Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
August 13, 2024

Administrator
Lakehouse Healthcare & Rehabilitation Center
3737 Bryant Avenue South
Minneapolis, MN 55409

RE: CCN: 245055
Cycle Start Date: August 1, 2024

Dear Administrator:

On August 1, 2024, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Pete Cole, RN Regional Operations Supervisor
Metro Team C District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
625 Robert Street N
P.O. Box 64975
Saint Paul, Minnesota 55164-0975
Email: peter.cole@state.mn.us
Office/Mobile: (651) 249-1724

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

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

If substantial compliance with the regulations is not verified by November 1, 2024 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by February 1, 2025 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

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

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

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

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

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

Please note that the failure to complete the informal dispute resolution process will not delay the

dates specified for compliance or the imposition of remedies.

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

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

Feel free to contact me if you have questions.

Sincerely,



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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245055	A. BUILDING _____ B. WING _____	C 08/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEHOUSE HEALTHCARE & REHABILITATION CENTER	3737 BRYANT AVENUE SOUTH MINNEAPOLIS, MN 55409

(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 7/29/24 through 8/1/24, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73 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 staff, individuals providing services under	E 037		9/17/24

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

Electronically Signed | 08/19/2024

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

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E 037	Continued From page 1 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. *[For PRTFs at §441.184(d):] (1) Training	E 037		

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E 037	Continued From page 2 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 Program. The LTC facility must do all of the	E 037		

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E 037	Continued From page 3 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. The CAH must do all of the following:	E 037		

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E 037	Continued From page 4 (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 training at least annually which was based on the facility emergency preparedness plan (EPP). This had the potential to affect all 228 residents, as well as staff, volunteers and	E 037	Preparation and/or execution of this plan does not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its	

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E 037	Continued From page 5 visitors at the facility. Findings include: Review of the facility's EPP did not include annual education content that was specific to the facility's EPP. The EPP did include annual education using a Relias (national electronic learning management system) module, undated, titled Disaster Preparedness: Essentials. Review of the facility Relias module, undated, titled Disaster Preparedness: Essentials lacked any specific mention of the facility or the facility's EPP that included their hazard vulnerability analysis and patient populations most at risk. During interview on 7/30/24, at 1:48 p.m. administrator (DON) confirmed the facility's annual emergency preparedness training for staff was not specific to the facility's EPP and the content used was from a nationally produced Relias module During interview on 7/30/24, at 1:56 p.m. director of engineering (DOE) confirmed the facility used a Relias module that was not specific the facility or the facility's EPP for annual EP education for all staff.	E 037	employees, agents or other individuals who draft or may be discussed in this response and plan of correction. This plan of correction is submitted as the facility's credible allegation of compliance. The facility has updated the training to include the current EPP manual. The Director of Maintenance and Administrator have been re-educated on the requirement The Administrator/designee will complete audits weekly for 4 weeks and then monthly x 2. Facility QA&A Committee will review audit results.	
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).	E 039		9/17/24

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E 039	Continued From page 6 *[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 (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	E 039		

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E 039	Continued From page 7 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 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	E 039		

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E 039	Continued From page 8 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 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	E 039		

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E 039	Continued From page 9 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. (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	E 039		

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	245055	A. BUILDING _____ B. WING _____	C 08/01/2024

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E 039	Continued From page 10 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 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	E 039		

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E 039	Continued From page 11 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: (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	E 039		

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E 039	Continued From page 12 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 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.	E 039		

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E 039	Continued From page 13 (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 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	E 039		

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E 039	Continued From page 14 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, 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 conduct a full-scale community based exercise, or to document activation of their emergency preparedness plan or incident command system in response to an actual emergency event the facility experienced during the last year. This had the potential to affect all 228 residents who currently resided in the facility, along with staff and volunteers who work in the facility. Findings include: Review of the facility's emergency preparedness plan (EPP) binder did not include a full-scale community based exercise or documentation which demostrated the facility had activated their EPP which demonstrated how the plan was	E 039	The facility will conduct a full-scale community based exercise, or document activation of their emergency preparedness plan or incident command system in response to an actual emergency event the facility experienced during the last year. If an actual event is used, an After Action Review or analysis of the event would be conducted. The Director of Maintenance and Administrator have been re-educated on the requirement The Administrator/designee will complete audits weekly for 4 weeks and then monthly x 2. Facility QA&A Committee will review audit results.	

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E 039	Continued From page 15 activated and an after action review. During interview on 7/30/24, at 1:48 p.m.. administrator confirmed the facility had not conducted an annual community based exercise or qualifying demostration of activation of their EP during the last year since thier last recertification survey on 6/29/23 and had not documented activation of their EPP or incident command system or an after action review in response to an actual emergency event the facility experienced during the last year.	E 039		
F 000	INITIAL COMMENTS On 7/29/24 through 8/1/24, 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 with no deficiency issued. MN00105324 (H50556346C) MN00104254 (H50554732C) MN00104242 (H50554695C) MN00101556 (H50556283C) MN00101529 (H50556281C) MN00100271 (H50556282C) MN00099745 (H50556286C) MN00099406 (H50556284C) MN00098982 (H50556285C) MN00095800 (H50556288C) MN00097518 (H50556287C) The following complaints were reviewed with	F 000		

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F 000	Continued From page 16 deficient practices identified related to survey findings. MN00105107 (H50556261C)- Non-compliance cited at F880 MN00105105 (H50556262C)- Non-compliance cited at F880 MN00100962 (H50556280C)- Non-compliance cited at F554 MN00098499 (H50556289C)- Non-compliance cited at F554 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 that substantial compliance with the regulations has been attained.	F 000		
F 550 SS=E	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that	F 550		9/17/24

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F 550	Continued From page 17 promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide a dignified dining experience for 6 of 6 residents (R18, R15, R53, R142, R208, R386) who were seated at the dining room table with other residents who were served meals without being served meals themselves resulting in them waiting for their meals while tablemates dined and for 1 of 1	F 550	R18, R15, R53, R142, R208, and R386 are being provided a dignified dining experience. R386 is being groomed and dressed prior to being brought out for meals. R164 has had dressing preferences reviewed and care plan has been updated to reflect changes. Dining service has been reviewed and	

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F 550	Continued From page 18 resident (R386) who was brought to the dining room ungroomed in a hospital gown. In addition, the facility failed to ensure dignity was maintained for 1 of 1 (R164) observed for lack of clothing in bed. Findings include: Dining R203's significant change Minimum Data Set (MDS), dated 7/2/24, indicated R203 was cognitively intact. During an interview on 7/29/24 at 1:51 p.m., R203 stated food trays would often sit out in a serving cart waiting to be served to residents for over 30 minutes, often causing food to be served cold and past scheduled mealtimes. During observation on 7/31/24 at 7:30 a.m., R53 and R208 were sitting out in the main dining area. R208 was sitting in her wheelchair with her head resting against the table. During observation on 7/31/24 at 8:30 a.m., breakfast trays were brought up and on the unit and four residents were sitting out in the main dining area, including R53 and R208. The four residents were seated without drinks or food. During observation on 7/31/24 at 8:36 a.m., R386 was brought out to the dining room in a hospital gown, a blanket over her lap and greasy, matted unbrushed hair. During observation and interview on 7/31/24 at 1:51 p.m., R386 was back in bed, family member (FM)-H was present and stated he had brought	F 550	altered as needed to promote a dignified dining experience. Resident's are offered to be dressed and groomed prior to coming out for meals. Licensed nursing staff and Nursing assistants were educated on resident dignity and dining service procedure. The Director of Nursing/Designee will conduct 3 audits weekly x 3 weeks of the dining process and resident grooming to ensure dignity in accordance with resident preferences. Findings of this audit will be reviewed at QAPI until substantial compliance has been met.	

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F 550	Continued From page 19 R386 clothes yesterday to wear, just one outfit because she had lost so much weight, and he was not sure what size clothes she wore. FM-H stated, "as long as her bottom isn't hanging out, that is the best we could hope for." During an interview on 8/1/24 at approximately 10:00 a.m., nurse manager and registered nurse (RN)-H voiced understanding of the importance of creating a dignified and home like dining experience for the residents. RN-H further confirmed she would not expect a resident to appear the way R386 looked, stating "I was surprised how her hair looked" and R386 should have had her hair brushed before going to the dining room. During observation on 7/31/24 at 8:50 a.m., an unnamed therapy staff member entered the dining room to see a resident for therapy and stated, "Oh! You haven't eaten yet" stating he would come back later to see the resident for therapy. During observation on 7/31/24 at 8:53 a.m., R80 was wheeled to the dining room and the first breakfast trays were being passed out. R80 was seated at a table with R53 and R208 and was immediately served her breakfast tray. R53, R80 and R208 still were not served any drinks and R53 and R208 had been waiting approximately 1.5 hours for breakfast and were still not served. During observation on 7/31/24 at 8:58 a.m., at a second table R381 entered the dining room and was given her breakfast tray. R386 was still at the table without any food. During observation on 7/31/24 at 9:03 a.m., R53	F 550		

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F 550	Continued From page 20 and R208 were given their breakfast trays. R53, R80 and R208 were still not offered or served any drinks with their food. During observation on 7/31/24 at 9:15 a.m., R381 asked R386 if she was hungry and wanted something to eat, R386 responded by nodding her head "yes". R53, R80, and R208 were brought drinks after asking surveyor for something to drink. A facility aide brought over cranberry juice without asking what R53 or R208 would like to drink, even when they had asked for water. At 9:18 a.m., R386 was served her breakfast tray, 20 minutes after her tablemate R381. During an interview on 7/31/24 nursing assistant (NA)-M stated morning breakfast service was "a bit rough" that morning because he was the only NA on the floor who knew the residents. During an interview on 8/1/24 at 12:40 p.m., the director of nursing (DON) stated the facility, "could work on something" to ensure the residents had a home like, dignified dining experience. R18's significant change Minimum Data Set (MDS) assessment dated 7/8/24, identified R18 had severe cognitive impairment and required moderate assistance of staff for eating. R142's significant change MDS assessment dated 7/20/24, identified R142 had severe cognitive impairment and required maximal assistance with eating.	F 550		

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F 550	Continued From page 21 On 7/31/24 at 8:33 a.m., the breakfast meal service was observed on 5th floor main dining room. There were tables of resident's already eating who had been served their entrée. Observed was a square table that could seat four residents by the nursing station along the side of dining room with resident rooms where R18, R142 and tablemates were seated. R18 and R142's tablemates were served breakfast and were eating independently. At 8:47 a.m., R18 and R142's tablemate had finished eating and was talking on her cell phone at the table. At 8:48 a.m., R142 was served breakfast. At 8:50 a.m., an unidentified staff came back to the table with drinks for R142, sat down next to her to assist her to eat and told R18 to "sit back" as R18 was resting her head on the table (17 minutes after observation began). At 8:56 a.m., an unidentified staff served R18 breakfast and grabbed a chair to sit down next to assist her with eating (23 minutes after observation began). 7th Floor Observation R15's significant change MDS assessment 6/1/24, identified R15 with intact cognition and required set up assistance with eating. On 8/01/24 at 12:21 p.m., the afternoon meal was observed in the main dining room on 7th floor. R15 was seated at a table of four and two of his tablemates had been served lunch. At 12:34 p.m., R15's third tablet mate received her food. At 12:35 p.m., R15 received his tray (14 minutes after observation began).	F 550		

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LAKEHOUSE HEALTHCARE & REHABILITATION CENTER	3737 BRYANT AVENUE SOUTH MINNEAPOLIS, MN 55409

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F 550	Continued From page 22 During interview on 7/31/2024 at 10:29 a.m., nursing assistant (NA)-H stated that residents that are independent with eating are served meals first and residents who need help are served afterwards. NA-H verified that residents that need assistance with meals sit at tables with residents that don't need assistance with meals. NA-H stated they are responsible for getting room trays ready and delivered to resident rooms also. During interview on 7/31/24 at 2:26 p.m., licensed practical nurse (LPN)-C verified that meals are served by staff. They stated, "the people who need assistance are the last one who get their meals." LPN-C verified that residents who need assistance with meals sit with residents who are independent with eating. LPN-C verified that serving meals can take time as they serve a lot of residents. During interview on 7/31/24 at 2:28 p.m., registered nurse (RN)-I verified there is an order to how trays are delivered to residents. RN-I stated, "to my understanding, independent residents get their meals first, moderate assistance get their meals next and then the residents who need the most assistance get served last." RN-I verified the more assistance the resident needs with eating, the longer they must wait to be served. RN-I verified residents with different need levels sit together at tables. RN-I stated they think this is so there is more staff to help assist residents to eat. Clothing R164's significant change Minimum Data Set (MDS) dated 10/12/23, indicated R164 had	F 550		

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F 550	Continued From page 23 severely impaired cognition. R164's quarterly MDS dated 7/14/24, indicated R164 did not speak, rarely/never understood verbal content, and was diagnosed with dementia. In addition, R164 was dependent on staff for bed mobility, lower body dressing, and toileting hygiene. R164's care plan dated 7/19/24, indicated R164 required the assistance of two for dressing. During an interview on 7/29/24 at 2:49 p.m., resident representative (RR)-C stated she visited R164 almost daily. RR-C stated after staff would assist R164 to bed, she noticed his pants would often be left off, left around his ankles, or left around his knees. RR-C stated she knew this was something R164 would not like and would not have done if he was still dressing himself. RR-C stated she could tell that it "bugged" him, and it bugged her that they kept doing it. RR-C stated she had told staff previously, but the facility used "so many" agency staff it never seemed to be communicated to the incoming shifts that he didn't like this. RR-C stated that although she had told staff she didn't feel like she should have to tell people not to do that. During observation and interview on 7/30/24 at 2:04 p.m., R164 was observed in bed wearing a T-shirt and a brief with no pants on. Nursing Assistant (NA)-J stated he had assisted R164 to bed after lunch. NA-J stated he had taken and left R164's pants off so R164 did not "wet the bed" and his pants because then he would have to change both of those. NA-J stated he worked for an agency and had never worked with R164 previously and that was how he was taught to put	F 550		

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F 550	Continued From page 24 people to bed. During an interview on 8/1/24 at 2:26 p.m., the director of nursing (DON) stated if R164 or his representative wished for R164's pants to be left on in bed, they should be left on.	F 550		
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: Based on observation, interview, and document review, the facility failed to ensure a self-administration of medications (SAM) assessment was completed to allow a resident to safely self-administer medications for 1 of 1 (R184) residents reviewed for self-administration of medications. Findings include: R184's admission Minimum Data Set (MDS) dated 5/28/24, indicated R184 had moderate cognitive impairment, didn't have signs of delirium, and didn't refuse cares or medications. The MDS indicated R184 was dependent with showers, lower body dressing, toileting, bed mobility, and transfers. R184 needed substantial assistance with upper body dressing, oral hygiene and eating. R184's Clinical diagnosis record printed 1/31/24, indicated diagnoses of dysphagia (difficulty swallowing) following unspecified cerebrovascular	F 554	A Self-Administration assessment has been completed for R184 and the plan of care was updated to reflect changes. Plans of care have been updated to include a Self-administration assessment. Nurse managers and Licensed Nurses have been educated on the need to complete an assessment for self-administration of medications. The Director of Nursing/Designee will conduct 3 audits weekly x 3 weeks to ensure an assessment is complete for residents that self-administer medications. Findings of this audit will be reviewed at QAPI until substantial compliance has been met.	9/17/24

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F 554	Continued From page 25 disease (condition that affect blood flow and the blood vessels in the brain), gastrostomy status (surgical procedure that creates an opening in the abdomen and into the stomach, allowing for the insertion of a feeding tube), hemiplegia (paralysis of one side of the body) and paraplegia (paralysis of the legs and lower body, typically caused by spinal injury or disease) following cerebral infarction (stroke) affecting right dominant side, chronic obstructive pulmonary disease (lung disease that blocks airflow and makes it difficult to breath), chronic respiratory failure with hypoxia (low oxygen level in the blood) , protein-calorie malnutrition, chronic atrial fibrillation (heart arrhythmia that causes the upper chambers of the heart to beat irregularly and quiver for5 more than 12 months), atrial flutter (condition in which the heart's upper chambers beat too quickly), and dysthymic disorder (a mild but long-term form of depression). R184's Clinical Physician orders printed 7/31/24 lacked orders for the self-administration of medications. R184's electronic medical record reviewed 7/31/24, lacked an assessment for self-administration of medications. During observation on 7/31/24 at 8:00 a.m., registered nurse (RN)-G filled the nebulizer chamber with albuterol sulfate (medication for shortness of breath) nebulizer 2.5 milligrams (mg)/3 milliliters (ml) vial. RN-G asked R184 if she should start the nebulizer machine. R184 answered, he will do it himself when he returned from smoking. RN-G stated that was okay and left the room.	F 554		

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F 554	Continued From page 26 During interview on 7/31/24 at 8:05 a.m., RN-G was questioned if R184 was able to start the nebulizer machine on his own. RN-G said, "He wants to smoke first, he can hold it by himself. He will ask somebody to turn it on." During observation on 7/31/24 at 11:30 a.m., residual nebulizer solution was observed remaining in the nebulizer cup. During interview on 7/31/24 at 11:37 a.m., RN-G said she started the nebulizer machine for him and left the room. RN-G added, "He doesn't like it when we stay in the room, and he is doing his neb treatment." RN-G said the order to self-administer medications should be okay by the doctor. RN-G was not sure if R184 had an order to self-administer medications. During interview on 7/31/24 at 1:09 p.m., R84 stated "the nurses pour the medication in the nebulizer cup. I don't need help to turn on and off the nebulizer machine. The nurse never stays in the room while I do my neb treatment." During interview on 7/31/24 at 1:42 p.m., nurse manager (RN-E) stated a doctor's order, and a self-administration assessment were needed to self-administer a nebulizer treatment. RN-E verified R184 didn't have a self administration order or an assessment. RN-E stated the assessment needed to be completed to establish if resident was able to safely administer his own medication. A facility's self-administration of medications policy and procedure was requested but not received.	F 554		

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F 584	Continued From page 27	F 584		
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to	F 584		9/17/24

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F 584	Continued From page 28 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to ensure vinyl floors were clean and in good condition for 2 of 5 resident dining rooms (2nd floor memory care unit and 3rd floor) and 1 of 1 (R134) resident rooms reviewed for environment. Findings include: R134's quarterly Minimum Data Set dated, 7/20/24 documented R134 with severe impairment of cognitive skills, physical and verbal symptoms directed towards others, had an indwelling catheter. In addition, R134 with diagnoses of Alzheimer's disease, dementia, seizures, depression, anemia, renal insufficiency (decreased kidney function), neurogenic bladder (disruption of the nervous system and the bladder) and obstructive uropathy (difficulty voiding). Also, R134 required extensive assistance of one staff member with bed mobility, eating, toilet use and required setup or clean-up assistance with oral hygiene. R134's Profile in the electronic medical record (EMR) listed family member (FM-A) as Responsible Party, primary Emergency Contact, Power of Attorney, Care Conference Person, Essential Caregiver, Financial Responsibility and Health Care Agent. During interview with FM-A on 7/29/24 at 3:25 p.m., FM-A stated, "The room is sometimes really	F 584	R134's room has been deep cleaned. The facilities 2 Raines memory care and 3 gamble dining rooms have been cleaned and removed stickiness. Dining room floors and resident rooms with laminate flooring have been scrubbed and free from sticky material. Environmental Servies department, have been educated on the process for routine and timely floor cleaning in dining rooms and resident rooms. Director of EVS/Designee will audit 2 resident rooms/dining rooms whose flooring is laminate to ensure cleanliness weekly x 3 weeks, then 2 resident rooms/dining rooms monthly x 3 months. Findings of this audit will be reviewed at QAPI until substantial compliance has been met.	

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F 584	Continued From page 29 smelly. I don't think it is cleaned as much as it should be. The floor looks unswept or mopped". During observation on 7/29/24 at 3:50 p.m., the floor in R134's room was observed to be tacky to walk on causing shoes to stick to the floor. During observation and interview on 7/30/24 at 7:33 a.m., and 7:43 a.m., the second-floor memory care unit main dining room floor was observed to be tacky to walk on causing shoes to stick to the floor at the Northwest corner in front of the window. Trained medication aide (TMA)-A stated the floors were, "super-sticky" and said the housekeeping staff was responsible for cleaning the floor after every meal. During observation and interview on 7/30/24 at 7:57 a.m., TMA-B verified the second-floor memory care unit main dining room floor was tacky to walk on causing shoes to stick to the floor at the Northwest corner in front of the window. TMA-B stated the housekeeping department, "is supposed to be cleaning it up." TMA-B then stated he would notify the housekeeping department to clean the floor. During observation and interview with the director of social services (SW)-A on 7/30/24 at 2:17 p.m., a section of the third-floor main dining room floor was tacky to walk on causing shoes to stick to the floor. An unidentified staff member walked to the resident refrigerator and walked around the sticky section of the floor. SW-A stated, "yes, it appears sticky" and stated she would notify housekeeping to clean the floor. During interview with head of maintenance (DOE) on 7/30/24 at 3:49 p.m., DOE stated, "the floor	F 584		

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F 584	Continued From page 30 care is done by a third-party company that we contracted for. Daily housekeepers are going by doing floor care in each resident room. The floors are cleaned after every meal in dining rooms". During observation and interview on 7/31/24 at 7:19 a.m., the second-floor memory care unit main dining room floor at the Northwest corner in front of the window was observed to be tacky to walk on causing shoes to stick to the floor. TMA-B verified the floor was sticky, "yes, it is for sure". TMA-B walked over to housekeeper (H-C) and asked him to use the floor machine to clean the floor. H-C stated the food spills, "make it [floor] dirty. My mop will not pick this sticky stuff up." And "I don't know when the floor was last cleaned by the machine, but it should be. This is too sticky." During observation and interview with registered nurse (RN)-C on 7/31/24 at 7:44 a.m. in R134's room, RN-C stated, "the floor is sticky here. It should be cleaned. We are to tell housekeeping. The dark matter on floor appears to be food which means the floor was not cleaned recently". During interview with RN-D on 7/31/24 at 7:52 a.m., in R134's room, RN-D stated, "the floor is dirty here at the head of the bed. It looks like old food on the floor here and should be mopped up. " During interview with facility associate administrator (AA) on 7/31/24 at 10:09 a.m., AA stated, "they [housekeepers] did not strip the floor before waxing it. I had to scrape it today and showed the contract team that it was waxed. They should not have waxed the old floor anyways. The old wax was never removed. All	F 584		

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F 584	Continued From page 31 the [memory care and third floor dining room floors] need to be waxed correctly." AA stated the same was true for R134's floor. Facility policy on environmental cleaning and maintenance of floors was requested but not received.	F 584		
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;	F 623		9/17/24

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F 623	Continued From page 32 (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and	F 623		

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F 623	Continued From page 33 (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure a written notice of transfer was sent to the office of the Ombudsman for long term care for 2 of 4 residents (R60, R27) reviewed for hospitalization. Findings include: R60 R60's quarterly Minimum Data Set (MDS) dated 5/5/24 identified R60 with diagnoses of a stroke	F 623	A log that includes the transfers for R60 and R27 on 4/23/24 and 1/23/24 were sent to the state ombudsman. The state ombudsman has been sent an updated Point Click Care action summary report of transfers that were overnight since 8/1/24. The transfer process going forward will be adjusted manually to include all hospital transfers including those under 24hrs. Social Services, have been educated on the requirement of state ombudsman notification	

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F 623	Continued From page 34 with paralysis affecting the right dominant side, renal insufficiency, urinary tract infection, diabetes, and an unhealed pressure ulcer to right heel. R60's electronic medical record (EMR) section titled "Profile" identified primary emergency contact, power of attorney (POA), care conference person, and financial responsibility person as emergency contact (EC)-A. R60's Progress Notes (PN) tab, the notes are listed in vertical columns titled, "Effective Date, Type, Note, Care Plan Item or Task, Dept, Shift Report, 24 Hour Report". R60's PN from licensed practical nurse (LPN)-D, dated 4/23/24 at 10:24 p.m. documented, "Note Text: Resident send to HCMC ER at 2130". PN on 4/23/24 at 10:28 p.m. documented EC-A was notified of R60's emergency room transfer. The PN failed to document a bed hold was discussed. R60's hospital discharge summary identified a hospitalization from 4/23/24 to 4/29/24 and that R60, "is unable to verbalize understanding of condition and treatment plan due to patient having dementia". During review of R60's EMR, no written notices of transfer was issued. R27 R27's quarterly MDS dated 5/6/24, identified R27 was cognitively intact and had diagnoses of coronary artery disease (narrowing or blockage of heart's arteries), heart failure (heart muscle does not pump blood as well as it should), hypertension (high blood pressure; pressure in	F 623	Director of Social Services/Designee will audit 2 residents who are transferred out of the building weekly x 3 weeks, then 2 residents monthly x 3 months. Findings of this audit will be reviewed at QAPI until substantial compliance has been met	

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F 623	Continued From page 35 blood vessels is too high), peripheral vascular disease (narrowed blood vessels reduce blood flow to legs or arms), kidney disease (loss of kidney function), diabetes mellitus (condition which causes high blood sugar), schizophrenia (mental health condition which affects how people think, feel and behave), and asthma (chronic condition which inflames and narrows the airways in the lungs and makes it hard to breathe). R27's EMR section titled "Profile" identified R27 as own responsible party and financial responsibility and EC-B as emergency contact one, care conference person, and health care agent. R27's PN from LPN-I dated 1/22/24 at 6:15 p.m., indicated R27 went to HCMC emergency room via ambulance and was admitted for atrial fibrillation (fast, abnormal heart rhythm). R27's hospital discharge summary identified a hospitalization from 1/22/24 to 1/25/24. R27's EMR lacked evidence a written notification of transfer was sent to the ombudsman for long term care. During interview with nurse manager of R60's resident unit, registered nurse (RN)-F on 8/1/24 at 10:43 a.m., RN-F stated the expectation of nursing staff was to provide a paper copy of the "Transfer Notice" to the resident or POA and then document in the resident's EMR under the Progress Notes with Type of note labeled as, "Bed Hold" and not "Note Text". RN-F reviewed PN for both R60 and R27 and stated, "I cannot find a bed hold or information that was offered. It should have been done and documented but	F 623		

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F 623	Continued From page 36 wasn't". During interview with the director of social services (SW)-A on 8/1/24 at 11:16 a.m., SW-A stated they faxed a report to the ombudsman which listed discharges, hospitalizations, deaths, and other information from the EMR portal. SW-A reviewed the reports for 1/24 and 4/24 and verified they did not include hospitalizations for R60 or R27. During interview with the director of social services (SW)-A on 8/1/24 at 11:26 a.m., SW-A stated the expectation of nursing staff was to fill out and provide the bed hold and transfer forms to residents prior to the transfer. Also, SW-A stated if the transfer were emergent then the resident or guardian would be notified by phone to request a bed hold. Regardless of whether the transfer or discharge were emergent, SW-A stated the expectation of staff to document the conversation or attempts in a progress note. SW-A reviewed R60's and R27's progress notes and stated, "it is not mentioned in [the] progress notes and it should be." During additional interview with SW-A on 8/1/24 at 12:12 p.m., SW-A and vice president of clinical operations (CO) noted a technical "glitch" between the EMR portal and the Admission/Discharge - To/From report. A ticket was submitted, and they would compare the portal and report until the report accurately pulled all needed information. During interview on 8/1/24 at 2:25 p.m., administrator acknowledged the technology issue with the report faxed to the ombudsman and stated communication with the ombudsman was	F 623		

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F 623	Continued From page 37 important and they did not lack communication with them. Per email communication with the Office of Ombudsman for Long-Term Care on 8/2/24 at 8:17 a.m., the Ombudsman was not notified of R60's and R27's transfers or discharges. The facility did not have a policy for notification of transfer to the ombudsman.	F 623		
F 645 SS=D	PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3) §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services; or (ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission- (A) That, because of the physical and mental condition of the individual, the individual requires	F 645		9/17/24

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F 645	Continued From page 38 the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability. §483.20(k)(2) Exceptions. For purposes of this section- (i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital. (ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual- (A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital, (B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and (C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services. §483.20(k)(3) Definition. For purposes of this section- (i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1). (ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as	F 645		

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F 645	Continued From page 39 described in 435.1010 of this chapter. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure a level I Pre-Admission Screening and Resident Review (PASARR) was completed prior to admission for 1 of 1 residents (R63). Findings include: R63's significant change Minimum Data Set (MDS) dated 5/17/24, indicated R63 had intact cognition. R63's medical diagnoses list dated 4/19/24, indicated R63 was diagnosed with generalized anxiety disorder, major depressive disorder, and schizoaffective disorder (a mental health condition that is marked hallucinations, delusions, and mood disorder symptoms, such as depression, mania) R63's PASARR dated 10/12/23, indicated "the PAS [PASARR] is not final until the lead agency sends the documentation to the nursing facility." R63's entire medical record was reviewed and lacked evidence a final determination had been received by the county or managed care program as directed by the PAS. During an interview on 7/31/24 at 8:43 a.m., the director of social services (SW)-A stated after reviewing R63's preadmission screening dated 10/12/23, she believed this was the final documented and indicated R63 did not require any additional screening. SW-A stated she would look into the issue and confirm that this was the final PASARR for R63.	F 645	the facility will reach out to the county for clarification on R63 PASSR for clarification on the final determination letter. Resident's who are a current resident of Lakehouse have a PASARR and final determination uploaded into their medical records Social Services and Admission team have been educated on obtaining PASARR's prior to admission to Lakehouse. Admissions Manager/Designee will audit resident charts to ensure a PASARR final determination is present for all new admissions. Audits will occur 2 x weekly x 2, then 4 x monthly for 3 months. Findings of this audit will be reviewed at QAPI until substantial compliance has been met	

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F 645	Continued From page 40 During an interview on 8/1/24 at 8:27 a.m., the senior linkage line representative (SLL) stated she had reviewed the PAS that they had on file for R63 that said "the PAS [PASARR] is not final until the lead agency sends the documentation to the nursing facility" dated 10/12/23 and this was not the final PASARR. SLL stated the facility needed to reach out the lead agency, in this case Hennepin County. SLL stated the lead agency would process the PAS and give the facility the final determination, what the document described was not the final PASARR. During email communication on 8/5/24 at 12:47 p.m., administrator indicated the facility had a copy of R63's PASARR in the medical record and did not trigger for a level two PASARR assessment. On review the PASARR document provided was the same one dated 10/12/23 as described as above and did not contain the required final PASARR determination from the lead agency. A policy regarding PASARR completion or maintenance was requested and not received.	F 645		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the	F 657		9/17/24

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F 657	Continued From page 41 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 record review the facility failed to ensure timeliness of person-centered care conferences for 3 of 5 residents (R9, R103, R134) reviewed for care conferences. R9 R9's quarterly Minimum Data Set (MDS) dated 5/11/24, indicated R9 was admitted on 5/17/22, and had no cognitive deficits. A review of R9's medical record indicated R9's last care conference was on 2/1/24 and did not demonstrate that a care conference occurred after 2/1/24 or a reason this would not have been practicable for R9. During an interview on 7/29/24 at 2:21 p.m., R9	F 657	R9, R103, and R134 care conferences have taken place Residents last care conference date have been reviewed and care conferences have been scheduled for out of date care conference. Social Workers, Nurse Manager have been educated on importance of quarterly care conferences. Administrator/Designee will conduct audits on 2 resident charts weekly for 3 weeks, then 3 resident charts monthly x 3 months to ensure care conferences are taking place and schedules are being followed. Findings of this audit will be reviewed at QAPI until substantial compliance has been met.	

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F 657	Continued From page 42 stated she didn't remember having a care conference with facility staff since the beginning of the year and wished she had been more updated and involved in her care. During an interview on 7/30/24 at 3:04 p.m., social worker (SW)-B stated the social work department had gone through a lot of turnover and there was a "backlog" of care conferences. SW-B stated after reviewing R9's medical record it looked like R9 should have had a care conference to correlate with her MDS in May but that had not occurred. R103 R103's quartely MDS dated 6/27/24 identified R103 as cognitively intact, with diagnoses of neuroleptic induced Parkinsonism, heart failure, and diabetes. During review of R103's Care Conference Summary section of the electronic medical record (EMR), R103's EMR lacked evidence of any care conferences between 1/25/24 and 8/1/24 despite MDS data was submitted on 3/27/24 and 6/27/24. During interview with R103 on 8/1/24 at 3:48 p.m., R103 stated, "no I haven't had a care conference this year. I don't know the plan for me. [sic] would like to know so I can plan or figure out what to do." R134 R134's quarterly Minimum Data Set dated, 7/20/24 indicated R134 with severe impairment of cognitive skills, physical and verbal symptoms	F 657		

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F 657	Continued From page 43 directed towards others, had an indwelling catheter. In addition, R134 with diagnoses of Alzheimer's disease, dementia, seizures, depression, anemia, renal insufficiency (decreased kidney function), neurogenic bladder (disruption of the nervous system and the bladder) and obstructive uropathy (difficulty voiding). Also, R134 required extensive assistance of one staff member with bed mobility, eating, toilet use and required setup or clean-up assistance with oral hygiene. During review of R134's Care Conference Summary section of the electronic medical record (EMR), R134's EMR lacked evidence of any care conferences between 1/25/24 and 6/26/24 despite MDS submission of data on 4/19/24. During interview with the director of social services (SW)-A on 7/30/24 at 8:04 a.m., SW-A stated she was responsible for ensuring care conferences were scheduled and completed corresponding to MDS timeframes including change of condition. SW-A reviewed R103 and R134's EMR and stated, "there probably has been a lapse in care conferences. Looks like there was one that wasn't done from January to June 2024." SW-A stated the importance of timely care conferences, "to review care with family and staff". During an interview on 8/1/24 at 2:24 p.m., the director of nursing (DON) stated they had a "massive turnover" with the social work department and was aware of issues with care conference completion. The DON stated the care conferences should have been completed quarterly, annually, and as needed. The DON stated this was important to ensure	F 657		

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F 657	Continued From page 44 communication was occurring between the facility and the resident, and to ensure the care plan included the resident's goals and wishes. Facility policy regarding timing of care conferences was requested but not received.	F 657		
F 677 SS=E	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure routine personal care and hygiene (i.e., bathing, nail care, hair combing) was offered and/or completed for 5 of 6 residents (R39, R184, R134, R179, R383) reviewed for activities of daily living (ADLs) and who required staff assistance to complete such care. Findings include: R39 R39's significant change Minimum Data Set (MDS), dated 6/4/24, identified R39 had moderate cognitive impairment, demonstrated no delusional thinking, and was not diabetic. On 7/29/24 at 2:01 p.m., R39 was observed seated in his electric wheelchair while in his room. R39 had visibly long fingernails present on both hands, and the edge of the nail being multiple millimeters (mm) long on several nails	F 677	R39, R184, R134, R179, and R383 have received personal hygiene; to include bathing, nail care, and hair combing. Residents requiring staff assistance with personal hygiene have received a care plan review to ensure ADL hygiene care is up to date and routine schedules are in place. Residents requiring staff assistance receive routine personal care, bathing, nail care, and hair combing per resident plan of care. Nurse Managers, Licensed Nurses, and Nursing Assistants have been educated on routine personal hygiene for residents needing assistance. The Director of Nursing/Designee will conduct 3 audits weekly x 3 weeks to ensure residents are receiving personal hygiene per their plan of care. Findings of this audit will be reviewed at QAPI until substantial compliance has been met.	9/17/24

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F 677	Continued From page 45 with a dark-colored substance present underneath multiple nail edges. R39 was interviewed and stated the bathing he was provided at the care center was usually inadequate adding, "[They] spray you a little bit and call it done." R39 stated the poor bathing assistance was "turning my fingernails brown." R39 stated he needed help to clip and clean them but nobody from the care center ever offered help reiterating he wanted them clipped adding aloud, "I sure would." R39's care plan, dated 6/15/24, identified R39 had an ADL self-care deficit with dictation reading, "Refuses to shower prefers to wash self-up in bathroom. Care needs fluctuate throughout the day." The plan listed several interventions for R39 including, "PERSONAL HYGIENE/ORAL CARE: The resident is independent." However, the care plan lacked information on what, if any, help or assistance R39 needed with nail care, including finger or toenails. The following day, on 7/30/24 at 1:50 p.m., R39 was observed laying in bed while in his room. R39's fingernails remained long and soiled as had been observed the day prior. R39's POC (Point of Care) Response History, printed 8/1/24, identified a 21-day review period of bathing support provided to R39. This identified staff recorded assistance on 7/16/24, 7/21/24, and 7/25/24. However, the data lacked further specific information on what cares were offered or completed. R39's medical record was reviewed, including progress notes and assessments (i.e., skin checks), and lacked evidence R39 had been offered or assisted with	F 677		

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F 677	Continued From page 46 nail care within the past several weeks despite having visibly long, soiled nails present. When interviewed on 7/30/24 at 1:58 p.m., nursing assistant (NA)-H stated they had worked with R39 multiple times prior and described him as often refusing care adding, "[he] will not let you do anything for him." NA-H stated R39 was scheduled for a shower that day (7/30) and, earlier, NA-H offered it but R39 refused. However, NA-H stated they did not offer R39 any nail care or clipping. NA-H stated the NA can do such care if the resident is not diabetic but nail care, including if offered or refused, was not usually charted or documented. NA-H stated R39 often scratches himself adding, "he does that a lot." Later, at 2:17 p.m., R39 came off the elevator in his electric wheelchair and NA-H observed R39's fingernails with the surveyor present. NA-H verified their length and condition expressing aloud, "It's dirty." R39 was again asked about clipping his fingernails and was agreeable. On 7/30/24 at 2:20 p.m., registered nurse manager (RN)-E was interviewed. RN-E stated nail care was typically done "as needed" but usually offered on the scheduled bath days. RN-E stated the NA was able to complete it if the resident was not diabetic and, if refused, the nurse should document a progress note in the medical record adding, "They document the refusal." At 2:22 p.m., the director of nursing (DON) joined the interview. DON stated R39 often refused care adding, "I'm surprised he said yes to [NA-H]." DON verified the NA charting doesn't have the ability to record any nail care offered and refused, but expressed nail care should be offered with bathing adding, "The	F 677		

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expectation is nail care is a part of it." RN-E stated the only documentation they could locate was a progress note (dated 7/2/24) which outlined R39 refused his shower, and RN-E verified R39 would need staff help to clip the nails. RN-E and DON both acknowledged the lack of any documentation to demonstrate nail care had been offered or provided within the past several weeks. DON stated it was important to ensure nail care was offered and, if able, completed to promote good hygiene and as it was "a dignity thing."

R184

R184's admission MDS, dated 5/28/24, identified R184 had moderate cognitive impairment, demonstrated no delusional thinking, required substanital/maximal assistance with personal hygiene, and was not diabetic.

On 7/29/24 at 5:57 p.m., R184 was observed while in his room. R184's right hand had a visible contracture with the finger turned into the palm making a nearly closed fist; however, the left hand had multiple long fingernails present with the nail edge being several millimeters (mm) in length and some having a dark-colored debris present underneath. R184 stated he was helped with a bath "every week" and looked down at his nails when asked about them. R184 was asked if staff helped him or offered to clip them ever and he responded aloud, "They haven't so far." R184 stated he wanted his nails clipped and kept shorter.

R184's care plan, dated 7/12/24, identified R184 had an ADL self-care deficit along with several interventions which included, "PERSONAL

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HYGIENE: The resident requires assistance from staff with personal hygiene and oral care." The care plan lacked information or direction on nail care for R184.

R184's POC Response History, printed 8/1/24, identified a 21-day review period of bathing support provided to R184. This identified staff recorded assistance on 7/14/24 and 7/21/24. However, the data lacked further specific information on what cares were offered or completed. R184's medical record was reviewed, including progress notes and assessments (i.e., skin checks), and lacked evidence R184 had been offered or assisted with nail care within the past several weeks despite having visibly long, soiled nails present.

On 7/31/24 at 10:15 a.m., NA-H was interviewed. NA-H explained they had worked with R184 prior and he was typically accepting of cares adding, "He's [R184] cool with me." NA-H stated nail care was typically done with bathing and not documented in the medical record, however, if it was offered and refused then the nurse would record it in the notes. Further, NA-H stated R184 was scheduled for a Sunday evening (PM) bath. At 10:24 a.m., NA-H and the surveyor looked at R184's nails while he was seated outside smoking. NA-H verified the length and condition adding, "They need to be trimmed down." NA-H stated the debris under the nails appeared "like he's itching or something." NA-H stated they would clip them that day.

When interviewed on 7/31/24 at 11:28 a.m., RN-G stated R184 was usually accepting of cares and the NA could clip his nails if he wanted them done. RN-G stated any nail care offered and

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F 677	Continued From page 49 refused, should be recorded in the progress notes and then staff should "let the manager know." R134 R134's quarterly Minimum Data Set dated, 7/20/24 documented R134 with severe impairment of cognitive skills, physical and verbal symptoms directed towards others, had an indwelling catheter. In addition, documented R134 with diagnoses of Alzheimer's disease, dementia, seizures, depression, anemia, renal insufficiency (decreased kidney function), neurogenic bladder (disruption of the nervous system and the bladder) and obstructive uropathy (difficulty voiding). Also, R134 required extensive assistance of one staff member with bed mobility, eating, toilet use and required setup or clean-up assistance with oral hygiene. R134's Profile in the electronic medical record (EMR) listed family member (FM-A) as Responsible Party, primary emergency contact, Power of Attorney, care conference person, essential caregiver, financial responsibility and health care agent. R134's Kardex (nursing assistant care sheet) printed 7/31/24, identified R134 requiring assistance of one staff member for personal hygiene. During interview with FM-A on 7/29/24 at 3:25 p.m., FM-A stated, "[R134] would not like it if he were unshaved and hair looking greasy and uncombed."	F 677		

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F 677	Continued From page 50 During observation on 7/29/24 at 3:50 p.m., R134 laying in bed sleeping with face unshaved and hair glossy and uncombed. Review of R134 electronic medical record (EMR) under "Tasks" tab, the nursing assistant daily documentation of "Task: ADL-Personal Hygiene" for the month of July 2024, R134 did not refuse support for "How resident maintains personal hygiene, including combing hair, brushing teeth, shaving, applying makeup, washing/drying face and hands". During observation on 7/31/24 at 7:38 a.m., R134 was observed laying on bed with a dried brown stain on pillowcase adjacent to his mouth. R134's hair was glossy, oily and uncombed and his face had whiskers .25 inches long. R134's lips were dry and chapped with a dried white substance in corner of left side of mouth. During observation and interview with registered nurse (RN)-C in R134's room on 7/31/24 at 7:44 a.m., RN-C verified the stained pillowcase, "it is soiled. [R134] it needs to get washed up. Appears like [R134] has not been shaved in over a week. Aides are to offer sponge baths and shave men if they allow them to. If they refuse the shave or bed bath, I expect the aides to let me know and we can re-approach." During observation and interview with registered nurse (RN)-D in R134's room on 7/31/24 at 7:52 a.m., RN-D stated, "Yes, [R134] appears to not have been shaved or cleaned up. Hair is oily looking". During interview with nursing assistant (NA)-B on 7/31/24 at 8:00 a.m., NA-B stated she was	F 677		

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familiar with R135. NA-B stated nursing assistants receive a verbal report each day and are expected to review the electronic medical record (EMR) in the care plan Kardex (nursing assistant care sheet) to determine what tasks such as personal cares, diet intake, and outputs, and dressing assistance are supposed to be done for each resident. NA-B stated the nursing assistants who work on the memory care unit do not receive any paper list or care sheets on the residents. NA-B stated nursing assistants are expected to shave men, "as needed or as allowed". NA-B looked in R135's EMR and verified she was unable to determine when R135 was shaved or cleaned up.

During interview with RN-C on 7/31/24 at 1:24 p.m., RN-C stated, "yes [R134] looked like he did not have shave in a long time."

R179

R179's quarterly MDS, dated 7/6/24, indicated R179 was admitted to the facility on 6/5/24, was cognitively intact and required partial to moderate assistance with personal hygiene.

R179's Care Plan, dated 6/5/24, indicated R179 had "an ADL [activities of daily living] self-care performance deficit r/t [related to] a recent hospitalization with right humerus [upper arm bone] fx [fracture], DM2 [diabetes mellites type II], and hx [history] of CVA [cerebral vascular accident]" and required staff assistance with personal hygiene.

During observation and interview on 7/29/24 at

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F 677	Continued From page 52 6:17 p.m., R179 was laying in her bed, her fingernails and toenails were noticeably long, approximately ¼ inch and her toenails appeared to be starting to curve over. R179 stated she had asked staff to cut her nails or see the podiatrist but had not "heard a thing about it." R179 stated staff had told her they could not cut her nails because she had diabetes. During an interview on 7/31/24 at 9:39 a.m., nursing assistant (NA)-M stated he would not cut a resident's fingernails or toenails if they had a diagnosis of diabetes, but the nursing assistants should notify the nurse if a resident needed toenails or fingernails cut or requested to see the podiatrist. During an interview on 7/31/24 at 11:38 a.m., licensed practical nurse (LPN)-F stated any nurse can cut or trim a resident's fingernails if they have a diagnosis of diabetes, toes nails would depend on an assessment and if he felt "comfortable enough" to cut them, often the resident would see podiatry for their toenails. During an interview on 8/1/24 at approximately 10:30 a.m., nurse manager and registered nurse (RN)-H stated it was expected that any nurse would be able to cut a resident's fingernails or toenails, even with a diagnosis of diabetes. RN-H stated she had cut R179's toenails yesterday evening, 7/31/24. During an interview on 8/1/24 at 12:40 p.m., the director of nursing (DON) stated it was expected that a resident with long toenails or fingernails should have their nails cut or trimmed on bath day.	F 677		

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R383

R383's admission MDS, dated 7/21/24, indicated R383 was admitted to the facility on 7/21/24, was cognitively intact and required partial to moderate assistance with activities of daily living (ADLs) to include toileting, bating and dressing.

R383's Care Plan, dated 7/15/24, indicated R383 had an "ADL self-care performance deficit r/t [related to] recent hospitalization for traumatic ischemia [reduced blood flow] of muscle, COPD [chronic obstructive pulmonary disease, lung disease causing restricted airflow and breathing problems], emphysema [a condition in which the air sacs of the lungs are damaged and enlarged, causing breathlessness], and schizoaffective disorder [a mental health condition including schizophrenia and mood disorder symptoms]" and required assistance from one staff member with showering or bathing.

R383's Task-ADL Bathing, printed 7/31/24, indicated R383 bath day was Wednesday and had not received a bath or shower since she admitted to the facility, indicating on 7/24/24 and 7/31/24 "resident refused."

During observation and interview on 7/29/24 at 2:29 p.m., R383 was sitting on her bed dressed in a hospital gown, her hair was noticeable greasy and matted. R383 stated she had not had, or been offered, a shower since she got the facility.

During an interview on 7/31/23 at 11:38 a.m., licensed practical nurse (LPN)-F stated if he was made aware of a resident refusing a bath or

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F 677	Continued From page 54 shower, he would approach the resident and explain the benefits of accepting a shower but was not "100% sure" what the facility policy or expectation was for refusal. LPN-F further stated he had never heard of R383 refusing cares and she was usually very easy to work with. During a follow up observation and interview on 8/1/24 at 12:01 p.m., R383's hair continued to look greasy and matted and her finger and toenails were approximately ¼ inch long with dark matter under the fingernails. R383 stated she had not refused a shower yesterday and a staff member had come to her room "a few hours ago" to ask her about a shower and offered to help her tomorrow with a shower. During an interview on 8/1/24 at approximately 10:30 a.m., nurse manager and registered nurse (RN)-H stated it was expected for a resident to be offered a shower at least three times and to pass it on to the next shift if they continue to refuse, stating it would also be expected that the nurse be made aware. RN-H was unaware of R383 refusing any cares or showers. RN-H further stated it would be expected that toe and fingernails be trimmed and clean, even if a resident refused a shower. During an interview on 8/1/24 the director of nursing (DON) stated it was expected that all residents are getting a shower or bath, stating "I will make sure it gets done."	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	F 684		9/17/24

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F 684	Continued From page 55 applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to develop proactive interventions to promote appropriate bowel function and decrease the risk for discomfort or further complications for 1 of 1 resident (R9) reviewed for bowel management. In addition, the facility failed to transcribe prescription orders for 1 of 1 (R78) reviewed for non-pressure related skin breakdown. Findings include: R9's quarterly Minimum Data Set (MDS) dated 5/11/24, indicated R9 had no cognitive deficits and required moderate assistance with transferring, bathing, and toileting hygiene. The MDS indicated R9 "always" had bowel incontinence and a toileting program was not currently being used. R9's medical diagnoses dated 3/22/24, indicated R9 was diagnosed with diabetes, bilateral lower extremity ulcers, respiratory failure, heart failure, kidney disease, and chronic pain syndrome. R9's care plan dated 3/22/24 indicated the resident had bowel incontinence with decreased physical functioning. R9's care plan included the following interventions last updated on 3/22/24: check resident every two hours and assist with	F 684	R9’s bowel program and plan of care has been reviewed with the resident and the resident’s provider. Changes to R9’s plan of care have been updated in the residents record to reflect changes. R78’s has received a medication review, and prescribed medications have been transcribed and processed. Resident’s bowel functions are reviewed with follow up per their provides orders and plan of care. Health Unit Coordinators, Licensed Nurses, and Nurse managers will be educated on the medication reconciliation and bowel management program policy and procedure. The Director of Nursing/Designee will conduct 3 audits weekly x 3 weeks on new and returning residents from an acute stay to ensure correct transcription of prescribed orders. The Director of Nursing/Designee will conduct 3 audits weekly x 3 weeks on residents that trigger for constipation to ensure residents treatment plan is being followed. Findings of this audit will be reviewed at QAPI until substantial compliance has been met.	

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F 684	Continued From page 56 toileting as needed until a routine was established, observe for a pattern of incontinence, and initiate toileting schedule if indicated. The care plan included the following interventions last updated on 5/18/22: provide bedpan/bedside commode and perineal care after each incontinent episode. R9's care plan dated 6/14/24, indicated R9 had pain to both lower extremities due to "injuries", with the following intervention dated 5/18/22, "monitor for side effects of pain medication such as constipation and report occurrences to the physician". The care plan did not indicate what R9's usual pattern or desired frequency of bowel movements. R9's Bowel/Bladder Assessment dated 5/11/24, indicated R9 had bowel incontinence and used a narcotic, antidepressant, and calcium channel blocker medication. The assessment indicated R9's activities of daily living goal was to improve her current level of function by the review date with the intervention of an assist of one staff member with close supervision to use the commode over the toilet. The assessment indicated that R9 had a "routine" bowel elimination pattern. The assessment indicated the care plan was updated to include checking on the resident every two hours to assist the resident with toileting as needed until a routine was established, they would observe for patterns of incontinence and initiate a toileting schedule as indicated, provide a bedpan/bedside commode, and provide peri-care after each incontinent episode. R9's order summary report dated 4/15/24, included an order for one tablet of 5-325 milligrams (mg) of oxycodone-acetaminophen (a	F 684		

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F 684	Continued From page 57 narcotic pain medication) scheduled for four times a day. The summary included an order dated 3/22/24, for one tablet of 8.6 mg of sennosides (medication for constipation) two times a day. The order summary did not include any additional scheduled bowel medications that had been attempted since the addition of sennosides on 3/22/24. R9's bowel movement task history dated 7/1/24 through 7/29/24, indicated R9 had no bowel movement on the following days, 7/2/24-7/5/24, 7/9/24- 7/12/24, 7/14/24-7/16/24, 7/20/24-7/22/24,7/24/24, 7/26/24-7/29/24. R9's provider note dated 7/12/24, indicated R9 denied nausea or an upset stomach at the time of assessment and her abdomen was soft. The note indicated R9 was taking multiple medications which put her at risk for "side effects". R9's progress note dated 7/19/24 at 10:51 p.m., indicated R9 had "normal" bowel sounds, was incontinent of bowel, and had no bowel symptoms. R9's progress notes dated 6/30/24 to 7/29/24 were reviewed and did not include additional bowel assessments (excluding 7/19/24) or new interventions to prevent R9 from developing feelings of constipation. R9's progress notes did not indicate the facility had updated the provider on R9's continued reports of constipation. The facility Standing Orders dated 2024, included the following steps to be followed when constipation was reported: consider rectal check for possible impaction, encourage 2000 milliliters (mL) of fluid daily unless contraindicated, consult	F 684		

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F 684	Continued From page 58 nutrition services for dietary recommendations, two tablets of 8.6 mg of sennosides given during the evening as needed for three days, one 10 mg suppository of Bisacodyl (medication for constipation) daily as needed for three days, reattempt sennosides or Bisacodyl if no results after 24 hours and notify the provider, and lastly monitor and record results from treatment. During an interview on 7/29/24 at 2:31 p.m., R9 stated she received one tablet of sennosides to help her prevent constipation, but she has been receiving it for a while and felt it was no longer helpful. R9 stated it had been about one to two weeks since she had a "full" bowel movement, and it was starting to feel uncomfortable and she had communicated this to nursing staff in the past. R9 stated they had not tried anything new to help her with her constipation in "a while". During an interview on 7/30/24 at 3:12 p.m., R9 stated she has been "chronically" constipated and it has been frustrating for her as she felt like no one had been doing anything to help her. R9 stated she would like to have a bowel movement more often than every three days, but the nursing staff didn't seem to intervene until she was already constipated. During an interview and observation on 7/30/24 at 3:18 p.m., registered nurse (RN)-A stated she was the nurse in charge of R9's care for the day shift. RN-A stated she had not assessed if R9 had active symptoms of constipation but R9 had not reported any symptoms to her and she was confident R9 would as R9 had reported feeling constipated various times in the past. RN-A stated nursing staff should have been assessing bowel movement status every day but thought	F 684		

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F 684	Continued From page 59 this occurred on the night shift. RN-A was observed attempting to locate a bowel movement history on the electronic medical record but was unable to locate this information. RN-A stated she was unsure what R9's usual bowel pattern was or what her goal was for often she wanted to have a bowel movement. RN-A stated after it had been three days of a resident not having a bowel movement, they would initiate the standing bowel management orders, but she was unsure if this was needed at this time. RN-A stated nursing staff did not notify the provider of constipation unless the standing orders were unsuccessful. RN-A stated R9 was receiving scheduled sennosides for constipation prevention but was unsure what else was being utilized to help prevent constipation. During an interview on 7/31/24 at 1:54 p.m., RN-K, the unit nurse manager, stated she and the day shift nurse oversaw monitoring and trending bowel movements. RN-K stated she was aware R9 had a history of struggling with constipation as it had been reported to nursing staff previously. RN-K acknowledged R9's risk for constipation related to her narcotic use and lack of activity. RN-K stated the last time she saw an update to her narcotic regimen was on 4/15/24 and it looked like R9 had not had any updates to her scheduled bowel medication regimen since before this date. RN-K stated she was unsure if the provider had been updated on R9's pattern of symptoms of constipation. RN-K stated nursing staff waited for R9 to report symptoms of constipation or after three days of R9 not having a bowel movement and then the floor nurse would initiate the standing orders. RN-K stated she was unaware if a toileting schedule had been initiated but after reviewing the medical record,	F 684		

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F 684	Continued From page 60 did not note any additional interventions to assist R9 with her feelings of constipation since 3/22/24. During an interview on 8/1/24 at 2:38 p.m., the director of nursing (DON) stated it was important that nursing staff review the bowel movement records and identify any patterns so the resident can be reassessed as needed and the provider can be updated if the current bowel regimen is not preventing the resident from having symptoms of constipation. A policy regarding bowel management was requested and not received. R78 R78's readmission Minimum Data Set (MDS) indicated R78 had substantial cognitive deficits and required substantial/maximal assistance to bathe, and dress lower body and partial moderate assist with dressing upper body. R78's medical diagnoses included altered mental status, dementia, rash and other nonspecific skin eruption and generalized pustular psoriasis (scaly skin with infected blisters). R78 progress notes dated 7/29/24, indicated R78 returned to the facility on 7/29/24 following a hospital admission on 7/20/24. R78's care plan indicated the resident required skin inspections during cares to observe for redness, open areas and nursing staff to complete weekly body audits. Hospital discharge summary dated 7/29/24, indicated R78 was admitted with urosepsis (generalized infection involving the urinary tract),	F 684		

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F 684	Continued From page 61 was given intravenous antibiotics and subsequently developed a rash due to generalized pustular psoriasis flare. Upon discharge R78 was prescribed Triamcinolone acetonide 0.1% cream (medication to treat psoriasis) and white petroleum jelly ointment to treat rash. Further, R78 was prescribed cyclosporine (psoriasis medication) 100 milligrams (mg), rosuvastatin (cholesterol lowering medication) 5 mg, and calcium (mineral supplement) 500 mg. A review of R78's medical record on 7/30/24 did not reflect the new orders for Triamcinolone acetonide 0.1 % cream and white petrolium jelly,to treat skin rash, however the additional new prescriptions were prescribed and had been given to R78. During interview on 7/31/24 at 08:43 a.m., registered nurse (RN)-F stated when a resident returned from the hospital the health unit coordinator (HUC) processes any new orders and the orders are second checked by a nurse to verify accuracy. If the HUC is unavailable the floor nurse would enter any new orders and a second nurse would verify. RN-F stated she could see the orders for the creams in R78's discharge summary but could not locate the creams in his active orders. RN-F stated when R78 came back from the hospital she was the verifying nurse and she had ultimately missed the order. During interview on 8/1/24, at 09:21, director of nursing (DON) stated upon admission or re-admission, new orders are processed by the HUC, and a nurse will verify the orders for accuracy. DON stated her expectation was nursing staff working the shift on which the	F 684		

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F 684	Continued From page 62 resident arrives, or at the latest on the next shift, would transcribe, verify, and order any new medications from the pharmacy. DON confirmed R78's new physician ordered creams were not transcribed within her expected time frame and in fact were not completed until two days later 7/31/24. She went on to state it was important for R78 to receive his prescribed treatment to assist in healing his skin and not cause pain or discomfort.	F 684		
F 685 SS=D	Treatment/Devices to Maintain Hearing/Vision CFR(s): 483.25(a)(1)(2) §483.25(a) Vision and hearing To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility must, if necessary, assist the resident- §483.25(a)(1) In making appointments, and §483.25(a)(2) By arranging for transportation to and from the office of a practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing assistive devices. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure orders for an audiology referral were acted upon in a timely manner to promote better hearing and quality of life for 1 of 2 residents (R39) reviewed who expressed difficulty with hearing. Findings include: R39's significant change Minimum Data Set	F 685	An appointment for audiology has been made for R39. Care plan has been reviewed and updated as appropriate. A house audit looking back 30 days was completed with audiology referrals made as needed. Nurse managers and Social Services have been educated on the Audiology referral process. The Director of Social Services/Designee	9/17/24

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F 685	Continued From page 63 (MDS), dated 6/4/24, identified R39 had moderate cognitive impairment but demonstrated no delusional thinking. Further, the MDS identified R39 had adequate hearing (i.e., no difficulty in normal conversation) and did not use hearing aids. On 7/29/24 at 1:56 p.m., R39 was interviewed. R39 stated his hearing seemed to be getting worse as of late and added, "The wax has gotta get cleaned out of my ears." R39 stated nobody from the care center had asked him about his hearing and wished they would so he could get new hearing aides. R39 stated he thought an audiology appointment was set-up with the VA (Veterans Administration) but was not adding, "I sure wish they'd get it set up." R39's Nursing Assessment - Admission/Readmission + Careplan - V13, dated 4/15/24, identified a section labeled, "Oral, Vision and Hearing Status," which outlined R39 was able to hear at level of conversation and did not use hearing aids. The section concluded with an area labeled, "Additional Hearing Ability/Ears Comments," which was answered with, "N/A." The completed evaluation lacked evidence the ears were physically inspected, including with an otoscope, to determine wax build-up or evidence if a hearing appointment was offered. R39's Progress Note, dated 4/16/24, identified R39 was seen by the medical provider for their initial visit. A physical exam was recorded which listed R39 as, "HOH [hard of hearing]," along with a diagnosis reading, "H91.93 Bilateral hearing loss, unspecified ...," with orders, "Consult to audiology." The note concluded with a section labeled, "Plan," which directed, "Consult in-house	F 685	will conduct 3 audits weekly x 3 weeks to ensure Audiology is being offered and appointments are being made appropriately. Findings of this audit will be reviewed at QAPI until substantial compliance has been met.	

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F 685	Continued From page 64 audiology. Dx [diagnosis]: HOH, eval for hearing aides." R39's Care Conference Summary - V2, dated 6/24/24, identified a care conference was held for R39 on 6/21/24, with R39 being invited but not attending. A section labeled, "Appointments," listed fields to record applicable appointment dates (either upcoming or last had) and this included a field labeled, "Audiology." However, this was left blank and not completed; nor was there evidence the audiology referral order from earlier (dated 4/16/24) was reviewed. When interviewed on 7/30/24 at 1:58 p.m., nursing assistant (NA)-H stated they had worked with R39 multiple times and described him as resistant to cares adding, "He will not let you do anything for him." NA-H stated they had "once in awhile" heard R39 complain about his hearing or make a comment like, "I can't hear you." NA-H stated they last heard this comment "sometime ago," adding, "Maybe about a month ago." NA-H stated they had not reported the comment to the nurses so they were "not sure" if they knew or not. R39's medical record was reviewed and lacked evidence R39's difficulty hearing had been comprehensively assessed to determine what, if any, immediate interventions could be completed to improve his hearing (i.e., wax removal); nor evidence the ordered audiology consult had been acted upon and scheduled despite staff hearing comments about ongoing, difficulty hearing. On 7/30/24 at 2:33 p.m., registered nurse manager (RN)-E and the director of nursing (DON) were interviewed. DON verified in-house	F 685		

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F 685	Continued From page 65 audiology services were available, however, had not been scheduled for R39 as they were unaware R39 had complaints of poor hearing. RN-E and DON both verified staff should be reporting those complaints so they can be acted upon and, if needed, a treatment (i.e., Debrox) could be started. RN-E verified R39's medical record lacked evidence the hearing difficulties had been evaluated or acted upon for immediate treatment adding, "I don't see anything." DON acknowledged the consultation order from April 2024, and stated they would look into it further. DON and RN-E both acknowledged hearing issues should be acted upon and, if needed, evaluated adding it was important because "we don't want it to get worse." On 7/31/24 at 7:55 a.m., DON was interviewed and verified the consult order had been transcribed into the medical record but not completed. DON stated they were going to reach out to the VA and get it scheduled. DON expressed the unit had a health unit coordinator (HUC) who resigned abruptly which could have contributed to the appointment being missed. A facility policy on audiology services and hearing examinations was requested, however, none was received.	F 685		
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	F 689		9/17/24

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F 689	Continued From page 66 supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure 1 of 1 residents (R195) with repeated falls had implemented interventions to promote safety and reduce the risk of falls. Findings include: R195's admission minimum data set (MDS), dated 5/31/24, indicated R195 had diagnoses including cerebral infarct (stoke), hemiplegia (paralysis on one side of the body), and hemiparesis (unable to fully use one side of the body), history of falling with injuries and muscle weakness. Further, R195 required extensive assistance with bed mobility, transfers, and toileting. R195's care plan indicated he was at risk for falls with history of falls related to unsteady gait, cognitive deficits, and syncope. Interventions included R195's call light should be within reach, and to provide a safe environment. R195's physical device assessment, dated 7/25/24, indicated R195 required a perimeter mattress (a mattress that creates a raised edge to decrease falls from bed). Additionally, the medical record indicated a physician order dated 7/25/24, for R195 to use a perimeter mattress. R195's care plan did not indicate the use of a perimeter mattress. During observations between on 7/30/24, at 09:41	F 689	R195 fall interventions have been implemented and are reflected in the resident plan of care. Residents that sustain a fall and require interventions will be reviewed by the IDT with validation that the intervention was implemented. Nurse managers and the Director of maintenance has received education on fall intervention implementation to promote safety and reduce risk of falls. The Director of Nursing/Designee will conduct 3 audits weekly x 3 weeks to ensure Fall interventions have been implemented. Findings of this audit will be reviewed at QAPI until substantial compliance has been met.	

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F 689	Continued From page 67 a.m., R195 way lying in bed watching TV with their left leg hanging slightly off edge of bed. R195 was observed with a standard air mattress on their bed. During subsequent observations on 7/31/24 and 8/1/24 R195 continued to be observed with a standard air mattress on their bed. During interview on 7/31/24, at 01:58 p.m., registered nurse (RN)-G stated residents who have falls can have multiple interventions included a low bed, call don't fall signs, floor mats or a perimeter mattress. RN-G stated falls are reviewed daily by the interdisciplinary team (IDT) and interventions are determined by the team. Furthermore, RN-G stated R195 had a physical device assessment on 7/25/24 and was determined R195 would benefit from a perimeter mattress. An order was received on 7/25/24 and a requisition should have been placed at that time. RN-G was unable to locate a request for the perimeter mattress and confirmed that R195 did not currently have a perimeter mattress in place. During interview on 8/1/24. At 09:21a.m., director of nursing (DON) stated the IDT reviews resident falls daily and collaboratively plan for interventions to best meet each residents' individual needs. DON stated if an order is received from a provider for a medical device to reduce falls, she would expect the device to be immediately put into place, or within 24 hours if device needed to come from an outside durable medical equipment company. DON stated she understood R195 had an order to use a perimeter mattress but confirmed it had not been implemented. DON stated it is important to implement interventions and physician orders to decrease the risk of falls and potential injuries to	F 689		

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F 689	Continued From page 68 residents. Facility policy Fall Mitigation Program dated April 1,2022 indicated each resident will be assessed for fall risk and will receive the care and services in accordance with their individualized level of risk to minimize the likelihood of falls.	F 689		
F 697 SS=D	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively reassess to determine what, if any, additional interventions with pain management were needed for 1 of 3 residents (R39); and failed to assessed and develop non-pharmacological interventions to promote comfort for 2 of 3 residents (R69, R131) reviewed for pain management. Findings include: R39 R39's significant change Minimum Data Set (MDS), dated 6/4/24, identified R39 had moderate cognitive impairment but demonstrated no delusional thinking. The MDS outlined R39 consumed scheduled pain medication and had pain on an almost constant basis during the review period.	F 697	A pain assessment has been completed for R39 and the resident's pain plan of care has been updated to reflect changes. R69 and R131 have been reassessed for pain management with updates made for non-pharmacological interventions to support pain management plan of care. Pain assessments were completed and plans of care have been updated to include non-pharmacological interventions and daily documentation to ensure pain programs and plans of care are effective. Nurse Managers, Licensed Nurses and Nursing assistants have been educated on managing residents' pain, non-pharmacologic pain interventions, and daily documentation to ensure pain management effectiveness. The Director of Nursing/Designee will conduct 3 audits weekly x 3weeks to	9/17/24

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F 697	Continued From page 69 R39's most recent Pain Interview 23 - V1, dated 6/5/24, identified R39 received schedule pain medication but no as-needed (PRN) or non-pharmacological interventions for pain. The evaluation outlined R39 reported pain almost constantly which occasionally affected his sleep. The pain was listed as being rated, "9," along with "Moderate." The evaluation concluded, "Resident has scheduled pain medications, has not used any prn meds this assessment period." The evaluation lacked further dictation, including from R39, to say if this plan was effective or sufficient for R39's pain management goals or needs. R39's care plan, dated 6/15/24, identified R39 had chronic pain due to a physical disability, previous stroke and depression. A goal was listed which read, "The resident will not have an interruption in normal activities due to pain through the review date," along with several interventions including administering medications as ordered, anticipating his pain needs, and monitoring his pain episodes to remove/limit causes when possible. On 7/29/24 at 2:04 p.m., R39 was observed while in his room and had no obvious physical signs of pain present (i.e., grimace, moaning). However, R39 was interviewed and expressed he had pain "ever since I broke my hip" prior. R39 described the pain as a "burning" and reiterated it was "just a nuisance." R39 stated his pain, at this time, was "about a five [5]" and was worse when moving around adding he took Tylenol "or something" but it was not always helpful to lower the pain. R39 stated he wished more could be done but added, "If you complain or something they [staff] think you're a sissy." R39 stated the staff rarely, if ever,	F 697	ensure residents experiencing pain have non-pharmacologic interventions in place and pain management plans of care are effective. Findings of this audit will be reviewed at QAPI until substantial compliance has been met.	

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F 697	Continued From page 70	F 697		

offer him heat or ice packs for his hip, either.

R39's recent Regulatory Visit note, dated 6/18/24, identified R39 was seen by the nurse practitioner to follow up on multiple chronic conditions. The note outlined R39's medications which included Biofreeze (topical pain gel; kept at bedside), Belbuca 450 micrograms (mcg) twice daily, and duloxetine 40 milligrams (mg; antidepressant, sometimes used for chronic pain). The evaluation listed a section labeled, "PLAN," which directed to discontinue R39's duloxetine dose and, "Start duloxetine 60 mg po [by mouth] once daily."

R39's Medication Administration Record (MAR), dated 7/2024, identified R39's physician-ordered and provided medications as initialed by staff. The MAR outlined the new order for duloxetine with dictation, "Duloxetine HCL ... 60 mg by mouth in the morning for musculoskeletal pain ..," along with a start date, "06/19/2024." The MAR included the order for Belbuca Buccal Film 450 mcg twice a day along with a space to record, "Pain Level," which had a daily number recorded for R39's reported pain level. These recorded pain levels ranged from 0 to 10, with over 15 episodes of pain rated at "5" or higher being listed despite the medication increase on 6/19/24.

When interviewed on 7/31/24 at 11:11 a.m., registered nurse (RN)-G stated they had worked with R39 multiple times and he often complained about pain adding, "He will tell you it's 10/10." RN-G stated they provide R39 his scheduled pain medication and, when that is given, they ask him about pain to which R39 states is "everywhere" but mostly in his leg. RN-G stated the floor nurses complete the Pain Interview (evaluation) but any re-evaluation, such as after pain medications are

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F 697	Continued From page 71 adjusted, would be done by "the nurse in charge" adding "the manager." RN-G stated any re-evaluation should be in the medical record under an assessment (i.e., Pain Interview) or progress note. R39's medical record, including progress notes and physician notes, was reviewed and lacked evidence R39 had been comprehensively reassessed after the medication adjustment to ensure it was effective or what, if any, additional interventions were wanted or needed to promote comfort despite R39 have multiple pain levels recorded at moderate (i.e., "5") or above. On 7/31/24 at 2:34 p.m., registered nurse manager (RN)-E was interviewed and verified they reviewed R39's medical record. RN-E verified the last completed Pain Interview was 6/5/24 and there had been no others since then despite R39's medication being increased afterward. RN-E stated, typically, the nurses will enter an order to follow-up after medication adjustments but expressed it was "good practice to follow up with a pain assessment." RN-E stated R39 was often difficulty to evaluate for pain as he'd often just say, "I'm OK, I'm OK." RN-E expressed it was important to ensure pain was re-evaluated after intervention adjustment (i.e., medication change) to help "make sure that it's effective" and if it isn't then "what our next intervention is going to be." RN-E acknowledged the lack of documentation in R39's medical record to show re-evaluation and expressed, "We'd [nursing leadership] like to see more [documentation]."	F 697		

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F 697	Continued From page 72	F 697		

R69

R69's significant change Minimum Data Set (MDS) assessment dated 4/30/24, indicated R69 had severely impaired cognition. Assessment indicated in section J-Health Conditions section J0100 pain medication section A: been on a schedule pain medication regimen marked "yes", section B: received PRN pain medication marked "yes", section C: received non-medication interventions for pain marked "no". Further the form indicated R131 frequently has pain which occasionally effects sleep and day-to day activities and rated pain at a 6 out of 10 on a pain scale.

R69's face sheet, printed on 8/1/24, identified the following diagnoses: chronic pain syndrome, epigastric (stomach) pain, low back pain, chronic pain, and dysphagia (difficulty swallowing).

During observation and interview on 7/29/2024 at 2:02 p.m., R69 reported having pain. A single page hanging on the wall at the end of the bed was observed which indicated, "Tube Feeding flush every 4 hours, scheduled pain meds every 4 hours please do this in a timely manner - thank you." R69 stated they "don't do anything except medication here and it's not helping." R69 further indicated he would like to try other things. R69 stated they have never offered him a cold or warm pack and believes it would help.

R69's care plan, printed 8/1/24, indicated, "resident is on pain medication therapy r/t [related to] nerve pain .... with an intervention of "use

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F 697	Continued From page 73 non-pharmacological interventions." The care plan lacked evidence of what non-pharmacological interventions have been tried, what has been effective and not effective and what non-pharmacological interventions should be used. R69's Order Summary Report, printed 8/1/24, indicated the following orders for pain/pain management: -Acetaminophen (medication used to relieve pain) give 1,000 milligrams (mg) via J-tube (tube placed into small intestine) three times a day for pain -Capsaicin Cream (topical cream used to relieve pain) 0.075 % Apply to Lower extremity topically three times a day for nerve pain -Gabapentin (anitconvulsant medication, sometimes used to relieve pain) Oral Solution Give 8 milliliters (ml) via G-Tube (tube place into the stomach) three times a day for pain 250 mg/5 ml -Lidoderm (topical patch used to relieve pain)Patch 5 % (Lidocaine) Apply to Right shoulder topically as needed for pain Apply for 12 hours and remove -Methocarbamol (medication used to relieve muscoloskeletal pain) give 750 mg via J-Tube four times a day for musculoskeletal pain -oxycodone (narcotic pain medication used to treat moderate to severe pain) HCl Oral Tablet give 5 mg by mouth every 4 hours as needed for G-tube pain -oxycodone HCl Oral Tablet 5 MG give 5 mg by mouth every 4 hours for Pain for 7 Days The order summary report lacked evidence of any non-pharmacological interventions. R69's July's MAR/TAR (medication administration	F 697		

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F 697	Continued From page 74 record and treatment administration record) lacked evidence of an order for any non-pharmacological intervention orders. It further lacked evidence of any non-pharmacological intervention being offered and/or declined. A pain scale was used on the administration of Tylenol and Oxycodone which showed pain scale ratings of 0-9. MAR/TAR lacked evidence of non-pharmacological interventions being offered prior to administration of pain medication. R169's pain interview, dated 7/31/24, indicated R69 received scheduled and PRN pain medication. A radio-button answered "not assessed/no information" was answered for non-medication intervention for pain. R69's progress note, dated 7/30/24, indicated "Res complained of new onset of pain to g-tube site on 7/30/24 with mediation administration and flushing. Primary NP updated and will assess res on 7/31/24. Res G-tube and surrounding skin intact and without issue at this time. According to res pain relief is effective but only for a short time. Nursing staff to continue to offer PRN and schedule pain relief and update primary NP as needed." R69's progress note, dated 7/31/24, indicated new order for oxycodone received abdominal x-ray ordered. A further review of R69's progress notes, dated 7/1/24 to 8/1/24, were reviewed. Progress notes lacked evidence of any non-pharmacological interventions being offered to R69 for pain. R131	F 697		

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F 697	Continued From page 75 R131's quarterly MDS assessment dated 6/15/24, identified R131 had intact cognition. Diagnoses included: hypertension (high blood pressure), traumatic brain injury (brain dysfunction caused by an outside force), abnormal weight loss, dysphagia (difficulty swallowing), and alcohol use. Assessment further indicated in section J-Health Conditions section J0100 pain medication section A: been on a schedule pain medication regimen marked "yes", section B: received PRN pain medication marked "no", section C: received non-medication interventions for pain marked "no". During observation and interview on 7/29/2024 at 1:33 p.m. R131 indicated he has chronic pain. R131 stated he has pain in his hip because he "broke it while ago" and pain in "my left shoulder." R131 stated they take Tylenol for the pain. R131 stated they have not been offered any other interventions for pain. R131 stated, "they don't offer me anything like a heating pad or ice," and further indicated he would like to try something besides medication. R131's care plan, printed 8/1/24, indicated, "resident is on pain medication therapy r/t [related to] left hip fx [fracture] pain with an intervention of "use non-pharmacological interventions." The care plan lacked evidence of what non-pharmacological interventions have been tried, what has been effective and not effective and what non-pharmacological interventions should be used. R131's Order Summary Report, printed 8/1/24, indicated all active orders for R131. The order summary report lacked evidence of any	F 697		

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F 697	Continued From page 76 non-pharmacological interventions. R131's July's MAR/TAR lacked evidence of an order for any non-pharmacological interventions. The record does indicate an order for the following: Tylenol extra strength 500 milligram (mg) - administer 1,000 mg by mouth three times a day for pain. The MAR/TAR lacks pain level rating with each administration of pain medication. R131's most recent Pain Interview Assessment, dated 6/17/24, indicated resident is on scheduled pain medication. Further the document indicated by a radio-button answered "no" that R131 received non-medication intervention for pain. The assessment indicated he had occasional pain in the last 5 days which occasionally limited his day-to-day activities and rated his pain at a 3 out of 10 on a pain scale. R131's progress notes, dated 1/1/24 to 8/1/24, were reviewed. Progress notes lacked evidence of any non-pharmacological interventions being offered to R131 for pain. During interview on 7/30/24 at 2:15 p.m., nursing assistant (NA)-I indicated they work full-time and are familiar with work processes. NA-I indicated that R69 and R131 both have chronic pain. NA-I indicated when pain is reported to them, they are trained to report the pain to the nurse for follow up. NA-I indicated that nurses provide any medication or non-pharmacological interventions to residents. NA-I verified nursing assistants do not provide any non-pharmacological interventions to residents without direction from a nurse as "this needs to be documented."	F 697		

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F 697	Continued From page 77 During interview on 7/31/2024 at 12:17 p.m., registered nurse (RN)-E verified they are familiar with R69 and R131. RN-E verified both residents have chronic pain. RN-E stated they are unaware of the last time R131 had physical therapy. RN-E verified pain needs to be evaluated by a nurse when reported. RN-E stated it is important to know the location of pain, how severe, if it is on-going or occasional, if they are scheduled or PRN (as-needed) medication and to update the provider. RN-E stated nursing assistants should report any pain that a resident reports to them to the nurse for follow up. RN-E stated any interventions provided, whether medication or non-pharmacological (any type of healthcare intervention which is not primarily based on medication) interventions, would be charted in the medication administration record. RN-E stated, "technically we are supposed to put in a progress note but it gets missed." RN-E verified non-pharmacological interventions should be documented in progress notes and on the MAR/TAR. During interview on 8/01/24 at 11:39 a.m., licensed practical nurse (LPN)-C verified they are familiar with R69 and R131. LPN-C verified R69 has known chronic pain and rates it at an 8 out of 10 on a pain scale. LPN-C verified R131 has known chronic pain that is controlled with scheduled pain medication and currently not using any PRN pain medication. LPN-C verified any non-pharmacological interventions would be listed in the order section of the medical record and would be charted on. LPN-C stated, "on second floor we use oils and stuff to help with some behaviors and those are charted on, but we don't use them up here." LPN-C verified neither R131 or R69 are being offered or utilizing any	F 697		

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F 697	Continued From page 78 non-pharmacological interventions to help manage their known chronic pain. On 8/1/24 at 2:47 p.m., director of nursing (DON) stated, "residents with pain should be offered non-pharmacological interventions such as repositioning, warm or cold packs and then the nurse is going to document whether or not it was effective or non-effective." DON verified non-pharmacological intervention would be found on the MAR/TAR (medication/treatment administration record). A policy on use of non-pharmacological interventions for pain was requested but not provided.	F 697		
F 726 SS=D	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c) §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care.	F 726		9/17/24

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F 726	Continued From page 79 §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure direct-care nursing staff were appropriately trained and competent in the use of a external ventilator machine used for 1 of 1 resident (R17) who used the machine on overnight hours and had significant respiratory disease/impairment. Findings include: R17's quarterly Minimum Data Set (MDS), dated 5/17/24, identified R17 had intact cognition along with several medical conditions including heart failure, Parkinson's Disease, seizure disorder, respiratory failure, and chronic lung disease (i.e., asthma, COPD). On 7/29/24 at 2:31 p.m., R17 was observed seated in an electric wheelchair while in her room with oxygen in place via a nasal cannula. R17 had a hospital-style bed placed next to the wall and adjacent to the bed was a Philips Respironics Trilogy 100 machine (a portable, external ventilator) positioned on a vertical stand with a nasal mask (i.e., nasal port with strap to secure around head) attached and draped over the	F 726	R17 continues to use the external ventilator as per the plan of care and providers orders. Residents that have orders for external ventilators received chart reviews to ensure instructions for use are written in the residents' medical record. Nurse Managers and licensed nursing staff have been educated and trained on the use of external ventilators. The Director of Nursing/Designee will conduct 3 audits weekly x 3 weeks to ensure Licensed Nursing staff have been educated and are competent with the use of external ventilators. Findings of this audit will be reviewed at QAPI until substantial compliance has been met.	

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F 726	Continued From page 80 device. The vertical stand and attached medical device consisted of the machine itself, a suspended bag of sterile water along with tubing connected to a visible water chamber with condensation present on the top (i.e., bubbling), and tubing then connected from the chamber to the mask draped over. R17 stated she used the device every night while asleep adding someone from an outside company comes in "every six to eight weeks" to change the tubing and "all that" on the ventilator. R17 stated staff did not touch or manage the device adding "not without getting yelled at by me." R17 stated she was unsure what, if any, actions staff took with the machine at night (i.e., adjusting, monitoring) adding when she was attached to it and asleep she was "dead and [whatever they did] probably wouldn't phase me." Further, R17's doorway, which opened to the hallway, had a white-colored sign posted on it which read, "Please do not disturb beween [sic] 10P and 7A [below] O2 check OK." R17's care plan, dated 7/25/24, identified R17 had an altered respiratory status with shortness of breath (SOB), sleep apnea and COPD (chronic obstructive pulmonary disease). The care plan listed, "Will refuse to wear trilogy at times or remove during the noc [night]." A goal was listed which outlined, " ... will have no complications r/t [related to] SOB through the review date," along with several interventions to help meet this goal. The interventions included giving medications as ordered, oxygen at 2 liters per minute (LPM), and, "Current Trilogy Settings: 1: please adjust flow rate/rise time for patient comfort 2: reduce target tidal volume to 380 cc (based on predicted lean body weight 43kg for 59 in height)," and, "Trilogy machine as ordered. Routine cleaning per SHO [house orders]." The care plan lacked information	F 726		

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F 726	Continued From page 81 on R17 self-use of the machine or what, if any, potential alarms on the machine meant or, if applicable, the needed staff actions. When interviewed on 7/31/24 at 11:22 a.m., registered nurse (RN)-G stated they had worked with R17 multiple times and verified they were currently assigned her care for that shift. RN-G stated R17 used the Trilogy machine during the overnight hours and, during the day and evening, only used oxygen in her cannula. RN-G stated the night shift mostly had to address or deal with the machine, however, the nurses on other shifts did, at times, have to clean it and wash the chamber. RN-G stated they did not, at least to their recall, remember anyone from the care center doing training with them on the device or what to do if it was in use and alarmed adding, "Not really." R17's Medication Administration Record (MAR) and Treatment Administration Record (TAR), dated 7/2024, identified R17's current treatments and spaces for staff to record their administration. The MAR included an order which read, "TRIOLOGY MACHINE AT HS [bedtime] and NAPS, Titrate oxygen as needed for Sats 89-94% at bedtime ...," with a listed start date, "04/20/2024." The MAR and TAR lacked any additional guidance on how to apply/remove the device, or alarm mitigation, if needed. Later on 7/31/24, at 1:45 p.m., R17 was interviewed and stated she had significant respiratory disease. R17 stated she applied and activated the Triology machine herself adding, "I wouldn't trust them [staff] to touch it." R17 stated she had woken up with the machine alarming at night before and, when asked how she addressed it, just responded, "I deal with it myself." R17	F 726		

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F 726	Continued From page 82 stated she would ask staff for help with it, if needed. When interviewed on 8/1/24 at 6:47 a.m., licensed practical nurse (LPN)-E verified they were the nurse assigned to R17 during the previous overnight shift adding they had worked on overnights with R17 multiple times. LPN-E stated R17 needed "not much" help or care during the nights but "once in awhile" would ask for help "with that machine [Triology]." LPN-E stated the machine was "like a CPAP" and usually R17 would only ask for the water to be replaced in it and never with the mask application or such. LPN-E stated R17 managed the machine "by herself" and they had never been told, either by staff or R17, it had ever alarmed prior. LPN-E stated if the machine alarmed, they would inspect it and "troubleshoot it" to figure out what happened and how to fix it adding R17 was "the only one with this kind of machine." LPN-E stated there was no user manual for the device present on the unit to their knowledge and expressed if something happened, R17 would wake up and tell them if she needed help. LPN-E stated the care center had not provided any education to them on the device to their recall, however, expressed they felt if something happened with it they could adequately address it adding, "I could figure it out." On 8/1/24 at 9:44 a.m., registered nurse manager (RN)-E was interviewed. RN-E stated R17 had used the Trilogy device for over a year now and the night nurse sometimes helped apply the mask to "ensure she's putting it on right." RN-E stated the machine' settings were pre-programmed so it was simply a turn-on or turn-off system. RN-E stated they could not recall what, if any, education	F 726		

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F 726	Continued From page 83 the device itself had been done with staff adding, "I don't think so, no [any done]." RN-E stated they felt the machine itself would display an error, if it happened, and then "tells you [itself] what's going on with it." RN-E stated if staff were unable to resolve an error or if the device developed air leaks, the staff could always call the vendor, Northwest Respiratory to help manage it. RN-E stated the facility used to have a nurse educator who would help, if needed, train staff on use of medical devices but added, "I'm not sure if we have one in place now." RN-E acknowledged the importance of ensuring staff are trained in the use of the Triology machine as staff "need to know how the machine operates" and "who to call" if issues developed with it. Further, RN-E stated there was no user manual for the device, at least to their knowledge, at the nurses' station but one was maybe kept in R17's room. During the recertification survey, from 7/29/24 to 8/1/24, evidence of what, if any, staff training with R17's Triology 100 was requested; however, none was received. In addition, a request was made of the device' reporting with what, if any, alarm(s) had triggered for the past 30 day period; however, this was not received or provided. On 8/1/24 at 10:53 a.m., the director of nursing (DON) and assistant director of nursing (ADON) were interviewed. DON stated the previous nurse educator had resigned several months prior and verified no education with staff on the device had been completed to their knowledge. DON expressed R17 had the device for a long period of time and had not, thus far, had any issues with using it on her own; however, acknowledged it was important to ensure staff knew how the device worked and what to do if an error or alarm	F 726		

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F 726	Continued From page 84 activated. Further, ADON stated they believed a user' manual for the device was in R17's somewhere and were going to go look for it. A Trilogy 100 Ventilator Information and User Guide for Qualified Health Professionals manual, dated March 2020, identified a detailed walk-through of the device including filter changing, screen icon details, and setting applications. The manual outlined two types of ventilation circuits were available using the device, including active and passive, and how to set-up each one with the machine along with a red-colored exclamation point warning reading, "Please check that circuit type if properly configured." The manual outlined how to connect oxygen to the device along with humidified air. The manual outlined how to review, set and monitor alarm parameters and indicated three types of alarms could trigger on the device including high-priority which, " ... require immediate response by the operator, the alarm mute button with flash red and the screen message will appear red." A graph showing multiple potential alarm reasons was included, along with corresponding staff-actions to resolve them. A facility' policy on staff competency with medical device training was requested, however, none was received.	F 726		
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.	F 756		9/17/24

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F 756	Continued From page 85 §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure consulting pharmacist recommendations were fully addressed or acted upon for 1 of 5 residents (R164) reviewed for	F 756	The pharmacy recommendations have been reviewed and completed for R164. The facilities Drug Regimen Review Policy and Procedure have been reviewed and	

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F 756	Continued From page 86 unnecessary medications. Findings include: R164's significant change Minimum Data Set (MDS) dated 10/12/23, indicated R164 had severely impaired cognition. R164's quarterly MDS dated 7/14/24, indicated R164 did not speak and rarely/never understood verbal content. In addition, R164 was dependent on staff for bed mobility, lower body dressing, and toileting hygiene. R164's medical diagnoses report dated 1/27/23, indicated R164 had dementia "without behavioral disturbance", epilepsy, and depression. R164's Order Summary Report dated 3/30/23, included an order dated 3/30/23 for 12.5 milligrams (mg) of quetiapine (an antipsychotic medication) every evening for "agitation". The report included an order dated 6/21/24, with no end date for one mg of as-needed lorazepam (a psychotropic medication used to treat seizures) that could be given every 15 minutes for two doses. R164's Consultant Pharmacist Recommendation to Physician dated 3/26/24,, indicated R164 received as-needed lorazepam. The report indicated that as-needed psychotropic medications should have a 14-day stop date, "unless a longer time frame is deemed appropriate" by the physician. The report indicated if the duration of use needed to be extended past 14 days, to provide a rationale for continuing use and "a specific duration" of therapy. The provider responded on 4/15/24 to	F 756	are current. Pharmacy recommendations are reviewed monthly and completed by nursing and providers in a timely manner. The Director of Nursing and Nurse Managers have been educated on fully completing the monthly pharmacy recommendations. The director of Nursing/designee will conduct an audit monthly x 3 months to ensure completion of the pharmacy recommendations. Findings of this audit will be reviewed at QAPI until substantial compliance has been met.	

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F 756	Continued From page 87 continue the as-needed lorazepam order "as written" as the benefits outweigh the risks. The response did not address the pharmacist's recommendation to include a specific duration of therapy. R164's Consultant Pharmacist Recommendation to Physician dated 3/26/24, indicated R164 was receiving quetiapine for a diagnosis of agitation "which is not considered an appropriate indication for antipsychotic use." The report indicated if the antipsychotic use was to continue, to clarify the appropriate diagnosis. The provider responded on 4/15/24 by indicating the medication was useful for insomnia and the family did not want the medication discontinued so the order would be continued for agitation and insomnia "per family's wishes". R164's Consultant Pharmacist Recommendation to Physician dated 4/26/24, indicated R164 received as-needed lorazepam. The report indicated that as-needed psychotropic medications should have a 14-day stop date, "unless a longer time frame is deemed appropriate" by the physician. The report indicated if the duration of use needed to be extended past 14 days, to provide a rationale for continuing use and "a specific duration" of therapy. The report did not include a signature with a correlating date but included the note, "completed on 4/15". The response did not address the pharmacist's recommendation to include a specific duration of therapy. R164's Consultant Pharmacist Recommendation to Physician dated 4/26/24, indicated R164 was receiving quetiapine for a diagnosis of agitation "which is not considered an appropriate indication	F 756		

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F 756	Continued From page 88 for antipsychotic use." The report indicated if the antipsychotic use was to continue to clarify the appropriate diagnosis. The report did not include a signature with a correlating date but had the note, "completed on 4/15". R164's Consultant Pharmacist Recommendation to Physician dated 5/26/24, indicated R164 received as-needed lorazepam. The report indicated that as-needed psychotropic medications should have a 14-day stop date, "unless a longer time frame is deemed appropriate" by the physician. The report indicated if the duration of use needed to be extended past 14 days, to provide a rationale for continuing use and "a specific duration" of therapy. The report did not include a signature with a correlating date but had the note, "completed 7/29/24". The response did not address the pharmacist's recommendation to include a specific duration of therapy. R164's Consultant Pharmacist Recommendation to Physician dated 5/26/24, indicated R164 was receiving quetiapine for a diagnosis of agitation "which is not considered an appropriate indication for antipsychotic use." The report indicated if the antipsychotic use was to continue, to clarify the appropriate diagnosis. The report did not include a signature with a correlating date but had the note, "completed 7/29/24". R164's nursing progress note dated 6/21/24 at 2:23 p.m., indicated the pharmacist had recommended a "14 day stop date on lorazepam" and per the provider, they were to continue the order as written as the benefits outweigh the risks. The progress note did not indicate a specific duration of therapy for the as-needed	F 756		

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F 756	Continued From page 89 lorazepam. R164's Consultant Pharmacist Recommendation to Physician dated 6/25/24, indicated R164 received as-needed lorazepam. The report indicated that as-needed psychotropic medications should have a 14-day stop date, "unless a longer time frame is deemed appropriate" by the physician. The report indicated if the duration of use needed to be extended past 14 days, to provide a rationale for continuing use and "a specific duration" of therapy. The provider responded on 7/29/24 to continue the as-needed lorazepam order due to its indication of use. The response did not address the pharmacist's recommendation to include a specific duration of therapy. R164's Consultant Pharmacist Recommendation to Physician dated 6/25/24, indicated R164 was receiving quetiapine for a diagnosis of agitation "which is not considered an appropriate indication for antipsychotic use." The report indicated if the antipsychotic use was to continue, to clarify the appropriate diagnosis. The provider responded on 7/29/24 and indicated the diagnosis was "resistant anxiety". R164's Medication Administration Record (MAR) dated 7/1/24 through 7/30/24, indicated one milligram (mg) of as-needed lorazepam was given on 7/21/24. The record included an order dated 1/31/23 that indicated R164 sleeps for "12hrs+ per family" and should be gotten up last in the morning. R164's nursing progress note dated 7/31/24 at 9:00 a.m., indicated the provider gave an order to continue the lorazepam as ordered due to the	F 756		

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F 756	Continued From page 90	F 756		

indication.

R164's nursing progress note dated 7/31/24 at 11:37 a.m., indicated the pharmacy recommendations were completed and to see the recommendations that were uploaded that day.

During an interview at 12:14 p.m., nurse practitioner (NP)-A stated she was the provider reviewing R164's pharmacist reviews. NP-A stated she had noticed that the pharmacy recommendations were reissued monthly but didn't think that the pharmacist had seen the previous provider response made on 4/15/24, so she had referenced back to that response. NP-A confirmed a stop date had not been added to the as-needed lorazepam as she did not know it was necessary. NP-A stated it was "unclear" why R164 was using quetiapine so on 7/29/24 she had updated the order to include an indication of "resistant anxiety" but was unable to specify what symptoms of resistant anxiety R164 currently had. NP-A stated she did not reach out to the pharmacist to receive clarification on why the recommendations were being reissued for the as-needed lorazepam use and the quetiapine use.

During an interview on 8/1/24 at 12:35 p.m., the consulting pharmacist (PH) stated she had difficulty getting the facility/providers to fully respond to her recommendations for R164, so she had been reissuing them monthly since March. The PH stated she sent recommendations to the facility once a month and would then follow up the next month to ensure the recommendations were completed. The PH stated she had reviewed the response from the March recommendation and an appropriate

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F 756	Continued From page 91 diagnosis for antipsychotic use was not given, so she had reissued the recommendation. The PH stated agitation was not an appropriate indication for antipsychotic use and would have expected a medical diagnosis such as schizophrenia, delusional disorder, or bipolar disorder. The PH stated the facility had not established a duration of use for R164's as-needed lorazepam so she had reissued that recommendation monthly also. The PH stated she had not had a conversation or further reached out to the provider, medical director, or other facility staff to explain the repeated recommendations to the facility staff. During an interview on 8/1/24 at 2:28 p.m., the director of nursing (DON) stated nursing staff had reviewed the pharmacy recommendations, but there had been a misunderstanding regarding the requirement for a stop date for as-needed psychotropic medication, so it had not been addressed. The DON stated agitation was not an appropriate indication for antipsychotic medication and the order should have been updated to include an appropriate indication before the start of the survey, but it had not been. The DON stated she was unaware of the nursing staff or the provider reaching out to the pharmacist for clarification on recommendations. A policy regarding pharmacist medication regimen reviews was requested and not received.	F 756		
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,	F 758		9/17/24

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F 758	Continued From page 92 but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is 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	F 758		

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F 758	Continued From page 93 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 observation, interview and document review the facility failed to have an indication for use and resident specific target behaviors while taking antipsychotic medications for 1 of 5 residents (R383) reviewed for unnecessary medications. In addition, the facility failed to ensure as-needed antipsychotic medications were limited to 14 days of use or given a specific duration of therapy to ensure necessity and reduce the risk of complication for 1 of 5 residents (R164) reviewed for unnecessary medication use. In addition, the facility failed to ensure an appropriate indication was given for continued antipsychotic medication for 1 of 5 residents (R164) reviewed for unnecessary medication use. Findings include: R383's admission Minimum Data Set (MDS), dated 7/21/24, indicated R383 was cognitively intact and had received an antipsychotic medication during the seven-day look back period. R383's Orders, dated 7/18/24, indicated an order for Olanzapine (an antipsychotic medication used to treat mental disorders, including schizophrenia and bipolar disorder) 10 milligrams (mg) by mouth twice a day, however it lacked an indication for use. R383's Orders, dated 7/11/24, indicated Psychotropic Behavior Monitoring with 26 generic behaviors for staff to monitor for.	F 758	R383 has received a medication review with indication for medication use added and specific target mood and behaviors care planned. R164 received a medication review and PRN antipsychotic has been discontinued. Residents with orders for Antipsychotic medications have received chart reviews to ensure indication for use and diagnosis is updated, target mood and behaviors are care planned, and PRNs have 14 day stop dates. Nurse managers and Social Services have been educated on appropriate indications for Antipsychotic medication use, Target mood and behavior care planning, and 14 day stop dates. The director of Nursing/designee will conduct 3 audits x 3 weeks to ensure Antipsychotic orders are being monitored and used appropriately. Findings of this audit will be reviewed at QAPI until substantial compliance has been met.	

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F 758	Continued From page 94 R383's Care Plan, dated 7/15/24 indicated R383 used "antipsychotic medication r/t [related to] Dx [diagnosis] of schizoaffective disorder [a mental health condition that is marked by a mix of schizophrenia symptoms, such as hallucinations and delusions, and mood disorder symptoms, such as depression, mania and a milder form of mania called hypomania], panic disorder with anxiety, and obsessive compulsive disorder [a long-lasting disorder in which a person experiences uncontrollable and recurring thoughts (obsessions), engages in repetitive behaviors (compulsions), or both]" however lacked any specific target behaviors. R383's July Medication Administration Record (MAR), indicated R383 had received Olanzapine 10 mg twice a day but lacked an indication for use to inform staff administering medication why R383 was receiving the medication. During an interview on 7/31/24 at 7:44 a.m., licensed practical nurse (LPN)-F confirmed the MAR did not contain an indication for use for R383's Olanzapine stating, "I would have to look it up [what the medication was used for] because it is not in the order." During an interview on 8/1/24 at approximately 10:00 a.m., nurse manager and registered nurse (RN)-H stated it was the expectation that all medications have an indication for use to monitor if a medication is effective or not. RN-H confirmed the psychotropic behavior monitoring was not tailored to be resident specific but was a generic check box to select for any resident taking a psychotropic medication.	F 758		

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F 758	Continued From page 95 During an interview on 8/1/24 at 12:40 p.m., the director of nursing (DON) indicated it would be expected for medications to have an indication for use and antipsychotic medications to have resident specific target behaviors. The DON stated it would be important to ensure they are treating the correct symptoms and to monitor for effectiveness of the medication. A facility policy on administering antipsychotic medication was requested and not received. R164's significant change Minimum Data Set (MDS) dated 10/12/23, indicated R164 had severely impaired cognition. R164's quarterly MDS dated 7/14/24, indicated R164 did not speak and rarely/never understood verbal content. In addition, R164 was dependent on staff for bed mobility, lower body dressing, and toileting hygiene. R164's medical diagnoses report dated 1/27/23, indicated R164 had dementia "without behavioral disturbance", epilepsy, and depression. R164's care plan dated 9/29/23, indicated R164 had a "mental health disorder" with physical behaviors of grabbing, yelling out, and being resistant to care related to an "intellectual disability" and dementia. R164's Order Summary Report dated 3/30/23, included an order dated 3/30/23, for 12.5 milligrams (mg) of quetiapine (an antipsychotic medication) every evening for "agitation". The report included an order dated 6/21/24 with no end date for one mg of as-needed lorazepam (a psychotropic medication used to treat seizures)	F 758		

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F 758	Continued From page 96 that could be given every 15 minutes for two doses. R164's Consultant Pharmacist Recommendation to Physician dated 3/26/24, indicated R164 received as-needed lorazepam. The report indicated that as-needed psychotropic medications should have a 14-day stop date, "unless a longer time frame is deemed appropriate" by the physician. The report indicated if the duration of use needed to be extended past 14 days, to provide a rationale for continuing use and "a specific duration" of therapy. The provider responded on 4/15/24 to continue the as-needed lorazepam order "as written" as the benefits outweigh the risks. The response did not address the pharmacist's recommendation to include a specific duration of therapy. R164's Consultant Pharmacist Recommendation to Physician dated 3/26/24, indicated R164 was receiving quetiapine for a diagnosis of agitation "which is not considered an appropriate indication for antipsychotic use." The report indicated if the antipsychotic use was to continue, to clarify the appropriate diagnosis. The provider responded on 4/15/24 by indicating the medication was useful for insomnia and the family did not want the medication discontinued so the order would be continued for agitation and insomnia "per family's wishes". R164's nursing progress note dated 6/21/24 at 2:23 p.m., indicated the pharmacist had recommended a "14 day stop date on lorazepam" and per the provider, they were to continue the order as written as the benefits outweigh the risks. The progress note did not indicate a	F 758		

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F 758	Continued From page 97 specific duration of therapy for the as-needed lorazepam. R164's Medication Administration Record (MAR) dated 7/1/24 through 7/30/24, indicated one milligram (mg) of as-needed lorazepam was given on 7/21/24. The record included an order dated 1/31/23 that indicated R164 sleeps for "12hrs+ per family" and should be gotten up last in the morning. R164's nursing progress note dated 7/31/24 at 9:00 a.m., indicated the provider gave an order to continue the lorazepam as ordered due to the indication. The MAR included target behaviors of R164 being resistant to care, yelling out, and grabbing, with interventions of speaking calmly, re-approaching, family assistance, or redirecting, which were documented on every shift. During an interview and observation on 7/29/24 at 2:42 p.m., resident representative (RR)-C stated she visited R164 frequently and has not noticed agitation but felt staff "don't have enough practice" on completing activities of daily living for R164's and can cause R164 to push during cares. R164 was observed sleeping in bed. During an interview on 8/1/24 at 10:29 a.m., nursing assistant (NA)-A stated he works with R164 frequently and had not noticed R164 being agitated or having any other behaviors when staff were not interacting with him. NA-A stated R164 was frequently sleeping during the day and only seemed to push staff when they were rolling him in bed and completing cares. R164 was observed sleeping in his wheelchair. R164's Consultant Pharmacist Recommendation	F 758		

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F 758	Continued From page 98 to Physician dated 6/25/24, indicated R164 received as-needed lorazepam. The report indicated that as-needed psychotropic medications should have a 14-day stop date, "unless a longer time frame is deemed appropriate" by the physician. The report indicated if the duration of use needed to be extended past 14 days, to provide a rationale for continuing use and "a specific duration" of therapy. The provider responded on 7/29/24 to continue the as-needed lorazepam order due to its indication of use. The response did not address the pharmacist's recommendation to include a specific duration of therapy. R164's Consultant Pharmacist Recommendation to Physician dated 6/25/24, indicated R164 was receiving quetiapine for a diagnosis of agitation "which is not considered an appropriate indication for antipsychotic use." The report indicated if the antipsychotic use was to continue, to clarify the appropriate diagnosis. The provider responded on 7/29/24 and indicated the diagnosis was "resistant anxiety". During an interview on 8/1/24 at 12:35 p.m., the consulting pharmacist (PH) stated she had difficulty getting the facility/providers to fully respond to her recommendations for R164, so she had been reissuing them monthly since March. The PH stated she had reviewed the response from the March recommendation and an appropriate diagnosis for antipsychotic use was not given, so she had reissued the recommendation. The PH stated agitation was not an appropriate indication for antipsychotic use and would have expected a medical diagnosis such as schizophrenia, delusional disorder, or bipolar disorder. The PH stated the facility had	F 758		

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F 758	Continued From page 99 not established a duration of use for R164's as-needed lorazepam so she had reissued that recommendation monthly also. During an interview at 12:14 p.m., nurse practitioner (NP)-A confirmed a stop date had not been added to the as-needed lorazepam as she did not know it was necessary. NP-A stated it was "unclear" why R164 was using quetiapine, so on 7/29/24 she had updated the order to include an indication of "resistant anxiety" but was unable to specify what symptoms of resistant anxiety R164 had. NP-A stated the previous provider had talked with RR-C who was upset because R164 was not falling asleep at the same time every night and had requested the medication be continued so they had. NP-A stated, "Maybe it [quetiapine] was more appropriate in the past" and was unable to give an indication for current use. During an interview on 8/1/24 at 2:28 p.m., the DON stated nursing staff had reviewed the pharmacy recommendations, but there had been a misunderstanding regarding the requirement for a stop date for as-needed psychotropic medication, so it had not been addressed. The DON stated agitation was not an appropriate indication for antipsychotic medication use and the order should have been updated to include an appropriate indication before the start of the survey, but it had not been.	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	F 759		9/17/24

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F 759	Continued From page 100 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure a medication administration error rate of less than 5 percent (%). Twenty medication administration errors occurred out of 31 opportunities resulting in a 64.52% medication error rate for 2 of 4 residents (R184 and R376). Findings include: R184's admission assessment Minimum Data Set (MDS) dated 5/28/24, indicated R184 had moderate cognitive impairment, didn't have signs of delirium, and didn't refuse cares or medications. MDS indicated R184 was dependent with showers, lower body dressing, toileting, bed mobility, and transfers. R184 needed substantial assistance with upper body dressing, oral hygiene and eating. R184's Clinical diagnosis record printed 1/31/24, indicated diagnoses of dysphagia (difficulty swallowing) following unspecified cerebrovascular disease (condition that affect blood flow and the blood vessels in the brain), gastrostomy status (surgical procedure that creates an opening in the abdomen and into the stomach, allowing for the insertion of a feeding tube), hemiplegia (paralysis of one side of the body) and paraplegia (paralysis of the legs and lower body, typically caused by spinal injury or disease) following cerebral infarction affecting right dominant side, chronic obstructive pulmonary disease (lung disease that blocks airflow and makes it difficult to breath), chronic respiratory failure with hypoxia (low oxygen level in the blood) , protein-calorie	F 759	Medication error reports were written up for R183 and R376. Both R183 and R376 received medication reviews from the pharmacy to ensure medications may be administered together via enteral tube. Provider orders were obtained. Residents who receive their medications via enteral tube have the potential to be affected by this practice. The pharmacy has reviewed medications for residents who receive medication via enteral feeding and provider orders have been written as appropriate. Licensed Nursing staff have been educated on medication administration via enteral tube. Director of Nursing/Designee will conduct 3 audits weekly x 3 weeks to ensure medications are being administered appropriately via enteral tube. Findings of this audit will be reviewed at QAPI until substantial compliance has been met.	

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F 759	Continued From page 101 malnutrition, chronic atrial fibrillation (heart arrhythmia that causes the upper chambers of the heart to beat irregularly and quiver for more than 12 months), atrial flutter (condition in which the heart's upper chambers beat too quickly), and dysthymic disorder (a mild but long-term form of depression). R184's Clinical Orders report printed 7/31/24, indicated "may crush meds unless contraindicated." The report indicated the following medications were to be administered via the gastric tube: 10 milligrams (mg) of baclofen three times a day (medicaton to treat neuropathic pain), 7.5 mg of metoprolol twice a day (medicaton to treat high blood pressure), 20 mg of escitalopram oxalate daily (medicaton to treat depression), 5 ml (100mg) of gabapentin three times daily (medicaton to neuropathic pain), one tablet of sennoside twice a day (medicaton to treat constipation), and 0.38 ounces of banatrol with bimudo probiotic twice as day. R184's Clinical Orders report lacked indication if medications could be crushed together or if they could be administered together. During an observation and interview on 7/31/24 at 8:00 a.m., registered nurse (RN)-G was observed removing the baclofen, metoprolol, escitalopram, and sennoside from its packaging and placing them in the same medication cup. The medications were then transferred to a clear medication bag and crushed together using a manual levered machine. RN-G measured the gabapentin solution and poured the solution in a plastic cup. RN-G added the crushed medications to the plastic glass, added the banatrol, filled the glass with water, and mixed all the medications	F 759		

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F 759	Continued From page 102 together. RN-G stated, "all the medications are going to the stomach, that's how we do it." RN-G administered 60 milliliters (ml) of water via the gastric tube, administered the combined medication solution through the gastric tube, and then again, flushed the tube with 60 ml of water. During interview on 7/31/24 at 11:37 a.m., RN-G verified they did not have a provider order to administer all the crushed medications medications together. RN-G added but they are all scheduled at the same time. During interview on 7/31/24 at 1:42 p.m., nurse manager RN-E stated medications administered via tube feedings needed to be crushed individually, administered one at the time, and to use water boluses between medications. NN-E stated administering medications together was not the correct way to do it and the medications needed to be administered one at the time. R376 R376's significant change Minimum Data Set (MDS) dated 6/28/24, indicated R376 was cognitively impaired, had no delirium or hallucinations and did not refused cares. R376 was independent with transfers, bed mobility, walked short distances, and needed supervision with personal hygiene and dressing. R376's Clinical Diagnosis record printed 7/31/24, indicated diagnosis of oropharyngeal phase dysphagia (swallowing problems in the mouth and/or the throat), gastrostomy status (surgical procedure that creates an opening in the abdomen and into the stomach, allowing for the	F 759		

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F 759	Continued From page 103 insertion of a feeding tube), ankylosis spondylitis of spine (inflammatory arthritis), traumatic brain injury, chronic obstructive pulmonary disease (inflammatory arthritis), severe protein-calorie malnutrition, and acute respiratory failure with hypoxia ((a medical emergency that occurs when the body's tissues don't have enough oxygen). R376's Clinical Orders report printed 7/31/24, indicated "may crush meds unless contraindicated". The report indicated the following medications were to be administered via the gastric tube: 50 mg - 3 tablets of sertraline (antidepressant) daily, 25 micrograms of cholecalciferol (vitamin D) capsule daily, 1 mg of folic acid (vitamin B-12), 15 ml -100 mg/ml of levetiracetam (medication for epilepsy) twice daily, one mineral multivitamin tablet daily, 17 grams of polyethylene glycol (medication for constipation) 3350 daily, 10 mg of Zyrtec (allergy medication), 100mg (10ml) of lacosamide (anticonvulsant) twice daily, 1000 mg (20ml) of valproate sodium (medication to treat seizures) solution twice daily. R376's Clinical Orders report lacked indication if medications could be crushed together or if they could be administered together. During an observation and interview on 7/31/24 at 8:35 a.m., licensed practical nurse (LPN)-F was observed removing the sertraline, cholecalciferol, folic acid, multivitamin, and Zyrtec in the same medication cap. The medications were then transferred to a clear medication bag and crushed together using a manual levered machine. LPN-F measured levetiracetam, lacosamide, and valproate sodium and poured them in the same plastic cup. LPN-F then added	F 759		

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F 759	Continued From page 104 the crushed medications and the polyethylene glycol to the liquid medications, filled the glass with water and mixed them together with a plastic spoon. LPN-F flushed the gastric tube with water, administered medications and flushed the gastric tube with water. LPN-F stated he wasn't sure if they had an order to crush and administer all the medications together. During interview on 7/31/24 at 1:28 p.m., LPN-F stated he wasn't sure if it was safe to mix all medications together. LPN-F stated that this was his first experience administering medications via a tube feeding. During interview on 8/1/24 at 8:27 a.m., nurse manager RN-H stated unless you have an provider order that is okay to mix the medications together, you should administer one medication at the time and flush with water in between. RN-H stated the concern of giving the medications together was a potential for interactions or a decrease in the efficacy of the medications. During interview on 8/1/24 at 12:29 p.m., pharmacist (PH) stated it was not recommended to combine and mix medication and then administer them via a gastric tube. PH stated there was not enough scientific data to know how the medications interact or how they were absorbed when they are crushed and administered together. PH stated it was up to the providers to authorize the crushing of medications together and administering them via gastric tubes. During interview on 8/1/24 at 2:55 p.m., director of nursing (DON) stated we have the	F 759		

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F 759	Continued From page 105 responsibility to clarify the orders on admission. We need to have the right medication, the right dose, the right diagnosis, and the right frequency. "The nurse must ask those questions. Some medications are prescribed for different reasons. But is their patient taking the medication for seizures or what?" Regarding the administration of medications via gastric tubes, DON stated a provider order is required to administer medications together because it could cause interactions. Interactions could even be life threatening or have a negative outcome. The order needs to come from the provider. DON stated "It is 101 nursing, if you have 10 meds, you need 10 med cups, one for each medication. It is basic nursing." Facility's policy titled Medication administration via Enteral Tube dated 4/1/22, indicated each medication will be administered separately. Policy also indicated medications may be administered together with a provider's order.	F 759		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper	F 761		9/17/24

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F 761	Continued From page 106 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 and interview, the facility failed to ensure mediations were kept locked or under direct observation of authorized staff in areas where residents, staff and guests could access medications on 3 of 5 resident floors. Findings include: During observation and interview on 7/29/24 at 6:14 p.m., an unattended and unlocked medication cart was observed located along a knee-high wall facing the seventh floor dining room during mealtime. Registered nurse (RN)-A returned to the medication cart and verified it was unlocked and, "it should be locked to stop anyone from getting in." During observation and interview on 7/31/24 at 1:10 p.m., an unattended and unlocked medication cart was observed located along a knee wall facing the fifth floor dining room with 12 seated residents in wheelchairs and walkers and two residents in wheelchairs rolling past the cart. During interview with licensed practical nurse (LPN)-B stated he was responsible for the	F 761	Medication carts remain locked when not under direct observation from a licensed nurse. Residents that reside at Lakehouse have the potential to be affected by this practice. Licensed nurses have been educated on medication storage and locking the medication carts when not in direct observation of cart. Director of Nursing/Designee will conduct 3 audits weekly x 3 weeks to ensure medications are stored appropriately. Findings of this audit will be reviewed at QAPI until substantial compliance has been met.	

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F 761	Continued From page 107 unlocked medication cart and stated, "I should always lock the cart when I leave it. Because the residents can get access to it." During observation and interview on 8/1/24 7:54 a.m., an unattended and unlocked medication cart was observed located along a knee wall facing the fifth floor dining room with 12 seated residents in wheelchairs and walkers in the area. LPN-C stated he was responsible for the unlocked medication cart and stated, "the med cart should be locked because it is regulation. [sic] keep others from getting into the cart and getting the meds." During continuous observation on 8/1/24 from 11:30 a.m. to 11:47 a.m., an unattended and unlocked medication cart was observed on second floor in front of the nursing station until the DON walked by and locked the medication cart. During interview with second floor nurse manager (RN)-H stated, "leaving the cart unlocked [sic]concern because anybody can open it and take medications". During interview with the third floor nurse manager RN-B on 8/1/24 at 7:58 a.m., stated, "medication carts [sic] always lock before leaving the cart [sic] when leaving because we have residents here that can rummage through them and get access to them, and we do not want to have the risk of them getting into the carts and accessing the meds." During interview with director of nursing (DON) on 8/1/24 at 9:02 a.m., DON stated, "we teach nurses to keep the med carts locked once you	F 761		

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F 761	Continued From page 108 are stepping away. No matter what. If you can't reach the cart, you must lock the cart." Facility policy titled Medication Administration dated May 2024 identified, "Medications are administered by licensed nurses, or other staff who are legally authorized to do so".	F 761		
F 790 SS=D	Routine/Emergency Dental Srvcs in SNFs CFR(s): 483.55(a)(1)-(5) §483.55 Dental services. The facility must assist residents in obtaining routine and 24-hour emergency dental care. §483.55(a) Skilled Nursing Facilities A facility- §483.55(a)(1) Must provide or obtain from an outside resource, in accordance with with §483.70(g) of this part, routine and emergency dental services to meet the needs of each resident; §483.55(a)(2) May charge a Medicare resident an additional amount for routine and emergency dental services; §483.55(a)(3) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; §483.55(a)(4) Must if necessary or if requested, assist the resident; (i) In making appointments; and (ii) By arranging for transportation to and from the	F 790		9/17/24

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F 790	Continued From page 109 dental services location; and §483.55(a)(5) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure routine dental services were provided or offered to promote oral hygiene and reduce the risk of complication (i.e., chewing issues, cavities) for 4 of 4 residents (R39, R50, R134, R179) reviewed for dental services. Findings include: R39 R39's significant change Minimum Data Set (MDS), dated 6/4/24, identified R39 admitted to the care center in April 2024 and had moderate cognitive impairment but demonstrated no delusional thinking. Further, the MDS section labeled, "Section L - Oral/Dental Status," outlined spaces to record if R39 had broken or loose-fitting dentures, abnormal mouth tissue, or obvious tooth cavities but the section was answered, "Z. None of the above were present." R39's Census listing, printed 7/31/24, identified R39 current payer source recorded as, "Veterans Administration."	F 790	R39, R50 R134 R179 have all been offered dental services Residents will be asked about dental services on admission and quarterly during care conference meetings. Nursing management, Social Services, have been educated on the utilization and offering of dental services. Director of Social Services/Designee will audit 2 residents for dental concerns noted weekly x 3 weeks, then 2 residents monthly x 3 months. Audits will be reviewed for continued quality assurance and performance improvement.	

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F 790	Continued From page 110 On 7/29/24 at 1:54 p.m., R39 was observed seated in his wheelchair while in his room. R39 was interviewed, and expressed he had little to no natural teeth adding, "I gotta go see the dentist." R39 explained he wore dentures previously, however, his family member lost them awhile back and, as a result, he had gone without them for a long time. R39 stated he typically went through the VA (Veterans Administration) for medical appointments, however, nobody from the care center had asked about or helped him arrange a dental examination or visit since he admitted. R39 stated he wanted to get to a dentist to check on getting new dentures and expressed frustration with both the care center and the VA adding, "They're even slacking now-a-days." R39's Nursing Assessment - Admission/Readmission + Careplan - V13, dated 4/10/24, identified R39 was alert and oriented to person, place, time and situation. The evaluation contained a section labeled, "Oral, Vision and Hearing Status," which provided several questions to be answered by staff. This section identified R39 used dentures with both an upper and lower partial being checked; R39 needed no assistance with oral cares; and he had a mouth condition recorded as, "Within Normal Limits." The evaluation continued and listed spacing to record, "Last Dental Visit," however, this was answered with, "N/A." The completed evaluation lacked evidence if the denture fitment (i.e., secure, loose) had been evaluated, nor if R39 had been asked or offered a dental examination. A subsequent Nursing Assessment - Admission/Readmission + Careplan - V13, dated 4/15/24, was also located. This completed evaluation outlined the same section labeled, "Oral, Vision and Hearing Status," however, now	F 790		

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F 790	Continued From page 111 recorded R39 as having natural teeth with the multiple options to check for denture use being left blank. The section provided labeled, "Last Dental Visit," was answered with, "Unknown," and another section labeled, "Additional Oral Status Comments," was answered, "WNL [within normal limits]." However, again, the completed evaluation lacked evidence if R39 had been asked or offered a dental examination, nor was there clarification on which evaluation (i.e., 4/10/24 or 4/15/24) was accurate regarding R39's actual oral condition (i.e., natural teeth or denture use). R39's care plan, dated 4/10/24, identified R39 had an ADL (activities of daily living) self-care deficit and listed multiple interventions including, "PERSONAL HYGIENE/ORAL CARE: The resident is independent." However, the care plan lacked any specific problem statements, goals or interventions for R39's oral condition or dental needs despite R39 having conflicted evaluations completed with, at least one, indicating denture use. R39's Care Conference Summary - V2, dated 6/24/24, identified R39 was invited to the care conference held on 6/21/24, but he did not attend. The summary contained multiple spaces to record various information discussed and/or obtained during the conference which included a section labeled, "Appointments," with directions included, "Dental and Vision are to be completed annually unless otherwise noted ...," and spaces to record dates of either upcoming or last known evaluations with another section labeled, "Appointment Comments," however, all of these spaces were left blank and not completed. The summary lacked evidence R39 had been asked, either before or after the conference since he	F 790		

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F 790	Continued From page 112 didn't attend, about the need for a dental appointment. When interviewed on 7/31/24 at 11:11 a.m., registered nurse (RN)-G explained if a resident developed dental issues, they would call the medical provider and get a referral order to the dentist. RN-G stated they had "heard some people [onsite dental] used to come" but was not sure if such still happened. RN-G stated the nurses, upon admission, complete a "general assessment" which included the oral cavity and verified this was documented using the evaluation in the record (i.e., Nursing Assessment - Admission/Readmission). RN-G reviewed R39's completed evaluations and verified 'N/A' was recorded on 4/10/24, but expressed they were not sure what such language meant or why it had been recorded. R39's entire medical record was reviewed and lacked evidence R39 had been asked, offered or refused a dental examination since admission to the care center several months prior. When interviewed on 7/31/24 at 2:34 p.m., registered nurse unit manager (RN)-E verified they had reviewed R39's medical record, and they explained the nurses' complete an initial evaluation upon admission and record it using the provided forms (i.e., Nursing Assessment - Admission/Readmission). RN-E verified R39 had multiple evaluations completed with conflicting data being recorded and expressed, since R39 in-fact had no natural teeth, someone should have followed up with him to see if a dental appointment was needed adding they were now working on getting one arranged. RN-E verified the nurses who complete the initial evaluations	F 790		

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F 790	Continued From page 113 should be asking about a dental appointment and recording such then, if wanted or needed, refer the information to the health unit coordinators (HUC) to get scheduled. RN-E verified the lack of documentation in the medical record to demonstrate R39 had ever been asked about a dental appointment and expressed it was important to offer such appointments as bad teeth or dentition could cause issues like bad nutrition, dehydration and it was "important for their health overall." Further, RN-E verified the Care Conference Summary had spacing to record appointments but this was left blank adding R39 had possibly been offered and refused then, "But we still didn't chart it." On 7/31/24 at 2:53 p.m., the licensed social worker (SW)-C verified they completed the Care Conference Summary for R39 (dated 6/24/24). SW-C acknowledged the spaces to record appointment information was left blank stating it was blank "cause I don't have anything [information on them]," and added the form typically has data entered to show when the last appointment for each discipline. SW-C stated they were unaware R39 didn't have his dentures present at the care center and expressed any need for a dental appointment, including initially being asked about one, would start with the nursing department adding, "That all goes through nursing." R50 R50's admission Minimum Data Set (MDS), dated 6/25/24, indicated R50 was admitted to the facility on 6/19/24, was cognitively intact and required partial to moderate assistance with oral care. The	F 790		

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F 790	Continued From page 114 MDS further indicated R50 had "broken or loose fitting full or partial dentures" and had "no natural teeth." R50's Nursing Admission Assessment, Oral, Vision, and Hearing Status, dated 6/19/24, indicated R50 had "no teeth" and her last dental visit was "unknown." R50's electronic medical record (EMR) lacked evidence that a dental visit had been offered to R50 since her admission on 6/19/24. R50's progress notes, dated 7/31/24 indicated, "social services was informed [by surveyor] that resident was interested in receiving a visit from the dentist." R50 confirmed her interest in having a dental appointment. During observation and interview on 7/29/24 at 6:47 p.m., R50 was lying in bed, with her dinner tray near her, and was edentulous (without teeth). R50 stated she had dentures, but they were broken. R50 further confirmed staff have not offered any dental services to her to address her broken dentures since she was admitted to the facility. R134 R134's quarterly Minimum Data Set dated, 7/20/24 indicated R134 with severe impairment of cognitive skills, physical and verbal symptoms directed towards others, had an indwelling catheter. In addition, R134 with diagnoses of Alzheimer's disease, dementia, seizures, depression, anemia, renal insufficiency, neurogenic bladder, obstructive uropathy and	F 790		

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F 790	Continued From page 115 receiving antipsychotics, antidepressants. Also, R134 required extensive assistance of one staff member with bed mobility, eating, toilet use. And required setup or clean-up assistance with oral hygiene. During interview with family member (FM)-A on 7/29/24 at 3:24 a.m., FM-A stated, "[R134] has dental issues. It's been over a year since he was seen". Review of Care Conference Summary dated 6/26/24, "Section D. Appointments" identified, "Dental and Vision are to be completed annually unless otherwise noted" and "1. Dental: [blank]". In the section titled, "Appointment Comments: "Reviewed desired/requested ancillary services as above". The summary lacked indication of any dental appointments. Review of R134's EMR lacked documentation of dental evaluations or visits after 10/6/22. R134's care plan dated 4/28/22 direct staff to, "Coordinate arrangements for dental care, transportation as needed/as ordered." During interview with the director of social services (SW)-A on 8/1/24 at 8:04 a.m., SW-A stated expectation of facility to "set up the [dental] referrals" and that family (FM-A), "decided that dental visits are not a priority". SW-A stated, "[dental services] should be offered and should be documented". SW-A reviewed R134's EMR and stated the EMR lacked documentation of discussion with FM-A regarding dental services. During interview with director of nursing (DON) on 8/1/24 at 9:05 a.m., DON stated expectation of	F 790		

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F 790	Continued From page 116	F 790		

dental services, "must be done every six months and prn. " DON stated the facility "had a gap in health unit coordinator (HUC)" and "that is what happened with missing dental appointments". DON stated, "if the [care conference] discussion involves delay or not doing it then it should be offered." And "should be documented".

R179

R179's quarterly MDS, dated 7/6/24, indicated R179 was admitted to the facility on 6/5/24 and was cognitively intact.

R179's Nursing Admission Assessment, Oral, Vision and Hearing Status, dated 7/25/24, indicated R179 had no oral concerns, and her last dental visit was approximately 1 year ago.

R179's electronic medical record (EMR) lacked evidence that a dental visit had been offered to R179 since her admission on 6/5/24.

R179's progress note, dated 7/31/24, indicated social services was informed [by surveyor] that R179 requested a dental appointment. R179 confirmed to social services wanting to see the dentist to address some tooth pain she was having.

During an interview on 7/29/24 at 6:32 p.m., R179 stated she has been having tooth pain, especially when she eats, stating she had told staff but has not been offered a dental visit.

During an interview on 7/31/24 at 11:38 a.m., licensed practical nurse (LPN)-F stated the initial oral assessments are done by either the

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F 790	Continued From page 117 assessment nurse or the floor nurse when a resident is admitted to the floor. LPN-F stated a dental visit was offered if there was an issue or problem identified with the initial oral assessment. During an interview on 7/31/24 at 7:53 a.m., nurse manager and registered nurse (RN)-H stated if a resident was admitted with broken or sore teeth then the nurses would assess when their last dental visit was, stating the social worker would set up the dental appointments. RN-H stated if a resident was admitted without dentures or broken dentures they should be offered dental services on admission. During an interview on 7/31/24 at 7:59 a.m., social worker (SW)-C stated if a resident had an issue with their oral assessment, such as mouth pain, it would get relayed to him and he would make a referral for a dental visit. SW-C stated he was unaware of any issues with R50 or R179. During a follow up interview on 8/1/24 at approximately 10:00 a.m., nurse manager and registered nurse (RN)-H stated it was expected that all residents were offered dental appointments at admission but was unable to produce any documentation that dental appointments were offered, stating dental appointments would start being offered at the resident 48-hour care conference. During an interview on 8/1/24 at 12:40 p.m., the director of nursing stated it was expected that a dental visit was offered to all residents at admission, long-term, and short-term residents. The DON further stated it was expected the staff document when a dental visit was offered.	F 790		

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F 790	Continued From page 118 A facility' provided Dental Services policy, dated 2/2024, identified routine and emergency dental services were available to meet a resident's oral health needs in accordance with the assessment and plan of care. The policy outlined social services will assist with making appointments and, if needed, transportation arrangements and outlined, "If dentures are damaged or lost, residents will be referred for dental services."	F 790		
F 804 SS=E	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure food was delivered and served in a timely manner to preserve desired temperatures of food for 3 of 3 residents (R158, R39 and R146) reviewed for dining. This had the potential to affect all residents of facility that received meal trays. Findings include: During survey initial kitchen tour on 7/29/24 at 11:57 a.m., the kitchen supervisor (KS) provided surveyor with printed copy of the document Mealtimes with three columns. First column identified meals and units. The other two columns	F 804	Identified residents meal services times have been altered. Dining room and meal time processes are being altered. Dietary and nursing department have been educated on the new process for dining and serving food at desired temperatures for the residents. Assigned Designee will audit 2 meal services weekly x 3 weeks, then 2 meal services monthly x 3 months. Audits will be reviewed for continued quality assurance and performance improvement	9/17/24

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LAKEHOUSE HEALTHCARE & REHABILITATION CENTER	3737 BRYANT AVENUE SOUTH MINNEAPOLIS, MN 55409

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F 804	Continued From page 119	F 804		

identified, "Dietary Starts:" and "Cart Arrives on Site: "There was notation at bottom of form stating, "Note: Meal delivery times may vary by 10 minutes from posted schedule" and was documented as below.

Meal Times: Cart Arrives on Site

BREAKFAST:
2R: 7:15 AM
3G: 7:30 AM
2G: 7:45 AM
7G: 8:00 AM
5G: 8:15 AM
6G: 8:30 AM

LUNCH:
2R: 11:15 AM
3G: 11:30 AM
2G: 11:45 AM
7G: 12:00 PM
5G: 12:15 PM
6G: 12:30 PM

DINNER:
2R: 4:45 PM
3G: 5:00 PM
2G: 5:15 PM
7G: 5:30 PM
5G: 5:45 PM
6G: 6:00 PM

During interview on 7/29/24 at 11:57 a.m., KS stated the expectation of facility staff was to start serving meal trays once they arrive to the units.

R158

R158's Significant Change Minimum Data Set

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F 804	Continued From page 120 (MDS) dated 6/1/24 identified R158 with intact cognition and resided on the 7G unit of facility. During interview with R158 on 7/29/24 at 4:38 p.m., R158 stated, "food is bad. Cold when it should be warm". During observation on 7/30/24 at 7:43 a.m., food cart was not present on 2R. Two residents were seated in dining room and no staff were present. Posted sign on kitchenette stated cart was to arrive at 7:15 AM. During observation on 7/30/24 at 8:04 a.m., food cart was present in 3G dining room with three residents sitting at the dining room tables. No meals were being passed and no staff were present. Posted sign on kitchenette stated cart was to arrive at 7:30 AM. During observation on 7/30/24 at 8:11 a.m., food cart was present in the 7G dining room with twenty-four residents seated at dining room tables. No food was served to any of the residents. Two rolling carts inside the kitchenette had milk and juice in plastic bins with ice. Posted sign on kitchenette stated cart was to arrive at 8:00 AM. During interview with nursing assistant (NA)-E on 7/30/24 at 8:38 a.m., on the 7G unit, NA-E stated he had worked for facility for over a year and, "no food is yet up here, even in the kitchen". NA-E stated, "I always thought it [meal cart] was brought up at nine-o-clock". NA-E stated, "We do try to serve the dining room first and then another aide will serve the room trays." During observation on 7/31/24 at 8:57 a.m., food	F 804		

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F 804	Continued From page 121 started to be served to 7G residents in the dining room, fifty-seven minutes after posted meal cart was to arrive per kitchenette posting. R39 R39's significant change Minimum Data Set (MDS), dated 6/4/24, identified R39 had moderate cognitive impairment but demonstrated no delusional thinking during the review period. When interviewed on 7/29/24 at 1:42 p.m., R39 expressed multiple complaints about the care center' meal service including the food on the room-delivered meal trays was often cool. R39 stated the kitchen brought them up and then the trays sit out in the dining room "for half an hour after they serve out there [to people seated in the dining room; see F807]." R39 stated it was an ongoing issues and he had complained about it prior but staff told him, "You keep complaining and you'll be gone [discharged]." R39 reiterated he wanted hot, palatable meals served but the service was poor adding, "It's still happening." R146 R146's significant change MDS, dated 5/4/24, identified R146 had intact cognition and demonstrated no delusional thinking during the review period. On 7/29/24 at 1:03 p.m., R146 was observed laying in bed while in his room. R146 had a bedside table pulled close to the bed which had a meal tray sitting on top with a domed lid covering. R146 was asked about the care center food and responded by shaking his head in a 'no' motion (side to side) and saying aloud, "like this," while	F 804		

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F 804	Continued From page 122 his hand making a side to side motion (i.e., 'so-so'). R39 stated he typically ate meals in his room and voiced the food was often bland tasting and not warm when it was finally served adding, "It [food] just isn't presented well." During interview on 8/1/24 at 8:50 a.m., family member (FM)-B explained R146 admitted to the care center about six months prior due to unsafe living conditions at the home and a series of falls. FM-B stated they visited often and R146 had been eating less lately adding aloud, "The food there sucks." FM-B explained the family was worried about R146's nutritional intake and, as a result, had been trying to bring in items to bolster his intake due, in part, to the poor meals served. During observation and interview with dietary aide (DA)-A and DA-B on 7/31/24 at 9:06 a.m. on the 7G dining room, DA-A temped R158's scrambled eggs that had immediately been set in front of him. Temperature registered 113 degrees Fahrenheit. DA-A stated the temp was too low and R158 stated the eggs were "too cold". DA-B stated, "[7G residents] supposed to get their food at 8:15 a.m., to 8:30 a.m., but we are late today. During interview with KS on 7/31/24 at 12:35 p.m., KS stated, "I would say the food that was delivered today was late. If the food did not get to 2R until after 9:00 a.m., then it is 45 minutes late and the food delivered this morning to 7th floor was late also." During observation on 7/31/24 at 1:02 p.m. on 6G, food was still being delivered to residents in the main dining room. Posted sign on kitchenette stated cart was to arrive at 12:30 p.m..	F 804		

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F 804	Continued From page 123 During interview with facility dietician (DC) on 7/31/24 at 1:43 p.m., DC stated, "Food should not be delivered late. If it is delivered late, then I would be concerned about potential for infection. Liquids being delivered to resident rooms must always be covered. I would be concerned about contamination and being served too warm. Scrambled eggs and oatmeal should be at least 140 degrees when delivered to rooms and when served." During interview with the regional director of dietary services (RD) on 7/31/24 at 2:21 p.m., RD stated the facility started a new food service company on May 1, 2024. RD stated, "forty-five minutes is too long to wait for the carts to be delivered to the units. Those carts are not insulated, and staff should not be giving trays to the residents 45 minutes to an hour after the food arrives on the floor." During interview with R158 on 8/1/24 at 11:15 a.m., R158 stated the scrambled eggs that were temped by DA-A on 7/31/24 for breakfast was, "not warm enough for me". During observation and interview with RD on 8/1/24 at 12:39 p.m., on the 7G unit, RD was asked to temp a lunch tray that was delivered to a resident room. The brat was temped at 124.2 degrees Fahrenheit. RD stated, "this is not where we need it [food temps] to be" and declined to offer surveyor a test tray. RD stated, "I noticed the staff pulled the meal trays out of the meals carts and put them on top of the counter and let them wait. The meal trays would at least be warmer when served directly from the meal cart and not allowed to be sitting on the counter getting cold."	F 804		

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F 804	Continued From page 124 Resident council meeting minutes for February 16, 2024, identified, "food is being brought to the floor in a timely manner however the aides on the floor aren't serving it right when it comes". Resident Council Action form dated 6/13/24 provided to the DON identified, "Residents expressed food isn't passed out right when the carts come up". There was no implementation date or staff signature on the form. Facility policy on food temperatures and timing of serving food was requested but not received.	F 804		
F 807 SS=D	Drinks Avail to Meet Needs/Prefs/Hydration CFR(s): 483.60(d)(6) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(6) Drinks, including water and other liquids consistent with resident needs and preferences and sufficient to maintain resident hydration. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure drinks of preference were offered or served to promote adequate fluid intake and improve meal satisfaction for 1 of 2 residents (R39) reviewed who expressed their preferences of meal items were not honored. Findings include: R39's significant change Minimum Data Set (MDS), dated 6/4/24, identified R39 had	F 807	Identified residents drink preferences have been reviewed and updated. Nursing department have been educated on the new process for dining and serving residents their preferred drink of choice. Assigned Designee will audit 2 meal services weekly x 3 weeks, then 2 meal services monthly x 3 months. Audits will be reviewed for continued quality assurance and performance improvement	9/17/24

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F 807	Continued From page 125 moderate cognitive impairment but demonstrated no delusional thinking during the review period. On 7/29/24 at 1:42 p.m., R39 was observed in his electric wheelchair while in his room. R39 had a meal tray present on his bedside dresser which had a coffee cup filled with coffee and a white Styrofoam cup filled with a dark-red colored juice. R39 expressed multiple complaints about the care center meal service and food quality, and stated he wished they'd serve him milk with meals "instead of that red crap" as he pointed to the cup on his meal tray. R39 stated he had repeatedly asked for milk with meals but added, "I ask them for milk but don't get it." R39 reiterated his displeasure multiple times with this and stated when he complains about it, it would get better "for a day to two" then go back to various juices instead of milk. R39's nutritional care plan, dated 7/25/24, identified R39 had a low body mass index (BMI) and consumed a regular diet with thin liquids. The care plan listed multiple interventions for R39's nutrition including, "Food/beverage preferences: like: strawberry," however, lacked any recorded beverage preferences or dislikes. On 7/31/24 at 8:24 a.m., the morning meal service on R39's unit was observed. A gray-colored mobile cart was pushed onto the unit which had numerous meal trays present inside. The trays contained plated, covered food along with white-colored menu slips on each which contained the respective resident' name, diet information and spacing to record likes, dislikes, and beverage preferences. At 8:27 a.m., nursing assistant (NA)-H helped remove various trays from the mobile cart and placed them on	F 807		

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F 807	Continued From page 126 another metallic rack while NA-G pushed a cart around the dining room which had multiple juices, water and milk on it with residents seated at the tables being asked for their drink preferences. NA-H stated the trays being placed on the metallic racks were "room trays." At 8:33 a.m., registered nurse manager (RN)-E removed R39's meal tray from the mobile cart and placed it on the metallic rack. R39's white-colored menu slip was on the tray which listed his name along with a listing of various food or drinks along the bottom which included, "* Apple ...," and, "* Milk, Low ..." However, a majority of the menu slip was covered with a napkin and not immediately visible. R39's meal tray then remained on the metallic rack until 8:43 a.m., (nearly 20 minutes after it arrived to the unit) when NA-H returned to the rack and pushed it over the the mobile juice cart. NA-H then started to pour and place various juices on the respective trays, including R39's, which remained on the metallic rack. When asked how they know which beverages or drinks to put on the room trays, NA-H stated they knew they knew their preferences adding aloud, "I'm used to them, so I know exactly." NA-H then looked at R39's meal tray, however, did not move the napkin to read the entire menu slip. NA-H removed a Styrofoam cup from a sleeve and filled it with ice and water, then poured another cup full of milk. NA-H placed the milk on the nurses' station ledge and then removed another cup and poured it full of a dark red-colored drink. NA-H placed the ice water and red-colored drink on R39's meal tray and started to push the metallic rack towards the rooms. The surveyor asked NA-H about the poured milk which remained on the nurses' station ledge and NA-H stated, "I skip	F 807		

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F 807	Continued From page 127 it." NA-H left the milk on the ledge and then pushed the metallic rack to the resident' rooms which included R39's room. At 8:56 a.m., NA-H placed R39's tray in his room on the bedside dresser. R39 was not present in the room and NA-H stated, "I just drop it here." NA-H was asked about the white-colored menu slip, dated 7/31/24, on the tray which had three items, including milk, listed on it with a star (i.e., *) next to them. NA-H reviewed the menu slip and verified the section labeled, "Beverage Pref:," was left blank but expressed the starred items were "the major things that they like." NA-H verified they didn't serve R39 any milk, despite it being starred on the slip, and expressed they served him the cranberry juice instead as, "He [R39] doesn't like milk." NA-H reiterated, "I'm used to them [residents] so I know." NA-H verified they had not asked or questioned R39 on what drinks he wanted with the breakfast meal that day. NA-H stated R39 would "once in awhile" complain about the drinks on his meal tray but they (NA-H) attributed such to just him changing his mind at times. Further, NA-H stated the kitchen staff made and sent-up the white-colored menu slips for each meal. When interviewed on 7/31/24 at 1:06 p.m., RN-E stated they believed the starred items on the menu slips were "what they prefer" but added, "I could be wrong though." RN-E stated the staff were told to review the menu slips and ensure the diet served matches the diet listed but also staff were told to "get to know your residents and what they like and don't like." RN-E stated the kitchen or dietary department had never, to their recall, explained to inform the staff what the starred items actually meant.	F 807		

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F 807	Continued From page 128 On 7/31/24 at 1:27 p.m., the kitchen supervisor (KS) was interviewed. KS explained the white-colored menu slips were made in the kitchen for each meal and sent up with the trays to the units adding the starred drink items were "a preference, a beverage preference." KS stated the kitchen sends up the drinks and beverages to the units and "the CNAs take it from there" to pass them out. KS stated the starred items didn't necessarily mean they should be passed at each meal but verified the NA should be asking the resident which drinks or beverages they wanted for each meal. KS stated this was important to do for "customer service" and "to ensure the resident is getting what they're wanting." A facility policy on resident drink preferences with meals was requested, however, none was received.	F 807		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility.	F 812		9/17/24

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F 812	Continued From page 129 §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 and interview the facility failed to ensure all food items were properly covered when served to residents to reduce and/or prevent the risk of food borne illness. This practice had the potential to affect all residents who received their meals from the kitchen. Findings include: During observation and interview on 7/29/24 at 6:00 p.m., nursing assistant (NA)-N poured beverages into cups and mugs and placed on multiple meal trays which were on an uncovered cart. Uncovered cheesecake desserts were also on the individual meal trays. NA-N wheeled the uncovered cart from the dining room down the hall and passed the meal trays to at least six individuals in their rooms pushing the cart further down the hall between rooms. NA-N stated the beverages came up to the sixth floor in covered pitchers and could be poured into cups in the dining room and taken uncovered to residents' rooms. During observation and interview on 7/31/24 at 9:12 a.m., NA-P wheeled an uncovered cart passing meal trays on the sixth floor which had uncovered bowels of cereal, brown sugar, milk, and other beverages. NA-P stated they did not have lids on the sixth floor to cover the brown sugar and other items. During observation and interview with dietary	F 812	Identified residents drinks are being covered while served down the resident hallways. Dietary and nursing department have been educated on the new process for covering all drinks and food items when walking down the resident hallway. Assigned Designee will audit 2 meal services weekly x 3 weeks, then 2 meal services monthly x 3 months. Audits will be	

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F 812	Continued From page 130 aide, (DA)-A on 7/31/24 at 9:12 a.m. on 6G, DA-A temped a room tray that was being delivered. Four room trays were present on the meal tower cart and all the trays with uncovered orange juice, coffee, apple juice, and hot chocolate. DA-A stated she was unaware of whether liquids needed to be covered when delivered to resident rooms. During interview with director of nursing (DON) on 7/31/24 at 10:04 a.m., DON stated, "liquid drinks should be covered when bringing them to resident rooms. During interview with kitchen supervisor (KS) on 7/31/24 at 12:35 p.m., KS stated, "Food is [to be] covered when traveling a distance like down a hallway, to a different unit or floor, based upon standards of practice for infection control and food safety." KS stated, "My understanding is that the food that is transported must have covers on them." During interview with NA-C on 7/31/24 at 1:05 p.m., NA-C stated, "it is not good to leave the drinks uncovered when delivering meal trays to residents in their rooms. We are supposed to cover them any time we deliver them to the resident rooms." During interview with facility dietician (DC) on 7/31/24 at 1:43 p.m., DC stated, "Liquids being delivered to resident rooms must always be covered. I would be concerned about contamination and being served too warm. " During interview with regional director of dietary services (RD) on 7/31/24 at 2:21 p.m., RD stated, "Fluids must be covered [sic] concern for cross	F 812		

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F 812	Continued From page 131 contamination and infection control if they are not covered when delivered to resident rooms." During observation and interview on 8/1/24 at 12:39 p.m. in the 7G unit dining room, RD stopped NA-F as he was pushing the meal cart tower down the hall to resident rooms. There were 3 resident room meal trays on the cart. The carrot cake rolls and liquids were uncovered. RD instructed NA-F that the carrot cake roll desserts needed to be covered along with all liquids before transporting. RD verified carrot cakes and liquids were not covered. During interview with NA-F on 8/1/24 at 1:13 p.m., NA-F stated, "we should be making sure the food is covered when transporting it including the milk and juice. I did not know or maybe I forgot the carrot cake needs to be covered also, which [it] wasn't when I was delivering those three trays." Facility policy on covering food during transport and delivery was requested but not received.	F 812		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at	F 880		9/17/24

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F 880	Continued From page 132 a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.	F 880		

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F 880	Continued From page 133 §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure laundered linens were handled and sorted in a clean, sanitary environment to reduce the risk of contamination for 1 of 1 main washrooms reviewed; failed to ensure staff consistently implemented transmission-based (TBP) and enhanced barrier precautions (EBP) to reduce the risk of infectious spread for 4 of 4 residents (R134, R83, R54 and R2); and failed to ensure general COVID-19 mitigation methods (i.e., masking) were correctly and consistently implemented on units with active infection. These findings have potential for a cumulative effect and, as a result, have potential to affect all 228 residents, staff and visitors within the care center. Findings include: Laundry Room: On 7/30/24 at 8:21 a.m., a tour of the campus main washroom was completed with laundry aide (LA)-A present. The washroom consisted of a	F 880	Linens are being laundered, stored and handled in a sanitary environment. Fans have been cleaned and a routine schedule for cleaning has been created. Staff have been educated on transmission-based precautions and enhanced barrier precautions and are correctly and consistently abiding by PPE practices. PPE practices have been reviewed and implemented. A sanitation schedule for the laundry room has been created to disinfect the fans and the linen laundry storage has been reviewed and is being handled in a sanitized manner. Staff in the departments of; Nursing, dietary, housekeeping, social services, therapy, maintenance, and administrative have been educated on transmission-based precautions and enhanced barrier precautions. Housekeeping and maintenance have been educated on environmental cleaning and disinfection practices that reduce	

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F 880	Continued From page 134 large single space with commercial washing machines on one side, and three Huebsch commercial dryers on the opposite. In the center of the room, positioned outside the dryers (direction they open to), were a series of tables pushed together with multiple, white-colored linens stacked on them to form a large pile. The wall surrounding the table had various mobile racks with various clothing items placed on them. However, attached to the wall were multiple "AirKing" bladed fans and the grates covering the blades of the fans had significant, copious gray and black-colored dust build-up present and were facing the cleaned linen stacked on the tables. In addition, a large Dayton Mobile Air Conditioner was on the floor and also facing the tables of stack linen. The machine was activated and moving air towards the clean linen, however, the grate covering the blades of the unit also had significant, dark gray-colored dust and debris build-up present. LA-A verified the condition of the grates and stated maintenance was supposed to be cleaning them to their knowledge, however, it had been "several weeks" since they were last done to their recall. LA-A stated staff could, if needed, make a maintenance slip out to have them cleaned but they had not done so themselves as they weren't exactly sure how to do it. At this time, the housekeeping supervisor (HS) entered the interview and expressed they had recently started working at the campus and were "going to find out" how the conditioner and fans were being cleaned. HS verified the devices were pointed at clean linen and soiled adding, "They need to be cleaned." HS stated the fans and conditioner should be kept clean to reduce possible contamination of the clean linens. The district	F 880	contamination. Infection Preventionist/Designee will conduct 3 audits weekly x 3 weeks on PPE practices related to transmission-based precautions and enhanced barrier precautions. Director of housekeeping/designee to conduct 3 audits weekly x 3 weeks on laundry storage and handling as well as fan cleaning and disinfecting. Findings of this audit will be reviewed at QAPI until substantial compliance has been met.	

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F 880	Continued From page 135 manager of environmental services (DMES) entered the interview and also verified the fan and conditioner grate' condition adding, "We should take care of them." LA-A verified the fans were not on a routine cleaning schedule to their knowledge. DMES stated the maintenance personnel may be cleaning them or have more information. On 7/30/24 at 3:47 p.m., the director of engineering (DOE) was interviewed. DOE verified they oversaw the maintenance department and expressed cleaning of the soiled devices observed in the washroom "really would fall under my department." DOE stated the fan and conditioner grates were cleaned on a "upon request" basis but they were going to likely implement a monthly schedule moving forward. DOE verified nobody had asked or presented the soiled grates to their department prior to survey and stated they should be cleaned adding them having built-up dust and debris posed "a fire safety hazard." During the recertification survey, from 7/29/24 to 8/1/24, no flowsheet(s) or documented tracking was provided to demonstrate the fans and air conditioner unit were on a cleaning schedule prior to the survey. On 8/1/24 at 1:03 p.m., the assistant director of nursing (ADON) and regional nurse consultant (RNC) were interviewed. ADON explained themselves, along with RNC, were helping to manage and oversee the facility' infection control program. ADON and RNC expressed the washroom was audited from "an environmental standpoint" at times, however, were unsure if it had been audited as part of the infection control	F 880		

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F 880	Continued From page 136 program. ADON verified staff are educated on clean linen handling and RNC expressed the fans and conditioner grate was going to be added to a schedule for routine cleaning moving-forward adding, "I think definitely the practice needs to change." ADON stated soiled grates blowing onto clean linen was a cross-contamination risk, and they verified the linens were used house-wide. A facility' policy on clean linen handling was requested, however, none was received. R134 R134's quarterly Minimum Data Set dated, 7/20/24 indicated R134 with severe impairment of cognitive skills, physical and verbal symptoms directed towards others and had an indwelling catheter. In addition, R134 with diagnoses of Alzheimer's disease, dementia, seizures, depression, anemia, renal insufficiency (form of kidney failure), neurogenic bladder(bladder control problem due to a brain, spinal cord, or nerve issue), obstructive uropathy (disorder of the urinary tract due to obstructed urine flow), and received antipsychotics, antidepressants. Also, R134 required extensive assistance of one staff member with bed mobility, eating, toilet use. R134's physician orders dated 7/29/24 direct staff for, "Isolation: Resident is on Enhanced respiratory precaution due to tested positive for COVID on 7/23/24 and is in a contagious stage. Resident will be on isolation for 10 days in a private room." R134's nursing progress note dated 7/23/24 stated, "Note Text: Resident test positive for covid	F 880		

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F 880	Continued From page 137 19 @ this time, Resident appeared to be lethragic [sic] today with poor appetite, T. 98.2, in bed @ this time and will encourage isolation." During observation on 7/29/24 at 3:50 p.m., an Airborne Infection Isolation room sign was posted on outside of resident door. Sign stated, "wear gown, N95, eye protection (Goggles or face shield), One pair of gloves." PPE cart was placed outside the door with N95 masks, gowns, gloves and hand sanitizer in the unit. PPE unit did not contain face shields or goggles. During continuous observation on 7/29/24 at 5:44 p.m. to 5:52 p.m., nursing assistant (NA)-A exited R134's room wearing PPE gown, N95 mask, and gloves. NA-A was wearing prescription eyeglasses and opened the PPE cart and then walked back into R134's room without eye protection. At 5:57 p.m., NA-A exited R134's room with a meal tray. During interview with NA-A on 7/29/24 at 5:58 p.m., NA-A verified R134 with Covid-19. NA-A verified he did not wear a face shield or goggles when assisting R134 with eating. NA-A stated, "I was told it was ok to just wear my eyeglasses". During interview with nursing manager and licensed practical nurse (LPN)-A on 7/29/24 at 6:03 p.m., LPN-A verified R134 was on respiratory precautions due to Covid. LPN-A stated, "[facility] they allow us to use our [eye]glasses as eye protection" and did not need to wear a face shield or goggles when working directly with R134. During observation on the second floor (with Covid outbreak) on 7/29/24 at 4:40 p.m., an	F 880		

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F 880	Continued From page 138 unidentified staff member was wearing surgical mask below their nose while pushing a resident in a Broda chair to the dining room. During interview with RN-B on 7/30/24 at 9:00 a.m., RN-B stated the expectation of all staff was to wear "required PPE gown, gloves, N95's and face shields or goggles" when providing any kind of care to a Covid positive resident. "Any time a staff enters a Covid room they are to don the PPE and remove it when they leave. Staff should not exit room with the PPE on to check the cart. [sic] important for staff to don and doff the PPE to prevent infection and to protect everyone including other staff, families and residents from infection". During interview with the DON on 7/31/24 at 10:04 a.m., DON stated Covid precautions include, "gown, gloves, face shield and N95 mask". And "staff should always wear all the required PPE including the face shield every time they enter the Covid positive room." Also, "surgical masks worn above nose and mouth should be worn by all staff during outbreaks especially on the Covid units." Uncovered Soiled Linen/Garbage Carts in hallways. During observation on 8/1/24 at 7:51 a.m., on the fifth floor, a three-bin unit with each bin having a large plastic bag inside a mesh bag was observed in the hallway outside of a fifth floor resident room. One of the bins had a white plastic cover while the other two had no covers at all. The uncovered middle bin had a visible mound of laundry with a soiled red plaid shirt. that had a	F 880		

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F 880	Continued From page 139 R30's name on a label inside the neck of the shirt. The uncovered right bin had soiled incontinence briefs and other trash in it. During observation and interview with nursing assistant (NA)-D on 8/1/24 at 7:53 a.m., NA-D exited room 505 with a small garbage bag and an arm full of soiled facility linen. NA-D placed the soiled facility linen including towels and bedsheet on top of the uncovered middle bin that had R30's personal shirt in it. NA-D then placed the small garbage bag into the uncovered soiled garbage bin. NA-D stated, "[the two uncovered bins] are supposed to be covered but this one doesn't have covers. [laundry] is supposed to be covered for infection control." During observation and interview on 8/1/24 at 7:58 a.m., on the third floor a three-bin unit with each having a large plastic bag inside a mesh bag was in the hallway outside of room 327. The middle bin was uncovered and had soiled Hoyer slings in it which were visible. Nursing manager and registered nurse (RN)-B grabbed the unit and wheeled it down the hall. RN-B stated, "soiled linen and garbage should not be visible from the hall". RN-B stated, "this is a concern for infection control. Each of these units [resident floors] have these 3 bin units for aides to put the trash and linen in them after providing care. One bin is for trash, one for personal laundry, and one for facility laundry. They should be covered when out in the hall." During interview with the director of nursing (DON) on 8/1/24 at 9:12 a.m., DON stated uncovered soiled linen and garbage, "should not be left visible in the hallway." DON stated rationale for covering soiled linen and garbage	F 880		

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F 880	Continued From page 140	F 880		

was, "infection control thing."

Enhanced Barrier Precautions:

R83's quarterly Minimum Data Set (MDS) dated 5/22/24, identified intact cognition and diagnoses of neurogenic bladder (when a person lacks bladder control due to brain, spincal cord or nerve problems), kidney disease, epilepsy, and diabetes mellitus. R83 required substantial and/or maximal assistance for transfers and rolling left and right and partial and/or moderate assistance for toileting hygiene. R83's MDS identified R83 had an indwelling catheter and was frequently incontinent of bowel.

R83's activities of daily living care plan revised 6/30/24, indicated R83 required a mechanical lift with two staff assistance for transfers. R83's care plan also indicated R83 had an indwelling catheter related to neurogenic bladder.

During observation on 7/29/24 at 5:29 p.m., R83's door had a sign which read "Enhanced Barrier Precautions" and instructed staff to wear gloves and a gown for high-contact resident care activities which included transferring. A cart of personal protective equipment (PPE) was next to R83's door. NA-N and NA-O wore gloves, mask, and no gown to assist R83. NA-N and NA-O hooked the sling underneath R83 to the mechanical lift machine, placed the urinary catheter, which was within its privacy bag, on R83's lap, and transferred R83 from the bed to wheelchair. NA-N removed gloves and performed hand hygiene prior to leaving the room. NA-O still had gloves on and no gown and placed urinary catheter bag under R83's wheelchair and made

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F 880	Continued From page 141 R83's bed. NA-O removed gloves, wheeled R83 out to the dining room, and washed hands at the nurses' station. During interview on 7/29/24 at 5:45 p.m., NA-O stated they looked at the sign on residents' doors to know what kind of PPE to wear. NA-O verified R83 had a urinary catheter and stated staff needed gown and gloves when completing care such as emptying the urinary catheter but wore gloves when transferring. During interview on 7/29/24 at 6:12 p.m., NA-N stated residents who had a urinary catheter were on enhanced barrier precautions and needed gown and gloves when providing cares related to urinary catheters. NA-N verified R83 was on enhanced barrier precautions and stated staff needed gloves to transfer R83. During interview on 8/1/24 at 9:17 a.m., LPN-H stated residents with urinary catheters were placed on enhanced barrier precautions and confirmed R83 had a urinary catheter and was on enhanced barrier precautions. LPN-H stated gown and gloves were required to transfer R83 and was important to follow proper PPE procedures for safety reasons, such as not spreading MRSA (methicillin-resistant Staphylococcus aureus; bacteria which is resistant to many antibiotics). During interview on 8/1/24 at 9:40 a.m., LPN-G verified R83 had a urinary catheter and was on enhanced barrier precautions which required gown and gloves for transfers. LPN-G stated it was important to wear gown and gloves when transferring residents with urinary catheters to prevent the spread of infection.	F 880		

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F 880	Continued From page 142 During interview on 8/1/24 at 1:03 p.m., the assistant director of nursing (ADON) stated residents with urinary catheters required enhanced barrier precautions, and staff were expected to wear gown and gloves when providing "hands on" cares which included transfers. During interview on 8/1/24 at 1:36 p.m., the director of nursing (DON) expected staff to follow the precaution signs on residents' doors, and precautions were important to follow to prevent the spread of infection. Facility policy "Enhanced Barrier Precautions" dated 3/24, defined EBP as the use of gown and gloves during high-contact resident care activities for residents known to be colonized or infected with a MDRO (multidrug-resistant organism) as well as those at increased risk for MDRO acquisition, such as residents with urinary catheters. The policy indicated high-contact resident care activities included transferring. PPE: R54 quarterly Minimum Data Set (MDS) dated 7/13/24, indicated R54 was cognitively intact. R54 was independent with oral and toileting hygiene, putting on and off footwear and mobility, required set-up and/or clean-up assistance with eating, showering, upper body dressing, and personal hygiene, and supervision and/or touching assistance with lower body dressing. R54's MDS identified diagnoses of schizophrenia (mental health condition which affects how people think, feel and behave), malnutrition, hypertension (high	F 880		

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F 880	Continued From page 143 blood pressure; pressure in blood vessels is too high), peripheral vascular disease (narrowed blood vessels reduce blood flow to legs or arms), coronary artery disease (narrowing or blockage of heart's arteries). R54's care plan undated, identified enhanced respiratory isolation due to COVID-19. R54's physician's order dated 7/29/24, identified enhanced respiratory precautions due to positive COVID test on 7/24/24. During observation on 7/29/24 at 6:09 p.m., R54's door had a sign which read "Enhanced Respiratory Precautions" and instructed staff to wear gown, N95 respirator, eye protection, and gloves to enter room. NA-N removed their surgical mask, performed hand hygiene, and donned N95, gown, gloves, and no eye protection and entered R54's room with a meal tray. At 6:10 p.m., NA-N exited R54's room and doffed gown, N95, gloves, performed hand hygiene, and placed on clean surgical mask. During interview on 7/29/24 at 6:12 p.m., NA-N verified R54 was on precautions for COVID-19 and required gown, gloves, and N95 to enter room. NA-N did not think there was eye protection in the PPE cart located next to R54's door. One face shield was observed in PPE cart. During interview on 7/31/24 at 1:47 p.m., NA-P verified R54 was on precautions for COVID-19 and required eye protection, gown, gloves, and N95 mask to enter room. NA-P stated R54 was independent to eat and had an occasional cough which made the eye protection important to wear.	F 880		

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F 880	Continued From page 144 During interview on 8/1/24 at 9:40 a.m., LPN-G verified R54 was on precautions for COVID-19, and gown, gloves, N95 mask and eye protection were required to enter room. LPN-G stated it was important to follow PPE procedures, even to give R54 a room tray, to prevent transmission of COVID-19. During interview on 8/1/24 at 1:36 p.m., the director of nursing (DON) expected staff to follow the precaution signs on residents' doors, and precautions were important to follow to prevent the spread of infection. The facility policy "Personal Protective Equipment" dated 1/24, indicated the need for transmission-based precautions was a factor which determined the appropriate selection of PPE for a particular task. The policy identified personal glasses were not a substitute for goggles. The policy directed the charge nurse to check isolation supply carts twice per shift. R2's significant change MDS assessment, dated 6/26/24, indicated R2 had intact cognition. R2 was maximum to dependent on staff assistance for all activities of daily living (ADLs) except eating which she needed set up assistance. R2's diagnoses included: dementia (memory loss that disrupts daily life), hemiplegia (paralysis/inability to move of one side of the body), epilepsy (disorder in which nerve cell activity in the brain is disrupted causing seizures) and pain. During observation on 7/31/24 at 11:55 a.m., R2 was observed to have a single page document in a plastic page protector hung on the door that	F 880		

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F 880	Continued From page 145 indicated: "Respiratory Precaution Room." The sign had a person on it with PPE (proper protective equipment), it also included a stop sign on the sign with a picture of a hand along with the words: gown, N95, eye protection, one pair of gloves. At the bottom of the page, it indicated "airborne infection isolation room: keep door closed if possible. "To the left of the door was a three-drawer plastic bin to the left of the door which contained disposable gowns, N95 masks and face shields. On top of the plastic bin was hand sanitizer, disposable gloves, and disposable masks. During observation on 7/31/24 at 11:55 a.m., housekeeper (HSK)-D was observed with a surgical mask on pushing their cleaning cart to the entrance of R2's. HSK-D was observed using hand sanitizer, grabbing a disposable gown from the bin, putting the gown on followed by a pair of disposable gloves. HSK-K then entered R2's room. Upon exit of the room, HSK-D was observed to take off the gown and gloves and use hand-sanitizer but did not remove the surgical mask. During continual observation, HSK-D was observed to move their cart down the hallway to an adjacent room with a sign on the door, "Enhanced Barrier Precautions." During the same continual observation, HSK-D was observed to use hand sanitizer, put on gloves and then a gown to enter the room, while continuing to wear the same surgical mask worn in R2's room. During interview at 7/31/24 at 12:09 p.m., HSK-D verified that they just completed cleaning R2's room. HSK-D verified they did not wear a N95 or a face shield. HSK-D stated, "I can't breathe with those masks on." HSK-D stated, "I changed my blue mask though, I carry them in my pocket."	F 880		

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F 880	Continued From page 146 HSK-D verified PPE is to be worn to stop the spread of diseases. HSK-D verified that R2 was on precautions for "COVID." During interview on 8/01/24 at 11:05 a.m., registered nurse (RN)-F verified R2 had COVID. RN-F stated that any staff needs to have "full attire" on when they enter "COVID" rooms, or any rooms PPE is needed in. RN-F verified that all staff get training on proper PPE use.	F 880		
F 883 SS=D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or	F 883		9/17/24

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F 883	Continued From page 147 refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure recommended pneumococcal immunizations, as outlined by the Centers for Disease Control (CDC), were offered and/or provided in a timely manner to reduce the risk of severe disease for 2 of 5 residents (R158, R17) reviewed for immunizations. Findings include:	F 883	R158 and R17 have been offered and received pneumococcal immunizations. Residents that reside at Lakehouse have received chart reviews, residents that are not up to date with current pneumococcal vaccines have been offered and administer. Nurse managers will review resident vaccine status quarterly and offer the pneumococcal vaccines as appropriate.	

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F 883	Continued From page 148 A CDC Pneumococcal Vaccine Timing for Adults feature, dated 3/2023, identified several tables with corresponding recommendations when to receive various versions (i.e., PPSV23, PCV13, PCV20) of the pneumococcal vaccine. The graph labeled, "Adults 19-64 years old with chronic health conditions ...," identified persons who received only a PPSV23 had an option to either get a PCV15 or PCV20 a year after the last PPSV23 dose. The conditions listed including alcoholism and cigarette smoking. Further, The graph labeled, "Adults [at or older than] 65 years old," outlined persons with a complete series of pneumococcal vaccination (i.e., PCV13 at any age, PPSV23 at or above 65 years old) should have shared clinical decision-making between the resident and healthcare provider to determine if PCV20 was appropriate. R158's significant change Minimum Data Set (MDS), dated 6/1/24, identified R158 had intact cognition, demonstrated no delusional thinking, and had several medical conditions including chronic lung disease (i.e., asthma, COPD). R158's PointClickCare electronic medical record (EMR) immunization listing, printed 8/1/24, identified R158 was 60 years old along with his respective immunization history. This identified R158 received two doses of the PPSV23, with the last one being in 2010. The record lacked any other pneumococcal vaccinations being offered or received. On 7/30/24 at 9:54 a.m., R158 was interviewed and verified he was a current smoker. R158 stated he admitted to the care center back in early 2024, and had not been asked about getting any of the other recommended pneumococcal	F 883	The Infection Preventionist has been educated on pneumococcal vaccines as outlined in the CDC guidance. DON/Designee will audit new admissions weekly x 3 weeks to ensure up to date with pneumococcal vaccines. Findings of this audit will be reviewed at QAPI until substantial compliance has been met	

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F 883	Continued From page 149 vaccinations since he admitted adding, "They never talked to me about it." R158 stated he was open to more information on the vaccinations adding, "I don't want to spread it to others." R158's medical record, including physician notes, was reviewed and lacked evidence any of the subsequent recommended pneumococcal vaccinations (i.e., PCV13 or PCV15/20) were discussed, offered or refused despite R158 admitting to the care center months prior. R17's quarterly MDS, dated 5/17/24, identified R17 had intact cognition, demonstrated no delusional thinking, and had several medical conditions including heart failure and respiratory failure. R17's PointClickCare EMR immunization listing, printed 8/1/24, identified R17 was 78 years old along with her respective immunization history. This identified R17 had received both the PPSV23 and PCV13, with the last administration being recorded as 3/2019 (over five years prior). The record lacked any other pneumococcal vaccinations being offered or received. On 7/31/24 at 1:45 p.m., R17 was interviewed and recalled getting some immunizations years prior "for pneumonia." R17 stated they had not been asked about getting the newer, recommended PCV15/20 vaccination though adding, "I have not." R17 stated had it been offered, they would have accepted it due to having poor breathing adding, "I would take it yesterday." R17's medical record, including physician notes, was reviewed and lacked evidence any of the	F 883		

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F 883	Continued From page 150 subsequent recommended pneumococcal vaccinations (i.e., PCV15/20) were discussed, offered or refused despite R17 having known cardiac and respiratory impairment. On 8/1/24 at 1:03 p.m., the assistant director of nursing (ADON) and regional nurse consultant (RNC) were interviewed. ADON explained themselves, along with RNC, were helping to manage and oversee the facility' infection control program since the previous infection preventionist (IP) had abruptly resigned a few months prior. ADON verified they had reviewed R158 and R17's respective medical records, and explained the PointClickCare information was the most current, including with data pulled from the MIIC (Minnesota Immunization Information Connection). ADON verified neither R158 or R17 had their respective, eligible doses offered or provided prior to the survey to their knowledge and expressed they had been, so far, unable to locate any documentation to demonstrate otherwise but would provide it, if located. ADON explained the previous IP apparently had been offering the vaccinations but not giving them. RNC stated, in hindsight, a quality assurance (QA) project should have likely been started for immunizations but had not been. RNC and ADON both verified they were going to review a 'whole house' audit now and get the immunizations offered, as needed, moving forward adding, "It's in the process." ADON stated it was important to ensure vaccinations were offered and, if accepted, provided to promote resident' health adding, "They have diagnoses that put them at risk." The facility' policy on pneumococcal vaccinations was requested, however, was not received.	F 883		

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F 925 SS=E	Maintains Effective Pest Control Program CFR(s): 483.90(i)(4) §483.90(i)(4) Maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to implement an effective pest control program to eliminate bed bugs from the building for 1 of 1 resident (R9) with the potential to affect all 11 residents residing on the odd side of the seventh floor. Findings include: R9's quarterly Minimum Data Set (MDS) dated 5/11/24, indicated R9 had no cognitive deficits and required moderate assistance with transferring, bathing, and toileting hygiene. The pest control company report dated 7/31/24 at 2:15 p.m., indicated R9's original room had been assessed by the pest control company, and a dead bed bug was noted. During an interview on 7/29/24 at 2:09 p.m., R9 stated she was moved from her original room to her current room last week because of a bed bug infestation. R9 stated she was supposed to move back to her old room soon but was "scared" as she didn't believe that the bed bugs were gone. During an interview and observation on 7/30/24 at 2:55 p.m., R9 was found still residing in the new room she had been given the previous week. R9 stated that the staff had moved her back to her old room yesterday. R9 stated staff had assisted her to bed, given her one of her bags, and then	F 925	R1 room has been fully treated, cleaned, inspected and audited to confirm bed bugs are not active in resident's original room. R1 has been safely moved back into original room. If a resident or staff member has a concern about an alive bug in the building, the pest control policy and procedure will be followed until bugs are completely removed. Maintenance and housekeeping director have been educated on the pest control process and procedure. Director of Maintenance/Designee will audit 2 residents rooms for pest concerns weekly x 3 weeks, then 2 resident rooms monthly x 3 months. Audits will be reviewed for continued quality assurance and performance improvement.	9/17/24

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F 925	Continued From page 152 left the room. R9 stated she soon noticed these blackish-brown bugs "everywhere" on her bed and when she would touch them, "blood would go everywhere." R9 stated the bed bugs kept climbing onto her body, leaving her covered in blood. R9 stated she was screaming for help and had her call light on, but she could not get out of bed by herself. During an interview on 7/30/24 at 3:02 p.m., registered nurse (RN)-K, the nurse manager for the unit, stated that R9's room had been found to have bed bugs last week after R9 had visitors. RN-K stated she was unsure how the bed bugs were managed as this was completed by the director of engineering (DOE). RN-K stated that R9 was moved out of the bed bug-infected room to a new one on 7/23/24 and moved back on 7/29/24. RN-K stated she was unsure who assessed the room before bringing R9 back. During an interview and observation on 7/30/24 at 3:33 p.m., R9's original room was observed with a bed on the left-hand side of the room pressed up against the wall. The bed sheets were observed with sporadic red/rust-colored stains and a small black-brown bug crawling across the bottom sheet. The bed frame was observed with a black/red grime-looking substance. The room was observed to have multiple open boxes with items overflowing and multiple personal bags on the floor of the room. The blinds were observed covered by a fabric topper. Clothing was observed overflowing out of the dresser. A multicolored personal blanket was observed on the floor. RN-K confirmed that the bug crawling on the bottom sheet was a bed bug. During an interview on 7/31/24 at 9:09 a.m., the	F 925		

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F 925	Continued From page 153 DOE stated R9 had a repeat issue of bed bugs that had been treated last week with a heating system by MS-A. The DOE stated R9 had "a lot" of items in her room that were making it hard to get rid of all the bed bugs, but they had so far not done anything to address this issue. The DOE was asked to provide documentation showing any audits of other resident rooms on the unit and any documentation of treatment used to treat the bed bug infestation in R9's original room. During an interview on 7/31/24 at 1:03 p.m., maintenance staff (MS)-A stated he had dealt with the bed bug infestation in R9's room. MS-A stated he had used an electric heating device that was manufactured to kill bed bugs and reached 130 degrees for three days. MS-A stated the facility does not normally call a pest control service until after the heat treatment has not worked. MS-A stated it was up to housekeeping to deep clean R9's room, launder any loose linens, and check to ensure there were no more bed bugs before allowing the resident to re-enter the room. MS-A stated he had noticed "a lot of stuff" in R9's room and the room looked like it needed to be cleaned to make the bed bug treatment more effective. MS-A stated he had noted the bags and boxes in R9's room but did not think anyone had dealt with these items. MS-A stated he had checked one additional room for the spread of bed bugs, but this room did not share a wall and was separated by a hallway, a sitting area, and an elevator from R9's original room. MS-A was asked to confirm that he had not inspected the room that shared a wall with R9's room and he stated yes, he had only inspected the room that did not share a wall and was separated by a hallway, sitting area, and an elevator from R9's original room.	F 925		

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F 925	Continued From page 154 During an interview on 7/31/24 at 1:34 p.m., the district manager for environmental services (DMES) stated he would have expected "edge to edge" cleaning, including the bed frame, all linens, all personal laundry, and curtains. The DMES agreed if grime and build-up were found on the bed frame he questioned if edge-to-edge had taken place. The DMES stated he did not expect housekeeping staff to bag up or clean personal items such as bags or boxes that were left in the resident's room. The DMES stated his staff was not responsible for assessing if bed bugs were still present before R9 moved back to her room. During an interview on 7/31/24 at 1:29 p.m., the associate administrator (AA) stated he began assisting with R9's bed bug issues this week but did not have knowledge of how it was handled the previous week. The AA stated he had been involved in moving R9 back to her original room on 7/29/24. The AA stated it should have been maintenance who assessed for bed bugs before R9 moved back to her room. The AA stated he had identified bed bugs on her bed after she had called facility staff into her room on 7/29/24. The AA stated that RN-K and he had decided R9 needed to be again removed from that room and they now had a pest control company on their way to assess the room before R9 returned. During an interview on 7/31/24 at 1:40 p.m., the DOE stated they had not previously had a pest control company out to inspect and give recommendations for the current bed bug infestation but one was here now. The DOE stated he had started three months ago, and MS-A was helping to train him. The DOE stated	F 925		

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F 925	Continued From page 155 that MS-A was the one who would know about how the bed bug infestation was managed. The DOE stated he did not have documentation showing any audits of other resident rooms on the unit or any documentation of the treatment used to manage the bed bug infestation in R9's original room. During an interview and observation on 7/31/24 at 1:44 p.m. in R9's original room, the outside pest control agent (PC)-A stated he had employee training on bed bug management that might be useful for the employees at the facility. PC-A stated it was important that all items that they could be, be placed in sealed bags and motioned at the bags and boxes on the floor. PC-A then stated it was important loose linens were also laundered and not left in the infested room and motioned to the loose linens on the floor and piling out of the resident closet. PC-A stated it was also important that the facility inspected the rooms near R9's room such as the room sharing a wall and the room below R9's room to ensure the bed bugs had not spread. The facility Bed Bug Protocol dated 3/14/24, indicated after staff were made aware of potential bed bugs, staff would attempt to capture the bug with scotch tape and then call maintenance to confirm the bug was a bed bug. Maintenance staff would then notify the supervisor of the presence of bed bugs. Staff would then bathe the resident and move them to a different room leaving all personal belongings behind. Maintenance staff would complete the heat treatment and then notify housekeeping so they could deep clean the room. Once the deep clean was completed, housekeeping would notify the administrator and the director of nursing that it	F 925		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245055	A. BUILDING _____ B. WING _____	C 08/01/2024

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F 925	Continued From page 156 was safe to move the resident back into their room.	F 925		

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
August 13, 2024

Administrator
Lakehouse Healthcare & Rehabilitation Center
3737 Bryant Avenue South
Minneapolis, MN 55409

Re: State Nursing Home Licensing Orders
Event ID: KS9F11

Dear Administrator:

The above facility was surveyed on July 29, 2024 through August 1, 2024 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

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

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

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

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

Pete Cole, RN Regional Operations Supervisor
Metro Team C District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
625 Robert Street N
P.O. Box 64975
Saint Paul, Minnesota 55164-0975
Email: peter.cole@state.mn.us
Office/Mobile: (651) 249-1724

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

Please feel free to call me with any questions.



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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00276	A. BUILDING: _____ B. WING _____	C 08/01/2024

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 7/29/24 through 8/1/24, a licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was not in compliance with the MN State Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you have reviewed these orders and	2 000		

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2 000	Continued From page 1 identify the date when they will be completed. In addition to the recertification survey, the following complaints were reviewed with no deficiency issued. MN00105324 (H50556346C) MN00104254 (H50554732C) MN00104242 (H50554695C) MN00101556 (H50556283C) MN00101529 (H50556281C) MN00100271 (H50556282C) MN00099745 (H50556286C) MN00099406 (H50556284C) MN00098982 (H50556285C) MN00095800 (H50556288C) MN00097518 (H50556287C) The following complaints were reviewed with deficient practices identified related to survey findings. MN00105107 (H50556261C)- Licensing order issued at 1385 MN00105105 (H50556262C)- Licensing order issued at 1385 MN00100962 (H50556280C)- Licensing order issued at 1565 MN00098499 (H50556289C)- Licensing order issued at 1565 Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of	2 000		

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2 000	Continued From page 2 the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 050	MN Rule 4658.0025 Subp. 4 Procedures for Licensing Nursing Homes Subp. 4. Transfer of interest; expiration of license. A transfer of a beneficial interest will result in the expiration of the nursing home's	2 050		9/17/24

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2 050	Continued From page 3 license: A. if the transferred beneficial interest exceeds ten percent of the total beneficial interest in the licensee, in the structure in which the nursing home is located, or in the land upon which the nursing home is located, and if, as the result of the transfer, the transferee then possesses a beneficial interest in excess of 50 percent of the total beneficial interest in the licensee, in the structure in which the nursing home is located, or in the land upon which the nursing home is located; or B. if the transferred beneficial interest exceeds 50 percent of the total beneficial interest in the licensee, the structure in which the nursing home is located, or in the land upon which the nursing home is located. Under either of these conditions, the nursing home license expires at the time of relicensure, 90 days after the date of the transfer, or 90 days after the date when notice of transfer is received, whichever date is later. If the current license expires before the end of the 90-day period, the licensee must apply for a renewed license in accordance with subpart 2. The department must notify the licensee by certified mail at least 60 days before the license expires. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure a written notice of transfer was sent to the office of the Ombudsman for long term care for 2 of 4 residents (R60, R27) reviewed for hospitalization. Findings include:	2 050	corrected	

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2 050	Continued From page 4 R60 R60's quarterly Minimum Data Set (MDS) dated 5/5/24 identified R60 with diagnoses of a stroke with paralysis affecting the right dominant side, renal insufficiency, urinary tract infection, diabetes, and an unhealed pressure ulcer to right heel. R60's electronic medical record (EMR) section titled "Profile" identified primary emergency contact, power of attorney (POA), care conference person, and financial responsibility person as emergency contact (EC)-A. R60's Progress Notes (PN) tab, the notes are listed in vertical columns titled, "Effective Date, Type, Note, Care Plan Item or Task, Dept, Shift Report, 24 Hour Report". R60's PN from licensed practical nurse (LPN)-D, dated 4/23/24 at 10:24 p.m. documented, "Note Text: Resident send to HCMC ER at 2130". PN on 4/23/24 at 10:28 p.m. documented EC-A was notified of R60's emergency room transfer. The PN failed to document a bed hold was discussed. R60's hospital discharge summary identified a hospitalization from 4/23/24 to 4/29/24 and that R60, "is unable to verbalize understanding of condition and treatment plan due to patient having dementia". During review of R60's EMR, no written notices of transfer was issued. R27 R27's quarterly MDS dated 5/6/24, identified R27 was cognitively intact and had diagnoses of	2 050		

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2 050	Continued From page 5 coronary artery disease (narrowing or blockage of heart's arteries), heart failure (heart muscle does not pump blood as well as it should), hypertension (high blood pressure; pressure in blood vessels is too high), peripheral vascular disease (narrowed blood vessels reduce blood flow to legs or arms), kidney disease (loss of kidney function), diabetes mellitus (condition which causes high blood sugar), schizophrenia (mental health condition which affects how people think, feel and behave), and asthma (chronic condition which inflames and narrows the airways in the lungs and makes it hard to breathe). R27's EMR section titled "Profile" identified R27 as own responsible party and financial responsibility and EC-B as emergency contact one, care conference person, and health care agent. R27's PN from LPN-I dated 1/22/24 at 6:15 p.m., indicated R27 went to HCMC emergency room via ambulance and was admitted for atrial fibrillation (fast, abnormal heart rhythm). R27's hospital discharge summary identified a hospitalization from 1/22/24 to 1/25/24. R27's EMR lacked evidence a written notification of transfer was sent to the ombudsman for long term care. During interview with nurse manager of R60's resident unit, registered nurse (RN)-F on 8/1/24 at 10:43 a.m., RN-F stated the expectation of nursing staff was to provide a paper copy of the "Transfer Notice" to the resident or POA and then document in the resident's EMR under the Progress Notes with Type of note labeled as, "Bed Hold" and not "Note Text". RN-F reviewed	2 050		

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2 050	Continued From page 6 PN for both R60 and R27 and stated, "I cannot find a bed hold or information that was offered. It should have been done and documented but wasn't". During interview with the director of social services (SW)-A on 8/1/24 at 11:16 a.m., SW-A stated they faxed a report to the ombudsman which listed discharges, hospitalizations, deaths, and other information from the EMR portal. SW-A reviewed the reports for 1/24 and 4/24 and verified they did not include hospitalizations for R60 or R27. During interview with the director of social services (SW)-A on 8/1/24 at 11:26 a.m., SW-A stated the expectation of nursing staff was to fill out and provide the bed hold and transfer forms to residents prior to the transfer. Also, SW-A stated if the transfer were emergent then the resident or guardian would be notified by phone to request a bed hold. Regardless of whether the transfer or discharge were emergent, SW-A stated the expectation of staff to document the conversation or attempts in a progress note. SW-A reviewed R60's and R27's progress notes and stated, "it is not mentioned in [the] progress notes and it should be." During additional interview with SW-A on 8/1/24 at 12:12 p.m., SW-A and vice president of clinical operations (CO) noted a technical "glitch" between the EMR portal and the Admission/Discharge - To/From report. A ticket was submitted, and they would compare the portal and report until the report accurately pulled all needed information. During interview on 8/1/24 at 2:25 p.m., administrator acknowledged the technology issue	2 050		

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2 050	Continued From page 7 with the report faxed to the ombudsman and stated communication with the ombudsman was important and they did not lack communication with them. Per email communication with the Office of Ombudsman for Long-Term Care on 8/2/24 at 8:17 a.m., the Ombudsman was not notified of R60's and R27's transfers or discharges. The facility did not have a policy for notification of transfer to the ombudsman. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON), or designee could review and/or develop policy and procedures that written notification was provided to the resident and their representative before a transfer. The facility could educate staff on these policies and audit periodically. The results of these audits will be reviewed by the quality assessment committee to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) days	2 050		
2 550	MN Rule 4658.0400 Subp. 4 Comprehensive Resident Assessment; Review Subp. 4. Review of assessments. A nursing home must examine each resident at least quarterly and must revise the resident's comprehensive assessment to ensure the continued accuracy of the assessment. This MN Requirement is not met as evidenced by: Based on interview, observation and document	2 550	Corrected	9/17/24

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2 550	Continued From page 8 review the facility failed to ensure the completed Minimum Data Set (MDS) was accurately coded for 1 of 1 resident (R69) reviewed for catheters. Findings include: R69's significant change Minimum Data Set (MDS) 4/30/24, identified R69's had severe impaired cognition with no hallucination or delusions. In Section H-Bladder and Bowel, in section H0100 Appliances under section A: Indwelling catheter (including suprapubic catheter and nephrostomy tube) it is marked with a check mark which indicated R69 has a catheter. During interview and observation on 7/29/2024 at 2:02 p.m., R69 was observed laying on his bed watching television. R69 stated he does not have a catheter and "I have never had a catheter." R69's progress notes, dated 3/13/24 to 8/1/24, were reviewed and lacked evidence R69 had an indwelling catheter. R69's order summary report, printed 8/1/24, lacked evidence of orders for an indwelling catheter or to care for an indwelling catheter. During interview on 7/30/24 at 2:15 p.m., nursing assistant (NA)-G verified they are familiar with R69. NA-G verified R69 does not have a catheter, has not had a catheter, and needs staff assist with cares. On 8/1/24 at 11:39 a.m., licensed practical nurse (LPN)-C verified they are familiar with R69 and work with him frequently. LPN-C stated, "He hasn't had a catheter that I have known about since he has been here."	2 550		

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2 550	Continued From page 9 On 8/01/24 at 12:47 p.m., registered nurse (RN)-J verified they complete MDSs' for the facility. RN-J verified they are one of the MDS RN's that complete the assessments. RN-J verified that R69's MDS listed above was marked as R69 has a catheter. After review of chart, RN-J verified that was incorrect and verified R69 does not have a catheter and did not have a catheter at the time the assessment was complete. RN-J stated accuracy of MDS assisted is important for the plan of care. On 8/1/24 at 2:47 p.m., director of nursing (DON) verified MDS accuracy is important as "this captures the care we provide and their needs." A policy on accuracy of MDS assessment was requested but not received. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures related to performing Minimum Data Set (MDS)assessments and the collection of required information. The director of nursing or designee should educate staff to the policy or procedure changes and audit other residents medical records to determine accuracy of their assessments. Audits should be measurable and specific. The results of those audits should be taken to the QAPI committee to determine compliance or the need for further monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 550		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General	2 830		9/17/24

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2 830	Continued From page 10 Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure 1 of 1 residents (R195) with repeated falls had implemented interventions to promote safety and reduce the risk of falls. Findings include: R195's admission minimum data set (MDS), dated 5/31/24, indicated R195 had diagnoses including cerebral infarct (stoke), hemiplegia (paralysis on one side of the body), and hemiparesis (unable to fully use one side of the body), history of falling with injuries and muscle weakness. Further, R195 required extensive assistance with bed mobility, transfers, and toileting. R195's care plan indicated he was at risk for falls with history of falls related to unsteady gait, cognitive deficits, and syncope. Interventions included R195's call light should be within reach,	2 830	corrected	

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2 830	Continued From page 11 and to provide a safe environment. R195's physical device assessment, dated 7/25/24, indicated R195 required a perimeter mattress (a mattress that creates a raised edge to decrease falls from bed). Additionally, the medical record indicated a physician order dated 7/25/24, for R195 to use a perimeter mattress. R195's care plan did not indicate the use of a perimeter mattress. During observations between on 7/30/24, at 09:41 a.m., R195 way lying in bed watching TV with their left leg hanging slightly off edge of bed. R195 was observed with a standard air mattress on their bed. During subsequent observations on 7/31/24 and 8/1/24 R195 continued to be observed with a standard air mattress on their bed. During interview on 7/31/24, at 01:58 p.m., registered nurse (RN)-G stated residents who have falls can have multiple interventions included a low bed, call don't fall signs, floor mats or a perimeter mattress. RN-G stated falls are reviewed daily by the interdisciplinary team (IDT) and interventions are determined by the team. Furthermore, RN-G stated R195 had a physical device assessment on 7/25/24 and was determined R195 would benefit from a perimeter mattress. An order was received on 7/25/24 and a requisition should have been placed at that time. RN-G was unable to locate a request for the perimeter mattress and confirmed that R195 did not currently have a perimeter mattress in place. During interview on 8/1/24. At 09:21a.m., director of nursing (DON) stated the IDT reviews resident falls daily and collaboratively plan for	2 830		

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2 830	Continued From page 12 interventions to best meet each residents' individual needs. DON stated if an order is received from a provider for a medical device to reduce falls, she would expect the device to be immediately put into place, or within 24 hours if device needed to come from an outside durable medical equipment company. DON stated she understood R195 had an order to use a perimeter mattress but confirmed it had not been implemented. DON stated it is important to implement interventions and physician orders to decrease the risk of falls and potential injuries to residents. Facility policy Fall Mitigation Program dated April 1,2022 indicated each resident will be assessed for fall risk and will receive the care and services in accordance with their individualized level of risk to minimize the likelihood of falls. SUGGESTED METHOD OF CORRECTION: The facility's director of nursing and/or the designee could review policies/procedures and revise as necessary. The facility could review all residents at a high risk for falls to assess whether current interventions are pertinent, appropriate and effective. After assessment, care plans could be updated with any new/changed interventions. All staff could be re-educated on fall prevention techniques and procedures. An audit tool could be developed to evaluate on-going compliance and results of those audits could be shared with the facility's quality assessment and assurance committee. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		

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2 850	Continued From page 13	2 850		
2 850	MN Rule 4658.0520 Subp. 2 D Adequate and Proper Nursing Care; Shaving Subp. 2. Criteria for determining adequate and proper care. The criteria for determining adequate and proper care include: D. Assistance with or supervision of shaving of all residents as necessary to keep them clean and well-groomed. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure routine personal care and hygiene (i.e., bathing, nail care, hair combing) was offered and/or completed for 5 of 6 residents (R39, R184, R134, R179, R383) reviewed for activities of daily living (ADLs) and who required staff assistance to complete such care. Findings include: R39 R39's significant change Minimum Data Set (MDS), dated 6/4/24, identified R39 had moderate cognitive impairment, demonstrated no delusional thinking, and was not diabetic. On 7/29/24 at 2:01 p.m., R39 was observed seated in his electric wheelchair while in his room. R39 had visibly long fingernails present on both hands, and the edge of the nail being multiple millimeters (mm) long on several nails with a dark-colored substance present underneath multiple nail edges. R39 was interviewed and stated the bathing he was	2 850	corrected	9/17/24

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2 850	Continued From page 14 provided at the care center was usually inadequate adding, "[They] spray you a little bit and call it done." R39 stated the poor bathing assistance was "turning my fingernails brown." R39 stated he needed help to clip and clean them but nobody from the care center ever offered help reiterating he wanted them clipped adding aloud, "I sure would." R39's care plan, dated 6/15/24, identified R39 had an ADL self-care deficit with dictation reading, "Refuses to shower prefers to wash self-up in bathroom. Care needs fluctuate throughout the day." The plan listed several interventions for R39 including, "PERSONAL HYGIENE/ORAL CARE: The resident is independent." However, the care plan lacked information on what, if any, help or assistance R39 needed with nail care, including finger or toenails. The following day, on 7/30/24 at 1:50 p.m., R39 was observed laying in bed while in his room. R39's fingernails remained long and soiled as had been observed the day prior. R39's POC (Point of Care) Response History, printed 8/1/24, identified a 21-day review period of bathing support provided to R39. This identified staff recorded assistance on 7/16/24, 7/21/24, and 7/25/24. However, the data lacked further specific information on what cares were offered or completed. R39's medical record was reviewed, including progress notes and assessments (i.e., skin checks), and lacked evidence R39 had been offered or assisted with nail care within the past several weeks despite having visibly long, soiled nails present. When interviewed on 7/30/24 at 1:58 p.m.,	2 850		

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2 850	Continued From page 15 nursing assistant (NA)-H stated they had worked with R39 multiple times prior and described him as often refusing care adding, "[he] will not let you do anything for him." NA-H stated R39 was scheduled for a shower that day (7/30) and, earlier, NA-H offered it but R39 refused. However, NA-H stated they did not offer R39 any nail care or clipping. NA-H stated the NA can do such care if the resident is not diabetic but nail care, including if offered or refused, was not usually charted or documented. NA-H stated R39 often scratches himself adding, "he does that a lot." Later, at 2:17 p.m., R39 came off the elevator in his electric wheelchair and NA-H observed R39's fingernails with the surveyor present. NA-H verified their length and condition expressing aloud, "It's dirty." R39 was again asked about clipping his fingernails and was agreeable. On 7/30/24 at 2:20 p.m., registered nurse manager (RN)-E was interviewed. RN-E stated nail care was typically done "as needed" but usually offered on the scheduled bath days. RN-E stated the NA was able to complete it if the resident was not diabetic and, if refused, the nurse should document a progress note in the medical record adding, "They document the refusal." At 2:22 p.m., the director of nursing (DON) joined the interview. DON stated R39 often refused care adding, "I'm surprised he said yes to [NA-H]." DON verified the NA charting doesn't have the ability to record any nail care offered and refused, but expressed nail care should be offered with bathing adding, "The expectation is nail care is a part of it." RN-E stated the only documentation they could locate was a progress note (dated 7/2/24) which outlined R39 refused his shower, and RN-E verified R39 would need staff help to clip the	2 850		

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2 850	Continued From page 16 nails. RN-E and DON both acknowledged the lack of any documentation to demonstrate nail care had been offered or provided within the past several weeks. DON stated it was important to ensure nail care was offered and, if able, completed to promote good hygiene and as it was "a dignity thing." R184 R184's admission MDS, dated 5/28/24, identified R184 had moderate cognitive impairment, demonstrated no delusional thinking, required substanital/maximal assistance with personal hygiene, and was not diabetic. On 7/29/24 at 5:57 p.m., R184 was observed while in his room. R184's right hand had a visible contracture with the finger turned into the palm making a nearly closed fist; however, the left hand had multiple long fingernails present with the nail edge being several millimeters (mm) in length and some having a dark-colored debris present underneath. R184 stated he was helped with a bath "every week" and looked down at his nails when asked about them. R184 was asked if staff helped him or offered to clip them ever and he responded aloud, "They haven't so far." R184 stated he wanted his nails clipped and kept shorter. R184's care plan, dated 7/12/24, identified R184 had an ADL self-care deficit along with several interventions which included, "PERSONAL HYGIENE: The resident requires assistance from staff with personal hygiene and oral care." The care plan lacked information or direction on nail care for R184. R184's POC Response History, printed 8/1/24,	2 850		

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2 850	Continued From page 17 identified a 21-day review period of bathing support provided to R184. This identified staff recorded assistance on 7/14/24 and 7/21/24. However, the data lacked further specific information on what cares were offered or completed. R184's medical record was reviewed, including progress notes and assessments (i.e., skin checks), and lacked evidence R184 had been offered or assisted with nail care within the past several weeks despite having visibly long, soiled nails present. On 7/31/24 at 10:15 a.m., NA-H was interviewed. NA-H explained they had worked with R184 prior and he was typically accepting of cares adding, "He's [R184] cool with me." NA-H stated nail care was typically done with bathing and not documented in the medical record, however, if it was offered and refused then the nurse would record it in the notes. Further, NA-H stated R184 was scheduled for a Sunday evening (PM) bath. At 10:24 a.m., NA-H and the surveyor looked at R184's nails while he was seated outside smoking. NA-H verified the length and condition adding, "They need to be trimmed down." NA-H stated the debris under the nails appeared "like he's itching or something." NA-H stated they would clip them that day. When interviewed on 7/31/24 at 11:28 a.m., RN-G stated R184 was usually accepting of cares and the NA could clip his nails if he wanted them done. RN-G stated any nail care offered and refused, should be recorded in the progress notes and then staff should "let the manager know." R134 R134's quarterly Minimum Data Set dated,	2 850		

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2 850	Continued From page 18 7/20/24 documented R134 with severe impairment of cognitive skills, physical and verbal symptoms directed towards others, had an indwelling catheter. In addition, documented R134 with diagnoses of Alzheimer's disease, dementia, seizures, depression, anemia, renal insufficiency (decreased kidney function), neurogenic bladder (disruption of the nervous system and the bladder) and obstructive uropathy (difficulty voiding). Also, R134 required extensive assistance of one staff member with bed mobility, eating, toilet use and required setup or clean-up assistance with oral hygiene. R134's Profile in the electronic medical record (EMR) listed family member (FM-A) as Responsible Party, primary emergency contact, Power of Attorney, care conference person, essential caregiver, financial responsibility and health care agent. R134's Kardex (nursing assistant care sheet) printed 7/31/24, identified R134 requiring assistance of one staff member for personal hygiene. During interview with FM-A on 7/29/24 at 3:25 p.m., FM-A stated, "[R134] would not like it if he were unshaved and hair looking greasy and uncombed." During observation on 7/29/24 at 3:50 p.m., R134 laying in bed sleeping with face unshaved and hair glossy and uncombed. Review of R134 electronic medical record (EMR) under "Tasks" tab, the nursing assistant daily documentation of "Task: ADL-Personal Hygiene" for the month of July 2024, R134 did not refuse support for "How resident maintains personal	2 850		

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2 850	Continued From page 19 hygiene, including combing hair, brushing teeth, shaving, applying makeup, washing/drying face and hands". During observation on 7/31/24 at 7:38 a.m., R134 was observed laying on bed with a dried brown stain on pillowcase adjacent to his mouth. R134's hair was glossy, oily and uncombed and his face had whiskers .25 inches long. R134's lips were dry and chapped with a dried white substance in corner of left side of mouth. During observation and interview with registered nurse (RN)-C in R134's room on 7/31/24 at 7:44 a.m., RN-C verified the stained pillowcase, "it is soiled. [R134] it needs to get washed up. Appears like [R134] has not been shaved in over a week. Aides are to offer sponge baths and shave men if they allow them to. If they refuse the shave or bed bath, I expect the aides to let me know and we can re-approach." During observation and interview with registered nurse (RN)-D in R134's room on 7/31/24 at 7:52 a.m., RN-D stated, "Yes, [R134] appears to not have been shaved or cleaned up. Hair is oily looking". During interview with nursing assistant (NA)-B on 7/31/24 at 8:00 a.m., NA-B stated she was familiar with R135. NA-B stated nursing assistants receive a verbal report each day and are expected to review the electronic medical record (EMR) in the care plan Kardex (nursing assistant care sheet) to determine what tasks such as personal cares, diet intake, and outputs, and dressing assistance are supposed to be done for each resident. NA-B stated the nursing assistants who work on the memory care unit do not receive any paper list or care sheets on the	2 850		

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2 850	Continued From page 20 residents. NA-B stated nursing assistants are expected to shave men, "as needed or as allowed". NA-B looked in R135's EMR and verified she was unable to determine when R135 was shaved or cleaned up. During interview with RN-C on 7/31/24 at 1:24 p.m., RN-C stated, "yes [R134] looked like he did not have shave in a long time. R179 R179's quarterly MDS, dated 7/6/24, indicated R179 was admitted to the facility on 6/5/24, was cognitively intact and required partial to moderate assistance with personal hygiene. R179's Care Plan, dated 6/5/24, indicated R179 had "an ADL [activities of daily living] self-care performance deficit r/t [related to] a recent hospitalization with right humerus [upper arm bone] fx [fracture], DM2 [diabetes mellites type II], and hx [history] of CVA [cerebral vascular accident]" and required staff assistance with personal hygiene. During observation and interview on 7/29/24 at 6:17 p.m., R179 was laying in her bed, her fingernails and toenails were noticeably long, approximately ¼ inch and her toenails appeared to be starting to curve over. R179 stated she had asked staff to cut her nails or see the podiatrist but had not "heard a thing about it." R179 stated staff had told her they could not cut her nails because she had diabetes. During an interview on 7/31/24 at 9:39 a.m., nursing assistant (NA)-M stated he would not cut a resident's fingernails or toenails if they had a diagnosis of diabetes, but the nursing assistants	2 850		

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2 850	Continued From page 21 should notify the nurse if a resident needed toenails or fingernails cut or requested to see the podiatrist. During an interview on 7/31/24 at 11:38 a.m., licensed practical nurse (LPN)-F stated any nurse can cut or trim a resident's fingernails if they have a diagnosis of diabetes, toes nails would depend on an assessment and if he felt "comfortable enough" to cut them, often the resident would see podiatry for their toenails. During an interview on 8/1/24 at approximately 10:30 a.m., nurse manager and registered nurse (RN)-H stated it was expected that any nurse would be able to cut a resident's fingernails or toenails, even with a diagnosis of diabetes. RN-H stated she had cut R179's toenails yesterday evening, 7/31/24. During an interview on 8/1/24 at 12:40 p.m., the director of nursing (DON) stated it was expected that a resident with long toenails or fingernails should have their nails cut or trimmed on bath day. R383 R383's admission MDS, dated 7/21/24, indicated R383 was admitted to the facility on 7/21/24, was cognitively intact and required partial to moderate assistance with activities of daily living (ADLs) to include toileting, bating and dressing. R383's Care Plan, dated 7/15/24, indicated R383 had an "ADL self-care performance deficit r/t [related to] recent hospitalization for traumatic ischemia [reduced blood flow] of muscle, COPD [chronic obstructive pulmonary disease, lung	2 850		

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2 850	Continued From page 22 disease causing restricted airflow and breathing problems], emphysema [a condition in which the air sacs of the lungs are damaged and enlarged, causing breathlessness], and schizoaffective disorder [a mental health condition including schizophrenia and mood disorder symptoms]" and required assistance from one staff member with showering or bathing. R383's Task-ADL Bathing, printed 7/31/24, indicated R383 bath day was Wednesday and had not received a bath or shower since she admitted to the facility, indicating on 7/24/24 and 7/31/24 "resident refused." During observation and interview on 7/29/24 at 2:29 p.m., R383 was sitting on her bed dressed in a hospital gown, her hair was noticeable greasy and matted. R383 stated she had not had, or been offered, a shower since she got the facility. During an interview on 7/31/23 at 11:38 a.m., licensed practical nurse (LPN)-F stated if he was made aware of a resident refusing a bath or shower, he would approach the resident and explain the benefits of accepting a shower but was not "100% sure" what the facility policy or expectation was for refusal. LPN-F further stated he had never heard of R383 refusing cares and she was usually very easy to work with. During a follow up observation and interview on 8/1/24 at 12:01 p.m., R383's hair continued to look greasy and matted and her finger and toenails were approximately ¼ inch long with dark matter under the fingernails. R383 stated she had not refused a shower yesterday and a staff member had come to her room "a few hours ago" to ask her about a shower and offered to help her tomorrow with a shower.	2 850		

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LAKEHOUSE HEALTHCARE & REHABILITATIO	3737 BRYANT AVENUE SOUTH MINNEAPOLIS, MN 55409

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 850	Continued From page 23 During an interview on 8/1/24 at approximately 10:30 a.m., nurse manager and registered nurse (RN)-H stated it was expected for a resident to be offered a shower at least three times and to pass it on to the next shift if they continue to refuse, stating it would also be expected that the nurse be made aware. RN-H was unaware of R383 refusing any cares or showers. RN-H further stated it would be expected that toe and fingernails be trimmed and clean, even if a resident refused a shower. During an interview on 8/1/24 the director of nursing (DON) stated it was expected that all residents are getting a shower or bath, stating "I will make sure it gets done." SUGGESTED METHOD OF CORRECTION: The director of nursing and/or designee could educate responsible staff to provide care to residents' dependant on facility staff, based on residents' comprehensively assessed needs. The DON or designee could conduct audits of dependent resident cares to ensure their personal hygiene needs are met consistently. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 850		
2 960	MN Rule 4658.0600 Subp. 1 Dietary Service - Food Quality Subpart 1. Food quality. Food must have taste, aroma, and appearance that encourages resident consumption of food.	2 960		9/17/24

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2 960	Continued From page 24 This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure food was delivered and served in a timely manner to preserve desired temperatures of food for 3 of 3 residents (R158, R39 and R146) reviewed for dining. This had the potential to affect all residents of facility that received meal trays. Findings include: During survey initial kitchen tour on 7/29/24 at 11:57 a.m., the kitchen supervisor (KS) provided surveyor with printed copy of the document Mealtimes with three columns. First column identified meals and units. The other two columns identified, "Dietary Starts:" and "Cart Arrives on Site: "There was notation at bottom of form stating, "Note: Meal delivery times may vary by 10 minutes from posted schedule" and was documented as below. Meal Times: Cart Arrives on Site BREAKFAST: 2R: 7:15 AM 3G: 7:30 AM 2G: 7:45 AM 7G: 8:00 AM 5G: 8:15 AM 6G: 8:30 AM LUNCH: 2R: 11:15 AM 3G: 11:30 AM 2G: 11:45 AM 7G: 12:00 PM 5G: 12:15 PM 6G: 12:30 PM	2 960	corrected	

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2 960	Continued From page 25 DINNER: 2R: 4:45 PM 3G: 5:00 PM 2G: 5:15 PM 7G: 5:30 PM 5G: 5:45 PM 6G: 6:00 PM During interview on 7/29/24 at 11:57 a.m., KS stated the expectation of facility staff was to start serving meal trays once they arrive to the units. R158 R158's Significant Change Minimum Data Set (MDS) dated 6/1/24 identified R158 with intact cognition and resided on the 7G unit of facility. During interview with R158 on 7/29/24 at 4:38 p.m., R158 stated, "food is bad. Cold when it should be warm". During observation on 7/30/24 at 7:43 a.m., food cart was not present on 2R. Two residents were seated in dining room and no staff were present. Posted sign on kitchenette stated cart was to arrive at 7:15 AM. During observation on 7/30/24 at 8:04 a.m., food cart was present in 3G dining room with three residents sitting at the dining room tables. No meals were being passed and no staff were present. Posted sign on kitchenette stated cart was to arrive at 7:30 AM. During observation on 7/30/24 at 8:11 a.m., food cart was present in the 7G dining room with twenty-four residents seated at dining room tables. No food was served to any of the	2 960		

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2 960	Continued From page 26 residents. Two rolling carts inside the kitchenette had milk and juice in plastic bins with ice. Posted sign on kitchenette stated cart was to arrive at 8:00 AM. During interview with nursing assistant (NA)-E on 7/30/24 at 8:38 a.m., on the 7G unit, NA-E stated he had worked for facility for over a year and, "no food is yet up here, even in the kitchen". NA-E stated, "I always thought it [meal cart] was brought up at nine-o-clock". NA-E stated, "We do try to serve the dining room first and then another aide will serve the room trays." During observation on 7/31/24 at 8:57 a.m., food started to be served to 7G residents in the dining room, fifty-seven minutes after posted meal cart was to arrive per kitchenette posting. R39 R39's significant change Minimum Data Set (MDS), dated 6/4/24, identified R39 had moderate cognitive impairment but demonstrated no delusional thinking during the review period. When interviewed on 7/29/24 at 1:42 p.m., R39 expressed multiple complaints about the care center' meal service including the food on the room-delivered meal trays was often cool. R39 stated the kitchen brought them up and then the trays sit out in the dining room "for half an hour after they serve out there [to people seated in the dining room; see F807]." R39 stated it was an ongoing issues and he had complained about it prior but staff told him, "You keep complaining and you'll be gone [discharged]." R39 reiterated he wanted hot, palatable meals served but the service was poor adding, "It's still happening."	2 960		

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2 960	Continued From page 27 R146 R146's significant change MDS, dated 5/4/24, identified R146 had intact cognition and demonstrated no delusional thinking during the review period. On 7/29/24 at 1:03 p.m., R146 was observed laying in bed while in his room. R146 had a bedside table pulled close to the bed which had a meal tray sitting on top with a domed lid covering. R146 was asked about the care center food and responded by shaking his head in a 'no' motion (side to side) and saying aloud, "like this," while his hand making a side to side motion (i.e., 'so-so'). R39 stated he typically ate meals in his room and voiced the food was often bland tasting and not warm when it was finally served adding, "It [food] just isn't presented well." During interview on 8/1/24 at 8:50 a.m., family member (FM)-B explained R146 admitted to the care center about six months prior due to unsafe living conditions at the home and a series of falls. FM-B stated they visited often and R146 had been eating less lately adding aloud, "The food there sucks." FM-B explained the family was worried about R146's nutritional intake and, as a result, had been trying to bring in items to bolster his intake due, in part, to the poor meals served. During observation and interview with dietary aide (DA)-A and DA-B on 7/31/24 at 9:06 a.m. on the 7G dining room, DA-A temped R158's scrambled eggs that had immediately been set in front of him. Temperature registered 113 degrees Fahrenheit. DA-A stated the temp was too low and R158 stated the eggs were "too cold". DA-B stated, "[7G residents] supposed to get their food at 8:15 a.m., to 8:30 a.m., but we are late today.	2 960		

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2 960	Continued From page 28 During interview with KS on 7/31/24 at 12:35 p.m., KS stated, "I would say the food that was delivered today was late. If the food did not get to 2R until after 9:00 a.m., then it is 45 minutes late and the food delivered this morning to 7th floor was late also." During observation on 7/31/24 at 1:02 p.m. on 6G, food was still being delivered to residents in the main dining room. Posted sign on kitchenette stated cart was to arrive at 12:30 p.m.. During interview with facility dietician (DC) on 7/31/24 at 1:43 p.m., DC stated, "Food should not be delivered late. If it is delivered late, then I would be concerned about potential for infection. Liquids being delivered to resident rooms must always be covered. I would be concerned about contamination and being served too warm. Scrambled eggs and oatmeal should be at least 140 degrees when delivered to rooms and when served." During interview with the regional director of dietary services (RD) on 7/31/24 at 2:21 p.m., RD stated the facility started a new food service company on May 1, 2024. RD stated, "forty-five minutes is too long to wait for the carts to be delivered to the units. Those carts are not insulated, and staff should not be giving trays to the residents 45 minutes to an hour after the food arrives on the floor." During interview with R158 on 8/1/24 at 11:15 a.m., R158 stated the scrambled eggs that were temped by DA-A on 7/31/24 for breakfast was, "not warm enough for me". During observation and interview with RD on	2 960		

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2 960	Continued From page 29 8/1/24 at 12:39 p.m., on the 7G unit, RD was asked to temp a lunch tray that was delivered to a resident room. The brat was temped at 124.2 degrees Fahrenheit. RD stated, "this is not where we need it [food temps] to be" and declined to offer surveyor a test tray. RD stated, "I noticed the staff pulled the meal trays out of the meals carts and put them on top of the counter and let them wait. The meal trays would at least be warmer when served directly from the meal cart and not allowed to be sitting on the counter getting cold." Resident council meeting minutes for February 16, 2024, identified, "food is being brought to the floor in a timely manner however the aides on the floor aren't serving it right when it comes". Resident Council Action form dated 6/13/24 provided to the DON identified, "Residents expressed food isn't passed out right when the carts come up". There was no implementation date or staff signature on the form. Facility policy on food temperatures and timing of serving food was requested but not received. SUGGESTED METHOD OF CORRECTION: The administrator, registered dietician, or designee could ensure proper temperature for meals served. The facility could update or create policies and procedures, and educate staff on proper temperature for meals served to residents. The administrator, registered dietician, or designee could perform audits for a designated amount of time as determined by the Quality Assurance Performance Improvement (QAPI) committee to ensure proper temperatures of meals served to residents. The facility could report those findings to QAPI for further	2 960		

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2 960	Continued From page 30 recommendations and determine the need for further monitoring or compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 960		
21025	MN Rule 4658.0615 Food Temperatures Potentially hazardous food must be maintained at 40 degrees Fahrenheit (four degrees centigrade) or below, or 150 degrees Fahrenheit (66 degrees centigrade) or above. "Potentially hazardous food" means any food subject to continuous time and temperature controls in order to prevent the rapid and progressive growth of infectious or toxigenic microorganisms. This MN Requirement is not met as evidenced by: Based on observation and interview the facility failed to ensure all food items were properly covered when served to residents to reduce and/or prevent the risk of food borne illness. This practice had the potential to affect all residents who received their meals from the kitchen. Findings include: During observation and interview on 7/29/24 at 6:00 p.m., nursing assistant (NA)-N poured beverages into cups and mugs and placed on multiple meal trays which were on an uncovered cart. Uncovered cheesecake desserts were also on the individual meal trays. NA-N wheeled the uncovered cart from the dining room down the hall and passed the meal trays to at least six individuals in their rooms pushing the cart further down the hall between rooms. NA-N stated the beverages came up to the sixth floor in covered	21025	Corrected	9/17/24

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21025	Continued From page 31 pitchers and could be poured into cups in the dining room and taken uncovered to residents' rooms. During observation and interview on 7/31/24 at 9:12 a.m., NA-P wheeled an uncovered cart passing meal trays on the sixth floor which had uncovered bowels of cereal, brown sugar, milk, and other beverages. NA-P stated they did not have lids on the sixth floor to cover the brown sugar and other items. During observation and interview with dietary aide, (DA)-A on 7/31/24 at 9:12 a.m. on 6G, DA-A temped a room tray that was being delivered. Four room trays were present on the meal tower cart and all the trays with uncovered orange juice, coffee, apple juice, and hot chocolate. DA-A stated she was unaware of whether liquids needed to be covered when delivered to resident rooms. During interview with director of nursing (DON) on 7/31/24 at 10:04 a.m., DON stated, "liquid drinks should be covered when bringing them to resident rooms. During interview with kitchen supervisor (KS) on 7/31/24 at 12:35 p.m., KS stated, "Food is [to be] covered when traveling a distance like down a hallway, to a different unit or floor, based upon standards of practice for infection control and food safety." KS stated, "My understanding is that the food that is transported must have covers on them." During interview with NA-C on 7/31/24 at 1:05 p.m., NA-C stated, "it is not good to leave the drinks uncovered when delivering meal trays to residents in their rooms. We are supposed to	21025		

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21025	Continued From page 32 cover them any time we deliver them to the resident rooms." During interview with facility dietician (DC) on 7/31/24 at 1:43 p.m., DC stated, "Liquids being delivered to resident rooms must always be covered. I would be concerned about contamination and being served too warm. " During interview with regional director of dietary services (RD) on 7/31/24 at 2:21 p.m., RD stated, "Fluids must be covered [sic] concern for cross contamination and infection control if they are not covered when delivered to resident rooms." During observation and interview on 8/1/24 at 12:39 p.m. in the 7G unit dining room, RD stopped NA-F as he was pushing the meal cart tower down the hall to resident rooms. There were 3 resident room meal trays on the cart. The carrot cake rolls and liquids were uncovered. RD instructed NA-F that the carrot cake roll desserts needed to be covered along with all liquids before transporting. RD verified carrot cakes and liquids were not covered. During interview with NA-F on 8/1/24 at 1:13 p.m., NA-F stated, "we should be making sure the food is covered when transporting it including the milk and juice. I did not know or maybe I forgot the carrot cake needs to be covered also, which [it] wasn't when I was delivering those three trays." Facility policy on covering food during transport and delivery was requested but not received. SUGGESTED METHOD OF CORRECTION: The administrator, registered dietician, or designee could ensure there are sufficient dietary and nursing support personnel to safely carry out	21025		

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21025	Continued From page 33 all of the functions of the food and nutrition services, including preparing and serving of meals in a timely fashion. The facility could update or create policies and procedures, and educate staff on facility scheduled time for meals, preparation and serving of meals within appropriate time frame. The administrator, registered dietician, or designee could perform audits for a designated amount of time as determined by the Quality Assurance Performance Improvement (QAPI) committee to ensure preparation and serving of resident meals is within appropriate time frame. The facility could report those findings to QAPI for further recommendations and determine the need for further monitoring or compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21025		
21325	MN Rule 4658.0725 Subp. 1 Providing Routine & Emergency Oral Health Ser Subpart 1. Routine dental services. A nursing home must provide, or obtain from an outside resource, routine dental services to meet the needs of each resident. Routine dental services include dental examinations and cleanings, fillings and crowns, root canals, periodontal care, oral surgery, bridges and removable dentures, orthodontic procedures, and adjunctive services that are provided for similar dental patients in the community at large, as limited by third party reimbursement policies. This MN Requirement is not met as evidenced by: Based on observation, interview and document	21325	Corrected	9/17/24

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21325	Continued From page 34 review, the facility failed to ensure routine dental services were provided or offered to promote oral hygiene and reduce the risk of complication (i.e., chewing issues, cavities) for 4 of 4 residents (R39, R50, R134, R179) reviewed for dental services. Findings include: R39 R39's significant change Minimum Data Set (MDS), dated 6/4/24, identified R39 admitted to the care center in April 2024 and had moderate cognitive impairment but demonstrated no delusional thinking. Further, the MDS section labeled, "Section L - Oral/Dental Status," outlined spaces to record if R39 had broken or loose-fitting dentures, abnormal mouth tissue, or obvious tooth cavities but the section was answered, "Z. None of the above were present." R39's Census listing, printed 7/31/24, identified R39 current payer source recorded as, "Veterans Administration." On 7/29/24 at 1:54 p.m., R39 was observed seated in his wheelchair while in his room. R39 was interviewed, and expressed he had little to no natural teeth adding, "I gotta go see the dentist." R39 explained he wore dentures previously, however, his family member lost them awhile back and, as a result, he had gone without them for a long time. R39 stated he typically went through the VA (Veterans Administration) for medical appointments, however, nobody from the care center had asked about or helped him arrange a dental examination or visit since he admitted. R39 stated he wanted to get to a dentist to check on getting new dentures and expressed	21325		

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21325	Continued From page 35 frustration with both the care center and the VA adding, "They're even slacking now-a-days." R39's Nursing Assessment - Admission/Readmission + Careplan - V13, dated 4/10/24, identified R39 was alert and oriented to person, place, time and situation. The evaluation contained a section labeled, "Oral, Vision and Hearing Status," which provided several questions to be answered by staff. This section identified R39 used dentures with both an upper and lower partial being checked; R39 needed no assistance with oral cares; and he had a mouth condition recorded as, "Within Normal Limits." The evaluation continued and listed spacing to record, "Last Dental Visit," however, this was answered with, "N/A." The completed evaluation lacked evidence if the denture fitment (i.e., secure, loose) had been evaluated, nor if R39 had been asked or offered a dental examination. A subsequent Nursing Assessment - Admission/Readmission + Careplan - V13, dated 4/15/24, was also located. This completed evaluation outlined the same section labeled, "Oral, Vision and Hearing Status," however, now recorded R39 as having natural teeth with the multiple options to check for denture use being left blank. The section provided labeled, "Last Dental Visit," was answered with, "Unknown," and another section labeled, "Additional Oral Status Comments," was answered, "WNL [within normal limits]." However, again, the completed evaluation lacked evidence if R39 had been asked or offered a dental examination, nor was there clarification on which evaluation (i.e., 4/10/24 or 4/15/24) was accurate regarding R39's actual oral condition (i.e., natural teeth or denture use). R39's care plan, dated 4/10/24, identified R39 had an ADL (activities of daily living) self-care	21325		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21325	Continued From page 36 deficit and listed multiple interventions including, "PERSONAL HYGIENE/ORAL CARE: The resident is independent." However, the care plan lacked any specific problem statements, goals or interventions for R39's oral condition or dental needs despite R39 having conflicted evaluations completed with, at least one, indicating denture use. R39's Care Conference Summary - V2, dated 6/24/24, identified R39 was invited to the care conference held on 6/21/24, but he did not attend. The summary contained multiple spaces to record various information discussed and/or obtained during the conference which included a section labeled, "Appointments," with directions included, "Dental and Vision are to be completed annually unless otherwise noted ...," and spaces to record dates of either upcoming or last known evaluations with another section labeled, "Appointment Comments," however, all of these spaces were left blank and not completed. The summary lacked evidence R39 had been asked, either before or after the conference since he didn't attend, about the need for a dental appointment. When interviewed on 7/31/24 at 11:11 a.m., registered nurse (RN)-G explained if a resident developed dental issues, they would call the medical provider and get a referral order to the dentist. RN-G stated they had "heard some people [onsite dental] used to come" but was not sure if such still happened. RN-G stated the nurses, upon admission, complete a "general assessment" which included the oral cavity and verified this was documented using the evaluation in the record (i.e., Nursing Assessment - Admission/Readmission). RN-G reviewed R39's completed evaluations and verified 'N/A' was	21325		

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21325	Continued From page 37 recorded on 4/10/24, but expressed they were not sure what such language meant or why it had been recorded. R39's entire medical record was reviewed and lacked evidence R39 had been asked, offered or refused a dental examination since admission to the care center several months prior. When interviewed on 7/31/24 at 2:34 p.m., registered nurse unit manager (RN)-E verified they had reviewed R39's medical record, and they explained the nurses' complete an initial evaluation upon admission and record it using the provided forms (i.e., Nursing Assessment - Admission/Readmission). RN-E verified R39 had multiple evaluations completed with conflicting data being recorded and expressed, since R39 in-fact had no natural teeth, someone should have followed up with him to see if a dental appointment was needed adding they were now working on getting one arranged. RN-E verified the nurses who complete the initial evaluations should be asking about a dental appointment and recording such then, if wanted or needed, refer the information to the health unit coordinators (HUC) to get scheduled. RN-E verified the lack of documentation in the medical record to demonstrate R39 had ever been asked about a dental appointment and expressed it was important to offer such appointments as bad teeth or dentition could cause issues like bad nutrition, dehydration and it was "important for their health overall." Further, RN-E verified the Care Conference Summary had spacing to record appointments but this was left blank adding R39 had possibly been offered and refused then, "But we still didn't chart it." On 7/31/24 at 2:53 p.m., the licensed social	21325		

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21325	Continued From page 38 worker (SW)-C verified they completed the Care Conference Summary for R39 (dated 6/24/24). SW-C acknowledged the spaces to record appointment information was left blank stating it was blank "cause I don't have anything [information on them]," and added the form typically has data entered to show when the last appointment for each discipline. SW-C stated they were unaware R39 didn't have his dentures present at the care center and expressed any need for a dental appointment, including initially being asked about one, would start with the nursing department adding, "That all goes through nursing." R50 R50's admission Minimum Data Set (MDS), dated 6/25/24, indicated R50 was admitted to the facility on 6/19/24, was cognitively intact and required partial to moderate assistance with oral care. The MDS further indicated R50 had "broken or loose fitting full or partial dentures" and had "no natural teeth." R50's Nursing Admission Assessment, Oral, Vision, and Hearing Status, dated 6/19/24, indicated R50 had "no teeth" and her last dental visit was "unknown." R50's electronic medical record (EMR) lacked evidence that a dental visit had been offered to R50 since her admission on 6/19/24. R50's progress notes, dated 7/31/24 indicated, "social services was informed [by surveyor] that resident was interested in receiving a visit from the dentist." R50 confirmed her interest in having a dental appointment.	21325		

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21325	Continued From page 39 During observation and interview on 7/29/24 at 6:47 p.m., R50 was lying in bed, with her dinner tray near her, and was edentulous (without teeth). R50 stated she had dentures, but they were broken. R50 further confirmed staff have not offered any dental services to her to address her broken dentures since she was admitted to the facility. R134 R134's quarterly Minimum Data Set dated, 7/20/24 indicated R134 with severe impairment of cognitive skills, physical and verbal symptoms directed towards others, had an indwelling catheter. In addition, R134 with diagnoses of Alzheimer's disease, dementia, seizures, depression, anemia, renal insufficiency, neurogenic bladder, obstructive uropathy and receiving antipsychotics, antidepressants. Also, R134 required extensive assistance of one staff member with bed mobility, eating, toilet use. And required setup or clean-up assistance with oral hygiene. During interview with family member (FM)-A on 7/29/24 at 3:24 a.m., FM-A stated, "[R134] has dental issues. It's been over a year since he was seen". Review of Care Conference Summary dated 6/26/24, "Section D. Appointments" identified, "Dental and Vision are to be completed annually unless otherwise noted" and "1. Dental: [blank]". In the section titled, "Appointment Comments: "Reviewed desired/requested ancillary services as above". The summary lacked indication of any dental appointments.	21325		

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21325	Continued From page 40 Review of R134's EMR lacked documentation of dental evaluations or visits after 10/6/22. R134's care plan dated 4/28/22 direct staff to, "Coordinate arrangements for dental care, transportation as needed/as ordered." During interview with the director of social services (SW)-A on 8/1/24 at 8:04 a.m., SW-A stated expectation of facility to "set up the [dental] referrals" and that family (FM-A), "decided that dental visits are not a priority". SW-A stated, "[dental services] should be offered and should be documented". SW-A reviewed R134's EMR and stated the EMR lacked documentation of discussion with FM-A regarding dental services. During interview with director of nursing (DON) on 8/1/24 at 9:05 a.m., DON stated expectation of dental services, "must be done every six months and prn. " DON stated the facility "had a gap in health unit coordinator (HUC)" and "that is what happened with missing dental appointments". DON stated, "if the [care conference] discussion involves delay or not doing it then it should be offered." And "should be documented". R179 R179's quarterly MDS, dated 7/6/24, indicated R179 was admitted to the facility on 6/5/24 and was cognitively intact. R179's Nursing Admission Assessment, Oral, Vision and Hearing Status, dated 7/25/24, indicated R179 had no oral concerns, and her last dental visit was approximately 1 year ago.	21325		

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21325	Continued From page 41 R179's electronic medical record (EMR) lacked evidence that a dental visit had been offered to R179 since her admission on 6/5/24. R179's progress note, dated 7/31/24, indicated social services was informed [by surveyor] that R179 requested a dental appointment. R179 confirmed to social services wanting to see the dentist to address some tooth pain she was having. During an interview on 7/29/24 at 6:32 p.m., R179 stated she has been having tooth pain, especially when she eats, stating she had told staff but has not been offered a dental visit. During an interview on 7/31/24 at 11:38 a.m., licensed practical nurse (LPN)-F stated the initial oral assessments are done by either the assessment nurse or the floor nurse when a resident is admitted to the floor. LPN-F stated a dental visit was offered if there was an issue or problem identified with the initial oral assessment. During an interview on 7/31/24 at 7:53 a.m., nurse manager and registered nurse (RN)-H stated if a resident was admitted with broken or sore teeth then the nurses would assess when their last dental visit was, stating the social worker would set up the dental appointments. RN-H stated if a resident was admitted without dentures or broken dentures they should be offered dental services on admission. During an interview on 7/31/24 at 7:59 a.m., social worker (SW)-C stated if a resident had an issue with their oral assessment, such as mouth pain, it would get relayed to him and he would make a referral for a dental visit. SW-C stated he was unaware of any issues with R50 or R179.	21325		

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21325	Continued From page 42 During a follow up interview on 8/1/24 at approximately 10:00 a.m., nurse manager and registered nurse (RN)-H stated it was expected that all residents were offered dental appointments at admission but was unable to produce any documentation that dental appointments were offered, stating dental appointments would start being offered at the resident 48-hour care conference. During an interview on 8/1/24 at 12:40 p.m., the director of nursing stated it was expected that a dental visit was offered to all residents at admission, long-term, and short-term residents. The DON further stated it was expected the staff document when a dental visit was offered. A facility' provided Dental Services policy, dated 2/2024, identified routine and emergency dental services were available to meet a resident's oral health needs in accordance with the assessment and plan of care. The policy outlined social services will assist with making appointments and, if needed, transportation arrangements and outlined, "If dentures are damaged or lost, residents will be referred for dental services." SUGGESTED METHOD OF CORRECTION: The administrator or designee could develop/revise and implement policies and procedures related to dental assessments and agreements and educate staff on these requirements. The quality assessment and assurance committee could perform random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) days	21325		

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21385	Continued From page 43	21385		
21385	MN Rule 4658.0800 Subp. 3 Infection Control; Staff assistance Subp. 3. Staff assistance with infection control. Personnel must be assigned to assist with the infection control program, based on the needs of the residents and nursing home, to implement the policies and procedures of the infection control program. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure laundered linens were handled and sorted in a clean, sanitary environment to reduce the risk of contamination for 1 of 1 main washrooms reviewed; failed to ensure staff consistently implemented transmission-based (TBP) and enhanced barrier precautions (EBP) to reduce the risk of infectious spread for 4 of 4 residents (R134, R83, R54 and R2); and failed to ensure general COVID-19 mitigation methods (i.e., masking) were correctly and consistently implemented on units with active infection. These findings have potential for a cumulative effect and, as a result, have potential to affect all 228 residents, staff and visitors within the care center. Findings include: Laundry Room: On 7/30/24 at 8:21 a.m., a tour of the campus main washroom was completed with laundry aide (LA)-A present. The washroom consisted of a large single space with commercial washing machines on one side, and three Huebsch	21385	Corrected	9/17/24

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21385	Continued From page 44 commercial dryers on the opposite. In the center of the room, positioned outside the dryers (direction they open to), were a series of tables pushed together with multiple, white-colored linens stacked on them to form a large pile. The wall surrounding the table had various mobile racks with various clothing items placed on them. However, attached to the wall were multiple "AirKing" bladed fans and the grates covering the blades of the fans had significant, copious gray and black-colored dust build-up present and were facing the cleaned linen stacked on the tables. In addition, a large Dayton Mobile Air Conditioner was on the floor and also facing the tables of stack linen. The machine was activated and moving air towards the clean linen, however, the grate covering the blades of the unit also had significant, dark gray-colored dust and debris build-up present. LA-A verified the condition of the grates and stated maintenance was supposed to be cleaning them to their knowledge, however, it had been "several weeks" since they were last done to their recall. LA-A stated staff could, if needed, make a maintenance slip out to have them cleaned but they had not done so themselves as they weren't exactly sure how to do it. At this time, the housekeeping supervisor (HS) entered the interview and expressed they had recently started working at the campus and were "going to find out" how the conditioner and fans were being cleaned. HS verified the devices were pointed at clean linen and soiled adding, "They need to be cleaned." HS stated the fans and conditioner should be kept clean to reduce possible contamination of the clean linens. The district manager of environmental services (DMES) entered the interview and also verified the fan and conditioner grate' condition adding, "We should	21385		

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21385	Continued From page 45 take care of them." LA-A verified the fans were not on a routine cleaning schedule to their knowledge. DMES stated the maintenance personnel may be cleaning them or have more information. On 7/30/24 at 3:47 p.m., the director of engineering (DOE) was interviewed. DOE verified they oversaw the maintenance department and expressed cleaning of the soiled devices observed in the washroom "really would fall under my department." DOE stated the fan and conditioner grates were cleaned on a "upon request" basis but they were going to likely implement a monthly schedule moving forward. DOE verified nobody had asked or presented the soiled grates to their department prior to survey and stated they should be cleaned adding them having built-up dust and debris posed "a fire safety hazard." During the recertification survey, from 7/29/24 to 8/1/24, no flowsheet(s) or documented tracking was provided to demonstrate the fans and air conditioner unit were on a cleaning schedule prior to the survey. On 8/1/24 at 1:03 p.m., the assistant director of nursing (ADON) and regional nurse consultant (RNC) were interviewed. ADON explained themselves, along with RNC, were helping to manage and oversee the facility' infection control program. ADON and RNC expressed the washroom was audited from "an environmental standpoint" at times, however, were unsure if it had been audited as part of the infection control program. ADON verified staff are educated on clean linen handling and RNC expressed the fans and conditioner grate was going to be added to a schedule for routine cleaning moving-forward	21385		

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21385	Continued From page 46 adding, "I think definitely the practice needs to change." ADON stated soiled grates blowing onto clean linen was a cross-contamination risk, and they verified the linens were used house-wide. R134 R134's quarterly Minimum Data Set dated, 7/20/24 indicated R134 with severe impairment of cognitive skills, physical and verbal symptoms directed towards others and had an indwelling catheter. In addition, R134 with diagnoses of Alzheimer's disease, dementia, seizures, depression, anemia, renal insufficiency (form of kidney failure), neurogenic bladder(bladder control problem due to a brain, spinal cord, or nerve issue), obstructive uropathy (disorder of the urinary tract due to obstructed urine flow), and received antipsychotics, antidepressants. Also, R134 required extensive assistance of one staff member with bed mobility, eating, toilet use. R134's physician orders dated 7/29/24 direct staff for, "Isolation: Resident is on Enhanced respiratory precaution due to tested positive for COVID on 7/23/24 and is in a contagious stage. Resident will be on isolation for 10 days in a private room." R134's nursing progress note dated 7/23/24 stated, "Note Text: Resident test positive for covid 19 @ this time, Resident appeared to be lethragic [sic] today with poor appetite, T. 98.2, in bed @ this time and will encourage isolation." During observation on 7/29/24 at 3:50 p.m., an Airborne Infection Isolation room sign was posted on outside of resident door. Sign stated, "wear gown, N95, eye protection (Goggles or face shield), One pair of gloves." PPE cart was placed	21385		

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21385	Continued From page 47 outside the door with N95 masks, gowns, gloves and hand sanitizer in the unit. PPE unit did not contain face shields or goggles. During continuous observation on 7/29/24 at 5:44 p.m. to 5:52 p.m., nursing assistant (NA)-A exited R134's room wearing PPE gown, N95 mask, and gloves. NA-A was wearing prescription eyeglasses and opened the PPE cart and then walked back into R134's room without eye protection. At 5:57 p.m., NA-A exited R134's room with a meal tray. During interview with NA-A on 7/29/24 at 5:58 p.m., NA-A verified R134 with Covid-19. NA-A verified he did not wear a face shield or goggles when assisting R134 with eating. NA-A stated, "I was told it was ok to just wear my eyeglasses". During interview with nursing manager and licensed practical nurse (LPN)-A on 7/29/24 at 6:03 p.m., LPN-A verified R134 was on respiratory precautions due to Covid. LPN-A stated, "[facility] they allow us to use our [eye]glasses as eye protection" and did not need to wear a face shield or goggles when working directly with R134. During observation on the second floor (with Covid outbreak) on 7/29/24 at 4:40 p.m., an unidentified staff member was wearing surgical mask below their nose while pushing a resident in a Broda chair to the dining room. During interview with RN-B on 7/30/24 at 9:00 a.m., RN-B stated the expectation of all staff was to wear "required PPE gown, gloves, N95's and face shields or goggles" when providing any kind of care to a Covid positive resident. "Any time a staff enters a Covid room they are to don the PPE	21385		

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21385	Continued From page 48 and remove it when they leave. Staff should not exit room with the PPE on to check the cart. [sic] important for staff to don and doff the PPE to prevent infection and to protect everyone including other staff, families and residents from infection". During interview with the DON on 7/31/24 at 10:04 a.m., DON stated Covid precautions include, "gown, gloves, face shield and N95 mask". And "staff should always wear all the required PPE including the face shield every time they enter the Covid positive room." Also, "surgical masks worn above nose and mouth should be worn by all staff during outbreaks especially on the Covid units." Uncovered Soiled Linen/Garbage Carts in hallways. During observation on 8/1/24 at 7:51 a.m., on the fifth floor, a three-bin unit with each bin having a large plastic bag inside a mesh bag was observed in the hallway outside of a fifth floor resident room. One of the bins had a white plastic cover while the other two had no covers at all. The uncovered middle bin had a visible mound of laundry with a soiled red plaid shirt. that had a R30's name on a label inside the neck of the shirt. The uncovered right bin had soiled incontinence briefs and other trash in it. During observation and interview with nursing assistant (NA)-D on 8/1/24 at 7:53 a.m., NA-D exited room 505 with a small garbage bag and an arm full of soiled facility linen. NA-D placed the soiled facility linen including towels and bedsheet on top of the uncovered middle bin that had R30's personal shirt in it. NA-D then placed the small	21385		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21385	Continued From page 49 garbage bag into the uncovered soiled garbage bin. NA-D stated, "[the two uncovered bins] are supposed to be covered but this one doesn't have covers. [laundry] is supposed to be covered for infection control." During observation and interview on 8/1/24 at 7:58 a.m., on the third floor a three-bin unit with each having a large plastic bag inside a mesh bag was in the hallway outside of room 327. The middle bin was uncovered and had soiled Hoyer slings in it which were visible. Nursing manager and registered nurse (RN)-B grabbed the unit and wheeled it down the hall. RN-B stated, "soiled linen and garbage should not be visible from the hall". RN-B stated, "this is a concern for infection control. Each of these units [resident floors] have these 3 bin units for aides to put the trash and linen in them after providing care. One bin is for trash, one for personal laundry, and one for facility laundry. They should be covered when out in the hall." During interview with the director of nursing (DON) on 8/1/24 at 9:12 a.m., DON stated uncovered soiled linen and garbage, "should not be left visible in the hallway." DON stated rationale for covering soiled linen and garbage was, "infection control thing." A facility' policy on clean linen handling was requested, however, none was received. Enhanced Barrier Precautions: R83's quarterly Minimum Data Set (MDS) dated 5/22/24, identified intact cognition and diagnoses of neurogenic bladder (when a person lacks bladder control due to brain, spincal cord or nerve problems), kidney disease, epilepsy, and diabetes	21385		

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21385	Continued From page 50 mellitus. R83 required substantial and/or maximal assistance for transfers and rolling left and right and partial and/or moderate assistance for toileting hygiene. R83's MDS identified R83 had an indwelling catheter and was frequently incontinent of bowel. R83's activities of daily living care plan revised 6/30/24, indicated R83 required a mechanical lift with two staff assistance for transfers. R83's care plan also indicated R83 had an indwelling catheter related to neurogenic bladder. During observation on 7/29/24 at 5:29 p.m., R83's door had a sign which read "Enhanced Barrier Precautions" and instructed staff to wear gloves and a gown for high-contact resident care activities which included transferring. A cart of personal protective equipment (PPE) was next to R83's door. NA-N and NA-O wore gloves, mask, and no gown to assist R83. NA-N and NA-O hooked the sling underneath R83 to the mechanical lift machine, placed the urinary catheter, which was within its privacy bag, on R83's lap, and transferred R83 from the bed to wheelchair. NA-N removed gloves and performed hand hygiene prior to leaving the room. NA-O still had gloves on and no gown and placed urinary catheter bag under R83's wheelchair and made R83's bed. NA-O removed gloves, wheeled R83 out to the dining room, and washed hands at the nurses' station. During interview on 7/29/24 at 5:45 p.m., NA-O stated they looked at the sign on residents' doors to know what kind of PPE to wear. NA-O verified R83 had a urinary catheter and stated staff needed gown and gloves when completing care such as emptying the urinary catheter but wore gloves when transferring.	21385		

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21385	Continued From page 51 During interview on 7/29/24 at 6:12 p.m., NA-N stated residents who had a urinary catheter were on enhanced barrier precautions and needed gown and gloves when providing cares related to urinary catheters. NA-N verified R83 was on enhanced barrier precautions and stated staff needed gloves to transfer R83. During interview on 8/1/24 at 9:17 a.m., LPN-H stated residents with urinary catheters were placed on enhanced barrier precautions and confirmed R83 had a urinary catheter and was on enhanced barrier precautions. LPN-H stated gown and gloves were required to transfer R83 and was important to follow proper PPE procedures for safety reasons, such as not spreading MRSA (methicillin-resistant Staphylococcus aureus; bacteria which is resistant to many antibiotics). During interview on 8/1/24 at 9:40 a.m., LPN-G verified R83 had a urinary catheter and was on enhanced barrier precautions which required gown and gloves for transfers. LPN-G stated it was important to wear gown and gloves when transferring residents with urinary catheters to prevent the spread of infection. During interview on 8/1/24 at 1:03 p.m., the assistant director of nursing (ADON) stated residents with urinary catheters required enhanced barrier precautions, and staff were expected to wear gown and gloves when providing "hands on" cares which included transfers. During interview on 8/1/24 at 1:36 p.m., the director of nursing (DON) expected staff to follow the precaution signs on residents' doors, and	21385		

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21385	Continued From page 52 precautions were important to follow to prevent the spread of infection. Facility policy "Enhanced Barrier Precautions" dated 3/24, defined EBP as the use of gown and gloves during high-contact resident care activities for residents known to be colonized or infected with a MDRO (multidrug-resistant organism) as well as those at increased risk for MDRO acquisition, such as residents with urinary catheters. The policy indicated high-contact resident care activities included transferring. COVID-19 PPE: R54 quarterly Minimum Data Set (MDS) dated 7/13/24, indicated R54 was cognitively intact. R54 was independent with oral and toileting hygiene, putting on and off footwear and mobility, required set-up and/or clean-up assistance with eating, showering, upper body dressing, and personal hygiene, and supervision and/or touching assistance with lower body dressing. R54's MDS identified diagnoses of schizophrenia (mental health condition which affects how people think, feel and behave), malnutrition, hypertension (high blood pressure; pressure in blood vessels is too high), peripheral vascular disease (narrowed blood vessels reduce blood flow to legs or arms), coronary artery disease (narrowing or blockage of heart's arteries). R54's care plan undated, identified enhanced respiratory isolation due to COVID-19. R54's physician's order dated 7/29/24, identified enhanced respiratory precautions due to positive COVID test on 7/24/24.	21385		

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21385	Continued From page 53 During observation on 7/29/24 at 6:09 p.m., R54's door had a sign which read "Enhanced Respiratory Precautions" and instructed staff to wear gown, N95 respirator, eye protection, and gloves to enter room. NA-N removed their surgical mask, performed hand hygiene, and donned N95, gown, gloves, and no eye protection and entered R54's room with a meal tray. At 6:10 p.m., NA-N exited R54's room and doffed gown, N95, gloves, performed hand hygiene, and placed on clean surgical mask. During interview on 7/29/24 at 6:12 p.m., NA-N verified R54 was on precautions for COVID-19 and required gown, gloves, and N95 to enter room. NA-N did not think there was eye protection in the PPE cart located next to R54's door. One face shield was observed in PPE cart. During interview on 7/31/24 at 1:47 p.m., NA-P verified R54 was on precautions for COVID-19 and required eye protection, gown, gloves, and N95 mask to enter room. NA-P stated R54 was independent to eat and had an occasional cough which made the eye protection important to wear. During interview on 8/1/24 at 9:40 a.m., LPN-G verified R54 was on precautions for COVID-19, and gown, gloves, N95 mask and eye protection were required to enter room. LPN-G stated it was important to follow PPE procedures, even to give R54 a room tray, to prevent transmission of COVID-19. During interview on 8/1/24 at 1:36 p.m., the director of nursing (DON) expected staff to follow the precaution signs on residents' doors, and precautions were important to follow to prevent the spread of infection.	21385		

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21385	Continued From page 54 The facility policy "Personal Protective Equipment" dated 1/24, indicated the need for transmission-based precautions was a factor which determined the appropriate selection of PPE for a particular task. The policy identified personal glasses were not a substitute for goggles. The policy directed the charge nurse to check isolation supply carts twice per shift. PPE R2's significant change MDS assessment, dated 6/26/24, indicated R2 had intact cognition. R2 was maximum to dependent on staff assistance for all activities of daily living (ADLs) except eating which she needed set up assistance. R2's diagnoses included: dementia (memory loss that disrupts daily life), hemiplegia (paralysis/inability to move of one side of the body), epilepsy (disorder in which nerve cell activity in the brain is disrupted causing seizures) and pain. During observation on 7/31/24 at 11:55 a.m., R2 was observed to have a single page document in a plastic page protector hung on the door that indicated: "Respiratory Precaution Room." The sign had a person on it with PPE (proper protective equipment), it also included a stop sign on the sign with a picture of a hand along with the words: gown, N95, eye protection, one pair of gloves. At the bottom of the page, it indicated "airborne infection isolation room: keep door closed if possible. "To the left of the door was a three-drawer plastic bin to the left of the door which contained disposable gowns, N95 masks and face shields. On top of the plastic bin was hand sanitizer, disposable gloves, and disposable masks.	21385		

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21385	Continued From page 55 During observation on 7/31/24 at 11:55 a.m., housekeeper (HSK)-D was observed with a surgical mask on pushing their cleaning cart to the entrance of R2's. HSK-D was observed using hand sanitizer, grabbing a disposable gown from the bin, putting the gown on followed by a pair of disposable gloves. HSK-K then entered R2's room. Upon exit of the room, HSK-D was observed to take off the gown and gloves and use hand-sanitizer but did not remove the surgical mask. During continual observation, HSK-D was observed to move their cart down the hallway to an adjacent room with a sign on the door, "Enhanced Barrier Precautions." During the same continual observation, HSK-D was observed to use hand sanitizer, put on gloves and then a gown to enter the room, while continuing to wear the same surgical mask worn in R2's room. During interview at 7/31/24 at 12:09 p.m., HSK-D verified that they just completed cleaning R2's room. HSK-D verified they did not wear a N95 or a face shield. HSK-D stated, "I can't breathe with those masks on." HSK-D stated, "I changed my blue mask though, I carry them in my pocket." HSK-D verified PPE is to be worn to stop the spread of diseases. HSK-D verified that R2 was on precautions for "COVID." During interview on 8/01/24 at 11:05 a.m., registered nurse (RN)-F verified R2 had COVID. RN-F stated that any staff needs to have "full attire" on when they enter "COVID" rooms, or any rooms PPE is needed in. RN-F verified that all staff get training on proper PPE use. SUGGESTED METHOD OF CORRECTION: The DON (Director of Nursing) or designee should	21385		

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21385	Continued From page 56 review/revise facility policies to ensure they contain all components of an infection control program to mitigate transmission of potential infections (EBP, COVID precautions, linen and laundry practices, immunizations, etc). The DON or designee could educate all staff on existing or revised policies and perform audits to ensure the policies are being followed. The results of those audits should be taken to Quality Assurance Performance Improvement committee to determine compliance and the need for further monitoring. Time Period for Correction: Twenty-one (21) days.	21385		
21530	MN Rule 4658.1310 A.B.C Drug Regimen Review A. The drug regimen of each resident must be reviewed at least monthly by a pharmacist currently licensed by the Board of Pharmacy. This review must be done in accordance with Appendix N of the State Operations Manual, Surveyor Procedures for Pharmaceutical Service Requirements in Long-Term Care, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system. It is not subject to frequent change. B. The pharmacist must report any irregularities to the director of nursing services and the attending physician, and these reports must be acted upon by the time of the next physician visit, or sooner, if indicated by the pharmacist. For purposes of this part, "acted upon" means the acceptance or rejection of the report and the signing or initialing by the director of nursing services and the attending physician.	21530		9/17/24

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21530	Continued From page 57 C. If the attending physician does not concur with the pharmacist's recommendation, or does not provide adequate justification, and the pharmacist believes the resident's quality of life is being adversely affected, the pharmacist must refer the matter to the medical director for review if the medical director is not the attending physician. If the medical director determines that the attending physician does not have adequate justification for the order and if the attending physician does not change the order, the matter must be referred for review to the quality assessment and assurance committee required by part 4658.0070. If the attending physician is the medical director, the consulting pharmacist must refer the matter directly to the quality assessment and assurance committee. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure consulting pharmacist recommendations were fully addressed or acted upon for 1 of 5 residents (R164) reviewed for unnecessary medications. Findings include: R164's significant change Minimum Data Set (MDS) dated 10/12/23, indicated R164 had severely impaired cognition. R164's quarterly MDS dated 7/14/24, indicated R164 did not speak and rarely/never understood verbal content. In addition, R164 was dependent on staff for bed mobility, lower body dressing, and toileting hygiene. R164's medical diagnoses report dated 1/27/23,	21530	Corrected	

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21530	Continued From page 58 indicated R164 had dementia "without behavioral disturbance", epilepsy, and depression. R164's Order Summary Report dated 3/30/23, included an order dated 3/30/23 for 12.5 milligrams (mg) of quetiapine (an antipsychotic medication) every evening for "agitation". The report included an order dated 6/21/24, with no end date for one mg of as-needed lorazepam (a psychotropic medication used to treat seizures) that could be given every 15 minutes for two doses. R164's Consultant Pharmacist Recommendation to Physician dated 3/26/24,, indicated R164 received as-needed lorazepam. The report indicated that as-needed psychotropic medications should have a 14-day stop date, "unless a longer time frame is deemed appropriate" by the physician. The report indicated if the duration of use needed to be extended past 14 days, to provide a rationale for continuing use and "a specific duration" of therapy. The provider responded on 4/15/24 to continue the as-needed lorazepam order "as written" as the benefits outweigh the risks. The response did not address the pharmacist's recommendation to include a specific duration of therapy. R164's Consultant Pharmacist Recommendation to Physician dated 3/26/24, indicated R164 was receiving quetiapine for a diagnosis of agitation "which is not considered an appropriate indication for antipsychotic use." The report indicated if the antipsychotic use was to continue, to clarify the appropriate diagnosis. The provider responded on 4/15/24 by indicating the medication was useful for insomnia and the family did not want the medication discontinued so the order would	21530		

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21530	Continued From page 59 be continued for agitation and insomnia "per family's wishes". R164's Consultant Pharmacist Recommendation to Physician dated 4/26/24, indicated R164 received as-needed lorazepam. The report indicated that as-needed psychotropic medications should have a 14-day stop date, "unless a longer time frame is deemed appropriate" by the physician. The report indicated if the duration of use needed to be extended past 14 days, to provide a rationale for continuing use and "a specific duration" of therapy. The report did not include a signature with a correlating date but included the note, "completed on 4/15". The response did not address the pharmacist's recommendation to include a specific duration of therapy. R164's Consultant Pharmacist Recommendation to Physician dated 4/26/24, indicated R164 was receiving quetiapine for a diagnosis of agitation "which is not considered an appropriate indication for antipsychotic use." The report indicated if the antipsychotic use was to continue to clarify the appropriate diagnosis. The report did not include a signature with a correlating date but had the note, "completed on 4/15". R164's Consultant Pharmacist Recommendation to Physician dated 5/26/24, indicated R164 received as-needed lorazepam. The report indicated that as-needed psychotropic medications should have a 14-day stop date, "unless a longer time frame is deemed appropriate" by the physician. The report indicated if the duration of use needed to be extended past 14 days, to provide a rationale for continuing use and "a specific duration" of therapy. The report did not include a signature	21530		

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21530	Continued From page 60 with a correlating date but had the note, "completed 7/29/24". The response did not address the pharmacist's recommendation to include a specific duration of therapy. R164's Consultant Pharmacist Recommendation to Physician dated 5/26/24, indicated R164 was receiving quetiapine for a diagnosis of agitation "which is not considered an appropriate indication for antipsychotic use." The report indicated if the antipsychotic use was to continue, to clarify the appropriate diagnosis. The report did not include a signature with a correlating date but had the note, "completed 7/29/24". R164's nursing progress note dated 6/21/24 at 2:23 p.m., indicated the pharmacist had recommended a "14 day stop date on lorazepam" and per the provider, they were to continue the order as written as the benefits outweigh the risks. The progress note did not indicate a specific duration of therapy for the as-needed lorazepam. R164's Consultant Pharmacist Recommendation to Physician dated 6/25/24, indicated R164 received as-needed lorazepam. The report indicated that as-needed psychotropic medications should have a 14-day stop date, "unless a longer time frame is deemed appropriate" by the physician. The report indicated if the duration of use needed to be extended past 14 days, to provide a rationale for continuing use and "a specific duration" of therapy. The provider responded on 7/29/24 to continue the as-needed lorazepam order due to its indication of use. The response did not address the pharmacist's recommendation to include a specific duration of therapy.	21530		

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21530	Continued From page 61 R164's Consultant Pharmacist Recommendation to Physician dated 6/25/24, indicated R164 was receiving quetiapine for a diagnosis of agitation "which is not considered an appropriate indication for antipsychotic use." The report indicated if the antipsychotic use was to continue, to clarify the appropriate diagnosis. The provider responded on 7/29/24 and indicated the diagnosis was "resistant anxiety". R164's Medication Administration Record (MAR) dated 7/1/24 through 7/30/24, indicated one milligram (mg) of as-needed lorazepam was given on 7/21/24. The record included an order dated 1/31/23 that indicated R164 sleeps for "12hrs+ per family" and should be gotten up last in the morning. R164's nursing progress note dated 7/31/24 at 9:00 a.m., indicated the provider gave an order to continue the lorazepam as ordered due to the indication. R164's nursing progress note dated 7/31/24 at 11:37 a.m., indicated the pharmacy recommendations were completed and to see the recommendations that were uploaded that day. During an interview at 12:14 p.m., nurse practitioner (NP)-A stated she was the provider reviewing R164's pharmacist reviews. NP-A stated she had noticed that the pharmacy recommendations were reissued monthly but didn't think that the pharmacist had seen the previous provider response made on 4/15/24, so she had referenced back to that response. NP-A confirmed a stop date had not been added to the as-needed lorazepam as she did not know it was necessary. NP-A stated it was "unclear" why R164 was using quetiapine so on 7/29/24 she	21530		

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LAKEHOUSE HEALTHCARE & REHABILITATIO	3737 BRYANT AVENUE SOUTH MINNEAPOLIS, MN 55409

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21530	Continued From page 62 had updated the order to include an indication of "resistant anxiety" but was unable to specify what symptoms of resistant anxiety R164 currently had. NP-A stated she did not reach out to the pharmacist to receive clarification on why the recommendations were being reissued for the as-needed lorazepam use and the quetiapine use. During an interview on 8/1/24 at 12:35 p.m., the consulting pharmacist (PH) stated she had difficulty getting the facility/providers to fully respond to her recommendations for R164, so she had been reissuing them monthly since March. The PH stated she sent recommendations to the facility once a month and would then follow up the next month to ensure the recommendations were completed. The PH stated she had reviewed the response from the March recommendation and an appropriate diagnosis for antipsychotic use was not given, so she had reissued the recommendation. The PH stated agitation was not an appropriate indication for antipsychotic use and would have expected a medical diagnosis such as schizophrenia, delusional disorder, or bipolar disorder. The PH stated the facility had not established a duration of use for R164's as-needed lorazepam so she had reissued that recommendation monthly also. The PH stated she had not had a conversation or further reached out to the provider, medical director, or other facility staff to explain the repeated recommendations to the facility staff. During an interview on 8/1/24 at 2:28 p.m., the director of nursing (DON) stated nursing staff had reviewed the pharmacy recommendations, but there had been a misunderstanding regarding the requirement for a stop date for as-needed psychotropic medication, so it had not been	21530		

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21530	Continued From page 63 addressed. The DON stated agitation was not an appropriate indication for antipsychotic medication and the order should have been updated to include an appropriate indication before the start of the survey, but it had not been. The DON stated she was unaware of the nursing staff or the provider reaching out to the pharmacist for clarification on recommendations. A policy regarding pharmacist medication regimen reviews was requested and not received. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) and pharmacist or their designee, could develop and implement policies/procedures and staff training related to assurance that consulting pharmacist recommendations are acted upon adequately. The DON or designee, along with the pharmacist, could audit medication reviews on a regular basis to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	21530		
21545	MN Rule 4658.1320 A.B.C Medication Errors A nursing home must ensure that: A. Its medication error rate is less than five percent as described in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (m), found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, which is incorporated by reference in part 4658.1315. For purposes of this part, a medication error means: (1) a discrepancy between what was prescribed and what medications are actually	21545		9/17/24

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21545	Continued From page 64 administered to residents in the nursing home; or (2) the administration of expired medications. B. It is free of any significant medication error. A significant medication error is: (1) an error which causes the resident discomfort or jeopardizes the resident's health or safety; or (2) medication from a category that usually requires the medication in the resident's blood to be titrated to a specific blood level and a single medication error could alter that level and precipitate a reoccurrence of symptoms or toxicity. All medications are administered as prescribed. An incident report or medication error report must be filed for any medication error that occurs. Any significant medication errors or resident reactions must be reported to the physician or the physician's designee and the resident or the resident's legal guardian or designated representative and an explanation must be made in the resident's clinical record. C. All medications are administered as prescribed. An incident report or medication error report must be filed for any medication error that occurs. Any significant medication errors or resident reactions must be reported to the physician or the physician's designee and the resident or the resident's legal guardian or designated representative and an explanation must be made in the resident's clinical record. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure a medication administration error rate of less than 5 percent (%). Twenty medication administration errors	21545	Corrected	

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21545	Continued From page 65 occurred out of 31 opportunities resulting in a 64.52% medication error rate for 2 of 4 residents (R184 and R376). Findings include: R184's admission assessment Minimum Data Set (MDS) dated 5/28/24, indicated R184 had moderate cognitive impairment, didn't have signs of delirium, and didn't refuse cares or medications. MDS indicated R184 was dependent with showers, lower body dressing, toileting, bed mobility, and transfers. R184 needed substantial assistance with upper body dressing, oral hygiene and eating. R184's Clinical diagnosis record printed 1/31/24, indicated diagnoses of dysphagia (difficulty swallowing) following unspecified cerebrovascular disease (condition that affect blood flow and the blood vessels in the brain), gastrostomy status (surgical procedure that creates an opening in the abdomen and into the stomach, allowing for the insertion of a feeding tube), hemiplegia (paralysis of one side of the body) and paraplegia (paralysis of the legs and lower body, typically caused by spinal injury or disease) following cerebral infarction affecting right dominant side, chronic obstructive pulmonary disease (lung disease that blocks airflow and makes it difficult to breath), chronic respiratory failure with hypoxia (low oxygen level in the blood) , protein-calorie malnutrition, chronic atrial fibrillation (heart arrhythmia that causes the upper chambers of the heart to beat irregularly and quiver for more than 12 months), atrial flutter (condition in which the heart's upper chambers beat too quickly), and dysthymic disorder (a mild but long-term form of depression).	21545		

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21545	Continued From page 66 R184's Clinical Orders report printed 7/31/24, indicated "may crush meds unless contraindicated." The report indicated the following medications were to be administered via the gastric tube: 10 milligrams (mg) of baclofen three times a day (medicaton to treat neuropathic pain), 7.5 mg of metoprolol twice a day (medicaton to treat high blood pressure), 20 mg of escitalopram oxalate daily (medicaton to treat depression), 5 ml (100mg) of gabapentin three times daily (medicaton to neuropathic pain), one tablet of sennoside twice a day (medicaton to treat constipation), and 0.38 ounces of banatrol with bimudo probiotic twice as day. R184's Clinical Orders report lacked indication if medications could be crushed together or if they could be administered together. During an observation and interview on 7/31/24 at 8:00 a.m., registered nurse (RN)-G was observed removing the baclofen, metoprolol, escitalopram, and sennoside from its packaging and placing them in the same medication cup. The medications were then transferred to a clear medication bag and crushed together using a manual levered machine. RN-G measured the gabapentin solution and poured the solution in a plastic cup. RN-G added the crushed medications to the plastic glass, added the banatrol, filled the glass with water, and mixed all the medications together. RN-G stated, "all the medications are going to the stomach, that's how we do it." RN-G administered 60 milliliters (ml) of water via the gastric tube, administered the combined medication solution through the gastric tube, and then again, flushed the tube with 60 ml of water. During interview on 7/31/24 at 11:37 a.m., RN-G verified they did not have a provider order to	21545		

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21545	Continued From page 67 administer all the crushed medications medications together. RN-G added but they are all scheduled at the same time. During interview on 7/31/24 at 1:42 p.m., nurse manager RN-E stated medications administered via tube feedings needed to be crushed individually, administered one at the time, and to use water boluses between medications. NN-E stated administering medications together was not the correct way to do it and the medications needed to be administered one at the time. R376 R376's significant change Minimum Data Set (MDS) dated 6/28/24, indicated R376 was cognitively impaired, had no delirium or hallucinations and did not refused cares. R376 was independent with transfers, bed mobility, walked short distances, and needed supervision with personal hygiene and dressing. R376's Clinical Diagnosis record printed 7/31/24, indicated diagnosis of oropharyngeal phase dysphagia (swallowing problems in the mouth and/or the throat), gastrostomy status (surgical procedure that creates an opening in the abdomen and into the stomach, allowing for the insertion of a feeding tube), ankylosis spondylitis of spine (inflammatory arthritis), traumatic brain injury, chronic obstructive pulmonary disease (inflammatory arthritis), severe protein-calorie malnutrition, and acute respiratory failure with hypoxia ((a medical emergency that occurs when the body's tissues don't have enough oxygen). R376's Clinical Orders report printed 7/31/24, indicated "may crush meds unless contraindicated". The report indicated the	21545		

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21545	Continued From page 68 following medications were to be administered via the gastric tube: 50 mg - 3 tablets of sertraline (antidepressant) daily, 25 micrograms of cholecalciferol (vitamin D) capsule daily, 1 mg of folic acid (vitamin B-12), 15 ml -100 mg/ml of levetiracetam (medication for epilepsy) twice daily, one mineral multivitamin tablet daily, 17 grams of polyethylene glycol (medication for constipation) 3350 daily, 10 mg of Zyrtec (allergy medication), 100mg (10ml) of lacosamide (anticonvulsant) twice daily, 1000 mg (20ml) of valproate sodium (medication to treat seizures) solution twice daily. R376's Clinical Orders report lacked indication if medications could be crushed together or if they could be administered together. During an observation and interview on 7/31/24 at 8:35 a.m., licensed practical nurse (LPN)-F was observed removing the sertraline, cholecalciferol, folic acid, multivitamin, and Zyrtec in the same medication cap. The medications were then transferred to a clear medication bag and crushed together using a manual levered machine. LPN-F measured levetiracetam, lacosamide, and valproate sodium and poured them in the same plastic cup. LPN-F then added the crushed medications and the polyethylene glycol to the liquid medications, filled the glass with water and mixed them together with a plastic spoon. LPN-F flushed the gastric tube with water, administered medications and flushed the gastric tube with water. LPN-F stated he wasn't sure if they had an order to crush and administer all the medications together. During interview on 7/31/24 at 1:28 p.m., LPN-F stated he wasn't sure if it was safe to mix all medications together. LPN-F stated that this was	21545		

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21545	Continued From page 69 his first experience administering medications via a tube feeding. During interview on 8/1/24 at 8:27 a.m., nurse manager RN-H stated unless you have an provider order that is okay to mix the medications together, you should administer one medication at the time and flush with water in between. RN-H stated the concern of giving the medications together was a potential for interactions or a decrease in the efficacy of the medications. During interview on 8/1/24 at 12:29 p.m., pharmacist (PH) stated it was not recommended to combine and mix medication and then administer them via a gastric tube. PH stated there was not enough scientific data to know how the medications interact or how they were absorbed when they are crushed and administered together. PH stated it was up to the providers to authorize the crushing of medications together and administering them via gastric tubes. During interview on 8/1/24 at 2:55 p.m., director of nursing (DON) stated we have the responsibility to clarify the orders on admission. We need to have the right medication, the right dose, the right diagnosis, and the right frequency. "The nurse must ask those questions. Some medications are prescribed for different reasons. But is their patient taking the medication for seizures or what?" Regarding the administration of medications via gastric tubes, DON stated a provider order is required to administer medications together because it could cause interactions. Interactions could even be life threatening or have a negative outcome. The order needs to come from the provider. DON	21545		

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21545	Continued From page 70 stated "It is 101 nursing, if you have 10 meds, you need 10 med cups, one for each medication. It is basic nursing." Facility's policy titled Medication administration via Enteral Tube dated 4/1/22, indicated each medication will be administered separately. Policy also indicated medications may be administered together with a provider's order. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures for medication errors. The director of nursing or designee could develop a system to educate staff and develop a monitoring system to ensure medications were correctly administered. The quality assurance committee could monitor these measures to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) days	21545		
21565	MN Rule 4658.1325 Subp. 4 Administration of Medications Self Admin Subp. 4. Self-administration. A resident may self-administer medications if the comprehensive resident assessment and comprehensive plan of care as required in parts 4658.0400 and 4658.0405 indicate this practice is safe and there is a written order from the attending physician. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure a self-administration of medications (SAM)	21565	Corrected	9/17/24

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21565	Continued From page 71 assessment was completed to allow a resident to safely self-administer medications for 1 of 1 (R184) residents reviewed for self-administration of medications. Findings include: R184's admission Minimum Data Set (MDS) dated 5/28/24, indicated R184 had moderate cognitive impairment, didn't have signs of delirium, and didn't refuse cares or medications. The MDS indicated R184 was dependent with showers, lower body dressing, toileting, bed mobility, and transfers. R184 needed substantial assistance with upper body dressing, oral hygiene and eating. R184's Clinical diagnosis record printed 1/31/24, indicated diagnoses of dysphagia (difficulty swallowing) following unspecified cerebrovascular disease (condition that affect blood flow and the blood vessels in the brain), gastrostomy status (surgical procedure that creates an opening in the abdomen and into the stomach, allowing for the insertion of a feeding tube), hemiplegia (paralysis of one side of the body) and paraplegia (paralysis of the legs and lower body, typically caused by spinal injury or disease) following cerebral infarction (stroke) affecting right dominant side, chronic obstructive pulmonary disease (lung disease that blocks airflow and makes it difficult to breath), chronic respiratory failure with hypoxia (low oxygen level in the blood) , protein-calorie malnutrition, chronic atrial fibrillation (heart arrhythmia that causes the upper chambers of the heart to beat irregularly and quiver for5 more than 12 months), atrial flutter (condition in which the heart's upper chambers beat too quickly), and dysthymic disorder (a mild but long-term form of depression).	21565		

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21565	Continued From page 72 R184's Clinical Physician orders printed 7/31/24 lacked orders for the self-administration of medications. R184's electronic medical record reviewed 7/31/24, lacked an assessment for self-administration of medications. During observation on 7/31/24 at 8:00 a.m., registered nurse (RN)-G filled the nebulizer chamber with albuterol sulfate (medication for shortness of breath) nebulizer 2.5 milligrams (mg)/3 milliliters (ml) vial. RN-G asked R184 if she should start the nebulizer machine. R184 answered, he will do it himself when he returned from smoking. RN-G stated that was okay and left the room. During interview on 7/31/24 at 8:05 a.m., RN-G was questioned if R184 was able to start the nebulizer machine on his own. RN-G said, "He wants to smoke first, he can hold it by himself. He will ask somebody to turn it on." During observation on 7/31/24 at 11:30 a.m., residual nebulizer solution was observed remaining in the nebulizer cup. During interview on 7/31/24 at 11:37 a.m., RN-G said she started the nebulizer machine for him and left the room. RN-G added, "He doesn't like it when we stay in the room, and he is doing his neb treatment." RN-G said the order to self-administer medications should be okay by the doctor. RN-G was not sure if R184 had an order to self-administer medications. During interview on 7/31/24 at 1:09 p.m., R84 stated "the nurses pour the medication in the	21565		

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21565	Continued From page 73 nebulizer cup. I don't need help to turn on and off the nebulizer machine. The nurse never stays in the room while I do my neb treatment." During interview on 7/31/24 at 1:42 p.m., nurse manager (RN-E) stated a doctor's order, and a self-administration assessment were needed to self-administer a nebulizer treatment. RN-E verified R184 didn't have a self administration order or an assessment. RN-E stated the assessment needed to be completed to establish if resident was able to safely administer his own medication. A facility's self-administration of medications policy and procedure was requested but not received. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures for medication errors. The director of nursing or designee could develop a system to educate staff and develop a monitoring system to ensure medications were correctly administered. The quality assurance committee could monitor these measures to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) days	21565		
21610	MN Rule 4658.1340 Subp. 1 Medicine Cabinet and Preparation Area;Storage Subpart 1. Storage of drugs. A nursing home must store all drugs in locked compartments under proper temperature controls, and permit only authorized nursing personnel to have	21610		9/17/24

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21610	Continued From page 74 access to the keys. This MN Requirement is not met as evidenced by: Based on observation and interview, the facility failed to ensure mediations were kept locked or under direct observation of authorized staff in areas where residents, staff and guests could access medications on 3 of 5 resident floors. Findings include: During observation and interview on 7/29/24 at 6:14 p.m., an unattended and unlocked medication cart was observed located along a knee-high wall facing the seventh floor dining room during mealtime. Registered nurse (RN)-A returned to the medication cart and verified it was unlocked and, "it should be locked to stop anyone from getting in." During observation and interview on 7/31/24 at 1:10 p.m., an unattended and unlocked medication cart was observed located along a knee wall facing the fifth floor dining room with 12 seated residents in wheelchairs and walkers and two residents in wheelchairs rolling past the cart. During interview with licensed practical nurse (LPN)-B stated he was responsible for the unlocked medication cart and stated, "I should always lock the cart when I leave it. Because the residents can get access to it." During observation and interview on 8/1/24 7:54 a.m., an unattended and unlocked medication cart was observed located along a knee wall facing the fifth floor dining room with 12 seated residents in wheelchairs and walkers in the area. LPN-C stated he was responsible for the unlocked medication cart and stated, "the med	21610	Corrected	

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21610	Continued From page 75 cart should be locked because it is regulation. [sic] keep others from getting into the cart and getting the meds." During continuous observation on 8/1/24 from 11:30 a.m. to 11:47 a.m., an unattended and unlocked medication cart was observed on second floor in front of the nursing station until the DON walked by and locked the medication cart. During interview with second floor nurse manager (RN)-H stated, "leaving the cart unlocked [sic]concern because anybody can open it and take medications". During interview with the third floor nurse manager RN-B on 8/1/24 at 7:58 a.m., stated, "medication carts [sic] always lock before leaving the cart [sic] when leaving because we have residents here that can rummage through them and get access to them, and we do not want to have the risk of them getting into the carts and accessing the meds." During interview with director of nursing (DON) on 8/1/24 at 9:02 a.m., DON stated, "we teach nurses to keep the med carts locked once you are stepping away. No matter what. If you can't reach the cart, you must lock the cart." Facility policy titled Medication Administration dated May 2024 identified, "Medications are administered by licensed nurses, or other staff who are legally authorized to do so". SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON) and consulting pharmacist could review and revise	21610		

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21610	Continued From page 76 policies and procedures for proper storage of medications. Nursing staff could be educated as necessary to the importance of properly securing medications. The DON or designee, along with the pharmacist, could conduct audits on a regular basis to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21610		
21730	MN Rule 4658.1415 Subp. 11 Plant Housekeeping, Operation, & Maintenance Subp. 11. Insect and rodent control. Any condition on the site or in the nursing home conducive to the harborage or breeding of insects, rodents, or other vermin must be eliminated immediately. A continuous pest control program must be maintained by qualified personnel. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to implement an effective pest control program to eliminate bed bugs from the building for 1 of 1 resident (R9) with the potential to affect all 11 residents residing on the odd side of the seventh floor. Findings include: R9's quarterly Minimum Data Set (MDS) dated 5/11/24, indicated R9 had no cognitive deficits and required moderate assistance with transferring, bathing, and toileting hygiene. The pest control company report dated 7/31/24 at 2:15 p.m., indicated R9's original room had been	21730	Corrected	9/17/24

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21730	Continued From page 77 assessed by the pest control company, and a dead bed bug was noted. During an interview on 7/29/24 at 2:09 p.m., R9 stated she was moved from her original room to her current room last week because of a bed bug infestation. R9 stated she was supposed to move back to her old room soon but was "scared" as she didn't believe that the bed bugs were gone. During an interview and observation on 7/30/24 at 2:55 p.m., R9 was found still residing in the new room she had been given the previous week. R9 stated that the staff had moved her back to her old room yesterday. R9 stated staff had assisted her to bed, given her one of her bags, and then left the room. R9 stated she soon noticed these blackish-brown bugs "everywhere" on her bed and when she would touch them, "blood would go everywhere." R9 stated the bed bugs kept climbing onto her body, leaving her covered in blood. R9 stated she was screaming for help and had her call light on, but she could not get out of bed by herself. During an interview on 7/30/24 at 3:02 p.m., registered nurse (RN)-K, the nurse manager for the unit, stated that R9's room had been found to have bed bugs last week after R9 had visitors. RN-K stated she was unsure how the bed bugs were managed as this was completed by the director of engineering (DOE). RN-K stated that R9 was moved out of the bed bug-infected room to a new one on 7/23/24 and moved back on 7/29/24. RN-K stated she was unsure who assessed the room before bringing R9 back. During an interview and observation on 7/30/24 at 3:33 p.m., R9's original room was observed with a bed on the left-hand side of the room pressed	21730		

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21730	Continued From page 78 up against the wall. The bed sheets were observed with sporadic red/rust-colored stains and a small black-brown bug crawling across the bottom sheet. The bed frame was observed with a black/red grime-looking substance. The room was observed to have multiple open boxes with items overflowing and multiple personal bags on the floor of the room. The blinds were observed covered by a fabric topper. Clothing was observed overflowing out of the dresser. A multicolored personal blanket was observed on the floor. RN-K confirmed that the bug crawling on the bottom sheet was a bed bug. During an interview on 7/31/24 at 9:09 a.m., the DOE stated R9 had a repeat issue of bed bugs that had been treated last week with a heating system by MS-A. The DOE stated R9 had "a lot" of items in her room that were making it hard to get rid of all the bed bugs, but they had so far not done anything to address this issue. The DOE was asked to provide documentation showing any audits of other resident rooms on the unit and any documentation of treatment used to treat the bed bug infestation in R9's original room. During an interview on 7/31/24 at 1:03 p.m., maintenance staff (MS)-A stated he had dealt with the bed bug infestation in R9's room. MS-A stated he had used an electric heating device that was manufactured to kill bed bugs and reached 130 degrees for three days. MS-A stated the facility does not normally call a pest control service until after the heat treatment has not worked. MS-A stated it was up to housekeeping to deep clean R9's room, launder any loose linens, and check to ensure there were no more bed bugs before allowing the resident to re-enter the room. MS-A stated he had noticed "a lot of stuff" in R9's room and the room looked like it	21730		

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21730	Continued From page 79 needed to be cleaned to make the bed bug treatment more effective. MS-A stated he had noted the bags and boxes in R9's room but did not think anyone had dealt with these items. MS-A stated he had checked one additional room for the spread of bed bugs, but this room did not share a wall and was separated by a hallway, a sitting area, and an elevator from R9's original room. MS-A was asked to confirm that he had not inspected the room that shared a wall with R9's room and he stated yes, he had only inspected the room that did not share a wall and was separated by a hallway, sitting area, and an elevator from R9's original room. During an interview on 7/31/24 at 1:34 p.m., the district manager for environmental services (DMES) stated he would have expected "edge to edge" cleaning, including the bed frame, all linens, all personal laundry, and curtains. The DMES agreed if grime and build-up were found on the bed frame he questioned if edge-to-edge had taken place. The DMES stated he did not expect housekeeping staff to bag up or clean personal items such as bags or boxes that were left in the resident's room. The DMES stated his staff was not responsible for assessing if bed bugs were still present before R9 moved back to her room. During an interview on 7/31/24 at 1:29 p.m., the associate administrator (AA) stated he began assisting with R9's bed bug issues this week but did not have knowledge of how it was handled the previous week. The AA stated he had been involved in moving R9 back to her original room on 7/29/24. The AA stated it should have been maintenance who assessed for bed bugs before R9 moved back to her room. The AA stated he had identified bed bugs on her bed after she had	21730		

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21730	Continued From page 80 called facility staff into her room on 7/29/24. The AA stated that RN-K and he had decided R9 needed to be again removed from that room and they now had a pest control company on their way to assess the room before R9 returned. During an interview on 7/31/24 at 1:40 p.m., the DOE stated they had not previously had a pest control company out to inspect and give recommendations for the current bed bug infestation but one was here now. The DOE stated he had started three months ago, and MS-A was helping to train him. The DOE stated that MS-A was the one who would know about how the bed bug infestation was managed. The DOE stated he did not have documentation showing any audits of other resident rooms on the unit or any documentation of the treatment used to manage the bed bug infestation in R9's original room. During an interview and observation on 7/31/24 at 1:44 p.m. in R9's original room, the outside pest control agent (PC)-A stated he had employee training on bed bug management that might be useful for the employees at the facility. PC-A stated it was important that all items that they could be, be placed in sealed bags and motioned at the bags and boxes on the floor. PC-A then stated it was important loose linens were also laundered and not left in the infested room and motioned to the loose linens on the floor and piling out of the resident closet. PC-A stated it was also important that the facility inspected the rooms near R9's room such as the room sharing a wall and the room below R9's room to ensure the bed bugs had not spread. The facility Bed Bug Protocol dated 3/14/24, indicated after staff were made aware of potential	21730		

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21730	Continued From page 81 bed bugs, staff would attempt to capture the bug with scotch tape and then call maintenance to confirm the bug was a bed bug. Maintenance staff would then notify the supervisor of the presence of bed bugs. Staff would then bathe the resident and move them to a different room leaving all personal belongings behind. Maintenance staff would complete the heat treatment and then notify housekeeping so they could deep clean the room. Once the deep clean was completed, housekeeping would notify the administrator and the director of nursing that it was safe to move the resident back into their room. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could educate staff regarding the importance of maintaining an effective pest control program. The DON or designee, could coordinate with maintenance and housekeeping staff to conduct periodic audits of areas residents frequent to ensure pests is controlled to ensure a clean, functional and homelike environment is maintained to the extent possible. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21730		
21805	MN St. Statute 144.651 Subd. 5 Patients & Residents of HC Fac.Bill of Rights Subd. 5. Courteous treatment. Patients and residents have the right to be treated with courtesy and respect for their individuality by employees of or persons providing service in a health care facility.	21805		9/17/24

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21805	Continued From page 82 This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide a dignified dining experience for 6 of 6 residents (R18, R15, R53, R142, R208, R386) who were seated at the dining room table with other residents who were served meals without being served meals themselves resulting in them waiting for their meals while tablemates dined and for 1 of 1 resident (R386) who was brought to the dining room ungroomed in a hospital gown. In addition, the facility failed to ensure dignity was maintained for 1 of 1 (R164) observed for lack of clothing in bed. Findings include: Dining R203's significant change Minimum Data Set (MDS), dated 7/2/24, indicated R203 was cognitively intact. During an interview on 7/29/24 at 1:51 p.m., R203 stated food trays would often sit out in a serving cart waiting to be served to residents for over 30 minutes, often causing food to be served cold and past scheduled mealtimes. During observation on 7/31/24 at 7:30 a.m., R53 and R208 were sitting out in the main dining area. R208 was sitting in her wheelchair with her head resting against the table. During observation on 7/31/24 at 8:30 a.m., breakfast trays were brought up and on the unit and four residents were sitting out in the main dining area, including R53 and R208. The four	21805	Corrected	

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21805	Continued From page 83 residents were seated without drinks or food. During observation on 7/31/24 at 8:36 a.m., R386 was brought out to the dining room in a hospital gown, a blanket over her lap and greasy, matted unbrushed hair. During observation and interview on 7/31/24 at 1:51 p.m., R386 was back in bed, family member (FM)-H was present and stated he had brought R386 clothes yesterday to wear, just one outfit because she had lost so much weight, and he was not sure what size clothes she wore. FM-H stated, "as long as her bottom isn't hanging out, that is the best we could hope for." During an interview on 8/1/24 at approximately 10:00 a.m., nurse manager and registered nurse (RN)-H voiced understanding of the importance of creating a dignified and home like dining experience for the residents. RN-H further confirmed she would not expect a resident to appear the way R386 looked, stating "I was surprised how her hair looked" and R386 should have had her hair brushed before going to the dining room. During observation on 7/31/24 at 8:50 a.m., an unnamed therapy staff member entered the dining room to see a resident for therapy and stated, "Oh! You haven't eaten yet" stating he would come back later to see the resident for therapy. During observation on 7/31/24 at 8:53 a.m., R80 was wheeled to the dining room and the first breakfast trays were being passed out. R80 was seated at a table with R53 and R208 and was immediately served her breakfast tray. R53, R80 and R208 still were not served any drinks and	21805		

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21805	Continued From page 84 R53 and R208 had been waiting approximately 1.5 hours for breakfast and were still not served. During observation on 7/31/24 at 8:58 a.m., at a second table R381 entered the dining room and was given her breakfast tray. R386 was still at the table without any food. During observation on 7/31/24 at 9:03 a.m., R53 and R208 were given their breakfast trays. R53, R80 and R208 were still not offered or served any drinks with their food. During observation on 7/31/24 at 9:15 a.m., R381 asked R386 if she was hungry and wanted something to eat, R386 responded by nodding her head "yes". R53, R80, and R208 were brought drinks after asking surveyor for something to drink. A facility aide brought over cranberry juice without asking what R53 or R208 would like to drink, even when they had asked for water. At 9:18 a.m., R386 was served her breakfast tray, 20 minutes after her tablemate R381. During an interview on 7/31/24 nursing assistant (NA)-M stated morning breakfast service was "a bit rough" that morning because he was the only NA on the floor who knew the residents. During an interview on 8/1/24 at 12:40 p.m., the director of nursing (DON) stated the facility, "could work on something" to ensure the residents had a home like, dignified dining experience. R18's significant change Minimum Data Set (MDS) assessment dated 7/8/24, identified R18 had severe cognitive impairment and required	21805		

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21805	Continued From page 85 moderate assistance of staff for eating. R142's significant change MDS assessment dated 7/20/24, identified R142 had severe cognitive impairment and required maximal assistance with eating. On 7/31/24 at 8:33 a.m., the breakfast meal service was observed on 5th floor main dining room. There were tables of resident's already eating who had been served their entrée. Observed was a square table that could seat four residents by the nursing station along the side of dining room with resident rooms where R18, R142 and tablemates were seated. R18 and R142's tablemates were served breakfast and were eating independently. At 8:47 a.m., R18 and R142's tablemate had finished eating and was talking on her cell phone at the table. At 8:48 a.m., R142 was served breakfast. At 8:50 a.m., an unidentified staff came back to the table with drinks for R142, sat down next to her to assist her to eat and told R18 to "sit back" as R18 was resting her head on the table (17 minutes after observation began). At 8:56 a.m., an unidentified staff served R18 breakfast and grabbed a chair to sit down next to assist her with eating (23 minutes after observation began). 7th Floor Observation R15's significant change MDS assessment 6/1/24, identified R15 with intact cognition and required set up assistance with eating. On 8/01/24 at 12:21 p.m., the afternoon meal was observed in the main dining room on 7th floor. R15 was seated at a table of four and two of his	21805		

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21805	Continued From page 86 tablemates had been served lunch. At 12:34 p.m., R15's third tablet mate received her food. At 12:35 p.m., R15 received his tray (14 minutes after observation began). During interview on 7/31/2024 at 10:29 a.m., nursing assistant (NA)-H stated that residents that are independent with eating are served meals first and residents who need help are served afterwards. NA-H verified that residents that need assistance with meals sit at tables with residents that don't need assistance with meals. NA-H stated they are responsible for getting room trays ready and delivered to resident rooms also. During interview on 7/31/24 at 2:26 p.m., licensed practical nurse (LPN)-C verified that meals are served by staff. They stated, "the people who need assistance are the last one who get their meals." LPN-C verified that residents who need assistance with meals sit with residents who are independent with eating. LPN-C verified that serving meals can take time as they serve a lot of residents. During interview on 7/31/24 at 2:28 p.m., registered nurse (RN)-I verified there is an order to how trays are delivered to residents. RN-I stated, "to my understanding, independent residents get their meals first, moderate assistance get their meals next and then the residents who need the most assistance get served last." RN-I verified the more assistance the resident needs with eating, the longer they must wait to be served. RN-I verified residents with different need levels sit together at tables. RN-I stated they think this is so there is more staff to help assist residents to eat.	21805		

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21805	Continued From page 87 Clothing R164's significant change Minimum Data Set (MDS) dated 10/12/23, indicated R164 had severely impaired cognition. R164's quarterly MDS dated 7/14/24, indicated R164 did not speak, rarely/never understood verbal content, and was diagnosed with dementia. In addition, R164 was dependent on staff for bed mobility, lower body dressing, and toileting hygiene. R164's care plan dated 7/19/24, indicated R164 required the assistance of two for dressing. During an interview on 7/29/24 at 2:49 p.m., resident representative (RR)-C stated she visited R164 almost daily. RR-C stated after staff would assist R164 to bed, she noticed his pants would often be left off, left around his ankles, or left around his knees. RR-C stated she knew this was something R164 would not like and would not have done if he was still dressing himself. RR-C stated she could tell that it "bugged" him, and it bugged her that they kept doing it. RR-C stated she had told staff previously, but the facility used "so many" agency staff it never seemed to be communicated to the incoming shifts that he didn't like this. RR-C stated that although she had told staff she didn't feel like she should have to tell people not to do that. During observation and interview on 7/30/24 at 2:04 p.m., R164 was observed in bed wearing a T-shirt and a brief with no pants on. Nursing Assistant (NA)-J stated he had assisted R164 to bed after lunch. NA-J stated he had taken and left R164's pants off so R164 did not "wet the bed" and his pants because then he would have to	21805		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEHOUSE HEALTHCARE & REHABILITATIO	3737 BRYANT AVENUE SOUTH MINNEAPOLIS, MN 55409

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21805	Continued From page 88 change both of those. NA-J stated he worked for an agency and had never worked with R164 previously and that was how he was taught to put people to bed. During an interview on 8/1/24 at 2:26 p.m., the director of nursing (DON) stated if R164 or his representative wished for R164's pants to be left on in bed, they should be left on. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON), or designee could develop and implement a plan of care by the interdisciplinary team to ensure residents dignity is being maintained. The facility could update policies and procedures, educate staff on these changes, and audit to ensure resident(s) dignity are maintained. The results of these audits will be reviewed by the quality assurance committee to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21805		

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	245055	A. BUILDING **01 - BUILDING 01** B. WING _____	**07/30/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEHOUSE HEALTHCARE & REHABILITATION CENTER	**3737 BRYANT AVENUE SOUTH** **MINNEAPOLIS, MN 55409**

(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	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 07/30/2024. At the time of this survey, Lakehouse Healthcare and Rehabilitation Center was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION	K 000		

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

Electronically Signed | 08/21/2024

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

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	245055	A. BUILDING **01 - BUILDING 01** B. WING _____	**07/30/2024**

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LAKEHOUSE HEALTHCARE & REHABILITATION CENTER	**3737 BRYANT AVENUE SOUTH** **MINNEAPOLIS, MN 55409**

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K 000	Continued From page 1 IS NOT REQUIRED. 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. Lakehouse Healthcare and Rehabilitation Center is an 8-story building with a full basement. The building was constructed at 2 different times. The original 5 story building was constructed in 1964 and was determined to be of Type II(222) construction. In 1983, an 8 story addition was constructed to the North that was determined to be of Type II(222) construction. Because the	K 000		

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	245055	A. BUILDING **01 - BUILDING 01** B. WING _____	**07/30/2024**

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K 000	Continued From page 2 original building and the 1 addition are of the same type of construction, the facility was surveyed as one building. The facility is fully protected throughout by an automatic fire sprinkler system and has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 260 beds and had a census of 228 at the time of the survey.	K 000		
K 211 SS=E	The requirements at 42 CFR, Subpart 483.70(a), are NOT MET as evidenced by: Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain clear path of egress per NFPA 101 (2012 edition), Life Safety Code, sections 19.2.3.3, 19.2.1, and 7.1.10.1. These deficient findings could have a patterned impact on the residents within the facility. Findings include:	K 211	Egress Corridors on 3,4 and 5 of Raines will have cleared pathways Pallets were removed from egress corridor near loading dock Chairs in the egress corridor outside of rooms 330 through 334 have been removed Egress corridors on Raines, near the loading dock will be checked. Director of Maintenance, Housekeeping,	9/17/24

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	245055	A. BUILDING **01 - BUILDING 01** B. WING _____	**07/30/2024**

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K 211	Continued From page 3 1. On 07/30/2024 between 09:00 AM and 02:15 PM, it was revealed by observation that there was storage in the egress corridors on floors three, four, and five in the rains building. 2. On 07/30/2024 at 12:58 PM, it was revealed by observation that pallets were being stored in the egress corridor near the loading dock. 3. On 07/30/2024 at 01:14 PM, it was revealed by observation that there were chairs in the egress corridor outside of rooms 330 through 334. An interview with the Administrator, Director of Maintenance, Maintenance Supervisor, and Operations Consultant verified these deficient findings at the time of discovery.	K 211	and Department Heads will be educated on egress corridors. Director of Maintenance/Designee will audit random egress corridors weekly x 4 and then monthly x 2. Results will be presented to QAPI committee	
K 225 SS=D	Stairways and Smokeproof Enclosures CFR(s): NFPA 101 Stairways and Smokeproof Enclosures Stairways and Smokeproof enclosures used as exits are in accordance with 7.2. 18.2.2.3, 18.2.2.4, 19.2.2.3, 19.2.2.4, 7.2 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain stairwell enclosures per NFPA 101 (2012 edition), Life Safety Code, sections 19.2.2.3, 7.2.2.5.1.1, and 7.1.3.2 (1). This deficient finding could have an isolated impact on the residents within the facility. Findings include:	K 225	Penetrations in the west stairwell on the 5th floor above the doors have been closed. Maintenance Team will be educated on penetrations Director of Maintenance/Designee will audit random areas above stairwell doors weekly x 4 and then monthly x 2. Results will be presented to QAPI	9/17/24

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K 225	Continued From page 4 On 07/30/2024 at 11:23 AM, it was revealed by observation that there was a penetration into the west stairwell on the 5th floor above the doors caused by a low voltage wire. An interview with the Director of Maintenance and the Operations Consultant verified this deficient finding at the time of discovery.	K 225	committee	
K 291 SS=C	Emergency Lighting CFR(s): NFPA 101 Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to test emergency lighting per NFPA 101 (2012 edition), Life Safety Code, sections 19.2.9.1 and 7.9.3.1.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 07/30/2024 between 09:00 AM and 02:15 PM, it was revealed by a review of available documentation that the emergency lighting documentation that was presented at the time of the survey did not list locations for the emergency lighting that had been tested. An interview with the Administrator and Director of Maintenance verified this deficient finding at the time of discovery.	K 291	Emergency Lighting will have the locations of the lighting added Maintenance Team will be educated on lighting location documentation Director of Maintenance and/or designee will monitor and maintain compliance with this regulation as required in NFPA 101,(2012 Edition). Results will be presented to QAPI committee	9/17/24

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K 293	Continued From page 5	K 293		
K 293 SS=E	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: Based on observation, and staff interview, the facility failed to maintain exit signs per NFPA 101 (2012 edition), Life Safety Code, sections 19.2.10.1, 7.10.5.1, and 7.10.5.2.1. These deficient findings could have a patterned impact on the residents within the facility. Findings include: 1. On 07/30/2024 at 12:32 PM, it was revealed by observation that the exit sign above the door exiting out of the therapy break room was not illuminated. 2. On 07/30/2024 at 01:01 PM, it was revealed by observation the exit sign on 1 rains near room 179 was not illuminated. 3. On 07/30/2024 at 01:26 PM, it was revealed by observation the exit sign on 4 rains near the south stairwell was not fully illuminated. 4. On 07/30/2024 at 01:35 PM, it was revealed by observation that the exit sign near the south stair	K 293	Exit sign above the door exiting out the therapy break room, on 1 raines near room 179, on 4 raines near the south stairwell and near the raines basement south stairwell have been fixed . Exit signs in raines will be reviewed. Director of Maintenance/Designee will audit random exit signs weekly x 4 and then monthly x 2. Results will be presented to QAPI committee	9/17/24

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K 293	Continued From page 6 in the rains building basement was not illuminated. An interview with the Administrator, Director of Maintenance, Maintenance Supervisor, and Operations Consultant verified these deficient findings at the time of discovery.	K 293		
K 324 SS=E	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 This REQUIREMENT is not met as evidenced by: Based on observation, a review of available documentation, and staff interview, the facility	K 324	Kitchen Hood has been inspected Residential stoves in third floor dining	9/17/24

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K 324	Continued From page 7 failed to install the required safety features for cooking equipment and inspect the kitchen hood per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.2.5.1, 19.3.2.5.3 (9) and 19.3.2.5.4, and NFPA 96 (2011 edition), Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, section 11.2.1. These deficient findings could have a patterned impact on the residents within the facility. Findings include: 1. On 07/30/2024 between 09:00 AM and 02:15 PM, it was revealed by a review of available documentation that at the time of the survey the facility could not provide documentation showing that their kitchen hood had been inspected within 6 months from the last inspection that was completed on 01/17/2024. 2. On 07/30/2024 at 12:16 PM, it was revealed by observation that the residential stove on the third floor in the dining room did not have a locked switch, or a switch located in a restricted location that is on a timer, not exceeding a 120-minute capacity, that automatically deactivates the cooktop or range, independent of staff action. 3. On 07/30/2024 at 12:33 PM, it was revealed by observation that the residential stove located in the therapy break room did not have a locked switch, or a switch located in a restricted location that is on a timer, not exceeding a 120-minute capacity, that automatically deactivates the cooktop or range, independent of staff action. 4. On 07/30/2024 at 12:35 PM, it was revealed by	K 324	room, therapy breakroom, in the chapel, and senior club have been corrected. Director of Maintenance and/or designee will monitor and maintain compliance with this regulation as required in NFPA 101,(2012 Edition). Results will be presented to QAPI committee	

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K 324	Continued From page 8 observation that the residential stove located in the chapel did not have a locked switch, or a switch located in a restricted location that is on a timer, not exceeding a 120-minute capacity, that automatically deactivates the cooktop or range, independent of staff action. 5. On 07/30/2024 at 12:33 PM, it was revealed by observation that the residential stove located in the senior club did not have a locked switch, or a switch located in a restricted location that is on a timer, not exceeding a 120-minute capacity, that automatically deactivates the cooktop or range, independent of staff action. An interview with the Administrator, Director of Maintenance, Maintenance Supervisor, and Operations Consultant verified these deficient findings at the time of discovery.	K 324		
K 346 SS=C	Fire Alarm System - Out of Service CFR(s): NFPA 101 Fire Alarm - Out of Service Where required fire alarm system is out of services for more than 4 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.6 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 alarm out-of-service policy per NFPA 101 (2012 edition), Life Safety Code, section 9.6.1.6. This	K 346	The contact information on the fire alarm policy was updated Director of Maintenance and/or designee will monitor and maintain compliance with	9/17/24

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K 346	Continued From page 9 deficient finding could have a widespread impact on the residents within the facility. Findings include: On 07/30/2024 between 09:00 AM and 02:15 PM, it was revealed by a review of available documentation that the fire alarm out-of-service policy that the facility provided at the time of the survey did not have the correct contact information for authority having jurisdiction (Minnesota State Fire Marshal Division). An interview with the Administrator, Director of Maintenance, Maintenance Supervisor, and Operations Consultant verified this deficient finding at the time of discovery.	K 346	this regulation as required in NFPA 101,(2012 Edition). Results will be presented to QAPI committee	
K 351 SS=E	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 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.	K 351		9/17/24

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K 351	Continued From page 10 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 interviews, the facility failed to install the fire sprinkler system per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.5.1 and 9.7.5, and NFPA 13 (2010 edition), Standard for the Installation of Sprinkler Systems, sections 8.15.5.1, 8.15.5.2, 8.15.5.3, 8.15.5.4, 8.15.2.1, and 8.15.2.3. These deficient findings could have a patterned impact on the residents within the facility. Findings include: 1. On 07/30/2024 at 01:10 PM, it was revealed by observation and staff interview that at the time of the survey, the Maintenance Supervisor informed surveyors that they did not think that the shaft for the dumb waiter had fire sprinklers installed in it and it could not be verified if there were. 2. On 07/30/2024 at 01:44 PM, it was revealed by observation and staff interview that there did not appear to be fire sprinklers located in the elevator shaft for elevators 5 and 6, and the Maintenance Supervisor did not know if there were fire sprinklers installed in the elevator shaft. An interview with the Administrator, Director of Maintenance, Maintenance Supervisor, and Operations Consultant verified these deficient findings at the time of discovery.	K 351	Sprinklers in the dumb waiter and 5 and 6 elevators shafts will be identified or added. Director of Maintenance and/or designee will monitor and maintain compliance with this regulation as required in NFPA 101,(2012 Edition). Results will be presented to QAPI committee	
K 353 SS=E	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing	K 353		9/17/24

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LAKEHOUSE HEALTHCARE & REHABILITATION CENTER	**3737 BRYANT AVENUE SOUTH MINNEAPOLIS, MN 55409**

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K 353	Continued From page 11 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 their sprinkler system per NFPA 101 (2012 edition), Life Safety Code, section 9.7.1.1 and 9.7.5, NFPA 25 (2011 edition), Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, sections 4.1.5, 4.1.5.2 (3), 4.1.6.1, 4.1.6.2, 5.1.1.2, 5.2.1.1.1, and 5.2.1.1.2 and NFPA 13 (2010 edition), Standard for the Installation of Sprinkler Systems, section 8.6.4.1.1.1. These deficient findings could have a patterned impact on the residents within the facility. Findings include: 1. On 07/30/2024 at 11:15 AM, it was revealed by observation that there were two sprinklers missing escutcheon plates in the stairwell going to the	K 353	Escutcheon plates were added to the two sprinkler heads in the stairwell going to the penthouse. The escutcheon plates in the therapy break room, on 4R South near room 581, and in central supply near the exit door have been replaced. The wires resting on the sprinkler pipes in the IT room on the 5th floor, and near resident room 324 have been corrected Maintenance team will be educated on escutcheon plates Director of Maintenance/Designee will audit random escutcheon plates weekly x 4 and then monthly x 2.	

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	245055	A. BUILDING **01 - BUILDING 01** B. WING _____	**07/30/2024**

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K 353	Continued From page 12 Penthouse. 2. On 07/30/2024 at 11:32 AM, it was revealed by observation that there were wires resting on the sprinkler pipe in the I.T. room on the 5th floor. 3. On 07/30/2024 at 12:07 PM, it was revealed by observation that there were wires resting on the sprinkler pipe above the ceiling near resident room 324. 4. On 07/30/2024 at 12:34 PM, it was revealed by observation that there were two sprinklers missing escutcheon plates and one that the ceiling tile was sagging down blocking the sprinkler in the therapy break room. 5. On 07/30/2024 at 01:23 PM, it was revealed by observation that there were two sprinklers missing escutcheon plates on 4R south near room 581. 6. On 07/30/2024 at 01:38 PM, it was revealed by observation that there was one sprinkler in the central supply room near the exit door that was missing an escutcheon plate. An interview with the Administrator, Director of Maintenance, Maintenance Supervisor, and Operations Consultant verified these deficient findings at the time of discovery.	K 353		
K 354 SS=C	Sprinkler System - Out of Service CFR(s): NFPA 101 Sprinkler System - Out of Service Where the sprinkler system is impaired, the extent and duration of the impairment has been determined, areas or buildings involved are	K 354		9/17/24

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K 354	Continued From page 13 inspected and risks are determined, recommendations are submitted to management or designated representative, and the fire department and other authorities having jurisdiction have been notified. Where the sprinkler system is out of service for more than 10 hours in a 24-hour period, the building or portion of the building affected are evacuated or an approved fire watch is provided until the sprinkler system has been returned to service. 18.3.5.1, 19.3.5.1, 9.7.5, 15.5.2 (NFPA 25) 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 sprinkler out-of-service policy per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.5.1 and 9.7.5, and NFPA 25 (2011 edition), Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, section 15.5.2. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 07/30/2024 between 09:00 AM and 02:15 PM, it was revealed by a review of available documentation that the fire sprinkler out-of-service policy that the facility provided at the time of the survey did not have the correct contact information for authority having jurisdiction (Minnesota State Fire Marshal Division). An interview with the Administrator, Maintenance Supervisor, and Operations Consultant verified this deficient finding at the time of discovery.	K 354	The contact information on the sprinkler policy was updated Director of Maintenance and/or designee will monitor and maintain compliance with this regulation as required in NFPA 101,(2012 Edition). Results will be presented to QAPI committee	
K 355	Portable Fire Extinguishers	K 355		9/17/24

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K 355 SS=F	Continued From page 14 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, a review of available documentation, and staff interview, the facility failed to inspect fire extinguishers per NFPA 101 (2012 edition), Life Safety Code sections 19.3.5.12 and 9.7.4.1, and NFPA 10 (2010 edition), Standard for Portable Fire Extinguishers, sections 6.1.3.8.2, 7.2.1.2 and 7.3.1.1.1. These deficient finding could have a widespread impact on the residents within the facility. Findings include: 1. On 07/30/2024 between 09:00 AM and 2:15 PM, it was revealed by observation the annual inspection for the fire extinguisher located by room 402 expired in 2023. 2. On 07/30/2024 between 09:00 AM and 2:15 PM, it was revealed by observation on the following extinguishers were not inspected for the month of June 2024. Only a sample of extinguishers were inspected by this surveyor. The following locations are as follows: - East Penthouse - By Resident room 176 -Senior Club in Kitchenette -1 Raines nurses station -By Resident Room 376 -Elevator Equipment Room	K 355	Fire extinguisher near room 402, and extinguishers in the east penthouse, by resident room 176, senior club kitchenette, 1 raines nurses' station, by resident room 376, and elevator equipment room have been inspected. Fire extinguisher by 1 raines has been moved. Director of Maintenance and/or designee will monitor and maintain compliance with this regulation as required in NFPA 101,(2012 Edition). Results will be presented to QAPI committee	

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K 355	Continued From page 15 3. On 07/30/2024 between 09:00 AM and 2:15 PM, it was revealed by observation a fire extinguisher located by the 1 Raines Nurses station was mounted at 68 inches. An interview with the Administrator and Maintenance Supervisor verified these deficient findings at the time of discovery.	K 355		
K 363 SS=D	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other	K 363		9/17/24

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K 363	Continued From page 16 materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain corridor doors per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.6.3.1. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 07/30/2024 at 12:13 PM, it was revealed by observation that there was a hole in the door to the mother's room (3W15). An interview with the Director of Maintenance and Operations Consultant verified this deficient finding at the time of discovery.	K 363	Hole in door in mothers room (3W15) has been corrected Director of Maintenance and/or designee will monitor and maintain compliance with this regulation as required in NFPA 101,(2012 Edition). Results will be presented to QAPI committee	
K 521 SS=F	HVAC CFR(s): NFPA 101 HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2	K 521		9/17/24

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K 521	Continued From page 17 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to inspect fire dampers per NFPA 101 (2012 edition), Life Safety Code, section 8.5.5.4.2, and NFPA 105 (2010 edition), Standard for Smoke Door Assemblies and Other Opening Protectives, section 6.5.2 and 6.5.12. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 07/30/2024 between 09:00 AM and 02:15 PM, it was revealed by a review of available documentation that at the time of the survey the facility could not provide an updated damper inspection report the last damper inspection was completed on 7/14/2020. An interview with the Administrator and Director of Maintenance verified this deficient finding at the time of discovery.	K 521	Damper inspection has been completed. Director of Maintenance and/or designee will monitor and maintain compliance with this regulation as required in NFPA 101,(2012 Edition). Results will be presented to QAPI committee	
K 541 SS=D	Rubbish Chutes, Incinerators, and Laundry Chu CFR(s): NFPA 101 Rubbish Chutes, Incinerators, and Laundry Chutes 2012 EXISTING (1) Any existing linen and trash chute, including pneumatic rubbish and linen systems, that opens directly onto any corridor shall be sealed by fire resistive construction to prevent further use or shall be provided with a fire door assembly having a fire protection rating of 1-hour. All new chutes shall comply with 9.5.	K 541		9/17/24

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K 541	Continued From page 18 (2) Any rubbish chute or linen chute, including pneumatic rubbish and linen systems, shall be provided with automatic extinguishing protection in accordance with 9.7. (3) Any trash chute shall discharge into a trash collection room used for no other purpose and protected in accordance with 8.4. (Existing laundry chutes permitted to discharge into same room are protected by automatic sprinklers in accordance with 19.3.5.9 or 19.3.5.7.) (4) Existing fuel-fed incinerators shall be sealed by fire resistive construction to prevent further use. 19.5.4, 9.5, 8.4, NFPA 82 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain laundry chutes per NFPA 101 (2012 edition), Life Safety Code, section 19.5.4.1. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 07/30/2024 at 11:11 AM, it was revealed by observation the door to the laundry chute in the soiled utility room 6N29 on the 6th floor does not self-close. An interview with the Director of Maintenance and Operations Consultant verified this deficient finding at the time of discovery.	K 541	Laundry chute door on 6 Gamble was repaired Director of Maintenance and/or designee will monitor and maintain the facility laundry chute doors in order to work properly and maintain compliance with NFPA 101, (2012 Edition). Results will be presented to QAPI committee	
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 conditions. Fire drills are held at expected and unexpected	K 712		9/17/24

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K 712	Continued From page 19 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 per NFPA 101 (2012 edition), Life Safety Code sections 19.7.1.4 and 19.7.1.6. These deficient findings could have a widespread impact on the residents within the facility. Findings include: 1. On 07/30/2024 between 09:00 AM and 02:15 PM, it was revealed by a review of available documentation that at the time of the survey the facility could not provide documentation showing that a fire drill was conducted during the second shift during the first quarter of 2024. 2. On 07/30/2024 between 09:00 AM and 02:15 PM, it was revealed by a review of available documentation that at the time of the survey the facility could not provide documentation showing that a fire drill was conducted during the third shift during the second quarter of 2024. 3. On 07/30/2024 between 09:00 AM and 02:15 PM, it was revealed by a review of available documentation that at the time of the survey the facility could not provide documentation showing that a fire drill was conducted during the second or third shifts during the fourth quarter of 2023.	K 712	Fire drills will be conducted as per regulations. Director of Maintenance and/or designee will maintain compliance with NFPA 101, (2012 Edition). Results will be presented to QAPI committee	

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K 712	Continued From page 20 4. On 07/30/2024 between 09:00 AM and 02:15 PM, it was revealed by a review of available documentation that the fire alarm was not sounded during the fire drill that took place on 6/27/2024 at 08:30 PM. An interview with the Director of Maintenance and Operations Consultant verified these deficient findings at the time of discovery.	K 712		
K 741 SS=C	Smoking Regulations CFR(s): NFPA 101 Smoking Regulations Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. (2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (3) Smoking by patients classified as not responsible shall be prohibited. (4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision. (5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is	K 741		9/17/24

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K 741	Continued From page 21 permitted. 18.7.4, 19.7.4 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to implement the smoking policy per NFPA 101 (2012 edition), Life Safety Code, section 19.7.4. These deficient findings could have a patterned impact on the residents within the facility. Findings include: 1. On 07/30/2024 at 01:47 PM, it was revealed by observation that the smoking area in the front and side of the building was unkept, with 50 plus discarded cigarettes on the sidewalk. 2. On 07/29/2024 at 2:04 PM, it was revealed by observation of a MDH Surveyor that the patient in Room 505-1 has multiple cigarette packs in their possession, one they have full and an empty one. There is a small white trash can with combustibles next to the bedside dresser that has multiple crushed butts in there. When the MDH Surveyor interviewed the resident, the resident said that they crushes them outside and place them in the small garbage can next to the bedside dresser. When LSC Surveyors arrived we walked into the room and the resident was not in the room and there were 2 staff members in the room. Garbages were recently emptied and no cigarette butts were found. An interview with the Administrator, Director of Maintenance and Maintenance Supervisor verified these deficient findings at the time of discovery.	K 741	Cigarette buts have been cleaned up. Residents are not permitted to smoke in their room. Director of Maintenance and/or designee will maintain compliance with NFPA 101, (2012 Edition).	

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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 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	K 918	Monthly generator checks and weekly	9/17/24

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K 918	Continued From page 23 staff interview, the facility failed to test their Emergency Power Supply System (EPSS) per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.4.4.1.1.3, and NFPA 110 (2010 edition), Standard for Emergency and Standby Power Systems, sections 8.3.4, 8.3.4.1 and 8.4.1. These deficient findings could have a widespread impact on the residents within the facility. Findings include: 1. On 07/30/2024 at 10:20 AM, it was revealed by a review of available documentation the facility failed to provide documentation for monthly generator testing on Generator 1 for April, May, and June of 2024. 2. On 07/30/2024 at 10:20 AM, it was revealed by a review of available documentation the facility failed to provide documentation for weekly generator inspections for Generator 1 for 03/08/2024 and exceeded the timeframe for the weeks of 09/13/2023- 09/28/2023, 10/02/2023-10/25/2023, 11/01/2023-11/14/2023. 3. On 07/30/2024 at 10:25 AM, it was revealed by a review of available documentation the facility failed to provide documentation for monthly generator testing on Generator 2 for June 2024. 4. On 07/30/2024 at 10:25 AM, it was revealed by a review of available documentation the facility exceeded the timeframe for the weekly inspections for the weeks of 11/01/2023 and 11/14/2023 and 01/05/2024-01/19/2024. An interview with the Director of Maintenance,	K 918	checks will be conducted timely Director of Maintenance and/or designee will maintain compliance with NFPA 101, (2012 Edition).	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245055	A. BUILDING **01 - BUILDING 01** B. WING _____	**07/30/2024**

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LAKEHOUSE HEALTHCARE & REHABILITATION CENTER	**3737 BRYANT AVENUE SOUTH** **MINNEAPOLIS, MN 55409**

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K 918	Continued From page 24 Maintenance Supervisor and Administrator verified this deficient finding at the time of discovery.	K 918		
K 920 SS=E	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the usage of electrical adaptive devices NFPA 99 (2012 edition), Health Care Facilities Code, sections 10.5.2.3.1 and 10.2.4.2.1, NFPA 101 (2012 edition), Life Safety Code, section 9.1.2, NFPA 70, (2011 edition), National Electrical Code, sections 400.8, and UL 1363. These deficient findings could have a	K 920	Power strips and extension cord in 609 have been removed from each other. Extension cord that was being used for the steamer has been removed. Power strip in central supply office has been unplugged The refrigerator and microwave plugged in to the extension cord have been	9/17/24

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	245055	A. BUILDING **01 - BUILDING 01** B. WING _____	**07/30/2024**

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LAKEHOUSE HEALTHCARE & REHABILITATION CENTER	**3737 BRYANT AVENUE SOUTH MINNEAPOLIS, MN 55409**

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K 920	Continued From page 25 patterned impact on the residents within the facility. Findings include: 1. On 07/30/2024 at 09:16 AM, it was revealed by observation that there was a power strip plugged into another power strip and an extension cord plugged into the second power strip in resident room 609. 2. On 07/30/2024 at 12:15 PM, it was revealed by observation that there was an extension cord being used to plug in two steamers in the kitchen. 3. On 07/30/2024 at 01:37 PM, it was revealed by observation that there was a refrigerator and a microwave plugged into a power strip in the lower level central supply room (office 5). 4. On 07/30/2024 at 01:39 PM, it was revealed by observation that there was an extension cord that went through the ceiling grid and back out to a desk that was plugging in a power strip in the middle of the room. An interview with the Administrator, Maintenance Supervisor, and Operations Consultant verified this deficient finding at the time of discovery.	K 920	disconnected from the power strip. Director of Maintenance and/or designee will maintain compliance with NFPA 101, (2012 Edition).	
K 923 SS=D	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and	K 923		9/17/24

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K 923	Continued From page 26 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited-combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain oxygen storage per NFPA 99 (2012 edition), Health Care Facilities Code, sections 11.3.2.6 and 11.6.2.3 (11). This deficient	K 923	O2 cylinder near the rear elevators on the third floor has been secured. Director of Maintenance and/or designee will maintain compliance with NFPA 101,	

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K 923	Continued From page 27 finding could have an isolated impact on the residents within the facility. Findings include: On 07/30/2024 at 01:17 PM, it was revealed by observation that there was one green oxygen cylinder near the rear elevators on third floor that was not secured in a rack or cart. An interview with the Administrator, Maintenance Supervisor, and Operations Consultant verified this deficient finding at the time of discovery.	K 923	(2012 Edition	
K 930 SS=E	Gas Equipment - Liguid Oxygen Equipment CFR(s): NFPA 101 Gas Equipment - Liquid Oxygen Equipment The storage and use of liquid oxygen in base reservoir containers and portable containers comply with sections 11.7.2 through 11.7.4 (NFPA 99). 11.7 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to store liquid oxygen per NFPA 99 (2012 edition), Health Care Facilities Code, section 11.7.4. This deficient finding could have an isolated impact on the residents within the facility Findings include: On 07/30/2024 at 01:17 PM, it was revealed by observation that there was one liquid oxygen container being stored near the rear elevators on the third floor. An interview with the Administrator, Maintenance	K 930	O2 cylinder near the rear elevators on the third floor has been secured. Director of Maintenance and/or designee will maintain compliance with NFPA 101, (2012 Edition).	9/17/24

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K 930	Continued From page 28 Supervisor, and Operations Consultant verified this deficient finding at the time of discovery.	K 930		

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
September 27, 2024

Administrator
Lakehouse Healthcare & Rehabilitation Center
3737 Bryant Avenue South
Minneapolis, MN 55409

RE: CCN: 245055
Cycle Start Date: August 1, 2024

Dear Administrator:

On September 25, 2024, the Minnesota Departments of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Correction of the Life Safety Code deficiency(ies) cited under K351 at the time of the August 1, 2024 survey, has not yet been verified. Your plan of correction for this deficiency, including your request for a temporary waiver with a date of completion of February 1, 2025, has been forwarded to the Region V Office of the Centers for Medicare and Medicaid Services (CMS) for their review and determination. Failure to come into substantial compliance with this deficiency by the date indicated in your plan of correction may result in the imposition of enforcement remedies.

Feel free to contact me if you have questions.

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

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

September 27, 2024

Administrator
Lakehouse Healthcare & Rehabilitation Center
3737 Bryant Avenue South
Minneapolis, MN 55409

Re: Reinspection Results
Event ID: KS9F12

Dear Administrator:

On September 19, 2024 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on August 1, 2024. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

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