ability to smoke without supervision. Based off individual assessments smoking materials will be stored either on person and/or in a secured area. I understand that failure to follow policy could result in temporary revocation from smoking privileges. The facility reserves the right to assist in finding alternate placement if persistent violation of smoking practices	F 689		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure tubing for oxygen therapy was changed weekly for 2 of 3 residents (R22, R36) and failed to ensure proper cleaning was performed on a positive airway pressure (BiPAP) machine for 1 of 1 resident (R35) reviewed for respiratory care. Finding include: R22's Admission Record, indicated diagnoses which included dementia, anxiety, muscle weakness, and age-related physical debility.	F 695	F695: Respiratory/Tracheostomy Care and Suctioning. Immediate Corrective action: Resident affected by F695 were immediately assessed for any adverse effects. A new Ambu-bag was placed at bedside for resident with tracheostomy. Identification of other residents: Audit completed of all residents identifying the use of C-Pap, Bi-pap, O2, or Tracheostomy completed.	7/24/23

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F 695	Continued From page 65 R22's significant change Minimum Data Set (MDS) assessment dated 4/27/23, indicated R22 was significantly cognitively impaired. R22's care plan dated 1/3/23, indicated R22 was at risk for complications with heart/circulation. Interventions included following orders for medications, laboratory, and treatments. In addition, staff were directed to observe for signs and symptoms of adverse side effects and complications related to treatments (oxygen use was not specifically addressed). R22's Active Order, directed staff to use oxygen one to four liters per nasal cannula to keep oxygen saturations greater than 90%. During an observation on 6/5/23 at 2:41 p.m., R22 was wearing oxygen via nasal cannula at two liters. R22's oxygen tubing was dated 5/8/23. During an observation on 6/6/23 at 3:19 p.m., R22 was lying in bed wearing oxygen, the tubing was dated 5/8/23. During an observation on 6/8/23 at 10:44 a.m., activity aide (AA)-A asked R22 about her oxygen, the tank and cannula were on the back of her chair. R22 said, "oh I forgot I don't have that on". AA-A brought R22 to the nurses station and staff checked on oxygen saturation, oxygen was not put on R22. R36's Admission Record, indicated diagnoses which included chronic obstructive pulmonary disease (a group of lung diseases that block airflow and make it difficult to breathe), arteriosclerotic heart disease of native coronary artery without angina pectoris (narrowing of the	F 695	Corrective Action: Changes to the Oxygen Administration policy. IDT has been educated on the Oxygen Administration policy. Nursing staff have been educated on the Oxygen Administration policy. IDT has been educated on the Cleaning of Bi-pap and C-pap policy. Nursing staff have been educated on the Cleaning of Bi-pap and C-pap policy. Monitoring/Audits: DON/Designee shall audit 5 residents utilizing O2 5 days a week X 1 week, then 2 times a week X 2 weeks then monthly X 2 months. DON/Designee shall audit 5 residents utilizing C-pap/Bi-pap for cleaning 5 days a week X 1 week, then 2 times a week X 2 weeks then monthly X 2 months. DON/Designees shall audit residents with tracheostomy to ensure adequate supplies are at bedside 5 days a week X 1 week, then 2 times a week X 2 weeks then monthly X 2 months. Audit results will be discussed in QAPI.	

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F 695	Continued From page 66 arteries close to the heart). R36's quarterly MDS dated 4/6/23, indicated R36 was cognitively intact and had a tracheostomy (an opening surgically created through the windpipe to allow air to fill the lungs). R36's care plan dated 8/20/20, indicated R36 had a tracheostomy, staff were directed to observe for signs and symptoms of shortness of breath. R36's care plan indicated he was independent with tracheostomy cares. R36's Order Summary report, directed staff to educate and document on independent tracheostomy care and tracheostomy care every shift. During an observation on 6/7/23 at 2:04 p.m., licensed practical nurse (LPN)-A verified R26's humidifier tubing was dated 4/10/23, and the ambu bag(a manual resuscitator/self-inflating bag used when a person is not breathing adequately) had an expiration date of 4/1/22. LPN-A verified the humidifier tubing had not been changed in almost two months and the ambu bag needed to be replaced as it was past the manufacturer's expiration date. During an interview on 6/9/23 at 2:37 p.m., the director of nursing (DON) verified oxygen tubing should be changed weekly as well as humidifier tubing to prevent infection. The policy Oxygen Administration dated 6/8/22, directed staff to change oxygen tubing weekly and as needed. In addition, if humidity was used it was to be changed every seven days or as needed. Tubing was to be labeled with date and	F 695		

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F 695	Continued From page 67 initials. R35 R35's significant change Minimum Data Set (MDS) assessment dated 5/24/23, indicated R35 was cognitively intact and had diagnoses of malignant neoplasm of unspecified part of left bronchus or lung, chronic obstructive pulmonary disease (COPD) with acute exacerbation, and obstructive sleep apnea. R35's care plan, dated 4/6/23, indicated a problem statement for respiratory needs which included symptoms of shortness of breath at all times, requiring oxygen, nebulizer treatments, and a bilevel positive airway pressure (BIPAP) device at night. Interventions did not include instructions on the care and cleaning of respiratory equipment. R35's medication administration record (MAR) indicated: -BIPAP (ResMed AirCurve 10 VAUTO) on at night every evening and night shift -Change nebulizer and oxygen tubing every Thursday night shift starting 6/8/23 During an interview on 6/05/23 at 1:33 p.m., R35 stated he put water in the humidifier tank of his rented BIPAP machine each night. The BIPAP machine was rented from Northwest Respiratory Services (NWRS) when he admitted to the facility. R35 stated his oxygen tubing had been changed once and the BIPAP machine had been cleaned "a couple of times" since he had admitted here two months ago. During an observation and interview on 6/08/23 at 8:44 a.m., R35 was sitting at bedside with watery	F 695		

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F 695	Continued From page 68 eyes and runny nose. R35 stated an unidentified nursing assistant (NA) cleaned his BIPAP machine last night and he thought he was having an allergic reaction to the soap used. Furthermore, R35 stated he put the mask on and slept for about three hours before waking up sneezing and feeling congested. R35 stated an unidentified nurse had given him something for his allergies and then re-cleaned the BIPAP machine with vinegar. During an interview on 6/08/23 at 8:50 a.m., unidentified nurse stated the CPAPs/BIPAPs were cleaned with vinegar once a week on the night shift. During an interview on 6/08/23 at 8:53 a.m., licensed practical nurse (LPN)-E stated the normal process to clean BIPAP or continuous positive airway pressure (CPAP) equipment is with diluted vinegar weekly and as needed. LPN-E was not sure how often oxygen tubing was changed and could not verify with the medical record as it did not say how often to change tubing. During an interview on 6/08/23 at 9:11 a.m., the director of nursing (DON) stated a CPAP/BIPAP mask would be cleaned with soap and water and let air dry. The machine's filters are changed by Northwest Respiratory Services (NWRS). The DON further stated she wasn't sure what the process was for cleaning the humidification tank. During an interview on 6/08/23 at 12:43 p.m., R35 stated he was feeling a little better, but still sneezing and having watery eyes. R35 also stated he didn't feel any more short of breath than normal and was able to walk to therapy.	F 695		

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HILLTOP HEALTHCARE REHABILITATION AND SKILLED NURS	2501 RICE LAKE ROAD DULUTH, MN 55811

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F 695	Continued From page 69 During an interview on 6/08/23 at 1:23 p.m., respiratory therapist (RT)-A with NWRS reviewed the cleaning instructions given to the facility with the set-up of a CPAP or BIPAP. RT-A normally recommended a mild soap and water for washing the humidification tank, and to do it in the morning so it had time to dry before it was used by the resident again. RT-A suggested if the equipment was not rinsed well prior to use the soap could have reached R35 and caused a reaction. During an interview on 6/12/23 at 9:28 a.m., R35 stated he started feeling better about 24 hours after his BIPAP was cleaned. During an interview on 6/12/23 at 10:55 a.m., the DON confirmed NAs did get training on cleaning CPAP/BIPAP equipment. The task for cleaning was assigned to a licensed nurse but the nurses could delegate it. A facility policy, titled "Cleaning and Maintenance of BIPAP and CPAP equipment" and dated 6/8/22, indicated a CPAP or BIPAP machine would be wiped down with a damp disposable cloth one time per week. Replace non-disposable filters every 3 months. Humidifier tank clean with soap and water weekly on day shift. Air dry after cleaning. A facility policy, titled Oxygen Administration and dated 6/8/22, indicated staff would change oxygen tubing weekly and as needed. The ResMed AirCurve 10 VAUTO owner's manual gives instruction to clean the humidifier tank weekly with warm water and a mild detergent. Rinse humidifier and tubing thoroughly	F 695		

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F 695	Continued From page 70 and allow to dry out of direct sunlight and/or heat.	F 695		
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure post-dialysis access site monitoring was consistently completed and documented to provide continuity of care and reduce the risk of complication (i.e., bleeding, clotting) for 1 of 1 resident (R36) reviewed for dialysis care and services. Findings include: R36's Admission Record, included diagnoses which included end stage renal disease (the final permanent stage of chronic kidney disease, where kidney function has declined to the point that the kidneys can no longer function on their own). R36's quarterly Minimum Data Set (MDS) assessment dated 4/6/23, indicated R36 was cognitively intact and had no rejections of care. In addition, R36's MDS indicated he was receiving dialysis. R36's care plan dated 8/20/20, indicated R36 had a left arm fistula (a special connection that is made by joining a vein onto an artery that can be	F 698	F698: Dialysis Immediate Corrective action: Resident identified by F698 were immediately assessed for and adverse effects. Identification of other residents: No other residents currently residing with a fistula. Corrective Action: Orders added to the TAR to complete patency assessments. Nursing have been educated on how to assess for patency. IDT has been educated on the Dialysis Policy. Team Leads (nursing) staff have been educated on the Dialysis Policy. Monitoring/Audits: DON/Designee shall audit 5 residents utilizing O2 5 days a week X 1 week, then 2 times a week X 2 weeks then monthly X 2 months. Audit results will be discussed in QAPI.	7/24/23

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F 698	Continued From page 71 used for Hemodialysis). Interventions included, wound care as ordered, access site checks daily (auscultate bruit [listening with a stethoscope for a "whooshing" sound], palpate pulse [feeling for a vibration], checking for color, warmth), and removing the Band-Aid the next day. Access site checks daily as resident allows, monitor shunt for signs/symptoms of infection. Dialysis to monitor for site patency. R36's Order Summary Report, directed staff to call or present to clinic for left arm swelling, pain, erythema, warmth or wound dehiscence, new drainage (clear or malodorous). Monitor shunt for signs/symptoms of infection. Dialysis to monitor for patency. No vital signs or blood draws to left arm related to dialysis fistula. Nursing care according to Nursing Management 10/2010, indicated a dialysis fistula site should be assessed for patency at least every eight hours. Palpate the vascular access to feel for a thrill or vibration that indicates arterial and venous blood flow and patency. auscultate the vascular access with a stethoscope to detect bruit or "swishing" sound that would indicate patency. Check the patient's circulation by palpating his pulses distal to the vascular access; observing capillary refill in his fingers; and assessing him for numbness, tingling, altered sensation, coldness, and pallor in the affected extremity. During an observation on 6/8/23 at 12:59 p.m., R36 walked down the hallway pushing a wheeled walker, he had a dressing on his left lower arm. On 6/8/23, at 1:33 p.m., licensed practical nurse (LPN)-A measured R36's blood pressure, heart rate, oxygen saturation and temperature. LPN-A	F 698		

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F 698	Continued From page 72 did not listen to for a bruit or palpate a thrill. During an interview on 6/8/23 at 1:47 p.m., LPN-A verified she did not check R36's dialysis access site when he returned. LPN-A stated she was not sure if it was being done by anyone and it was her understanding they were checking only for signs and symptoms of infection. LPN-A verified the care plan directed staff to check for bruit, thrill, color, and warmth. During an interview on 6/8/23 at 3:19 p.m., the assistant director of nursing (ADON) did not think staff were checking R36's dialysis access site. During an interview on 6/9/23 at 2:33 p.m., the director of nursing (DON) stated they were following orders provided by dialysis, she thought the orders were only to watch for signs and symptoms of infection and that dialysis would check for patency. The DON stated the purpose of checking for a bruit and thrill was to ensure patency and could possibly recognize if the site was clotted and rescue the access site. The dialysis policy dated 6/8/22, indicated the dialysis center's expectations of care to be completed by the facility included: Checking thrills/bruit of grafts and fistulas, documented on TAR When to remove dressing from the access site placed on from the dialysis center. Emergency protocol for uncontrolled bleeding from any dialysis site. No B/P or lab draws obtained from arm with dialysis site.	F 698		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records	F 755		7/24/23

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F 755	Continued From page 73 CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure physician orders were followed for 1 of 5 residents (R66), ensure the locked medication room remained	F 755	F755: Services/Pharmacy Services/Records Immediate Corrective action: Resident was given water pitcher	

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F 755	Continued From page 74 under direct supervision when unlicensed personnel were in the medication room, ensure an accurate reconciliation of controlled medications. This failure prohibited the prompt identification of loss or diversion of controlled medications and had the potential to affect all residents who received controlled medications. Findings include: R66's Admission Record, indicated R66 had diagnoses which included diabetes mellitus, chronic combined systolic and diastolic heart failure (a chronic condition in which the heart doesn't pump blood as well as it should), old myocardial infarction (heart attack), depression, and chronic kidney disease (the kidneys filter waste and excess fluid from the blood. As kidney's fail, waste builds up). R66's significant change Minimum Data Set (MDS) assessment dated 5/3/23, indicated R66 was cognitively intact, R66 received a diuretic, antidepressant, and anticoagulant medications on 7 of 7 days during the assessment period. R66's care plan dated 4/5/23, indicated R66 was at increased nutritional risk related to disease history of diabetes, heart disease, depression, chronic kidney disease, and heart failure. Interventions included to follow cardiac/diabetic no added salt two gram diet, staff to follow dietary profile for fluids with meals, nursing to offer and encourage fluids with medication pass. The care plan did not address the order to provide a pitcher of water. R66's Active Orders, indicated R66 was on a low sodium diet less than 2000 milligrams (mg) per	F 755	immediately. Clarification was to discontinue pitcher as resident is CHF patient. Medication room was locked. Refrigerator moved. New narcotic books were ordered. Identification of other residents: All residents could be affected by Services/Pharmacy Services/Records Corrective Action: IDT has been educated on Physician Orders Policy Team leads education on Physician Orders Policy Personal Refrigerator Policy was revised. IDT has been educated on Personal Refrigerator Policy All staff education on Personal Refrigerator Policy Residents with personal refrigerators educated on Policy. IDT has been educated on Narcotic Count Team leads education on Narcotic Count Monitoring/Audits: DON/Designee shall audit 5 Orders 5 days a week X 1 week, then 2 times a week X 2 weeks then monthly X 2 months. DON/Designee shall audit 5 resident personal refrigerator placement 5 days a week X 1 week, then 2 times a week X 2 weeks then monthly X 2 months. DON/Designee shall audit 5 narcotic books 5 days a week X 1 week, then 2 times a week X 2 weeks then monthly X 2 months.	

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F 755	Continued From page 75 day and staff were directed to provide a pitcher of water each day/every shift. The order was dated 4/12/23. During an interview on 6/5/23 at 1:34 p.m., R66 stated she was not provided with fresh water unless she asked for it and then would have "to wait a long time". During an observation on 6/6/23 at 3:33 p.m., R66 had no water in her room. During an observation and interview on 6/7/23 at 8:59 a.m., R66 had no water pitcher. R66 stated she "never" received a pitcher of water despite having brought it up at resident council. During an observation on 6/8/23 at 11:45 a.m., R66 had no water pitcher or water glass in her room. During an observation and interview on 6/9/23 at 12:17 p.m., R66 had no water pitcher in her room. During an interview on 6/9/23 at 10:57 a.m., nursing assistant (NA)-I stated resident were given fresh water with their breakfast tray. NA-I said she was not aware of any residents who were supposed to receive a pitcher of water daily. NA-I checked her worksheet and said there wasn't anything on it to indicate any residents who were supposed to receive a pitcher of water daily. NA-I said if a resident was supposed to receive a pitcher of water the nurses would tell her. During an interview on 6/9/23 at 12:32 p.m. NA-C stated there was not a specific time to pass fresh water to the residents, she stated she was not	F 755	Audit results will be discussed in QAPI.	

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F 755	Continued From page 76 aware of any special instructions for any residents to receive a pitcher of water daily. During an interview on 6/9/23 at 1:15 p.m., licensed practical nurse (LPN)-A stated residents should be provided with fresh water and should not have to ask. LPN-A verified there was an order to provide a pitcher of water daily for R66. During an interview on 6/9/23 at 2:20 p.m., the director of nursing (DON) stated she would expect staff to follow a provider order to provide a pitcher of water as ordered. During an interview on 6/9/23 at 3:46 p.m., the administrator stated if staff did not understand an order they should call the provider and seek clarification. During an observation on 6/7/23 at 1:15 p.m., the medication room door on Elm unit was open, nursing assistant (NA)-D was in the medication room getting food from a resident refrigerator that was being stored in the medication room. Registered nurse (RN)-A was at the medication cart with is back to the door. NA-D brought food out of the medication room, closed the door and asked RN-A to unlock the medical supply room door where the microwave was located, NA-D entered that room, RN-A remained at the medication cart outside the door. During an observation on 6/8/23, at 8:42 a.m. the medication room door on Elm was open, no staff were in the room, no staff were at the desk, one resident was at the nurse's station desk on the telephone. During an observation on 6/8/23 at 1:04 p.m.,	F 755		

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F 755	Continued From page 77 NA-I asked TMA-B to unlock the medication room door which she did and then walked back to her medication cart with her back toward the medication room. NA-I went into the medication room, walked back out leaving the door part-way open and called the kitchen, finished the phone call and went back into the medication room. On 6/8/23 at 1:06 p.m., NA-I came out of the medication room with a bag with bread in it. During an interview on 6/8/23 at 1:18 p.m., NA-I stated one of the resident's had her personal refrigerator in the medication room, so she had to get the nurse on the cart to open the medication room at each meal so she could get the resident's food. During an observation on 6/8/23 at 1:20 p.m., TMA-B unlocked the medication room and NA-I went into the medication room. TMA-B left the area and walked down the hallway with NA-I in the medication room. On 6/8/23, at 1:21 p.m., NA-I exited the medication room, leaving the door open and went into the medical supply room. No staff at the nurses station desk outside the medication room. On 6/8/23 at 1:22 p.m., the medication room door was closed by NA-I. During an interview on 6/9/23, at 12:49 p.m. TMA-B stated there was a resident's personal refrigerator in the medication room because the resident would not allow the refrigerator to be in her room because of "electrical waves". TMA-B verified the medication room should be monitored at all times and not left unattended by the nurse	F 755		

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F 755	Continued From page 78 or TMA. During an interview on 6/9/23 at 1:23 p.m., licensed practical nurse (LPN)-A stated the nurse or TMA had the key to the medication room. LPN-A verified the nurse or TMA should stay in the medication room while the NA was in the medication room. LPN-A stated this was important because of the medications stored in the room. During an interview on 6/9/23 at 2:30 p.m., the director of nursing (DON) stated nurses and TMAs had access to the locked medication room. The DON stated she would expect the nurse or TMA to stand by/in the room until the NA was done getting food from the refrigerator. The DON stated she would never expect to see the room unattended and open or a NA left alone in the room, this would be important to prevent any possible diversion of medications During an observation and interview on 6/12/23 at 2:57 p.m., licensed practical nurse (LPN)-B confirmed the index of the bound narcotic book for Elm unit medication cart was blank. LPN-B added the index should be completed for each medication entered into the book so that when reconciliation was done, the count was accurate. LPN-B confirmed the count was currently done by reading off the medication cards and not the index. During an observation and interview on 6/12/23 at 3:12 p.m., trained medication aid (TMA)-B confirmed the index of the bound narcotic book is	F 755		

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F 755	Continued From page 79	F 755		

incomplete. There are pages of medications that do not appear in the index.

During an interview on 6/12/23 at 3:20 p.m., registered nurse (RN)-A stated the correct process would be to log the medication into the index first, and then fill in corresponding page with medication details.

During an interview on 6/12/23 at 3:22 p.m., LPN-A stated the expectation for the narcotic logbook, was that the index be completed when controlled medications were received. LPN-A stated it is important to use the index to accurately track and count controlled medications.

During an interview on 6/12/23 at 3:54 p.m., the director of nursing (DON) confirmed nursing staff should use the index of the narcotic book for identifying and counting controlled medications. The off-going shift reads from the index, and the on-coming shift reads the cards to reconcile controlled medications.

The policy Physician's orders dated 6/8/22, indicated orders would be put into the treatment record and the care plan.

The policy Hydration dated 6/8/22, indicated fluids would be provided at the bedside unless contraindicated.

The policy Medication Re-ordering dated 6/8/22, indicated medications would be re-ordered by fax, point click care, or phone. The policy did not address stock supply medications.

A policy on medication administration was

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F 755	Continued From page 80 requested but not provided. A facility policy on medication disposition was requested but not received.	F 755		
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 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	F 758		7/26/23

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F 758	Continued From page 81 §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 as-needed (PRN) psychoactive medications were reordered with appropriate re-evaluation by the physician, and consistently attempt and/or document non-pharmacological interventions prior to the administration of PRN psychotropic medication for 1 of 5 residents (R10) reviewed for unnecessary medication use. Findings include: R10's significant change Minimum Data Set (MDS) assessment dated 5/19/23, indicated R10 was cognitively intact. Diagnoses included anxiety disorder, depression and psychotic disorder. Care Area Assessment indicated specialized care areas included ADL functional ability, falls and psychotropic drug use. R10's Medication review form dated 4/14/23, indicated R10 had a current order for lorazepam	F 758	F758: Free from unnecessary psychotropic meds/PRN use Immediate Corrective action: Resident order was addressed. Behavior charting inputted. Identification of other residents: All residents could be affected by Free from Unnecessary psychotropic meds/PRN use Residents with psychotropic medications were audited for orders/charting. Corrective Action: IDT has been educated on Unnecessary Drugs – Psychotropic Drugs Policy Team Leads education on Unnecessary Drugs – Psychotropic Drugs Policy Monitoring/Audits: DON/Designee shall audit 5 residents for unnecessary psychotropic 5 days a week	

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F 758	Continued From page 82 0.5 mg by mouth daily as needed for anxiety, started on 2/20/23. the medication review form also included guidance to include "clinical rationale and specification duration", if the as needed psychoactive medication was continued. The new order, signed on 5/8/23, stated "continue PRN lorazepam order for 6 months, as the benefits outweigh the risks". The documentation lacked any clinical rationale the lorazepam was needed to be continued. R10's Care plan dated 2/27/23, indicated R10 had anxiety with triggers that included noisy/over stimulating areas. Non pharmacological interventions included snack, remove stimuli, music, walk and aroma therapy. R10's Medication Administration Record (MAR), dated 2/1/23 to 5/30/23, identified R10 received lorazepam (a psychotropic medication used to reduce anxiety and/or seizure disorders) with directions reading, "Give [0.5 milligrams] by mouth every daily as needed [PRN] for generalized anxiety disorder ... -Start Date-2/20/2023 ... " The MAR(s) recorded the PRN lorazepam was administered on 4/12/23, 4/17/23, 4/29/23, and 5/19/23. R10's corresponding progress note(s), dated 2/1/23 to 4/6/23, identified the administered lorazepam doses. The documentation did not consistently describe R10's symptoms or displayed behaviors, and only one administration had non-pharmacological interventions recorded. The remaining notes outlined: On 4/12/23, R10's PRN lorazepam was given with no recorded symptoms or target symptoms displayed for R10. A follow-up note, dated	F 758	X 1 week, then 2 times a week X 2 weeks then monthly X 2 months. Audit results will be discussed in QAPI.	

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F 758	Continued From page 83 4/12/23, indicated the dose was effective. However, neither of the completed notes outlined what, if any, non-pharmacological interventions were attempted prior to the administration of the PRN medication. On 4/17/23, R10's PRN lorazepam was given with no recorded symptoms or target symptoms displayed for R10. A follow-up note, dated 4/17/23, indicated the dose was effective. However, neither of the completed notes outlined what, if any, non-pharmacological interventions were attempted prior to the administration of the PRN medication. On 4/29/23, R10's PRN lorazepam was given. Progress notes lacked documented effectiveness. The notes also lacked triggers exhibited along with what, if any, non-pharmacological interventions were attempted prior to the administration of the PRN medication. On 5/19/23, R10's PRN lorazepam was given. A follow-up note, dated 5/19/23, indicated the dose was effective. However, neither of the completed notes outlined triggers exhibited or what, if any, non-pharmacological interventions were attempted prior to the administration of the PRN medication. R10's medical record was reviewed and lacked any recorded physician statements or clinical justification supporting the ongoing use of PRN lorazepam. During an interview on 6/9/23 at 10:02 a.m., TMA. stated if a resident had PRN medication for anxiety or behavior TMA would ask the nurse if it	F 758		

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F 758	Continued From page 84 was appropriate to give and I would try non pharmacological interventions first. TMA stated sometimes in the careplan it would give tidbits of what could help. As a TMA she wouldn't do progress notes, the nurse would have to put those in. There is behavior charting that we would do, it would ask if R10 had behaviors, how often and what non-pharmacological interventions were attempted. During an interview on 6/12/23 at 12:49 p.m. the director of nursing (DON) stated an expectation behavior documentation would be done for patients with behaviors and or when a prn is being considered and given. First non pharmacy interventions would be done and documentation should include what was attempted and if effective and then give medication intervention if needed. TMA can document behaviors how many and if actions /interventions worked R10's behavior charting documentation was requested but not provided. Facility Policy Unnecessary Drugs-Generic dated 6/8/22, indicated a residents would be free from unnecessary meds which were meds for excessive duration, without documentation and without adequate indications for the use.	F 758		
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced	F 759		7/24/23

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F 759	Continued From page 85 by: Based on observation, interview, and document review, the facility failed to ensure medications were administered as ordered by the physician for 1 of 5 residents (R43) reviewed during medication administration this practice resulted in a medication error rate of 12%. Findings include: R43's Admission Record, indicated diagnoses which included gastroparesis (a condition that affects the stomach muscles and prevents proper stomach emptying), thyroidtoxosis with diffuse goiter (an immune system disorder of the thyroid gland in the throat), gastroesophageal reflux disease (a digestive disease in which stomach acid or bile irritates the food pipe lining), localized visual field defect right eye, and essential hypertension. R43's quarterly Minimum Data Set (MDS) assessment dated 5/26/23, indicated R43 was cognitively intact. In addition, R43 received insulin, antidepressant, anticoagulant, and opioid medications on 7 of 7 days during the assessment period. R43's Order Summary Report dated 6/9/23, indicated R43 was on several medication including the following medications: artificial tears solution 1% instill one drop in both eyes four times a day for dry eyes and as needed up to two more times hydralazine 10 mg give 40 mg by mouth four times a day for HOLD IF BLOOD PRESSURE IS LESS THAN 110/80 millimeter of mercury	F 759	F759: Free of Medication Error Rates 5% or more. Immediate Corrective action: Resident affected by F759 was assessed for any side effects. Physician notified of medication error. Identification of other residents: All residents could be affected by F759. Corrective Action: IDT has been educated on Physicians Order Policy Team Leads education on Physicians Order Policy Team Leads educated on re-ordering medications and what to do if unavailable. Monitoring/Audits: DON/Designee shall audit 5 residents for medications errors 5 days a week X 1 week, then 2 times a week X 2 weeks then monthly X 2 months. Audit results will be discussed in QAPI.	

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F 759	Continued From page 86 (mmHg) pantoprazole delayed release 40 mg give by mouth in the evening related to gastro-esophageal reflux disease During an observation on 6/5/21 at 5:46 p.m., registered nurse (RN)-G administered medications for R43, she was unable to locate artificial tears and pantoprazole for administration, she wrote a note but did not administer the medications. In addition, RN-G measured R43's blood pressure as 144/79, she then gave all the medications for the administration which included hydralazine 40 mg. When back at the medication cart RN-G recorded R43's blood pressure and stated she didn't think she should have given the hydralazine base on the blood pressure. During an interview on 6/9/23 at 12:07 p.m. nurse practitioner (NP)-I said he was notified of the medication given (hydralazine) on 6/5/23. NP-I verified it was a medication error based on the diastolic pressure. During an interview on 6/9/23 at 3:24 p.m., the director of nursing (DON) stated she was notified of the concern and well as the NP on 6/5/23, and planned to discuss the way the blood pressure parameters were written. The DON stated nurses should call the provider when an order (parameters to give) is not clear. The policy Physician's Order 6/8/22, indicated dosage ambiguities would be avoided and parameters for giving medications would be listed under the medications to which they pertain.	F 759		

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F 761	Continued From page 87	F 761		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure prescribed medications were appropriately and accurately labeled with current physician-ordered administration instructions (including open and expiration dates) to reduce the risk of administration error for 3 of 5 residents (R23, R25, R4) observed to receive medication during medication administration. In addition, the facility	F 761	F761: Storage of Drugs and Biologicals Immediate Corrective action: Drugs improperly stored were immediately removed and destroyed. Identification of other residents: Areas of medication storage were audited for appropriate storage.	7/26/23

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F 761	Continued From page 88 failed to indicate dates medications were opened for medications with a shortened expiration date once opened for 4 of 4 residents (R22, R27, R89, R113) reviewed for medication storage and labeling. Findings include: During an observation on 6/7/23 at 1:39 p.m., on the Cedar nursing unit licensed practical nurse (LPN)-C was preparing medication for R23. The medication acetaminophen 500 milligrams (mg) did not have an open date. During an observation on 6/7/23 at 1:44 p.m., on the Cedar nursing unit R25's mag64 did not have an open date. During an observation on 6/7/23 at 1:56 p.m., on the Cedar nursing unit R4's extended release acetaminophen 650 mg did not have an open date. During an interview on 6/7/23, at 2:00 p.m., LPN-C verified the open dates were missing and the bottles should have been dated with an open date. During an interview on 6/9/23 at 3:24 p.m., the director of nursing (DON) stated she would expect staff to date all medication bottles when opened with an open date. Inspection of the Cedar unit medication cart on 6/12/23 at 2:57 p.m. with licensed practical nurse (LPN)-B revealed the following medications which were opened and in use, but not dated: -R27 insulin glargine (Lantus) pen, quantity of two	F 761	Corrective Action: IDT has been educated on Medication Labeling Policy. Team Leads education on Medication Labeling Policy. Monitoring/Audits: DON/Designee shall audit 5 areas of medication storage 5 days a week X 1 week, then 2 times a week X 2 weeks then monthly X 2 months. Audit results will be discussed in QAPI.	

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F 761	Continued From page 89 -R113 insulin aspart (NovoLog) Inspection of the Elm unit medication cart on 6/12/23 at 3:12 p.m. with trained medication aid (TMA)-B revealed the following medications which were opened and in use, but not dated: -R22 bottle of prednisolone 1% eye drops -R89 insulin glargine (Lantus) pen Review of R22, R27, R89, and R113 current provider orders revealed these are current medications for the above-mentioned medications. During an interview on 6/12/23 at 2:57 p.m., LPN-B stated medications needed to be dated with date opened. During an interview on 6/12/23 at 3:22 p.m., LPN-A stated medications should be dated when opened. During an interview on 6/12/23 at 3:54 p.m., the director of nursing (DON) stated the expectation is that insulin's and eye drops should be labeled with the dates they were opened. According to the "PharMerica's (American Pharmacy Company) abridged list of medications with shortened expiration dates" published on 3/6/23, indicated "once certain products are opened and in use, they must be used within a specific timeframe to avoid reduced stability and sterility and potentially reduced efficacy ..." A drug product's Beyond Use Date (BUD) is the manufacturers supplied expiration date OR the shortened date after opening .... whichever comes first"	F 761		

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F 761	Continued From page 90 Further review of this list revealed, "these in-use medications should be labeled such that the date opened is noted, clearly visible and securely attached to a part of the package to not be discarded. This date is to be referenced when auditing to clear medications prior to expiration" .... -Insulin glargine (Lantus) 28 days -Insulin aspart (Novolog) 28 days -prednisolone 1% eye drop 60 days Facility policy titled, Medications-Labeling and dated 6/8/22, indicated medications will be labeled with open date.	F 761		
F 806 SS=D	Resident Allergies, Preferences, Substitutes CFR(s): 483.60(d)(4)(5) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(4) Food that accommodates resident allergies, intolerances, and preferences; §483.60(d)(5) Appealing options of similar nutritive value to residents who choose not to eat food that is initially served or who request a different meal choice; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and documentation review, the facility failed to ensure food requests were honored for 1 of 5 residents (R65) reviewed for choices. Findings include:	F 806	F806: Resident Allergies, Preferences, Substitutes Immediate Corrective action: Resident affected by F806 care plan was updated. Identification of other residents:	7/26/23

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F 806	Continued From page 91 R65's quarterly Minimum Data Set (MDS) assessment dated 5/29/23, indicated R65's cognition was moderately impaired, diagnoses included post-traumatic stress disorder, dementia, type II diabetes, obstructive sleep apnea, atrial fibrillation, Alzheimer's disease, and chronic heart failure. HDG-SNF-Act- Activity tool (MDS 3.0) dated 3/24/23, listed R65's religion as Jehovah's witness. R65's care plan did not identify religious preference/need. Care conference documentation reviewed from admit to date did not include religious based food preferences. When interviewed on 6/5/23 at 3:03 p.m., R65 stated he was Jewish, and had asked staff multiple times to not be served ham on his meal trays, but he still continued to be sent ham. R65 stated he received ham just often enough to feel upset and irritated by it. R65 indicated ham was typically not sent for breakfast, just bigger meals. During an observation on 6/7/23 at 8:41 a.m., R65 was seated at a table with three other residents. R65 was eating biscuits and gravy. When interviewed on 6/9/23 at 9:50 a.m. dietary clerk (DC)-A stated every new admit gets asked question about their dietary preferences so it can be entered into the dietary system. DC-A explained the printed menu slips had the following information on them: diet, needed assistive devices, diet consistency, and likes and dislikes etc. DC-A printed a menu ticket for R65. The ticket listed: No ham or pork.	F 806	All residents were asked their preferences or substitutes. Corrective Action: IDT has been educated on Diet Religious Policy. All Staff educated on Diet Religious Policy. Monitoring/Audits: DON/Designee shall audit 5 resident food trays 5 days a week X 1 week, then 2 times a week X 2 weeks then monthly X 2 months. DON/Designee shall audit 5 resident care plans for religious diet 5 days a week X 1 week, then 2 times a week X 2 weeks then monthly X 2 months. Audit results will be discussed in QAPI.	

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F 806	Continued From page 92 When interviewed on 6/9/23 at 9:58 a.m., the dietary manger (DM) provided an ingredient list for the gravy R65 had consumed for breakfast. The gravy ingredient included rendered bacon fat. The DM stated the food system is supposed to remove all pork products from R65's menu, and indicated the gravy being on R65's menu choices was a system failure. The DM confirmed the facility did serve a sliced ham meal and stated staff should follow the menu ticket, they should not be putting pork products on R65's tray. When interviewed on 6/9/23 at 10:27 a.m., nursing assistant (NA)-H stated she did not know if there were any residents that didn't eat certain things. NA-H stated we would look at the care plan or the food ticket for information like that. When interviewed on 6/9/23 at 10:30 a.m., NA-G stated I think we just have one resident that doesn't eat pork and information would be in the resident's care plan. When interviewed on 6/9/23 at 10:40 a.m., licensed practical nurse (LPN)-D confirmed R65 was Jewish and stated R65's religious preference was to not be served pork products and indicated at R65's last care conference both R65 and his wife shared R65 had been receiving pork on his meal trays. LPN-D stated R65's religious preferences should be on the care plan since it was a big part of who he was. When interviewed on 6/9/23 at 3:55 p.m., the director of nursing (DON) stated R65's Jewish heritage should be placed on his care plan and said it is important for the facility to identify individual preferences, needs, and choices as they should be honored and met.	F 806		

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F 806	Continued From page 93 A facility provided Dietary Communication form dated 5/20/23 completed by a NA stated resident could not eat pork or ham because he was Jewish. Facility Policy Diets - Religious included: diets are designed to meet the religious, cultural, and ethnical needs of the resident population, as well as input received from residents and resident groups. Some religious sects abstain, or are forbidden, from consuming certain foods and drinks; others restrict foods and drinks during holy days. Dietary department will maintain a list of residents' religious restrictions. Facility policy Resident Rights included: Person centered care means to focus on the resident as the focus of control and support the resident in making their own choices; having control over their daily lives. The facility assessment dated 2/20/23 indicated the facility was able to provide/meet individualized dietary requirements, liberal diets, specialized diets, IV nutrition, tube feeding, cultural or ethnic dietary needs, assistive devices, fluid monitoring or restrictions.	F 806		
F 812 SS=D	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.	F 812		7/24/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245366	A. BUILDING _____ B. WING _____	C 06/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLTOP HEALTHCARE REHABILITATION AND SKILLED NURS	2501 RICE LAKE ROAD DULUTH, MN 55811

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 94 (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to store food in accordance with professional standards for food service safety, monitoring refrigerator/freezer temperatures and outdated and/or unlabeled food. This had the potential to affect all residents who consumed food and beverages from this fridge. Findings include: During an observation and interview on 6/8/23 at 3:17 p.m., with trained medication aide (TMA)-A of resident refrigerator on the Elm unit medication room. The freezer had frozen and dated food in containers or bags. The fridge had food in containers, which were dated, including leftovers dated 6/2/23. There was no log for temperature monitoring, no instructions for safe temperatures for food storage and no direction for how long thawed food could be kept in the fridge. TMA-A stated she was not sure who was responsible for monitoring and cleaning this fridge since it belonged to a resident. A second fridge was identified as a facility fridge for resident food in another locked medication/storage room. There was ice cream with a permanent marker date of	F 812	F812: Food procurement, store/prepare/serve Immediate Corrective action: Resident Refrigerator was emptied of all items that were outdated. Resident Refrigerator moved. Identification of other residents: All residents with personal fridges were educated on personal fridge policy. Corrective Action: Personal Fridge Policy was revised. IDT has been educated on Personal Fridge Policy. All Staff educated on Personal Fridge Policy. Monitoring/Audits: DON/Designee shall audit 5 resident personal refrigerator education 5 days a week X 1 week, then 2 times a week X 2 weeks then monthly X 2 months. Audit results will be discussed in QAPI.	

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F 812	Continued From page 95 6/20/22 written on the container. TMA-A stated she would be discarding this because it was old. A facility plate with a cover sitting on top of canned beverages. TMA-A removed the lid to find scrambled eggs and hard-boiled eggs on the plate. There was a strong smell of sulfur, TMA-A stated she didn't know what that was doing in there and would be throwing it out. There was no name or date. During an interview on 6/12/23 at 3:54 p.m., the director of nursing (DON) stated the resident or family would be responsible for labeling and cleaning the resident refrigerators and the facility did not have a process for temperature monitoring resident refrigerators. The DON acknowledged there was a resident fridge in the locked medication room on the Elm unit that family would not have free access to clean and monitor the fridge. The DON's expectation was that nursing staff were responsible for cleaning, dating, labeling, and temperature monitoring the facility refrigerators. A facility policy titled, Food Refrigerators and dated 6/8/22, indicated to check for cleanliness, discard all items that are unlabeled. Items to be discarded if three days out from initial open date unless the item has a printed expiration date on them. If refrigerator temperatures were above 40 degrees staff were to notify the maintenance department. A facility policy titled, Personal Food Refrigerators and dated 6/8/22, indicated the resident and/or family will be educated on the use of refrigerator and the food storage policy related to labeling, dating, and discarding expired or perishable food items. Staff shall check, maintain, and record	F 812		

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HILLTOP HEALTHCARE REHABILITATION AND SKILLED NURS	2501 RICE LAKE ROAD DULUTH, MN 55811

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F 812	Continued From page 96 temperature logs daily.	F 812		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions	F 880		7/24/23

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F 880	Continued From page 97 to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to ensure proper hand hygiene was completed during cares for 2 of 4 residents (R22, R11) and in addition the facility failed to follow enhanced based precautions (EBP) with cares for 1 of 3 residents, R19 reviewed for infection control.	F 880	F880: Infection Prevention Immediate Corrective action: Staff were corrected upon notification. Identification of other residents: All residents on Enhanced Barrier Precautions have signage on doors.	

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F 880	Continued From page 98 Findings include: R22's Admission Record, indicated diagnoses which included dementia, anxiety, blindness of one eye, low vision of other eye, muscle weakness, age-related physical debility, and urinary incontinence. R22's significant change Minimum Data Set (MDS) assessment dated 4/27/23 indicated R22 was significantly cognitively impaired, had highly impaired vision, required limited assistance with transfers and with toilet use. In addition, R22's MDS indicated she was always incontinent of bowel and bladder. R22's care plan dated 1/3/23 indicated R22 was at risk for complications related to current/medical status. Interventions included incontinence care with incontinent brief changes. R22's care plan also indicated she was at risk for complications related to current medical/physical status. Interventions included to toilet upon rising, between meals, at bedtime, and as needed. During an observation on 6/8/23 at 11:08 a.m., nursing assistant (NA)-D brought R22 to her room to take her to the bathroom. Once in the room, NA-D put a gait belt on R22 then put on gloves, she then assisted R22 to standing, then pivoted her to the toilet. NA-D removed R22's brief which was wet, R22 then voided some in the toilet. NA-D asked R22 if she wanted to sit, R22 declined saying it hurt to sit on the toilet. NA-D put a new brief in position and assisted R22 to stand. R22 was able to stand on her own holding the grab bars near the toilet. NA-D told R22 she'd had a small bowel movement and proceeded to wipe front to back using a new wipe each time.	F 880	Corrective Action: IDT has been educated on Enhanced Barrier Precautions Policy. All Staff educated on Enhanced Barrier Precautions Policy. Monitoring/Audits: DON/Designee shall audit 5 staff on enhanced barrier precautions 5 days a week X 1 week, then 2 times a week X 2 weeks then monthly X 2 months. Audit results will be discussed in QAPI.	

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F 880	Continued From page 99 NA-D pulled up R22's new brief, then pulled up her slacks, pivoted R22 into her wheelchair and then removed her gloves (no hand hygiene was performed). NA-D moved R22 from the bathroom to near her bed via the wheelchair and assisted her to stand and pivot into the bed. NA-D moved the wheelchair out of the way, covered her, gave R22 her call light, then performed hand hygiene. NA-D gathered the garbage to remove it from the room. During an interview on 6/8/23 at 11:22 a.m. NA-D verified she should have washed her hands or used hand sanitizer after removing her gloves after wiping R22 (after her bowel movement). During an interview on 6/9/23 at 1:20 p.m. licensed practical nurse (LPN)-A stated hand hygiene should be completed after removing gloves especially after assisting with peri-care that involved a bowel movement. During an interview on 6/9/23 at 2:28 p.m., the director of nursing stated hand hygiene should be performed before entering a resident's room, when leaving a resident's room, after removing gloves and after assisting a resident with peri-care after a bowel movement. The DON stated hands should be washed with soap and water if/when they are visibly soiled. R11's discharge Minimum Data Set (MDS) assessment dated 4/26/23 indicated R11 had severe cognitive impairment. Diagnoses included: acute and chronic respiratory failure with hypoxia, kidney failure, hallucinations unspecified, epilepsy, degenerative disease of nervous system and methicillin resistant staphylococcus aureus	F 880		

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F 880	Continued From page 100 infection. During an observation on 6/7/23 at 7:51 a.m., licensed practical nurse (LPN)-C and nursing assistant (NA)-G put on personal protective gowns and gloves after sanitizing hands. LPN-C lifted R11's feet off the pillow and placed them on the bed. NA-G removed R11's Foley from a pink bin on the floor and placed R11's Foley bag in a dignity bag attached to the bed. LPN-C told R11 they were going to reposition and change R11's brief. LPN-C lowered the head of the bed and R11 was rolled towards LPN-C. NA-G tucked a new pad under R11 and rolled R11 towards NA-G, LPN-C pulled new linen in place. NA-G removed Foley bag from dignity bag and emptied urine into a graduated cylinder. NA-G secured bag clamp and returned the Foley bag to the dignity bag. NA-G emptied cylinder in bathroom, removed gloves, hand sanitized and applied new gloves. At 8:06 a.m. LPN-C secured catheter tube to R11's leg with a securement device. R11 was rolled back towards window and a clean pad and brief was placed under R11 by NA-G. NA-G cleaned R11's peri area and once completed R11 was rolled so LPN-C could get new pad and brief in place, and then R11 was rolled onto back. NA-G put old brief in the garbage can and then NA-G and LPN-C grabbed linen and moved R11 towards NA-G. Both secured closures on R11's brief. NA-G and LPN-C used linen to boost resident up toward head of bed. LPN-C adjusted R11's feet. LPN-C advised NA-G to change gloves before assisting to reposition R11's feet and legs. NA-G removed gloves, sanitized hands. LPN-C and NA-G lifted and placed R11's legs on pillows. R11 was repositioned on his back for	F 880		

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F 880	Continued From page 101 breakfast. LPN-C gave R11 his call light. TMA-C and NA-G removed gloves, gown, and hand sanitized. LPN-C address R11's requests before leaving the room. During an interview on 6/7/23 at 8:22 a.m., TMA-C stated typically I would clean my hands after I helped with rolling and changing someone. I should have stopped and cleaned my hands after R11's old brief was removed before I repositioned and touched things like the call light and linens. TMA-C stated and washing was important because it helped prevent infection. During an interview at 6/7/23 at 8:30 a.m., NA-G stated I should have stopped, hand sanitized and applied new gloves right after I was done with R11's peri care and before touching things that were clean. NA-G stated hand sanitization needed to be done for infection prevention reasons. During an interview on 6/12/23 at 10:52 a.m., the infection preventionist (IP) stated any staff providing or assisting with peri care should stop when peri care is done, sanitize hands and if needed put on new gloves before proceeding with additional care, or before touching the resident or items in the room. The IP stated she would expect hand sanitization to be completed when entering and leaving a resident room, after cares involving body fluids, after resident touch, or after touching dirty objects. The IP identified handwashing as the number one way staff could prevent the spread of infection, and indicated it was important for staff to sanitize hands at proper times. The IP stated the facility had had statistical improvement in handwashing, and attributed this	F 880		

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HILLTOP HEALTHCARE REHABILITATION AND SKILLED NURS	2501 RICE LAKE ROAD DULUTH, MN 55811

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F 880	Continued From page 102 to audits, and educational interventions to support proper hand sanitization and timing. R19's quarterly Minimum Data Set (MDS) assessment dated 3/18/23, indicated intact cognition and diagnoses of bipolar disorder, and vascular dementia with behavioral disturbance. R19 needed extensive assist with bed mobility, transfers, dressing, toileting, and personal hygiene. R19's care plan, dated 3/29/23, indicated EBP were in place related to multidrug resistant organisms (MDRO) colonization. Gown and gloves were required prior to high contact activity including dressing, bathing, transferring, providing hygiene, changing linens, changing incontinent products, or assisting with toileting. During an observation on 6/07/23 at 9:39 a.m., nursing assistant (NA)-A assisted R19 in the bathroom. This resident room had EBP signage on the door indicating a gown and gloves were needed to provide care in the above-mentioned scenarios. There was an isolation cart with gowns, gloves, and hand sanitizer outside the room alongside a plastic-lined receptacle with lid. NA-A, who was not wearing a gown or gloves, came out of the resident room to retrieve a sit-to-stand lift and then went back into the room. NA-A came out and went back into the resident room two more times and was not wearing a gown or gloves. R19 did not want this writer in the bathroom with them. At 10:01 a.m. a nurse brought a tube of cream and an isolation gown to the doorway of R19's room and handed them to NA-A. At 10:05 a.m., NA-A came out of the room, without PPE on, and put the sit-to-stand lift	F 880		

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F 880	Continued From page 103 into hallway. During an interview on 6/07/23 at 10:05 a.m., NA-A stated she had infection control training at hire and annually. The sign on R19's door meant you would need a gown and gloves for providing care to this resident. Further, NA-A stated she didn't have an opportunity to put a gown on but confirmed she did provide personal care to R19. The policy Hand Washing dated 6/8/22 directed staff to wash their hands after each direct contact with a resident for which handwashing is indicated by accepting professional practice. In addition, handwashing should be conducted per recommendations from the Centers for Disease Control and Prevention (CDC) guidelines. Facility policy, titled "Enhanced Barrier Precautions" and dated 3/24/23, indicated the expanded use of PPE during high-contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing. Examples of high-contact activities included transferring, providing hygiene, changing briefs or assisting with toileting.	F 880		
F 882 SS=F	Infection Preventionist Qualifications/Role CFR(s): 483.80(b)(1)-(4) §483.80(b) Infection preventionist The facility must designate one or more individual(s) as the infection preventionist(s) (IP) (s) who are responsible for the facility's IPCP. The IP must: §483.80(b)(1) Have primary professional training in nursing, medical technology, microbiology, epidemiology, or other related field;	F 882		7/16/23

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F 882	Continued From page 104 §483.80(b)(2) Be qualified by education, training, experience or certification; §483.80(b)(3) Work at least part-time at the facility; and §483.80(b)(4) Have completed specialized training in infection prevention and control. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the acting infection preventionist (IP) had completed specialized training in infection prevention and control. This had the potential to affect all 60 residents residing in the facility. Findings include: During an interview on 6/12/23 at 10:52 a.m., the IP stated she had been assisting with IP since January and had become the full-time IP in March. Documentation of IP's infection prevention education was requested upon completion of the interview. The IP stated she would need to gather education. During a follow-up interview on 6/12/23 at 2:58 p.m., the IP stated she did not have the required IP education completed, but that she was working on IP modules now.	F 882	F882: Infection Preventionist qualifications/role Immediate Corrective action: Erika completed IP course requirements. Identification of other residents: All residents could have been affected by F882. Corrective Action: IDT has been educated on Infection Preventionist qualifications/Role. Infection Preventionist has proper qualifications for role completed. Monitoring/Audits: Compliance is achieved. Citation results will be discussed in QAPI.	

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	245366	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**06/06/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLTOP HEALTHCARE REHABILITATION AND SKILLED NURS	**2501 RICE LAKE ROAD** **DULUTH, MN 55811**

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 06/06/2023. At the time of this survey, Hilltop Healthcare Rehabilitation & Skilled Nursing was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.	K 000		

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

Electronically Signed | 07/20/2023

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245366	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**06/06/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLTOP HEALTHCARE REHABILITATION AND SKILLED NURS	**2501 RICE LAKE ROAD** **DULUTH, MN 55811**

(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 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. Hilltop Healthcare and Rehabilitation & Skilled Nursing is a 3-story building with a partial basement. The building was constructed at 3 different times. The original building was constructed in 1967 and was determined to be of Type II(111) construction. In 1974 & 1985 an additions were constructed to the building that were determined to be of Type II(111) construction. Because the original building and the additions meet the construction type allowed for existing buildings, the facility was surveyed as	K 000		

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K 000	Continued From page 2 one building. The building is fully fire sprinkler protected and has a complete fire alarm system with smoke detection in the corridors and spaces open to the corridor, that is monitored for automatic fire department notification. The facility has a licensed capacity of 140 beds and had a census of 115 at the time of the survey. The requirements at 42 CFR, Subpart 483.70(a), are NOT MET as evidenced by:	K 000		
K 293 SS=D	Exit Signage CFR(s): NFPA 101 Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) This REQUIREMENT is not met as evidenced by: The building is divide Based on observation and staff interview, the facility failed to maintain and/or install proper exit signage under NFPA 101 (2012 edition), Life Safety Code sections 19.2.10.1, 7.10.1.2.2, 7.10.83, 7.10.8.31 and 7.10.8.3.2. These deficient findings could have an isolated impact on the residents within the facility. Findings include:	K 293	K293 - SS=D - Exit Signage Immediate Corrective Action Completed immediate audit of all doors. Installed stickers on required doors. Corrective Action: Ordered and acquired stickers as per fire marshals' specification. All other exits check and are within compliance.	7/21/23

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K 293	Continued From page 3 On 06/06/2023 between 11:45am and 3:45pm, it was revealed by observation that the door leading to the Smoking Pad Courtyard was missing a "NO EXIT" sign. An interview with the Maintenance Director and Acting Facility Administrator verified these deficient findings at the time of discovery.	K 293	Maintenance staff are educated to identify and monitor. Monitoring: Incorporated check into monthly audit. The Maintenance Director or designee will audit TELS and verify completion in rounds or as needed. • Will audit 2 times a week X 4 weeks All issues will be reported to administrator and brought to QAPI until compliance achieved.	
K 324 SS=D	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2	K 324		7/21/23

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K 324	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on documentation review and staff interview, the facility failed to test and inspect the kitchen hood ventilation and fire suppression system per NFPA 101 (2012 edition), Life Safety Code, section 9.2.3 and NFPA 96 (2011 edition), Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, section 11.2.1. This deficient finding could have an isolated impact on the residents within the facility. Findings Include: On 06/06/2023, between 11:45am and 3:45pm, it was revealed by a review of available documentation that inspection documentation for the kitchen hood ventilation and fire suppression system was not available. The facility could not provide completed test/inspection documentation for the semi-annual kitchen hood suppression system inspections for the last 12 months. An interview with the Maintenance Director and the Acting Facility Administrator verified this deficient finding at the time of discovery.	K 324	K324 - SS=D - Cooking Facilities Corrective Action: Hood Inspection had been completed. Paperwork had not yet been received at time of audit. Paperwork requested and received. Paperwork uploaded and stored electronically in share drive. System Change: This inspection has been added to the TELS system and it will monitor and alert when due. Education on K324 to Maintenance and Dietary director. Monitoring: All inspections are automatically scheduled through TELS and scheduled through the preventative maintenance. • Audited Semiannually X1 year All issues will be reported to administrator immediately for follow up and brought to QAPI committee until compliance achieved.	
K 351 SS=F	Sprinkler System - Installation CFR(s): NFPA 101 Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an	K 351		7/21/23

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K 351	Continued From page 5 approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) 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. These deficient findings could a widespread impact on the residents within the facility. Findings include: On 06/06/2023, between 11:45am and 3:45pm, it was revealed by observation that storage materials had been placed on a storage rack, bringing the storage materials within the required 18 inch clearance area under the sprinkler heads. These obstructions were found in: 1) Clean Linen Room - Spruce Wing	K 351	K351 - SS=F - Sprinkler System - Installation Immediate Corrective Action: Immediately removed obstructions maintaining the 18-inch clearance from sprinkler heads. All other storage areas check for compliance. Corrective action: Maintenance Staff Educated on K351. Central Supply educated on K351 Monitoring: Maintenance Director or designee will audit and verify completion and accuracy. • 5 Times X 1 week • 2 times a week X 4 weeks All issues will be reported to administrator and brought to QAPI until compliance	

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K 351	Continued From page 6 2) Clean Linen - Memory Care Wing 3) Kitchen Dry Storage - Lower Level An interview with the Maintenance Director and Acting Facility Administrator verified these deficient findings at the time of discovery.	K 351	achieved.	
K 353 SS=E	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 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 the sprinkler system in accordance with the 2012 edition of the Life Safety Code (NFPA 101), section 9.7.5, and NFPA 25 2011 edition, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, section 5.2.2.2. This deficient condition could have a	K 353	K353 - SS=E - Sprinkler System - Maintenance and Testing Immediate Corrective Action: Removal of cable ties from sprinkler piping. All other sprinkler pipe checked for compliance.	7/21/23

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K 353	Continued From page 7 patterned impact on the residents within the facility. Findings include: On 06/06/2023, between 11:45am and 3:45pm, it was revealed that several data cables and low voltage wires were cable tied on multiple sprinkler pipes in the housekeeping closet on the Cedar Wing. This deficient condition was verified by the Maintenance Director and Acting Facility Administrator.	K 353	Corrective Action: Maintenance Staff educated on K353. Monitoring: Will ensure contractual work form to be monitored by Maintenance Director or designee upon completion of any project to be in compliance. All issues will be reported to administrator and brought to QAPI until compliance achieved. Maintenance Director or designee will check sprinkler piping: • Weekly x 4 weeks	
K 355 SS=D	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain access to portable fire extinguishers per NFPA 101 (2012 edition), Life Safety Code, section 9.7.4.1, and NFPA 10 (2010 edition), Standard for Portable Fire Extinguishers, section 7.3.1.1.1. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 06/06/2023 between 11:45am and 3:45pm, it	K 355	K355 - SS=D - Portable Fire Extinguishers Corrective Action: Called external company in. Annual inspection scheduled and completed. Paperwork requested and received. All fire extinguishers have been inspected and are in compliance. Paperwork uploaded and stored electronically in share drive. System change:	7/21/23

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K 355	Continued From page 8 was revealed by documentation review that the fire extinguishers annual inspection documentation could not be provided. An interview with Maintenance Director and Acting Facility Administrator verified this deficient finding at the time of discovery.	K 355	This inspection has been added to the TELS system and it will monitor and alert when due. Education to maintenance staff on K355 Monitoring: All inspections are automatically scheduled through TELS and scheduled through the preventative maintenance. • Audited annually X 1 year All issues will be reported to administrator and brought to QAPI until compliance achieved.	
K 372 SS=F	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain their smoke barrier per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.7.1, 19.3.7.3, 8.5.2.2, and 8.5.6.5. These deficient findings could have a widespread	K 372	K372 - SS=F - Subdivision of Building Spaces - Smoke Barrier Immediate Corrective Action: Resealed all holes in smoke barrier as required.	7/21/23

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K 372	Continued From page 9 impact on the residents within the facility. Findings include: On 06/06/2023 between 11:45am and 3:45pm, it was revealed by observation that there was a penetration running from one smoke compartment to another above ceiling in following areas: 1) Over doors Rehabilitation area 2) Main doors to Spruce Wing 3) Spruce Wing, third door set 4) Spruce Wing Dinning Room An interview with Maintenance Director and Acting Facility Administrator verified these deficient findings at the time of discovery	K 372	Corrective Action: Will ensure contractual work to be monitored by Maintenance Director or designee upon completion of any project to be in compliance. All other smoke barriers checked for compliance. Maintenance Staff educated on K372. Monitoring: Maintenance Director or designee will audit and verify completion and accuracy: • Weekly X 4 weeks All issues will be reported to administrator and brought to QAPI until compliance achieved.	
K 511 SS=F	Utilities - Gas and Electric CFR(s): NFPA 101 Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to secure electrical panels per NFPA 99 (2012 edition), Health Care Facilities Code,	K 511	K511 - SS=F - Utilities - Gas and Electric Immediate Corrective Action Maintenance Director locked electrical	7/21/23

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K 511	Continued From page 10 section 6.3.2.2.1.3 and failed to maintain the Gas and Utility System per NFPA 101 (2012 edition), Life Safety Code section 9.2.2 and NFPA 54 (2012 edition), National Fuel Gas Code, sections 9.2.2 and 10.3.2.2. These deficient findings could have a widespread impact on the residents within the facility. Findings include: 1) On 06/06/2023, Between 11:45am and 3:45pm, it was revealed by observation that the electrical panel located on the Spruce Wing was not locked. 2) On 06/06/2023, Between 11:45am and 3:45pm, it was revealed by observation that the electrical panels on the Cedar Wing were not locked. 3) On 06/06/2023, Between 11:45am and 3:45pm, it was revealed by observation that the electrical panels on the Main Corridor were not locked. An interview with the Maintenance Director and Acting Facility Administrator verified this deficient finding at the time of discovery.	K 511	panels. All other electrical panels check for compliance. Corrective Action: Educated Maintenance Staff K511. Monitoring: Maintenance Director or designee will audit and verify completion and accuracy. • 5 Times X 1 week • Weekly X 4 weeks	
K 711 SS=F	Evacuation and Relocation Plan CFR(s): NFPA 101 Evacuation and Relocation Plan There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. Employees are periodically instructed and kept informed with their duties under the plan, and a copy of the plan is readily available with telephone	K 711		7/21/23

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K 711	Continued From page 11 operator or with security. The plan addresses the basic response required of staff per 18/19.7.2.1.2 and provides for all of the fire safety plan components per 18/19.2.2. 18.7.1.1 through 18.7.1.3, 18.7.2.1.2, 18.7.2.2, 18.7.2.3, 19.7.1.1 through 19.7.1.3, 19.7.2.1.2, 19.7.2.2, 19.7.2.3 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to implement a fire safety plan per NFPA 101 (2012 edition), Life Safety Code, section 19.7.2.2. These deficient findings could have a widespread impact on the residents within the facility. Findings include: On 06/06/2023 between 11:45am and 3:45pm, it was revealed in a review of available documentation that the facility could not provide a written fire safety plan at the time of survey. An interview with the Maintenance Director and the Acting Facility Administrator verified these deficient findings at the time of discovery.	K 711	K711 - SS=F - Evacuation and Relocation Plan Immediate Corrective Action: Proper documentation was provided at time of survey. Corrective Action: The Maintenance Director retyped the fire safety plan for clarity. Fire Safety plan is stored in the Inspections binder and uploaded electronically to the shared drive. Maintenance Staff was educated on K711. Education: Department heads educated on K711. Maintenance Staff was educated on K711. Monitoring: Maintenance Director or designee will audit and verify present of documentation in EPB book. • Monthly X 2 months	
K 712 SS=F	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire	K 712		7/21/23

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HILLTOP HEALTHCARE REHABILITATION AND SKILLED NURS	**2501 RICE LAKE ROAD DULUTH, MN 55811**

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K 712	Continued From page 12 conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to conduct fire drills under varied times and conditions per NFPA 101 (2012 edition), Life Safety Code, sections 19.7.1.6, 4.7.4, and 4.6.1.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: 1. On 06/06/2023, between 11:45am and 3:45pm, it was revealed by a review of available documentation that fire drills did not meet the varying time requirement: second shift 03/31/2023 at 3:47pm, 04/14/2023 at 4:47pm. 2. 06/06/2023, between 11:45am and 3:45pm, it was revealed by a review of available documentation that fire drills were not completed: first shift missing first quarter (January - March) and second quarter (April - June) and fourth quarter (October - December), second shift missing third and fourth quarter, third shift missing second, third and fourth quarter drills completely. An interview with the Maintenance Director and Acting Facility Administrator verified this deficient	K 712	K712 - SS=F - Fire Drills Immediate Corrective Action: Acquired proper paperwork or forms for recording fire drills. Corrective Action: Maintenance Director or designee scheduled first shift quarterly fire drill. Maintenance Director or designee scheduled second shift quarterly fire drill. Maintenance Director or designee scheduled third shift quarterly fire drill. The Maintenance Director or designee will educate staff on proper fire drills. The Maintenance Director or Designee will be alerted through TELS to complete the fire drills and will audit as notified and/or as required to ensure completion and accuracy. System Change: The fire drills have been added to the TELS system and it will monitor and alert when due. Education on K712 to IDT team. Monitoring: Audits of mandatory quarterly drills	

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	245366	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**06/06/2023**

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K 712	Continued From page 13 finding at the time of discovery.	K 712	recorded: • Monthly X 6 months All issues will be reported to administrator and brought to QAPI until compliance achieved.	
K 761 SS=F	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to inspect fire doors per NFPA 101 (2012 edition), Life Safety Code section 8.3.3.1, and NFPA 80 (2010 edition), Standard for Fire Doors and Other Opening Protectives, section 5.2.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 06/06/2023, between 11:45am and 3:45pm, it	K 761	K761 - SS=F - Maintenance, Inspection & Testing - Doors Immediate Corrective Action: Maintenance Director or designee completed the annual fire door inspection. All required documentation is stored in the inspection binder and stored electronically on the share drive. Corrective Action: This inspection has been added to the	7/21/23

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K 761	Continued From page 14 was revealed by review of available documentation the required annual door inspection documentation was not available at the time of the survey. An interview with the Maintenance Director and Acting Facility Administrator verified these deficient findings at the time of discovery.	K 761	TELS system and it will monitor and alert when due. Maintenance Staff education on K671 Monitoring: All issues will be reported to administrator and brought to QAPI as compliance is achieved.	
K 914 SS=F	Electrical Systems - Maintenance and Testing CFR(s): NFPA 101 Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to conduct	K 914	K914 - SS=F - Electrical Systems - Maintenance and Testing	7/21/23

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K 914	Continued From page 15 the electrical testing and maintenance per NFPA 99 Standards for Health Care Facilities 2012 edition, section 6.3.3.2, 6.3.4.1.3, and 6.3.4.2.1.2. This deficient findings could have a widespread impact on the residents within the facility. Findings include: On 06/06/2023, between 11:45am and 3:45pm, it was revealed by review of available documentation the required annual receptacle inspection documentation was not available at the time of the survey. An interview with the Maintenance Director and Acting Facility Administrator verified these deficient findings at the time of discovery.	K 914	Immediate Maintenance Director or designee completed the annual electrical receptacle inspection. All required documentation is stored in an inspection binder and electronically Corrective Action: This inspection has been added to the TELS system and it will monitor and alert when due. All inspections automatically scheduled. The Maintenance Director or designee will be alerted through TELS and PM schedule Maintenance Staff educated on K914. Monitoring: All issues will be reported to administrator and brought to QAPI as compliance is achieved.	
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36	K 918		7/21/23

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K 918	Continued From page 16 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to test and inspect the generator per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.4.4.1.1.4, and NFPA 110 (2010 edition), Standard for Emergency and Standby Power Systems, section 8.4.1 and 8.4.2. These deficient findings could have a widespread impact on the residents within the facility. Findings include: 1) On 06/06/2023, between 11:45am and 3:45pm, it was revealed by a review of available documentation of the emergency generator maintenance and testing weekly generator inspections were not performed from 06/06/2022	K 918	K918 - SS=F - Electrical Systems - Essential Electric Systems Corrective Action: The Maintenance Director or designee will complete weekly generator non-load tests following the required procedure. All required documentation recorded in inspections binder. Maintenance Director or designee will complete monthly generator load tests following the required procedure. All required documentation recorded in inspections binder. Maintenance Director or designee contacted external company for generator	

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K 918	Continued From page 17 to 06/06/2023. 2) On 06/06/2023, between 11:45am and 3:45pm, it was revealed by a review of available documentation of the emergency generator maintenance and testing monthly generator inspections were not performed between 06/06/2022 to 06/06/2023. 3) On 06/06/2023, between 11:45am and 3:45pm, it was revealed by a review of available documentation of the emergency generator maintenance and annual generator inspections was not performed. 4) On 06/06/2023, between 11:45am and 3:45pm, it was revealed by a review of available documentation of the emergency generator maintenance that a 36 month 4-hour load-bank test could not be provided. An interview with Maintenance Director and Acting Facility Administrator verified these deficient findings at the time of discovery.	K 918	contract. Requested and received contract paperwork. Scheduled 4-hour load bank test with external company. Scheduled annual service with external company. System Change: These inspections has been added to the TELS system and it will monitor and alert when due. All inspections automatically scheduled. The Maintenance Director or designee will be alerted through TELS and verify completion and accuracy. • Weekly Non-load Test • Monthly Load Test Monitoring: Audit generator test weekly X 2 months. All issues will be reported to administrator immediately for follow up and brought to QAPI committee at least quarterly.	