Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
February 14, 2025

Administrator
The Estates At Bloomington LLC
9200 Nicollet Avenue South
Bloomington, MN 55420

RE: CCN: 245324
Cycle Start Date: January 30, 2025

Dear Administrator:

On January 30, 2025, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Stefanie Salberg, Regional Operations Supervisor
Metro B District Office
Health Regulation Division
Minnesota Department of Health
625 Robert Street N
P.O. Box 64975
Saint Paul, Minnesota 55164-0975
Email: stefanie.salberg@state.mn.us
Office: 651-201-4393 Mobile: 651-279-5602

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 April 30, 2025 (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 July 30, 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)

In accordance with 42 CFR 488.331 **and Minnesota Statute 144A.10 subd 15**, 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: **https://forms.web.health.state.mn.us/form/NHDisputeResolution**

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. 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.

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. 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: https://forms.web.health.state.mn.us/form/NHDisputeResolution

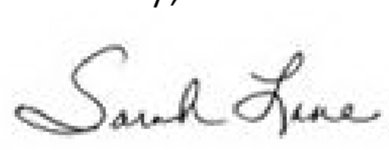
A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

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,



Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us

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February 14, 2025

Administrator
The Estates At Bloomington LLC
9200 Nicollet Avenue South
Bloomington, MN 55420

Re: State Nursing Home Licensing Orders
Event ID: KX3O11

Dear Administrator:

The above facility was surveyed on January 27, 2025 through January 30, 2025 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:

Stefanie Salberg, Regional Operations Supervisor
Metro B District Office
Health Regulation Division
Minnesota Department of Health
625 Robert Street N
P.O. Box 64975
Saint Paul, Minnesota 55164-0975
Email: stefanie.salberg@state.mn.us
Office: 651-201-4393 Mobile: 651-279-5602

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

Please feel free to call me with any questions.

Sincerely,

Sarah Lane

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245324	A. BUILDING _____ B. WING _____	C 01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ESTATES AT BLOOMINGTON LLC	9200 NICOLLET AVENUE SOUTH BLOOMINGTON, MN 55420

(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 1/27/25 to 1/30/25, a survey for compliance with CMS Appendix Z, the Emergency Preparedness Requirements, was conducted during a standard recertification survey. The Estates at Bloomington was found to be in compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On 1/27/25 to 1/30/25, a standard recertification survey was conducted by surveyors from the Minnesota Department of Health (MDH). In addition, multiple complaint investigations were also completed. The Estates at Bloomington was found not in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed with no associated deficiencies issued: H53246005C (MN99852) H53246001C (MN100820) H53246002C (MN101938) H53246003C (MN105784) H53246004C (MN107534) H53246006C (MN108153) H53245600C (MN109889) The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are	F 000		

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

Electronically Signed | 02/24/2025

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

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F 000	Continued From page 1 enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F 000		
F 584 SS=D	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	F 584		3/10/25

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F 584	Continued From page 2 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 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 a comfortable and homelike environment for 2 of 2 residents (R19, R23) who shared a room with a large area of the wall patched but left unfinished, unsanded, and unpainted. Findings include: R19's quarterly Minimum Data Set (MDS) dated 12/10/24, identified R19 had intact cognition. R23's annual MDS dated 12/9/24, identified had intact cognition. During observation and interview on 1/27/25 at 6:01 p.m., a shared wall of R19 and R23's room had an area of white joint compound that measured one hundred and three inches long by thirty-seven inches tall spanning most of the wall. The area was not sanded, smoothed out, or painted to match the rest of the wall and room. R23 stated, "the wall has been like this since [sic] moved to this room in October of 2024."	F 584	R19 and R23's shared room was painted. Full house audit completed to identify painting needs in resident rooms and work orders submitted. Facility will continue to work on any other identified rooms in need of painting or general repairs to ensure a homelike environment. Staff education completed on submitting and completing work orders through TELS. Audit 5 resident rooms for wall damage and repairs weekly x 4 weeks. The results of these audits will be reviewed at the facility QAPI meeting for input on the need to increase, decrease, or discontinue the audits. Corrections will be monitored by: Administrator/ Designee	

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F 584	Continued From page 3 During interview with registered nurse (RN)-B on 1/28/25 at 10:01 a.m., RN-B stated she was familiar with all the residents. RN-B stated there was an expectation of staff to notify the maintenance staff for repair work through an email request form. "All staff can do it." RN-B denied noticing the unfinished wall repair in R19 and R23's room or submitting a maintenance request to complete the sanding and painting. During interview with nursing assistant (NA)-A on 1/28/25 at 10:25 a.m., NA-A stated she was familiar with all the residents. NA-A stated staff were expected to notify the maintenance staff for repair work, "online. If [maintenance director] is not here, I may talk to the nurse manager." NA-A denied noticing the unfinished wall repair in R19 and R23's room or submitting a maintenance request to complete the sanding and painting. During interview on 1/28/25 at 10:44 a.m., R23's stated, "I don't like it because it tells me the place has not been totally taken care of and not necessarily clean. I would never stand for that in my own home." During interview with NA-B on 1/28/25 at 11:00 a.m., NA-B stated she was familiar with the residents. NA-B stated expectation of staff to notify the maintenance staff for repair work "in the computer". NA-B denied noticing the unfinished wall repair in R19 and R23's room or submitting a maintenance request to complete the sanding and painting. During interview with NA-C on 1/28/25 at 11:12 a.m., NA-C stated she was familiar with all the residents. NA-A stated expectation of staff to notify the maintenance staff for repair work	F 584		

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F 584	Continued From page 4 through an email request form. NA-C denied noticing the unfinished wall repair in R19 and R23's room or submitting a maintenance request to complete the sanding and painting. During observation and interview on 1/28/25 at 11:26 a.m., LPN-B looked at R19 and R23's shared wall and stated, "I don't know when they [maintenance staff] did that work on the wall but it is not finished. It does not look good. I have not noticed that before." At 2:02 p.m., LPN-B stated staff was expected to use a communication system with the maintenance department if a repair was needed, "like for painting a hallway or resident room." During observation and interview with the maintenance director (MD) on 1/28/25 at 12:14 p.m., MD looked at R19's and R23's bedroom wall and stated, "I have patched this. In order for me to paint, I have to pull everyone out of their rooms, and we have been full lately. And we don't have the colors in here anymore. We don't have rooms to put [R19 and R23] in. If I had extra room to put these residents in while I fix the paint, then I would be able to do something about it." MD stated he could not remember when he patched their wall. MD stated he did not have a work order or documentation of ever working on the wall but that he was aware of it needing to be "fixed". During interview with R19 and R23 on 1/30/25 at 9:25 a.m., R19 stated, "it [wall patch] has been here since I got here. I think at one point [maintenance] was fixing something on the wall over there [pointing to R23's side of the room] and he did this. Looking at it makes me think it is dirty, not cared for. I don't like it. I would like it painted." R23 stated, "I am embarrassed by it."	F 584		

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F 584	Continued From page 5 During interview with assistant director of nursing (ADON) on 1/30/25 at 10:50 a.m., ADON stated, "the wall should be painted. Don't know how long that is has been there. It is not appealing." Facility policy on building maintenance and repair was requested and not received.	F 584		
F 676 SS=D	Activities Daily Living (ADLs)/Mntn Abilities CFR(s): 483.24(a)(1)(b)(1)-(5)(i)-(iii) §483.24(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that: §483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section ... §483.24(b) Activities of daily living. The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living: §483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care, §483.24(b)(2) Mobility-transfer and ambulation, including walking,	F 676		3/10/25

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F 676	Continued From page 6 §483.24(b)(3) Elimination-toileting, §483.24(b)(4) Dining-eating, including meals and snacks, §483.24(b)(5) Communication, including (i) Speech, (ii) Language, (iii) Other functional communication systems. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure dental appliances (i.e., dentures) were offered or provided to promote safety and independence with eating for 1 of 4 residents (R60) reviewed for activities of daily living (ADL). Findings include: R60's quarterly Minimum Data Set (MDS), dated 11/19/24, identified R60 had severe cognitive impairment and demonstrated no rejection of care behaviors. Further, the MDS outlined R60 needed substantial and/or maximum assistance to complete oral hygiene (inc. dentures). R60's most recent MHM (Monarch Healthcare Management) Oral/Dental Evaluation, dated 11/18/24, identified R60's oral cavity had no issues and R60 used an upper and lower denture with their condition being recorded, "Good condition." R60 was recorded as edentulous (no natural teeth) and a summary outlined, "Resident wears full upper and lower dentures. He denies pain with chewing. He is dependent on staff to perform oral hygiene. No mouth sores noted with oral inspection." The completed evaluation lacked evidence R60 refused to wear his dentures.	F 676	R60 was offered to have his dentures applied and R60 refused. A new oral assessment was completed, and care plan & NAR guide were updated with his current plan for denture cares. Full house audit completed to identify others with dentures or partials. Resident care plans and NAR guides were reviewed to ensure they list the individualized plan for oral cares. Clinical leaders educated to ensure the individualized plan for oral care is documented in the oral assessment and is reflected in the care plan and NAR guides Education with all nursing staff to follow the care plan/NAR guide regarding oral cares/dentures including what to do if resident refuses. Audit oral assessments for 3 residents with dentures/partials weekly x 4 weeks to ensure refusals are documented and information on the oral assessments are in the NAR guide and care plan. The	

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F 676	Continued From page 7 On 1/27/25 at 1:36 p.m., R60 was observed seated in his wheelchair while in the hallway. R60 stated he was unsure how long he had lived at the care center and often mumbled his speech with responses. R60 had no visible natural teeth or dentures in place at this time. R60 stated his dentures were "at the dentist office," however, just mumbled a response when asked if he had issues with chewing his food without them. The following day, on 1/28/25 at 10:36 a.m., R60 was again observed in his wheelchair while in his room. R60 had no visible teeth or dentures in and, when asked, opened his mouth to show edentulous palates. R60 was again asked where his dentures were and responded aloud "at the dentist" again. R60 stated he would wear them if he had them adding aloud, "yea, why not," with a mumbled tone. When interviewed on 1/28/25 at 10:46 a.m., nursing assistant (NA)-A stated they had worked at the center for a few months and had worked with R60 prior. NA-A described R60 as needing help with transfers and could be "restless" at times. NA-A stated R60 was typically accepting of cares but added, "It depends on the day." NA-A stated R60 would "sometimes" refuse oral care adding, "He doesn't like to be touched too much." NA-A stated R60 did not wear dentures to their recall nor had they ever seen him with any placed adding, "I don't think so." NA-A stated dentures, if he had them, would be kept in his room. NA-A and the surveyor then inspected R60's room and found a single, lower denture in his bedside dresser in a pink-colored cup. NA-A stated aloud, "I didn't even know that [he had one]." NA-A verified they had helped R60 with his morning	F 676	results of these audits will be reviewed at the facility QAPI meeting for input on the need to increase, decrease, or discontinue the audits. Corrections will be monitored by: DON/ Designee	

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F 676	Continued From page 8 cares that day and acknowledged they didn't offer the dentures to R60 due to not knowing about them. NA-A stated resident's with dentures should have them offered and placed before meals as it "helps to eat them for the food." R60's care plan, printed 1/28/25, identified all of R60's current or potential medical or mobility issues along with their corresponding goals and interventions. The care plan outlined R60 wore dentures and listed a single intervention which read, "Provide mouth care as per ADL personal hygiene." The care plan lacked when or how often to provide R60 his dentures nor evidence R60 refused to wear his dentures prior to 1/28/25. When interviewed on 1/28/25 at 11:02 a.m., registered nurse (RN)-D stated they had worked with R60 prior and we unsure off-hand if he used dentures or not adding aloud, "I'd have to check his room or record." RN-D stated R60 consumed a soft diet and had not, at least to their recall, ever voiced complaints about his mouth or eating. RN-D stated if a resident used dentures, they should be offered with morning cares and placed if able. R60's medical record was reviewed and lacked evidence R60 had been offered or refused his dentures on 1/27/25 and 1/28/25 when observed without them. On 1/28/25 at 1:16 p.m., the interim director of nursing (DON) was interviewed, and verified R60 had dentures but expressed he would often refuse to wear them when offered. DON stated staff were expected to offer them to him and expressed refusals were not documented. DON stated it was important to offer and, if able,	F 676		

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F 676	Continued From page 9 provide dentures as it "helps the resident with their food" and it was "just good quality care." A provided Activities of Daily Living (ADLs)/Maintain Abilities Policy, dated 3/2023, identified the facility would provide necessary care and services to ensure a resident' abilities in ADLs did not diminish unless unavoidable. The policy included, "3. The facility will provide care and services for the following ... d. Dining-eating, including meals and snacks, ..."	F 676		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure routine nail care was provided for 1 of 1 resident (R58) reviewed for activities of daily living (ADLs) who needed assistance from staff for nail care. Findings include: R58's quarterly Minimum Data Set (MDS) dated 12/17/24 indicated, R58 was cognitively intact, had no behaviors and did not refuse cares. MDS indicated R58 was independent with ADLs and needed set up or clean up assistance with showers. R58's Clinical Diagnosis Report printed 1/30/25, indicated diagnoses of gout (a form of arthritis that causes severe pain, swelling, redness and	F 677	R58 nails were trimmed. Full house audit completed to identify residents with long nails. Staff will offer to trim nails and document refusals. Residents that prefer long nails or frequently refuse nail care will have this information listed in the care plan. Education with all nursing staff to offer to trim finger and toenails during shower day and as needed, including what to do if the resident refused. Audit 4 residents' fingernails and toenails per week x 4 weeks to ensure nails are short and neat. Will ensure refusals are documented including care planned if	3/10/25

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F 677	Continued From page 10 tenderness in joints), generalized muscle weakness, other reduced mobility, need for assistance with personal care, protein calorie malnutrition and failure to thrive. R58's ADLs care plan printed 1/30/25 indicated R58 needed assistance with personal cares. An undated Group Report Sheet used by nursing assistants to know how to care for the residents, indicated R58 needed assistance of one staff for bathing and grooming. R58's Weekly Skin Assessments forms printed on 1/30/25, completed on 1/11/25, 1/18/25, 1/25/15 and 1/26/25, indicated under the Bath and Nail Care, R58's fingernails and toenails did not need to be trimmed. During observation and interview on 1/27/25 at 1:00 p.m., R58 was laying on top of the bed and not wearing socks. R58's fingernails were about half an inch long. His nails were yellow and had dark orange matter underneath most of them. R58's toenails were also about half an inch long and the toenail on his right big toe was cracked with a sharp edge. R58 stated, "They don't help me cut my fingernails or toenails; they are like an inch long. When my family or friends come to see me, they said I could do better with my personal care. I would like them to help me cut my nails. The last time they help me was 4 weeks ago. You ask them and they never come back." During observation and interview on 1/28/25 at 11:16 a.m., R58 was in bed watching TV and not wearing socks. R58's nails were still long. During observation and interview on 1/28/25 at	F 677	applicable. The results of these audits will be reviewed at the facility QAPI meeting for input on the need to increase, decrease, or discontinue the audits. Corrections will be monitored by: DON/ Designee	

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F 677	Continued From page 11 1:13 p.m., nursing assistant (NA)-C stated they cut the residents nails on shower days. If a resident is diabetic, the nurses will cut their nails. NA-C verified R58's fingernails and toenails were long. She said they were, "yellow/orange and had stuff underneath the fingernails." NA-C asked R58 if somebody offered to help him. R58 said, "No, it's been at least a month since they helped me with my nails." During interview on 1/29/25 at 8:29 a.m., R58 stated the staff set up the shower room for him, gave him towels, and he was able to shower by himself. R58 said the nurses had not checked his skin or cut his nails. R58 said, "This morning, a short nice blonde lady came to cut my fingernails. It feels so good, so much better." R58 toenails were not clipped. R58 was not sure who this person was. During interview on 1/29/25 at 8:49 a.m., the admission coordinator, who is a trained medical assistant and NA-D, stated sometimes she was pulled to help on the floor, and she visited all the residents and offered nail care. NA-D stated, she cut R58's fingernails and said, "they were about half an inch long, they were yellow and there was stuff underneath the pinky nails." NA-D added, the podiatrist would cut his toenails that day. During interview on 1/29/25 on 9:31 a.m., nurse manager, a licensed practical nurse (LPN)-B, stated the residents' nails and toenails were trimmed on bath day by the nursing assistants. The nurses were responsible to take care of diabetic residents' nails, while some of the residents were seen by the podiatrist. LPN-B verified the Weekly Skin Assessments forms dated 1/11/25, 1/18/25, 1/25/25 and 1/26/25,	F 677		

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F 677	Continued From page 12 under section C, Bath and Nail care, indicated R58's nails did not require trimming. During interview on 1/29/25 at 9:05 a.m., the assistant director of nursing (ADON) stated the expectation was nail care needed to be completed and documented, and if a resident refused nail care, it also needed to be documented. Residents with long nails were a concern because residents could scratch themselves and develop skin problems. Dirty nails are an infection control problem. ADON stated "we will need to provide education to the staff and make sure those cares get done." Facility policy title Activities of Daily Living dated 3/31/23, indicated a resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.	F 677		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to assess and, if needed, develop interventions or refer to contracted therapy services to address poor wheelchair	F 684	R60 was provided with a different wheelchair. R15 palm protectors were applied.	3/10/25

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F 684	Continued From page 13 posture for 1 of 2 residents (R60), and failed to provide assessed interventions from occupational therapy to reduce the risk of skin injury or further mobility loss (i.e., contracture worsening) for 1 of 1 resident (R15) reviewed for limited range of motion (ROM). Findings include: R60 R60's quarterly Minimum Data Set (MDS), dated 11/19/24, identified R60 had severe cognitive impairment and demonstrated no rejection of care behaviors during the review period. Further, the MDS outlined R60 had a functional limitation in range of motion (ROM) to both lower extremities and used a wheelchair for mobility. On 1/27/25 at 1:36 p.m., R60 was observed seated in a standard wheelchair in the hallway. R60 stated he was unsure how long he had lived at the center and presented with mostly mumbled responses which, at times, were non-sensical. R60's feet were flat on the floor while seated and he had a upright posture while seated, however, his arms overhung the wheelchair's armrests despite being seated upright with his arms coming to rest on the top of the wheels. The wheelchair had a visible, thick black cushion on the seat. Further, the wheels of the chair were worn down with a large portion of the gray-colored rubber material being worn away exposing the orange-colored resin below with cracks and crevices on the wheel surface. Later, on 1/27/25 at 2:28 p.m., R60 was again observed while seated in the same wheelchair. R60's posture remain upright with his arm's bent approximately 90-degrees at the elbow; however,	F 684	Full house audit completed for residents who use a wheelchair to ensure adequate wheelchair posture. Full house audit completed of residents with palm protectors and splints to ensure they are applied, care planned, and on NAR guide. Education with all staff to notify clinical leadership if a resident has poor posture in wheelchair. Clinical leaders educated on what to do when residents have poor posture in a wheelchair. Education with all nursing staff to follow orders for palm protectors/splints and what to do if not available. Education included that palm protectors are to only be washed by hand and will remain in resident room to air dry. No longer sending them to laundry. Audits will be completed for 5 resident weekly x 4 weeks to ensure adequate posture in wheelchair. Audits will be completed for 2 residents weekly x 4 weeks to ensure palm protectors/splints are in place per orders. The results of these audits will be reviewed at the facility QAPI meeting for input on the need to increase, decrease, or discontinue the audits. Corrections will be monitored by:	

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F 684	Continued From page 14 again, his arms weren't able to rest on the wheelchair' armrests without him having to hunch up his shoulders. R60 was pushing himself backward down the hallway while seated in the wheelchair, and the wheels of the chair remained in disrepair as had been observed earlier. R60's care plan, printed 1/28/25, identified all of R60's current or potential medical or mobility issues along with their corresponding goals and interventions. The care plan outlined R60 had an alteration in mobility due to multiple medical diagnoses and listed a goal, "Resident will move safely within their environment." The care plan listed several interventions including physical therapy as ordered, assistance with bed mobility and transfers, and a low bed for safety. However, the care plan lacked any information on R60's wheelchair (i.e., type used, positioning interventions). The following day, on 1/28/25 at 10:04 a.m., R60 was observed seated in the same wheelchair as the day prior. R60 was in the commons area for an activity and his positioning while seated remained poor with his arms being bent 90-degrees and remaining down at the side of the wheelchair and at wheel-level when at rest. The armrests of the chair were up between his torso and arms. Later, on 1/28/25 at 10:36 a.m., R60 was asked about his wheelchair, including if it was comfortable to be seated in, and responded aloud, "[It] could be tighter." R60 did not elaborate further when asked. The wheel's of the chair were inspected at this time and, again, remained in disrepair with the gray-colored rubber coating being nearly worn off in the middle of the wheel causing cracks and a large circumference divet in the middle of the wheel.	F 684	DON/ Designee	

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F 684	Continued From page 15 When interviewed on 1/28/25 at 10:46 a.m., nursing assistant (NA)-A stated they had worked with R60, and described R60 as needing help to transfer adding he could be "restless" at times. NA-A stated R60 had used the same wheelchair for awhile to their recall and expressed they noticed R60 seemed to be "sliding down" in it causing poor posture. NA-A stated R60 often slept in a near fetal-position and expressed they were not sure what had been causing R60's posture while seated in his wheelchair adding, "I don't think about what's causing it." NA-A stated they tried, at times, to boost R60 up to be more upright sitting, however, acknowledged even with doing such his arms would often remain down past the armrests when seated. NA-A stated they were unsure if OT (occupational therapy) had ever worked with R60 for his positioning or not adding aloud, "I don't know" When interviewed on 1/28/25 at 11:02 a.m., registered nurse (RN)-D stated they had worked with R60 prior. RN-D explained they felt R60's arm's were typically rested on the armrests when seated, however, mentioned they had noticed he "does kind of slouch over" adding such posture was typically seen for him. RN-D stated they didn't recall OT working with R60 recently and was unsure if OT had ever addressed R60's positioning in the wheelchair adding aloud, "That is a good question." R60's medical record was reviewed and lacked evidence R60 had been evaluated recently for his wheelchair positioning despite having potentially poor, uncomfortable posture and direct care staff being aware of the same observation.	F 684		

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F 684	Continued From page 16 When interviewed on 1/28/25 at 12:56 p.m., the director of rehabilitation (i.e., PT, OT) (DOR) stated R60 was last on their service in November 2024 and, at that time, had not been using the wheelchair he was currently seated in. DOR stated R60 had multiple hospitalizations and the chair had potentially been "switched out" at some point. DOR verified they had just observed R60 while seated in the wheelchair and, from that, placed a referral for the OT to review him adding his posture was "not terrible" but could be improved. DOR stated the chair's armrests were possibly too tall and expressed they had noticed the wheelchair's wheels in disrepair, so they went and obtained a new wheelchair and cushion which "was better" fitting. DOR verified nobody from nursing had reported any concerns to them about R60's wheelchair or positioning and expressed if staff saw a concern they could report it to be acted upon. DOR expressed poor posture while seated in a wheelchair could cause skin concerns but also "low back tightness or discomfort." On 1/28/25 at 1:16 p.m., the interim director of nursing (DON) was interviewed. DON stated they were notified of the wheelchair concern just prior and were working to get one with "a suitable fit and position-wise." DON verified they had observed R60's wheelchair and the wheels were in disrepair, adding it appeared like it had seen "a good few thousand miles." DON stated nobody had reported any concerns to them about R60's wheelchair condition or positioning and expressed it should have been reported so it could be addressed. A provided Range of Motion (ROM) and Positioning policy, undated, identified a procedure	F 684		

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F 684	Continued From page 17 to ensure proper positioning while seated in a chair including ensuring the patient's buttocks are firmly against the back of the chair and spine is straight; however, lacked further information on how to ensure ongoing concerns are addressed (i.e., referred to therapy). R15 R15's quarterly Minimum Data Set (MDS) dated 11/13/24, indicated R15 had severely impaired cognition with no rejection of care behaviors. The MDS indicated R15 had highly impaired hearing, had no speech, and was "rarely/never" able to express her ideas or wants with either verbal or non-verbal expression. The MDS indicated R15 had a limited ROM for all extremities and was dependent on staff for all activities of daily living. R15's care plan dated 7/10/24, indicated R15 had alterations in skin integrity related to dementia, malnutrition, immobility, and contractures of all extremities. The care plan indicated R15 had a history of refusing palm protector use while she was in treatment with therapy. The care plan indicated R15 was to wear palm protectors daily and they were to be removed daily to inspect skin and observe for skin breakdown. The care plan indicated nursing staff were to monitor skin integrity daily during cares and weekly skin inspections were to be completed by the nurse. R15's Weekly Skin Inspection reports dated 12/8/24 through 1/19/25 were reviewed and indicated R15 received a bed bath but fingernail trimming was "not necessary", leaving "refused" unchecked. A Weekly Skin Inspection report for the week of 1/20/25-1/26/25 was not found.	F 684		

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F 684	Continued From page 18 R15's occupational therapy note dated 12/11/24, indicated the occupational therapist had assessed the resident and recommended R15 wear palm protectors, and her bilateral elbows be positioned in a slight extension with the use of rolled towels/ a small pillow to maximize function and decrease the risk of skin breakdown. The note indicated R15 had previously not tolerated hand splints related to the severity of her contractures. The note indicated the occupational therapist recommended gentle hand/elbow hygiene daily to protect skin integrity. R15's medication/treatment administration record dated 1/1/25 through 1/28/25, indicated R15 had an order dated 3/30/23 for palm protector application. The order also indicated staff were to remove them once a shift for hand cleaning and skin inspection. The order was documented on every shift with 24/81 shifts documented as "on", 53/81 shifts documented as "off", and 4/81 shifts not documented on, or documented as "0". The record included an order dated 12/20/24 for positioning of R15's elbows in a slight extension with the use of a rolled towel or small pillow to increase the angle and protect skin integrity was documented as completed (approximately) every shift. R15's medical record was reviewed for this period and did not indicate refusal of palm protectors/alternatives for hand protection or refusal of the towel/pillow for R15's elbow extension. The undated 100 Hallway- Group 1 Report Sheet, indicated R15 was to be turned and repositioned every two to three hours with a pillow placed between her legs but did not include towels/ palm protector application to her hands or	F 684		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 19 towels/pillows between her elbows and body. During an observation on 1/27/25 at 12:40 p.m., R15 was lying in bed with her hands balled into fists with no towels, palm protector, or other device noted in her hands. R15's arms were observed tightly against her body with each hand close to the opposite shoulder with no noted towels or small pillows between her arms and her body. During an observation on 1/28/25 at 8:10 a.m., R15 was lying in bed with her hands balled into fists with no towels, palm protector, or other device noted in her hands. R15's arms were observed tightly against her body with each hand close to the opposite shoulder with no noted towels or small pillows between her arms and her body. During an observation and interview on 1/28/25 at 2:02 p.m., R15 was lying in bed with her hands balled into fists with no towels, palm protector, or other device noted in her hands. R15's arms were observed tightly against her body with each hand close to the opposite shoulder with no noted towels or small pillows between her arms and her body. Nursing assistant (NA)-B stated they had just repositioned R15, and pillows were observed between her knees. NA-B stated she was not aware R15 needed a pillow between her body and her elbows, so she had not been placing one when she was working with R15. NA-B stated she did do gentle range of motion with R15's arms and hands every day. NA-B was observed demonstrating this range of motion to R15's arms. NA-B was then observed to do range of motion to R15's hands and a white/ yellow build-up was noted on both of R15's palms as	F 684		

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F 684	Continued From page 20 well as four bright pink nail marks on R15's left hand. R15's fingernails were observed over ¼ of an inch beyond the end of the fingertip with a white build-up noted underneath. NA-B confirmed R15's hands had a strong odor when she opened them. NA-B stated R15's hands looked "dirty" and thought nursing staff was to clean her hands only on bath days so it should have been cleaned last Sunday (1/26/25) but thought that must not have been completed. During an interview on 1/28/25 at 2:21 p.m., registered nurse (RN)-B stated R15's nails were "getting long". RN-B stated nursing staff should cut them every week on her bath day but was unsure if this had been completed. RN-B confirmed she had not attempted to clean R15's hands today and had not assessed her palms. RN-B stated R15 had refused to let her place palm protectors or towels in her hands in the past and she had not attempted to apply either yet today. RN-B stated that R15's palm protectors had gone down to the laundry and had been damaged, so she had informed the former director of nursing but was unsure if new ones were ever ordered. RN-B stated she thought the therapy department had been told of R15's refusal to use the palm protector but was not given a different intervention to try instead and was unsure if the therapy department had been told the palm protectors were damaged. RN-B stated she was not aware pillows/towels needed to be applied between R15's body and her elbows so she had not been ensuring this was completed. During an interview on 1/28/25 at 2:27 p.m., the director of rehabilitation (DOR) stated R15 was last seen by occupational therapy on 12/11/24	F 684		

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F 684	Continued From page 21 when they did an evaluation for the appropriateness of a splint which R15 did not qualify for, so they had recommended palm protectors be applied. The DOR stated they were not aware R15 had been refusing to wear the palm protector. During a follow-up interview on 1/28/25 at 3:01 p.m. with the DOR and occupational therapist (OT)-A, the DOR stated she had checked with nursing that day and thought R15's palm protectors had gone down to the laundry department and were damaged. The DOR stated she was unsure when they had been damaged, but they do have extra palm protectors R15 could have used. OT-A stated if they had been made aware of R15 refusing the palm protectors they would have reassessed her for an appropriate alternative as the palm protectors were important in protecting R15's skin and ensuring contractures did not worsen. OT-A stated applying towels in R15's hands would have been an appropriate intervention to attempt if R15 was refusing the palm protectors. During an observation on 1/29/25 at 9:05 a.m., R15 was in bed with bilateral palm protectors applied with eyes closed and no observed signs of pain such as grimacing, furrowed brow, or agitation. During an observation on 1/30/25 at 10:33 a.m., R15 was in bed with bilateral palm protectors applied with eyes closed and no observed signs of pain such as grimacing, furrowed brow, or agitation. During an interview on 1/30/25 at 11:42 a.m., the interim director of nursing (DON) confirmed that	F 684		

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F 684	Continued From page 22 she had reviewed R15's medical record and did not find that staff had documented refusals to applying the palm protectors or alternatives and would expect staff to clean R15's hands every shift when they were assessing her hands for skin breakdown. A policy regarding range of motion, mobility, and palm protector application was requested and an undated Range of Motion and Positioning procedure was received. The procedure indicated staff should reposition a resident "as needed, per protocol and written RN instructions" but did not when occupational therapy should be reconsulted and address palm protector application.	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 an order for an audiology (medical specialty assisting with hearing) referral was acted upon promptly to promote better hearing and quality of life for 1 of 1 residents	F 685	R13 audiology appointment scheduled. Full house audit completed by reviewing all orders and after visit summaries from the past month to ensure all appointments	3/10/25

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F 685	Continued From page 23 (R13) reviewed who expressed difficulty with hearing. Findings include: R13's quarterly Minimum Data Set (MDS) dated 10/24/24, indicated R13 had intact cognition with no delusional thinking. The MDS indicated R13 had adequate hearing (i.e., no difficulty in normal conversation) and did not use hearing aids. R13's referral form dated 2/22/24, indicated R13 had an order from her provider for an audiology consult for a diagnosis of "hearing loss". R13's provider note dated 7/1/24, indicated R13 had reported worsening hearing loss and as a result, "withdraws" from social interaction and "stays in her room". The note indicated the plan for the resident's hearing loss was to provide an audiology consult. During an interview on 1/27/25 at 1:46 p.m., R13 stated she had needed her ears checked for a while and did not recall anyone offering to help her set up an appointment to see the ear doctor. R13 stated she thought she had told someone that her hearing was getting worse but was unsure who. During an interview on 1/30/25 at 9:03 a.m., the interim director of nursing (DON) stated the health information manager (HIM) oversaw making resident appointments and recommended questions regarding whether resident appointments were scheduled/attended be directed to her. During an interview on 1/30/25 at 10:29 a.m., the	F 685	were identified and set up per orders. A dedicated space was made at each nursing station for new referrals/appointments orders to be placed. Implemented new process on how to enter orders for appointments/referrals. Education with all nurses and HUC regarding the process of new referrals/appointments orders including how to enter the orders and where to place the orders once entered. HUC was educated on collecting the orders and following up on those orders. Audit 3 residents to ensure process was followed including entering orders, placing them in designated location and appointment was set up weekly x 4 weeks. The results of these audits will be reviewed at the facility QAPI meeting for input on the need to increase, decrease, or discontinue the audits. Corrections will be monitored by: DON/ Designee	

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F 685	Continued From page 24 HIM stated she oversaw making resident appointments for things such as seeing the audiologist. The HIM confirmed she had reviewed R13's medical and found an order from the provider for R13 to see the audiologist in February of 2024 but did not find that this appointment had ever been made or refused by R13. The HIM stated she would make this appointment now, but it would take about four months for the resident to be seen by an audiologist. A policy regarding audiology services was requested and not 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 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 an unsecured bed mattress was assessed for correct fit for a resident's bed for 1 of 1 residents (R59) reviewed for safety hazards. Findings include: R59's quarterly Minimum Data Set dated 12/19/24 identified R59 had intact cognition and was independent with most mobility related	F 689	R59 mattress was secured to the frame. Full house audit completed to ensure all other beds/mattresses were secured, and footboard in place. Staff education on submitting and completing work orders through TELS, including importance of secured mattresses and to notify Admin/clinical leaders if a bed is not long enough for	3/10/25

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F 689	Continued From page 25 activities (i.e., dressing, toileting and personal hygiene, and ambulation). In addition, R59 had diagnoses of cellulitis (bacterial infection of the skin that can cause redness, pain and swelling at the site) of left lower extremity, anxiety, and depression. During observation and interview with R59 on 1/27/25 at 1:26 p.m., R59 was observed to be lying in bed which was positioned along the wall with the foot of the bed just inside door to hallway. The bed had no footboard, and the unsecured mattress hung over the foot of the bed frame by about 12 inches. There was no retainer bar at the foot of the bed frame to prevent mattress from sliding down. R59 stated, "it is hard to get on and off of it" and "I have to move my feet" to allow roommate and others to open and close the door to the hallway. During observation on 1/28/25 at 8:04 a.m., R59 unsecured mattress continued to hang off the foot of the bed frame by about twelve inches. During observation and interview with nursing assistant (NA)-B on 1/28/25 at 11:00 a.m., NA-B stated she was familiar with R59 and pointed to his bed mattress. "[R59] is tall and a big guy. That mattress does not fit him. I haven't noticed it or said anything to anyone about it and I haven't heard anyone saying or doing anything about it." During observation and interview with RN-C on 1/28/25 at 1:10 p.m., RN-C stated she was familiar with R59. RN-C pointed out "no footboard. I would expect it to be there. All beds should have headboards and foot boards. I don't know why it is like that. " RN-C identified the unsecured mattress as a safety risk.	F 689	residents, or otherwise unsafe. Education completed with Maintenance Director, Admin, and clinical leaders on alternative options for bed frames and responsibility to ensure hazard free environment. Audit all new admissions plus 3 residents to ensure mattress is secured to the frame and frame/mattress is appropriate for the resident weekly x 4 weeks. The results of these audits will be reviewed at the facility QAPI meeting for input on the need to increase, decrease, or discontinue the audits. Corrections will be monitored by: Administrator/ Designee	

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F 689	Continued From page 26 During interview with the maintenance director (MD) on 1/28/25 at 1:21 p.m., MD stated, "[R59] should have footboard. He kicked it off. [Facility] don't have bed extenders for these beds. We don't have alternatives, and I haven't looked for any." MD stated he was aware of R59's unsecured mattress sliding down past the bedframe and was not responsible for assessing the appropriateness of the mattress and bedframe. MD stated, "no I have not asked [R59] for alternatives or options to the overhanging mattress". During interview with R59 pm 1/28/25 at 1:28 p.m., R59 stated he "kicked off" the footboard. R59 stated, "[mattress] is uncomfortable. I was not told about any alternative to the mattress or bed." R59 stated facility staff were aware of the missing footboard because staff "put it in my closet." During interview with licensed practical nurse (LPN)-C on 1/28/25 at 2:06 p.m., LPN-B stated he was also the nurse manager for the resident wing R59 resided on. LPN-B stated he was told that R59's missing footboard and slipping mattress "was his preference. The staff removed the foot board. Since then, I did not visit back with him about it." LPN-B stated, "I think [R59] would benefit from an extension to the mattress or bed[frame]. He is at risk for pressure ulcers to feet." LPN-B stated the electronic medical record (EMR) failed to address the footboard and his unsecured mattress sliding down past the frame of the bed. During observation and interview with assistant director of nursing (ADON) on 1/28/25 at 2:30	F 689		

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F 689	Continued From page 27 p.m., ADON and surveyor walked to R59's room. ADON stated R59 "would rest his feet on top of the footboard and it is not appropriate and [R59] said he likes to hang his feet over it. [R59] did not want the footboard. He slides down in the bed. I don't know if maintenance addressed the mattress or bed. As far as I know, we do have extensions for beds. [R59] is very much alert and oriented and knows what his wants and needs are." ADON stated, "it is awkward" and facility did not have documentation of assessing [R59's] bed frame and unsecured mattress. During interview with MD on 1/28/25 at 3:10 p.m., MD stated, "[facility] do[sic] have extensions and longer mattresses and bed[frames]. I do not document or have anything about offering alternatives for extending the bed frame or mattress." MD stated R59 "slides down". During interview with ADON on 1/30/25 at 11:17 a.m., ADON stated, "[facility] did not assess and reassess for the mattress to stay secured on the bed frame. The mattress does slide down off the foot of the bed without the foot board and his feet do dangle off the mattress at times." Facility policy on Bed Safety was requested and not received.	F 689		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of	F 695		3/10/25

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F 695	Continued From page 28 practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure ongoing monitoring of resident oxygen use was completed to reduce the risk of respiratory complications for 1 of 1 residents (R13) reviewed for oxygen use. Findings include: R13's quarterly Minimum Data Set (MDS) dated 10/24/24, indicated R13 had intact cognition and was diagnosed with heart failure, kidney failure, Chronic Obstructive Pulmonary Disease (COPD-incurable lung disease causing breathlessness, frequent coughing, and chest tightness), and respiratory failure. The MDS indicated R13 required setup help with eating and oral hygiene and maximum assistance with dressing. The MDS indicated R13 was on oxygen therapy. R13's care plan dated 9/7/24, indicated R13 had an alteration in respiratory status and would remove her oxygen cannula and adjust her oxygen administration rate herself. R13's care plan indicated oxygen was to be administered as ordered and oxygen saturations were to be monitored. The care plan indicated staff were to monitor and document R13's respiratory status. R13's medication and treatment record dated 1/1/25 through 1/26/25, indicated R13 ' s oxygen saturations were taken (approximately) every shift with values ranging from 92 to 99 percent but did not indicate how many liters per minute (LPM) of oxygen R13 was receiving at the time of the	F 695	R13 oxygen liter flow was updated on the oxygen order. A full house audit completed for all residents that receive oxygen to ensure liter flow is included in the order. Education with all nursing staff and HUC to include liter flow when entering oxygen orders. Included an area in the oxygen section of the daily clinical meeting to double check liter flow was added to all oxygen orders going forward. Audit 3 residents with oxygen orders to ensure the order includes the liter flow weekly x 4 weeks. The results of these audits will be reviewed at the facility QAPI meeting for input on the need to increase, decrease, or discontinue the audits. Corrections will be monitored by: DON/ Designee	

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F 695	Continued From page 29 reading. The record included an order dated 3/1/24 to "wean" oxygen back to "baseline" of two to three LPM to keep oxygen saturation above 92 percent. This order was documented on (approximately) every shift with oxygen saturation values ranging from 92 to 99 percent but did not indicate how many LPM of oxygen R13 was receiving at the time of the reading. R13's medical record was reviewed and did not include correlating a measurement of the LPM of oxygen used to assist R13 in reaching the oxygen saturations measured. R13's provider note dated 1/10/25, indicated R13 had complained of "bouts" of shortness of breath so a chest x-ray and labs were ordered on 1/10/25. The note indicated R13's chest x-ray showed lung congestion, so a diuretic was ordered on 1/17/25. The note indicated R13 had a history of acute on chronic respiratory failure with hypercapnia (a condition that can lead to shortness of breath that is caused by a buildup of a waste product that your body gets rid of with exhale) that had led to a prior hospitalization in 8/24. R13's progress note dated 1/28/25 at 2:09 p.m., indicated R13 was sent to the hospital related to shortness of breath. During an interview and observation on 1/27/25 at 4:16 p.m., R13 was observed sitting in a recliner in her room receiving oxygen via a nasal cannula. The oxygen concentrator was observed running at a rate of four LPM. R13 stated she had been feeling very short of breath that day and so her nurse had increased her oxygen. R13 was observed taking breaks between words to take deep breaths before she continued talking.	F 695		

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F 695	Continued From page 30 During an observation on 1/28/25 at 8:06 a.m., R13 was observed sitting in a recliner in her room receiving oxygen via a nasal cannula. The oxygen concentrator was observed running at a rate of four LPM. During an interview on 1/28/25 at 12:41 p.m., registered nurse (RN)-C stated the computer system they used did not allow nursing staff to put in how many LPM of oxygen they were administering to the resident so she could only see what oxygen saturation the previously nurse had recorded but not the dosage of oxygen being administered at the time of the measurement. RN-C stated R13 had a history of increasing her oxygen administration level and she thought she had done that this morning, so RN-C had decreased her oxygen to three liters. RN-C stated the previous nurse had not passed along how many LPM of oxygen R13 had needed the previous shift and confirmed she was unable to find this information in the medical record. RN-C stated R13 had been feeling very short of breath that day and if it did not get better, she was going to have to go to the hospital. During an observation on 1/28/25 at 1:53 p.m., R13 was observed telling outside emergency medical personnel she "can't breathe" and it started about four days ago. During an interview on 1/30/25 at 8:22 a.m., nurse practitioner (NP)-A stated she would expect nursing staff to document how many liters of oxygen were administered when documenting oxygen saturation so the facility could track respiratory status changes.	F 695		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 695	Continued From page 31 During an interview on 1/30/25 at 11:37 a.m., the interim director of nursing (DON) confirmed she had reviewed R13's medical record and stated the facility usually included an order for recording how many LPM of oxygen was administered to a resident and then it would allow nurses to document how many LPM were being administered, but it had been missed for R13. The DON stated it was important her oxygen flow rate was recorded so changes in respiratory status could be tracked, and interventions could be attempted as needed. A policy regarding oxygen use was requested and not received.	F 695		
F 700 SS=D	Bedrails CFR(s): 483.25(n)(1)-(4) §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. §483.25(n)(4) Follow the manufacturers'	F 700		3/10/25

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	245324	A. BUILDING _____ B. WING _____	C 01/30/2025

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F 700	Continued From page 32 recommendations and specifications for installing and maintaining bed rails. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to accurately or comprehensively assess the use of side rails and ensure installed side rails were secured to prevent injury or potential entrapment for 1 of 1 resident (R33) reviewed who used bilateral quarter-sized side rails on their bed. Findings include: R33's admission Minimum Data Set (MDS), dated 1/9/25, identified R33 had intact cognition and demonstrated no delusional thinking. Further, the MDS outlined R33 required substantial and/or maximum assistance for bed mobility. On 1/27/25 at 1:14 p.m., R33 was observed lying in bed while in her room. R33 used a standard-size hospital bed and each side had a mounted, affixed metallic one-quarter side rail attached to the frame via a center arm. The rail on the open side of the bed (opposite the wall) was loose when touched and allowed movement of approximately eight to 10 inches back-and-forth towards and away from the bed which increased the spacing between the mattress and rail. R33 stated the rail had been loose since she got the bed and expressed she told staff about it but staff responded, "They keep telling me that's OK but I don't know." R33 stated the whole side rail on the open side "wiggles like that" and she was concerned about falling out when they roll her but staff kept telling her it wasn't an issue as they "are standing right there." R33 stated nobody from nursing maintenance	F 700	R33 bilateral quarter side rails are tight & secure. A new bed mobility assessment was completed to ensure accuracy and care plan is up to date. A full house audit completed on all quarter side rails and grab bars to ensure they were tight & secured. A full house audit completed for all residents that utilize side rails and/or grab bars to ensure a bed mobility assessment is completed within last quarter, and care plan accurately reflects comprehnsive assessment. Education with clinical leaders on completion of quarterly bed mobility assessments and care plans. Education with maintenance director on routine checks & maintenance for grab bars and/or quarter side rails. Audit 3 residents with quarter side rails/ grab bars to ensure equipment is tight, the bed mobility assessment is completed and care plan accurately reflects assessment weekly x 4 weeks. The results of these audits will be reviewed at the facility QAPI meeting for input on the need to increase, decrease, or discontinue the audits. Corrections will be monitored by:	

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F 700	Continued From page 33 had been in to review the side rail despite it being loose adding, "Not that I'm aware of anyway." R33 repeated, "I think somebody should tighten that up." Further, R33 stated she couldn't recall being offered or told what, if any, other options instead of a side rail were available to help her roll side-to-side in bed adding, "I don't know if there are any other options." R33's most recent MHM (Monarch Healthcare Management) Bed Mobility Device Evaluation 7/18, dated 1/3/25, identified a section labeled, "What type of bed mobility device does resident/legal representative prefer[?]," which was answered, "Bilateral grab bars." The evaluation identified R33 or their representative was educated on the risks of such device and R33 had no history of injury using such device, either. A section labeled, "Evaluation of Alternatives," listed a radio-button response of, "Yes," along with dictation reading, " ... is an assist of 2-3 with a lift ... has been educated on the devised [sic] being used and is aware reason why its being used." However, the evaluation lacked further information what which specific devices had been attempted or discussed with R33 (i.e., smaller grab bar, trapeze). The evaluation continued and identified, "Assist/Grab bar(s)," would be used along with a summary reading, "Resident uses grab bars to assist with turn and repositioning." The evaluation was signed by the interim director of nursing (DON) on 1/7/25. R33's care plan, printed 1/28/25, identified all of R33's current or potential medical or mobility issues along with their corresponding goals and interventions. The care plan outlined R33 was at risk of falls and injury, and had an alteration in mobility due to edema and wounds. The care	F 700	DON/ Designee	

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F 700	Continued From page 34 plan directed to assist R33 with movement in-and-out of bed and use a mechanical lift for transfers. However, the care plan lacked information or direction on R33's use of side rails. When interviewed on 1/28/25 at 10:46 a.m., nursing assistant (NA)-A stated they had worked with R33 prior and described her as needing total assistance with most cares. NA-A stated R33 used a mechanical lift and "two people" to transfer in-and-out of bed, adding R33 would help with repositioning when in bed by "hold[ing] on to the thing on the side of the bed." NA-A verified R33 used the side rails to help with turning and brief changes, indicating she had them attached to the bed "when she moved in" to their recall. NA-A stated they had noticed the one rail, on the open side of the bed, was loose adding aloud, "It wiggles." NA-A stated it had been loose awhile and they were unsure if other alternatives (i.e., grab bar, trapeze) had ever been installed on the bed but reiterated the loose rail needed to be fixed adding, "I think it needs to be tightened." NA-A stated staff could notify maintenance to have it done "on TELS" (the maintenance software system) but expressed they themselves had not completed one as they "wasn't [weren't] pay attention that much." On 1/28/25 at 1:10 p.m., the director of maintenance (DOR) was interviewed. DOR stated staff had "just brought it up" about R33's side rail being loose and, as a result, they were going around to everyone with such device to ensure they were tight and secured. DOR verified nobody had alerted him or completed a 'TELS' about it prior to that day (1/28/25,) and expressed side rails and grab bars should be tight and secured for safety reasons. DOR stated grab bars or side	F 700		

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F 700	Continued From page 35 rails were not routinely checked for fit and condition by their department because they felt nursing would let them know if a device was loose. DOR stated a monthly check of the devices moving forward would possibly help the issue. When interviewed on 1/28/25 at 1:22 p.m., the interim director of nursing (DON) verified they had reviewed R33's medical record. DON stated the evaluation (dated 1/7/25,) was completed in error and should have reflected side rail use versus grab bars being installed. DON explained R33's bed was rented and no alternatives were able to be done because of that, adding the usual "u-bars" wouldn't attach to it. However, DON stated they were unsure if maintenance or "an outside person" set the bed up. DON stated side rails and bars should be checked "just with every day care" and, if needed, a 'TELS' should be done so it can be fixed. DON added, "[We] put it in TELS right away so we can get it fixed." Further, DON stated a loose side rail could cause falls or entrapment adding, "It can cause harm to the patient." A facility' policy on side rail evaluation and maintenance was requested, however, none was received.	F 700		
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. §483.45(c)(2) This review must include a review	F 756		3/10/25

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F 756	Continued From page 36 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 (R13) reviewed for unnecessary medications.	F 756	R13 pharmacy recommendation was addressed. All other recommendations have been reviewed and addressed.	

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F 756	Continued From page 37 Findings include: R13's quarterly Minimum Data Set (MDS) dated 10/24/24, indicated R13 had intact cognition and utilized antipsychotic, antianxiety, and antidepressant medication. R13's diagnostic report dated 7/1/24, indicated R13 was diagnosed with major depressive disorder, bipolar disorder, and an anxiety disorder. R13's Order Summary report dated 1/30/25, included the following orders: -dated 6/2/23 for 200 milligrams (mg) of quetiapine (an antipsychotic medication used to treat bipolar disorder) daily for bipolar disorder. -dated 8/14/23 for 300 mg of bupropion XL (an antidepressant) daily for major depressive disorder. -dated 8/14/23 for 120 mg of duloxetine (an antidepressant) daily for major depressive disorder. -dated 8/14/23 for 400 mg of lamotrigine (an anticonvulsant sometimes used to treat bipolar disorder) daily for a bipolar disorder. -dated 12/29/23 for five mg of aripiprazole (an antipsychotic medication used to treat bipolar disorder) daily for bipolar disorder. -dated 12/29/23 for three mg of melatonin (a dietary supplement used to assist with sleep) daily for insomnia. -dated 1/23/24 for 10 mg of buspirone (an anti-anxiety medication) twice a day for an anxiety disorder. R13's Consultant Pharmacist Recommendation to Physician dated 12/23/24, indicated R13 received "psychotic medication" including five mg	F 756	Clinical leaders were educated to complete pharmacy recommendations prior to the next review including which provider to contact, and what to do if the provider does not respond. Audit all pharmacy recommendations for the next two months to ensure all were followed up on before the next pharmacy consultant review occurred. The results of these audits will be reviewed at the facility QAPI meeting for input on the need to increase, decrease, or discontinue the audits. Corrections will be monitored by: DON/ Designee	

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F 756	Continued From page 38 of aripiprazole daily, 10 mg of buspirone twice a day, 400 mg of lamotrigine daily, 300 mg of bupropion XL daily, and 120 mg of duloxetine daily. The pharmacist recommended the prescriber review if R13 was on the lowest effective doses of the medications listed above. The pharmacist indicated if a dose reduction was contraindicated, that the clinical rationale be documented below. The recommendation had a blank for a signature, date, and prescriber response that were left blank. R13's Consultant Pharmacist Recommendation to Physician dated 1/27/25, indicated R13 received "psychotropic medications" including five mg of aripiprazole daily, 10 mg of buspirone twice a day, 400 mg of lamotrigine daily, 300 mg of bupropion XL daily, 120 mg of duloxetine daily, three mg of melatonin daily, and 200 mg of quetiapine daily. The pharmacist recommended the prescriber review if R13 was on the lowest effective doses of the medications listed above. The pharmacist indicated if a dose reduction was contraindicated, that the clinical rationale be documented below. The recommendation had a blank for a signature, date, and prescriber response that were left blank. R13's medical record was reviewed and did not include a provider response to the above pharmacist recommendations. During an interview on 1/30/25 at 9:26 a.m., the consulting pharmacist (CP) stated when she had reviewed R13's medication record she had not found evidence the provider had attempted or declined to attempt a dose reduction of her psychotropic medications in the current quarter. The CP stated she had given a similar	F 756		

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F 756	Continued From page 39 recommendation in January as the previous CP had in December, as she could not find that the provider had responded to the recommendation given in December, and it was important that they attempt to reduce psychotropic medication use when possible. During an interview on 1/30/25 at 11:43 a.m., the interim director of nursing (DON) confirmed she had reviewed R13's medical record and could not find that a response was received from the provider regarding the pharmacist's recommendation for a dose reduction. The interim DON stated she thought the recommendation should have been sent to R13's psychiatrist as they managed her psychotropic medications but as R13 had changed psychiatrists recently, was unsure who this was sent to as the previous DON oversaw this task. The interim DON stated she expected these to be faxed to the provider and the response uploaded to the medical record. The facility's Medication Regimen Review policy dated 8/19, indicated the pharmacist would review each resident's medication regimen at least monthly, and the recommendations would be acted upon and documented by facility staff and/or the prescriber. The prescriber would accept and act upon the suggestions or reject the suggestion and give an explanation for disagreeing.	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	F 758		3/10/25

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F 758	Continued From page 40 processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is 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.	F 758		

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F 758	Continued From page 41 §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure acute, potentially distressing psychoactive symptoms were recorded and non-pharmacological interventions were attempted or recorded to ensure efficacy of as-needed (i.e., PRN) psychotropic medication for 1 of 5 residents (R2) reviewed for unnecessary medication use. Findings include: R2's quarterly Minimum Data Set (MDS), dated 1/9/25, identified R2 had severe cognitive impairment and continuous inattention, disorganized thinking, and altered consciousness. The MDS recorded R2 having multiple signs of potential depression, including appear or feeling down and being short-tempered, but demonstrated no behaviors (i.e., physical, verbal, other). Further, the MDS identified R2 consumed multiple psychotropic's including both antipsychotic and antianxiety medications. R2's Doctor's Order, dated 1/6/25, identified an order from hospice was received which read, "Restart lorazepam concentrate ... 0.5 mg [milligrams] (0.25 ml) PO/SL [by mouth] Q4H PRN [every four hours as needed]." The order listed a diagnosis which read, "Terminal agitation [a state of extreme restlessness, anxiety, and confusion that can occur in people who are nearing the end of their life]."	F 758	R2 was reviewed; target behaviors and non-pharmacological interventions were added to the orders and care plan so the resident can be monitored, and behaviors and interventions are documented. Full house audits completed to ensure individualized Target behaviors monitoring orders and non-pharmacological interventions are in place for residents who use psychotropic medications. Clinical leaders and social services were educated to the target behaviors policy and procedure including ensuring individualized target behavior monitoring and non-pharmacological interventions are in place in the orders and the care plan for residents who use psychotropic medications Audit 4 residents that receive psychotropic medications to ensure target behaviors and non-pharmacological interventions are in place in the orders and the care plan weekly x 4 weeks. The results of these audits will be reviewed at the facility QAPI meeting for input on the need to increase, decrease, or discontinue the audits. Corrections will be monitored by:	

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F 758	Continued From page 42 On 1/27/25 at 1:28 p.m., R2 was observed seated in a geri-chair in the hallway by the nurses' station. R2's eye were open and she was alert as registered nurse (RN)-E held up her right leg and exposed a large, dark area on her right heel. R2 demonstrated no physical signs of pain or anxiousness at this time but had little, if any, verbal response to RN-E or the surveyor. Two days later, on 1/29/25 at 8:45 a.m., R2 was observed lying in bed while in her room. R2 was alert with her eyes open and speaking aloud with "I want to tell you something," however, just mumbled a response afterward. R2 appears comfortable and without obvious physical signs of pain or anxiousness at this time. R2's Medication Administration Record (MAR) and Treatment Administration Record (TAR), dated 1/2025, identified R2's administered medications and treatments for the period. The MAR recorded a total of five (5) administrations of PRN lorazepam including: On 1/9/25 at 7:20 p.m., with the results listed as, "E [effective]." A corresponding progress note, dated 1/9/25, identified the medication was given but lacked any recorded symptoms or behaviors which supported use of the medication, nor any non-pharmacological interventions being attempted or done prior to the medication. On 1/13/25 at 9:32 a.m., with the results listed as, "E." A corresponding progress note, dated 1/13/25, identified the medication was given but lacked any recorded symptoms or behaviors which supported use of the medication, nor any non-pharmacological interventions being attempted or done prior to the medication.	F 758	DON/ Designee	

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F 758	Continued From page 43 On 1/23/25 at 11:07 a.m., with the results listed as, "E." A corresponding progress note, dated 1/23/25, identified the medication was given but lacked any recorded symptoms or behaviors which supported use of the medication, nor any non-pharmacological interventions being attempted or done prior to the medication. None of the recorded doses or corresponding notes for the 1/2025 administration(s) contained any recorded symptoms or behaviors which supported use of the PRN psychotropic medication, nor any non-pharmacological interventions being attempted or done prior to the medication. R2's care plan, printed 1/29/25, identified R2's current identified problems, goals, and interventions to help R2 meet those goals. The care plan identified R2 was on hospice care and had an alteration in her mood and behavior related to her medical complications. The care plan outlined, "Resident has hx [history] of refusing all cares, meds and food. Resident speaks another language [and] understands a little English." The care plan directed, "Monitor and document mood state/behaviors upon occurrence." Further, the care plan identified R2 was at risk for psychotropic medication adverse reactions due to using them daily, and directed staff to update the provider regarding the efficacy of the medications or, if any, adverse reactions noted. When interviewed on 1/29/25 at 8:49 a.m., trained medication aide (TMA)-B stated they had worked with R2 multiple times prior and described her as having "good days and bad days" with her	F 758		

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F 758	Continued From page 44 care needs. TMA-B explained R2 would, at times, help staff complete basic cares like dressing and expressed she (R2) used to have more behaviors, such as hallucinations, but those had subsided adding, "[She's] very calm now." TMA-B stated R2 was "very loving" and often would "tell you she loves you" to the staff members. TMA-B stated they recalled one episode of R2 being a little anxious "a week ago" but otherwise had not seen any indications R2 was anxious or distressed. TMA-B stated when they witnessed the episode the week prior, the nurse stepped in and gave R2 medication which made it "much better." TMA-B stated R2 seemed to speak in her native language when anxious or upset and, in response, staff just remind her they're not able to understand her and to use English, if able. However, TMA-B verified they had a translator service available and could use it, if needed. R2's medical record was reviewed and lacked evidence what, if any, physical or verbal symptoms were present to warrant use of the medication on each of the administered doses of the PRN lorazepam; nor evidence what, if any, non-pharmacological interventions had been attempted prior to using the medication to see if the behaviors deescalated without medication intervention. When interviewed on 1/29/25 at 11:02 a.m., registered nurse (RN)-B stated they had worked with R2 multiple times and described R2 as being "total cares." RN-B stated R2 could have "very different" behaviors including yelling, screaming and, at times, throwing items at the staff. However, RN-B stated then, "I think in the last month she's been doing better." RN-B stated it was now mostly "outbursts here and there." RN-B	F 758		

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F 758	Continued From page 45 stated if R2 had behaviors, they themselves had tried to wheel her around the hallways and noticed R2 seeing other people tended to make her "more calm." RN-B verified R2 had an active order for PRN lorazepam and stated they typically gave it to R2 only after non-pharmacological interventions failed. RN-B reviewed R2's completed MAR and associated charting and acknowledged it lacked any recorded symptoms or non-pharmacological interventions prior and expressed staff possibly were just giving it and not recording those things. RN-B stated staff should be attempting to figure out why R2 was agitated or anxious, and expressed behavior monitoring and non-pharmacological interventions were tracked "on the TAR." RN-B reviewed R2's TAR and stated aloud, "Her's is different here." RN-B verified it did not have the typical order set used to track non-pharmacological interventions and reiterated, "[Maybe] it's something they don't put in [interventions] and just give it [medication]." Further, RN-B stated they were unsure if anyone from nursing leadership had ever told them to record symptoms or non-pharmacological interventions with PRN psychotropic medication administration adding aloud, "I'm not sure." On 1/29/25 at 11:52 a.m., the regional nurse consultant (RNC)-A was interviewed. RNC-A verified they reviewed R2's medical record and it lacked the behavior monitoring order set which was used to document non-pharmacological interventions on each shift to support medication' use. RNC-A stated it should have been in there as it was used to show "resident specific target behaviors and interventions." RNC-A stated staff could have also completed a progress note with such information. RNC-A verified symptoms and	F 758		

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F 758	Continued From page 46 non-pharmacological interventions were to be attempted and tracked as doing such helped determine if the medication was "actually helping with it [symptoms]." When interviewed on 1/30/25 at 9:29 a.m., the consulting pharmacist (CP) explained specific behavior monitoring was more completed "on the nursing end," however, verified witnessed behaviors should be recorded with any PRN medication administration. CP explained non-pharmacological interventions were also to be attempted adding aloud, "They definitely should attempt non-pharms prior." However, CP reiterated doing such things was, again, more up to the nurses and nursing leadership to ensure it was done. A provided Psychotropic Medication Use policy, dated 11/2024, identified such medications could be considered for resident with symptoms which have been identified by the interdisciplinary team (IDT) and whom have deemed such medications would benefit the resident. The policy directed, "Pertinent non-pharmacological interventions must be attempted, unless contraindicated, and documented." Further, the policy outlined, "Residents will not receive PRN doses of psychotropic medications unless that medication is necessary to treat a specific condition that is documented in the clinical record."	F 758		
F 880 SS=E	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	F 880		3/10/25

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F 880	Continued From page 47 comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 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	F 880		

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F 880	Continued From page 48 circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure community use glucometers (machines to check blood sugar) were properly cleaned and disinfected between patient use, and failed to ensure staff who performed blood glucose checks were knowledgeable of process for cleaning and disinfecting blood glucose devices prior to and after use per manufacturer instructions. This had the potential to affect 9 of 9 (R10, R13, R15, R26, R29, R41, R49, R54, and R118) residents who were diabetic, had orders for blood glucose monitoring, and used a community glucometer. Findings include:	F 880	R10, R13, R15, R26, R29, R41, R49, R54, R18 - Residents provided with individual glucometers to eliminate cross contamination. Full house audits completed to ensure residents with blood glucose checks have their own glucometer. Nursing staff educated to use individual glucometer for residents including where to obtain supplies for new admits, and what to do with the glucometer for residents that discharge. Nursing staff educated regarding how to	

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F 880	Continued From page 49 The manufacturer's instructions for use of the Arkray Assure Platinum Blood Glucose Monitoring System in Section B: To reduce the chance of infection, the clinician is to, "Wash hands thoroughly with soap and water before putting on a new pair of gloves and performing the next patient test." And, prior to obtaining blood sample, "Step 1: Wash patient's hands with soap and warm water." Guidelines for cleaning and disinfecting the unit state, "To minimize the risk of transmitting blood-borne pathogens, the cleaning and disinfection procedure should be performed". Per the manufacturer's instructions, the clinician is to utilize the approved and recommended Environmental Protection Agency (EPA)-registered wipe to cleanse and disinfect the unit after each use. One of the approved wipes is, "Super Sani-Cloth Germicidal Disposable Wipes"[Saniwipe]. General guidelines for use of the wipe is to "Allow treated surface to remain wet for two (2) minutes. Let air dry." The procedure for cleaning and disinfecting the Assure Platinum Blood Glucose Monitoring System is to wear appropriate protective gear such as disposable gloves, wipe the surface of the meter to clean it, and wipe around the test strip port with unit facing down to prevent the disinfectant liquid from entering the meter. "Treated surface must remain wet for recommended contact time" per the wipes manufacturer's instructions. The product description for Super Sani-Cloth Germicidal Disposable Wipe list the "Overall Contact Time" (time a cleaner needs to kill germs on a surface or device) as two minutes. During continuous observation and interview on 1/27/25 at 5:44 p.m., registered nurse (RN)-A	F 880	clean glucometers including what to use to clean it. Nursing staff educated regarding need to cleanse residents hands with soap and water prior to blood glucose checks. Audit nursing staff completing glucometer checks for 3 resident per week x 4 weeks to ensure the resident hands are wash and use of individual glucometer and that they know how to clean it. The results of these audits will be reviewed at the facility QAPI meeting for input on the need to increase, decrease, or discontinue the audits. Corrections will be monitored by: DON/ Designee	

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F 880	Continued From page 50 stated she was familiar with the residents. RN-A walked to the nursing medication cart and removed a yellow plastic container from the cart with R10's name written on top of it. From the container RN-A removed an Arkray Assure Platinum Blood Glucose Monitoring System glucometer, one lancet, container of test strips, two cotton balls, and two alcohol wipe towelettes. RN-A walked to R10's room with the supplies. RN-A entered R10 room and asked if she could "take your blood sugar before you eat?" R10 had started to eat dinner and was holding silverware and his wheelchair armrest when RN-A entered room. RN-A sanitized hands and applied gloves, then placed supplies directly on top of bedside table next to dinner tray. There was no barrier used between the supplies and the bedside table. RN-A did not wash R10's fingers with soap and water. RN-A wiped R10's right pointer finger with an alcohol wipe, then inserted a glucometer strip into the machine turning it on. RN-A then used the lancet to the right pointer finger and obtained a sample of blood. RN-A wiped the finger with a cotton swab and then applied a drop of blood to the glucometer strip. RN-A obtained the result, wiped the finger with second alcohol wipe, and removed the strip from glucometer. RN-A then disposed of the lancet in a Sharps container (puncture-resistant waste container), and disposed of the used strip, cotton ball, alcohol towelettes, and gloves into the resident garbage container. RN-A walked back to medication cart with glucometer after sanitizing hands and placed supplies on top of medication cart to document results on a care sheet. RN-A then obtained a facial tissue from top of medication cart, pumped hand sanitizer onto the tissue, and wiped the entire glucometer. RN-A obtained second facial tissue and immediately wiped the entire	F 880		

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F 880	Continued From page 51 glucometer with a dry tissue. RN-A unlocked the medication cart and returned the supplies back into R10's box, closed the lid and placed it back into the medication cart. RN-A did not use an approved and recommended Environmental Protection Agency (EPA)-registered wipe to cleanse and disinfect the unit prior to and/or following use. Immediately afterwards at 5:51 p.m., RN-A removed a blue plastic container from the cart with R54's name written on top of it. RN-A obtained an Arkray Assure Platinum Blood Glucose Monitoring System glucometer and supplies and walked to R54's bedroom and knocked on the door before entering the room. RN-A did not clean glucometer prior to use. RN-A asked permission to obtain blood sugar result and then placed supplies directly on top of bedside table next to his dinner tray. There was no barrier used between the supplies and the bedside table. RN-A did not wash R54's fingers with soap and water. RN-A wiped R54's left pointer finger with an alcohol wipe, then inserted glucometer strip into the machine turning it on. RN-A then used the lancet to the left pointer finger and obtained a sample of blood. RN-A wiped the finger with a cotton swab and applied a drop of blood to the glucometer strip. RN-A obtained result and wiped finger with second alcohol wipe and removed the strip from the glucometer. RN-A then disposed of the lancet in a Sharps container, and disposed of the used strip, cotton ball, alcohol towelettes, and gloves into the resident garbage container. RN-A walked to medication cart, sanitized her hands, applied gloves, and used a facial tissue with hand sanitizer applied to it and then wiped the glucometer and dried it immediately with a dry facial tissue. RN-A then placed R54's glucometer and supplies into the blue container with his	F 880		

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F 880	Continued From page 52 name on it and put it in the locked medication cart. RN-A did not use an approved and recommended Environmental Protection Agency (EPA)-registered wipe to cleanse and disinfect the unit it prior to and/or following use. RN-A opened her care sheet and wrote the information on it. RN-A stated, "I always clean the glucometer with that sanitizer [pointing to an 8 fl ounce (oz) container of McKessan brand hand sanitizer on the medication cart]. It's what I have always done." During observation and interview with RN-C on 1/28/25 at 7:12 a.m., RN-C obtained communal Arkray Assure Platinum Blood Glucose Monitoring System, used for multiple residents in the facility, and supplies from medication cart and entered R26's room. RN-C did not clean glucometer prior to use. RN-C asked permission to obtain blood sugar result and then placed supplies directly on top of bedside table. There was no barrier used between the supplies and the bedside table. RN-C did not wash R26's fingers with soap and water. RN-C wiped right pointer finger with alcohol wipe, then inserted a glucometer strip into the machine turning it on. RN-C then used the lancet to the left pointer finger and obtained a sample of blood. RN-C wiped the finger with a cotton swab and then applied a drop of blood to the glucometer strip. RN-C obtained result and wiped finger with second alcohol wipe and removed the strip from the glucometer. RN-A then disposed of the lancet in a Sharps container and disposed of the used strip, cotton ball, alcohol towelettes, and gloves into the resident garbage container. RN-C then walked to medication cart and sanitized hands prior to applying gloves. RN-C wiped glucometer with Saniwipe cloth and immediately placed it	F 880		

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F 880	Continued From page 53	F 880		

back into the medication cart. This was not done according to the Saniwipe recommendations. RN-C stated, "no hand sanitizer" for cleaning glucometer.

During interview with licensed practical nurse (LPN)-A on 1/28/25 at 10:54 a.m., LPN-A stated the process for cleaning and disinfecting the glucometer was "clean it with the purple Saniwipe for thirty seconds and put on a paper towel and let it dry." LPN-A stated," hand sanitizer would not be ok to clean a glucometer because I think it needs more of the Saniwipe thing, it says two minutes". LPN-A provided surveyor a list of facility residents requiring blood glucose monitoring using the Arkray Assure Platinum Blood Glucose Monitoring System. The list was marked with icons that identified the residents who had personal dedicated glucometers in the locked medication carts and the residents who used the shared glucometers. Personal dedicated glucometers were identified as R10, R13, and R54. Shared glucometers were used for R15, R26, R29, R41, R49, and R118.

During interview with LPN-B on 1/28/25 at 11:26 a.m., LPN-B stated glucometer cleaning and disinfecting was done by the nurses. LPN-B stated expectation of glucometer cleaning as, "[sic] must use the Saniwipe or the alcohol wipe". LPN-B then opened a locked medication cart and removed an alcohol towelette and showed it to the surveyor. "This is what we can use".

During interview with registered nurse (RN)-C on 1/29/25 at 7:12 a.m., RN-C removed an Arkay Assure Platinum Blood Glucose Monitoring System glucometer from a medication cart and wiped it with a Saniwipe, then placing it on a facial

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F 880	Continued From page 54 tissue. RN-C stated, "no. [hand] sanitizer does not apply [to cleaning] it". During interview with RN-B on 1/30/25 at 9:31 a.m., RN-B stated the procedure to clean and disinfect the Arkay Assure Platinum Blood Glucose Monitoring System glucometer was to "wipe down the machine with one of the [Saniwipe} wipes" and to do this procedure "before and after use." RN-B stated, "I don't not usually wash fingers with soap and water before obtaining result. " During interview with trained medication aide (TMA)-A on 1/30/25 at 9:35 a.m., TMA-A stated staff were expected to clean and disinfect the glucometer with a Saniwipe "not alcohol wipe or hand sanitizer" before resident use. TMA-A also stated, "I don't know if the last person cleaned it or not." TMA-A stated, "I do not use soap and water to wash [resident] finger before poking finger [obtaining result]". During interview with assistant director of nursing (ADON) who was also the facilitys infection control preventionist on 1/30/25 at 10:43 a.m., ADON stated, "we use the purple Saniwipe between glucometer use and allow it sit for three minutes." ADON stated the expectation of nurses was to clean and disinfect the glucometer "always before and after" use. "I expect staff to follow manufacturers guidelines and instructions to wash hands with soap and water before testing and to clean and sanitize the machine with Saniwipe before and after use." ADON stated, "alcohol wipes are not the same as a Saniwipe" and they are not appropriate to clean a glucometer.	F 880		

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F 880	Continued From page 55 Facility policy on cleaning and disinfecting medical equipment was requested and not received.	F 880		

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THE ESTATES AT BLOOMINGTON LLC	9200 NICOLLET AVENUE SOUTH BLOOMINGTON, MN 55420

(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
2 000	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 1/27/25 to 1/30/25, 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. The following complaints were reviewed with no associated licensing orders issued: H53246005C (MN99852) H53246001C (MN100820) H53246002C (MN101938) H53246003C (MN105784) H53246004C (MN107534) H53246006C (MN108153) H53245600C (MN109889) Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled " ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for	2 000		

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2 000	Continued From page 2 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		
2 550	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 observation, interview, and document review, the facility failed to ensure the Minimum Data Set (MDS) was accurately coded to reflect anticoagulation status for 1 of 4 residents (R41) reviewed for MDS accuracy. Findings include: The Centers for Medicare and Medicaid Services (CMS) Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, dated 10/2018, identified the purpose of the RAI	2 550	Corrected.	3/10/25

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2 550	Continued From page 3 process was to help ensure holistic care was provided. According to the RAI/MDS the coding instructions for N0415 High Risk Drug Classes identify, "Residents taking medication in these medication categories and pharmacologic classes are at risk of side effects that can adversely affect health, safety, and quality of life." Section N0415 Anticoagulant include: "Column 1: Check if the resident is taking any medications by pharmacological classification during the 7-day observation period (or since admission/entry or reentry if less than 7 days). Column 2: If Column 1 is checked, check if there is an indication noted for all medications in the drug class." R41's quarterly MDS dated 12/23/24, identified R41, had intact cognition, and diagnoses of a stroke affecting right dominant side, diabetes, and seizure disorder. Section N0415 High Risk Drug Classes identified R41 as not taking an anticoagulant. R41's physician orders (PO) dated 9/18/24 identified, "Eliquis Oral Tablet (Apixaban), Give 5mg by mouth every morning and at bedtime related to CEREBRAL INFARCTION DUE TO EMBOLISH OF LEFT MIDDLE CEREBRAL ARTERY (I63.4120". The order identified "Medication Class: ANTICOAGULANTS". R41's care plan dated, 10/1/24 identified, "Potential for alteration in blood formation and coagulation, R/T use of anticoagulant medication". During interview with facility MDS Coordinator (MDS-C) on 1/29/25 at 1:32 p.m., MDS-C stated	2 550		

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2 550	Continued From page 4 she had worked for the facility for "year and a half" and was responsible for all the resident MDS submissions. MDS-C reviewed R41's quarterly MDS dated 12/23/24, and stated she had documented the N0415 section. MDS-C stated, "looks like I missed that one. I think I miscoded it." MDS-C stated "it is important to code the MDS accurately for quality of care and drives our payment, quality measures and care planning. " Facility policy on accuracy of MDS assessments was requested and 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		
2 915	MN Rule 4658.0525 Subp. 6 A Rehab - ADLs Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that: A. a resident is given the appropriate treatments and services to maintain or improve abilities in activities of daily living unless	2 915		3/10/25

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2 915	Continued From page 5 deterioration is a normal or characteristic part of the resident's condition. For purposes of this part, activities of daily living includes the resident's ability to: (1) bathe, dress, and groom; (2) transfer and ambulate; (3) use the toilet; (4) eat; and (5) use speech, language, or other functional communication systems; and This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure dental appliances (i.e., dentures) were offered or provided to promote safety and independence with eating for 1 of 4 residents (R60) reviewed for activities of daily living (ADL). Findings include: R60's quarterly Minimum Data Set (MDS), dated 11/19/24, identified R60 had severe cognitive impairment and demonstrated no rejection of care behaviors. Further, the MDS outlined R60 needed substantial and/or maximum assistance to complete oral hygiene (inc. dentures). R60's most recent MHM (Monarch Healthcare Management) Oral/Dental Evaluation, dated 11/18/24, identified R60's oral cavity had no issues and R60 used an upper and lower denture with their condition being recorded, "Good condition." R60 was recorded as edentulous (no natural teeth) and a summary outlined, "Resident	2 915	Corrected.	

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2 915	Continued From page 6 wears full upper and lower dentures. He denies pain with chewing. He is dependent on staff to perform oral hygiene. No mouth sores noted with oral inspection." The completed evaluation lacked evidence R60 refused to wear his dentures. On 1/27/25 at 1:36 p.m., R60 was observed seated in his wheelchair while in the hallway. R60 stated he was unsure how long he had lived at the care center and often mumbled his speech with responses. R60 had no visible natural teeth or dentures in place at this time. R60 stated his dentures were "at the dentist office," however, just mumbled a response when asked if he had issues with chewing his food without them. The following day, on 1/28/25 at 10:36 a.m., R60 was again observed in his wheelchair while in his room. R60 had no visible teeth or dentures in and, when asked, opened his mouth to show edentulous palates. R60 was again asked where his dentures were and responded aloud "at the dentist" again. R60 stated he would wear them if he had them adding aloud, "yea, why not," with a mumbled tone. When interviewed on 1/28/25 at 10:46 a.m., nursing assistant (NA)-A stated they had worked at the center for a few months and had worked with R60 prior. NA-A described R60 as needing help with transfers and could be "restless" at times. NA-A stated R60 was typically accepting of cares but added, "It depends on the day." NA-A stated R60 would "sometimes" refuse oral care adding, "He doesn't like to be touched too much." NA-A stated R60 did not wear dentures to their recall nor had they ever seen him with any placed adding, "I don't think so." NA-A stated dentures, if he had them, would be kept in his room. NA-A and the surveyor then inspected R60's room and	2 915		

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2 915	Continued From page 7 found a single, lower denture in his bedside dresser in a pink-colored cup. NA-A stated aloud, "I didn't even know that [he had one]." NA-A verified they had helped R60 with his morning cares that day and acknowledged they didn't offer the dentures to R60 due to not knowing about them. NA-A stated resident's with dentures should have them offered and placed before meals as it "helps to eat them for the food." R60's care plan, printed 1/28/25, identified all of R60's current or potential medical or mobility issues along with their corresponding goals and interventions. The care plan outlined R60 wore dentures and listed a single intervention which read, "Provide mouth care as per ADL personal hygiene." The care plan lacked when or how often to provide R60 his dentures nor evidence R60 refused to wear his dentures prior to 1/28/25. When interviewed on 1/28/25 at 11:02 a.m., registered nurse (RN)-D stated they had worked with R60 prior and we unsure off-hand if he used dentures or not adding aloud, "I'd have to check his room or record." RN-D stated R60 consumed a soft diet and had not, at least to their recall, ever voiced complaints about his mouth or eating. RN-D stated if a resident used dentures, they should be offered with morning cares and placed if able. R60's medical record was reviewed and lacked evidence R60 had been offered or refused his dentures on 1/27/25 and 1/28/25 when observed without them. On 1/28/25 at 1:16 p.m., the interim director of nursing (DON) was interviewed, and verified R60 had dentures but expressed he would often refuse to wear them when offered. DON stated	2 915		

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2 915	Continued From page 8 staff were expected to offer them to him and expressed refusals were not documented. DON stated it was important to offer and, if able, provide dentures as it "helps the resident with their food" and it was "just good quality care." A provided Activities of Daily Living (ADLs)/Maintain Abilities Policy, dated 3/2023, identified the facility would provide necessary care and services to ensure a resident' abilities in ADLs did not diminish unless unavoidable. The policy included, "3. The facility will provide care and services for the following ... d. Dining-eating, including meals and snacks, ..." SUGGESTED METHOD OF CORRECTION: The director of nursing (DON), or designee, could review applicable policies and procedures to ensure dentures were offered and, if applicable, placed for residents to ensure independence and safety with eating. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	2 915		
2 920	MN Rule 4658.0525 Subp. 6 B Rehab - ADLs Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that: B. 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 MN Requirement is not met as evidenced by:	2 920		3/10/25

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2 920	Continued From page 9 Based on observation, interview, and document review, the facility failed to ensure routine nail care was provided for 1 of 1 resident (R58) reviewed for activities of daily living (ADLs) who needed assistance from staff for nail care. Findings include: R58's quarterly Minimum Data Set (MDS) dated 12/17/24 indicated, R58 was cognitively intact, had no behaviors and did not refuse cares. MDS indicated R58 was independent with ADLs and needed set up or clean up assistance with showers. R58's Clinical Diagnosis Report printed 1/30/25, indicated diagnoses of gout (a form of arthritis that causes severe pain, swelling, redness and tenderness in joints), generalized muscle weakness, other reduced mobility, need for assistance with personal care, protein calorie malnutrition and failure to thrive. R58's ADLs care plan printed 1/30/25 indicated R58 needed assistance with personal cares. An undated Group Report Sheet used by nursing assistants to know how to care for the residents, indicated R58 needed assistance of one staff for bathing and grooming. R58's Weekly Skin Assessments forms printed on 1/30/25, completed on 1/11/25, 1/18/25, 1/25/15 and 1/26/25, indicated under the Bath and Nail Care, R58's fingernails and toenails did not need to be trimmed. During observation and interview on 1/27/25 at 1:00 p.m., R58 was laying on top of the bed and not wearing socks. R58's fingernails were about	2 920	Corrected.	

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2 920	Continued From page 10 half an inch long. His nails were yellow and had dark orange matter underneath most of them. R58's toenails were also about half an inch long and the toenail on his right big toe was cracked with a sharp edge. R58 stated, "They don't help me cut my fingernails or toenails; they are like an inch long. When my family or friends come to see me, they said I could do better with my personal care. I would like them to help me cut my nails. The last time they help me was 4 weeks ago. You ask them and they never come back." During observation and interview on 1/28/25 at 11:16 a.m., R58 was in bed watching TV and not wearing socks. R58's nails were still long. During observation and interview on 1/28/25 at 1:13 p.m., nursing assistant (NA)-C stated they cut the residents nails on shower days. If a resident is diabetic, the nurses will cut their nails. NA-C verified R58's fingernails and toenails were long. She said they were, "yellow/orange and had stuff underneath the fingernails." NA-C asked R58 if somebody offered to help him. R58 said, "No, it's been at least a month since they helped me with my nails." During interview on 1/29/25 at 8:29 a.m., R58 stated the staff set up the shower room for him, gave him towels, and he was able to shower by himself. R58 said the nurses had not checked his skin or cut his nails. R58 said, "This morning, a short nice blonde lady came to cut my fingernails. It feels so good, so much better." R58 toenails were not clipped. R58 was not sure who this person was. During interview on 1/29/25 at 8:49 a.m., the admission coordinator, who is a trained medical assistant and NA-D, stated sometimes she was	2 920		

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2 920	Continued From page 11 pulled to help on the floor, and she visited all the residents and offered nail care. NA-D stated, she cut R58's fingernails and said, "they were about half an inch long, they were yellow and there was stuff underneath the pinky nails." NA-D added, the podiatrist would cut his toenails that day. During interview on 1/29/25 on 9:31 a.m., nurse manager, a licensed practical nurse (LPN)-B, stated the residents' nails and toenails were trimmed on bath day by the nursing assistants. The nurses were responsible to take care of diabetic residents' nails, while some of the residents were seen by the podiatrist. LPN-B verified the Weekly Skin Assessments forms dated 1/11/25, 1/18/25, 1/25/25 and 1/26/25, under section C, Bath and Nail care, indicated R58's nails did not require trimming. During interview on 1/29/25 at 9:05 a.m., the assistant director of nursing (ADON) stated the expectation was nail care needed to be completed and documented, and if a resident refused nail care, it also needed to be documented. Residents with long nails were a concern because residents could scratch themselves and develop skin problems. Dirty nails are an infection control problem. ADON stated "we will need to provide education to the staff and make sure those cares get done." Facility policy title Activities of Daily Living dated 3/31/23, indicated a resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review all physician orders and care plans for residents	2 920		

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2 920	Continued From page 12 who are depedent with personal cares to ensure cares are performed as ordered. The director of nursing or designee, could conduct routine audits to ensure appropriate care and services were implemented as ordered. The results of those audits should be taken to the QAPI committee for a determined amount of time to ensure compliance or the need for further monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	2 920		
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 community use glucometers (machines to check blood sugar) were properly cleaned and disinfected between patient use, and failed to ensure staff who performed blood glucose checks were knowledgeable of process for cleaning and disinfecting blood glucose devices prior to and after use per manufacturer instructions. This had the potential to affect 9 of 9 (R10, R13, R15, R26, R29, R41, R49, R54, and R118) residents who were diabetic, had orders for blood glucose monitoring, and used a community glucometer.	21385	Corrected.	3/10/25

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21385	Continued From page 13 Findings include: The manufacturer's instructions for use of the Arkray Assure Platinum Blood Glucose Monitoring System in Section B: To reduce the chance of infection, the clinician is to, "Wash hands thoroughly with soap and water before putting on a new pair of gloves and performing the next patient test." And, prior to obtaining blood sample, "Step 1: Wash patient's hands with soap and warm water." Guidelines for cleaning and disinfecting the unit state, "To minimize the risk of transmitting blood-borne pathogens, the cleaning and disinfection procedure should be performed". Per the manufacturer's instructions, the clinician is to utilize the approved and recommended Environmental Protection Agency (EPA)-registered wipe to cleanse and disinfect the unit after each use. One of the approved wipes is, "Super Sani-Cloth Germicidal Disposable Wipes"[Saniwipe]. General guidelines for use of the wipe is to "Allow treated surface to remain wet for two (2) minutes. Let air dry." The procedure for cleaning and disinfecting the Assure Platinum Blood Glucose Monitoring System is to wear appropriate protective gear such as disposable gloves, wipe the surface of the meter to clean it, and wipe around the test strip port with unit facing down to prevent the disinfectant liquid from entering the meter. "Treated surface must remain wet for recommended contact time" per the wipes manufacturer's instructions. The product description for Super Sani-Cloth Germicidal Disposable Wipe list the "Overall Contact Time" (time a cleaner needs to kill germs on a surface or device) as two minutes. During continuous observation and interview on	21385		

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21385	Continued From page 14 1/27/25 at 5:44 p.m., registered nurse (RN)-A stated she was familiar with the residents. RN-A walked to the nursing medication cart and removed a yellow plastic container from the cart with R10's name written on top of it. From the container RN-A removed an Arkray Assure Platinum Blood Glucose Monitoring System glucometer, one lancet, container of test strips, two cotton balls, and two alcohol wipe towelettes. RN-A walked to R10's room with the supplies. RN-A entered R10 room and asked if she could "take your blood sugar before you eat?" R10 had started to eat dinner and was holding silverware and his wheelchair armrest when RN-A entered room. RN-A sanitized hands and applied gloves, then placed supplies directly on top of bedside table next to dinner tray. There was no barrier used between the supplies and the bedside table. RN-A did not wash R10's fingers with soap and water. RN-A wiped R10's right pointer finger with an alcohol wipe, then inserted a glucometer strip into the machine turning it on. RN-A then used the lancet to the right pointer finger and obtained a sample of blood. RN-A wiped the finger with a cotton swab and then applied a drop of blood to the glucometer strip. RN-A obtained the result, wiped the finger with second alcohol wipe, and removed the strip from glucometer. RN-A then disposed of the lancet in a Sharps container (puncture-resistant waste container), and disposed of the used strip, cotton ball, alcohol towelettes, and gloves into the resident garbage container. RN-A walked back to medication cart with glucometer after sanitizing hands and placed supplies on top of medication cart to document results on a care sheet. RN-A then obtained a facial tissue from top of medication cart, pumped hand sanitizer onto the tissue, and wiped the entire glucometer. RN-A obtained second facial tissue and immediately wiped the entire	21385		

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21385	Continued From page 15 glucometer with a dry tissue. RN-A unlocked the medication cart and returned the supplies back into R10's box, closed the lid and placed it back into the medication cart. RN-A did not use an approved and recommended Environmental Protection Agency (EPA)-registered wipe to cleanse and disinfect the unit prior to and/or following use. Immediately afterwards at 5:51 p.m., RN-A removed a blue plastic container from the cart with R54's name written on top of it. RN-A obtained an Arkray Assure Platinum Blood Glucose Monitoring System glucometer and supplies and walked to R54's bedroom and knocked on the door before entering the room. RN-A did not clean glucometer prior to use. RN-A asked permission to obtain blood sugar result and then placed supplies directly on top of bedside table next to his dinner tray. There was no barrier used between the supplies and the bedside table. RN-A did not wash R54's fingers with soap and water. RN-A wiped R54's left pointer finger with an alcohol wipe, then inserted glucometer strip into the machine turning it on. RN-A then used the lancet to the left pointer finger and obtained a sample of blood. RN-A wiped the finger with a cotton swab and applied a drop of blood to the glucometer strip. RN-A obtained result and wiped finger with second alcohol wipe and removed the strip from the glucometer. RN-A then disposed of the lancet in a Sharps container, and disposed of the used strip, cotton ball, alcohol towelettes, and gloves into the resident garbage container. RN-A walked to medication cart, sanitized her hands, applied gloves, and used a facial tissue with hand sanitizer applied to it and then wiped the glucometer and dried it immediately with a dry facial tissue. RN-A then placed R54's glucometer and supplies into the blue container with his name on it and put it in the locked medication	21385		

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21385	Continued From page 16 cart. RN-A did not use an approved and recommended Environmental Protection Agency (EPA)-registered wipe to cleanse and disinfect the unit it prior to and/or following use. RN-A opened her care sheet and wrote the information on it. RN-A stated, "I always clean the glucometer with that sanitizer [pointing to an 8 fl ounce (oz) container of McKessan brand hand sanitizer on the medication cart]. It's what I have always done." During observation and interview with RN-C on 1/28/25 at 7:12 a.m., RN-C obtained communal Arkray Assure Platinum Blood Glucose Monitoring System, used for multiple residents in the facility, and supplies from medication cart and entered R26's room. RN-C did not clean glucometer prior to use. RN-C asked permission to obtain blood sugar result and then placed supplies directly on top of bedside table. There was no barrier used between the supplies and the bedside table. RN-C did not wash R26's fingers with soap and water. RN-C wiped right pointer finger with alcohol wipe, then inserted a glucometer strip into the machine turning it on. RN-C then used the lancet to the left pointer finger and obtained a sample of blood. RN-C wiped the finger with a cotton swab and then applied a drop of blood to the glucometer strip. RN-C obtained result and wiped finger with second alcohol wipe and removed the strip from the glucometer. RN-A then disposed of the lancet in a Sharps container and disposed of the used strip, cotton ball, alcohol towelettes, and gloves into the resident garbage container. RN-C then walked to medication cart and sanitized hands prior to applying gloves. RN-C wiped glucometer with Saniwipe cloth and immediately placed it back into the medication cart. This was not done according to the Saniwipe recommendations.	21385		

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21385	Continued From page 17 RN-C stated, "no hand sanitizer" for cleaning glucometer. During interview with licensed practical nurse (LPN)-A on 1/28/25 at 10:54 a.m., LPN-A stated the process for cleaning and disinfecting the glucometer was "clean it with the purple Saniwipe for thirty seconds and put on a paper towel and let it dry." LPN-A stated," hand sanitizer would not be ok to clean a glucometer because I think it needs more of the Saniwipe thing, it says two minutes". LPN-A provided surveyor a list of facility residents requiring blood glucose monitoring using the Arkray Assure Platinum Blood Glucose Monitoring System. The list was marked with icons that identified the residents who had personal dedicated glucometers in the locked medication carts and the residents who used the shared glucometers. Personal dedicated glucometers were identified as R10, R13, and R54. Shared glucometers were used for R15, R26, R29, R41, R49, and R118. During interview with LPN-B on 1/28/25 at 11:26 a.m., LPN-B stated glucometer cleaning and disinfecting was done by the nurses. LPN-B stated expectation of glucometer cleaning as, "[sic] must use the Saniwipe or the alcohol wipe". LPN-B then opened a locked medication cart and removed an alcohol towelette and showed it to the surveyor. "This is what we can use". During interview with registered nurse (RN)-C on 1/29/25 at 7:12 a.m., RN-C removed an Arkay Assure Platinum Blood Glucose Monitoring System glucometer from a medication cart and wiped it with a Saniwipe, then placing it on a facial tissue. RN-C stated, "no. [hand] sanitizer does not apply [to cleaning] it".	21385		

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21385	Continued From page 18 During interview with RN-B on 1/30/25 at 9:31 a.m., RN-B stated the procedure to clean and disinfect the Arkay Assure Platinum Blood Glucose Monitoring System glucometer was to "wipe down the machine with one of the [Saniwipe} wipes" and to do this procedure "before and after use." RN-B stated, "I don't not usually wash fingers with soap and water before obtaining result. " During interview with trained medication aide (TMA)-A on 1/30/25 at 9:35 a.m., TMA-A stated staff were expected to clean and disinfect the glucometer with a Saniwipe "not alcohol wipe or hand sanitizer" before resident use. TMA-A also stated, "I don't know if the last person cleaned it or not." TMA-A stated, "I do not use soap and water to wash [resident] finger before poking finger [obtaining result]". During interview with assistant director of nursing (ADON) who was also the facilitys infection control preventionist on 1/30/25 at 10:43 a.m., ADON stated, "we use the purple Saniwipe between glucometer use and allow it sit for three minutes." ADON stated the expectation of nurses was to clean and disinfect the glucometer "always before and after" use. "I expect staff to follow manufacturers guidelines and instructions to wash hands with soap and water before testing and to clean and sanitize the machine with Saniwipe before and after use." ADON stated, "alcohol wipes are not the same as a Saniwipe" and they are not appropriate to clean a glucometer. Facility policy on cleaning and disinfecting medical equipment was requested and not received.	21385		

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21385	Continued From page 19 SUGGESTED METHOD OF CORRECTION: The DON (Director of Nursing) or designee should review/revise facility policies to ensure appropriate disinfection between resident use. 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		3/10/25

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21530	Continued From page 20 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 (R13) reviewed for unnecessary medications. Findings include: R13's quarterly Minimum Data Set (MDS) dated 10/24/24, indicated R13 had intact cognition and utilized antipsychotic, antianxiety, and antidepressant medication. R13's diagnostic report dated 7/1/24, indicated R13 was diagnosed with major depressive disorder, bipolar disorder, and an anxiety disorder. R13's Order Summary report dated 1/30/25,	21530	Corrected.	

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21530	Continued From page 21 included the following orders: -dated 6/2/23 for 200 milligrams (mg) of quetiapine (an antipsychotic medication used to treat bipolar disorder) daily for bipolar disorder. -dated 8/14/23 for 300 mg of bupropion XL (an antidepressant) daily for major depressive disorder. -dated 8/14/23 for 120 mg of duloxetine (an antidepressant) daily for major depressive disorder. -dated 8/14/23 for 400 mg of lamotrigine (an anticonvulsant sometimes used to treat bipolar disorder) daily for a bipolar disorder. -dated 12/29/23 for five mg of aripiprazole (an antipsychotic medication used to treat bipolar disorder) daily for bipolar disorder. -dated 12/29/23 for three mg of melatonin (a dietary supplement used to assist with sleep) daily for insomnia. -dated 1/23/24 for 10 mg of buspirone (an anti-anxiety medication) twice a day for an anxiety disorder. R13's Consultant Pharmacist Recommendation to Physician dated 12/23/24, indicated R13 received "psychotic medication" including five mg of aripiprazole daily, 10 mg of buspirone twice a day, 400 mg of lamotrigine daily, 300 mg of bupropion XL daily, and 120 mg of duloxetine daily. The pharmacist recommended the prescriber review if R13 was on the lowest effective doses of the medications listed above. The pharmacist indicated if a dose reduction was contraindicated, that the clinical rationale be documented below. The recommendation had a blank for a signature, date, and prescriber response that were left blank. R13's Consultant Pharmacist Recommendation to Physician dated 1/27/25, indicated R13	21530		

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21530	Continued From page 22 received "psychotropic medications" including five mg of aripiprazole daily, 10 mg of buspirone twice a day, 400 mg of lamotrigine daily, 300 mg of bupropion XL daily, 120 mg of duloxetine daily, three mg of melatonin daily, and 200 mg of quetiapine daily. The pharmacist recommended the prescriber review if R13 was on the lowest effective doses of the medications listed above. The pharmacist indicated if a dose reduction was contraindicated, that the clinical rationale be documented below. The recommendation had a blank for a signature, date, and prescriber response that were left blank. R13's medical record was reviewed and did not include a provider response to the above pharmacist recommendations. During an interview on 1/30/25 at 9:26 a.m., the consulting pharmacist (CP) stated when she had reviewed R13's medication record she had not found evidence the provider had attempted or declined to attempt a dose reduction of her psychotropic medications in the current quarter. The CP stated she had given a similar recommendation in January as the previous CP had in December, as she could not find that the provider had responded to the recommendation given in December, and it was important that they attempt to reduce psychotropic medication use when possible. During an interview on 1/30/25 at 11:43 a.m., the interim director of nursing (DON) confirmed she had reviewed R13's medical record and could not find that a response was received from the provider regarding the pharmacist's recommendation for a dose reduction. The interim DON stated she thought the recommendation should have been sent to R13's	21530		

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21530	Continued From page 23 psychiatrist as they managed her psychotropic medications but as R13 had changed psychiatrists recently, was unsure who this was sent to as the previous DON oversaw this task. The interim DON stated she expected these to be faxed to the provider and the response uploaded to the medical record. The facility's Medication Regimen Review policy dated 8/19, indicated the pharmacist would review each resident's medication regimen at least monthly, and the recommendations would be acted upon and documented by facility staff and/or the prescriber. The prescriber would accept and act upon the suggestions or reject the suggestion and give an explanation for disagreeing. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures for pharmacy reviews and irregularities. The director of nursing or designee could develop a system to educate staff and develop a monitoring system to ensure pharmacy reviews are timely and irregularities are being acted upon. The quality assurance committee could monitor these measures to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) days	21530		
21665	MN Rule 4658.1400 Physical Environment A nursing home must provide a safe, clean, functional, comfortable, and homelike physical environment, allowing the resident to use	21665		3/10/25

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21665	Continued From page 24 personal belongings to the extent possible. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure an unsecured bed mattress was assessed for correct fit for a resident's bed for 1 of 1 residents (R59) reviewed for safety hazards. Findings include: R59's quarterly Minimum Data Set dated 12/19/24 identified R59 had intact cognition and was independent with most mobility related activities (i.e., dressing, toileting and personal hygiene, and ambulation). In addition, R59 had diagnoses of cellulitis (bacterial infection of the skin that can cause redness, pain and swelling at the site) of left lower extremity, anxiety, and depression. During observation and interview with R59 on 1/27/25 at 1:26 p.m., R59 was observed to be lying in bed which was positioned along the wall with the foot of the bed just inside door to hallway. The bed had no footboard, and the unsecured mattress hung over the foot of the bed frame by about 12 inches. There was no retainer bar at the foot of the bed frame to prevent mattress from sliding down. R59 stated, "it is hard to get on and off of it" and "I have to move my feet" to allow roommate and others to open and close the door to the hallway. During observation on 1/28/25 at 8:04 a.m., R59 unsecured mattress continued to hang off the foot of the bed frame by about twelve inches.	21665	Corrected.	

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21665	Continued From page 25 During observation and interview with nursing assistant (NA)-B on 1/28/25 at 11:00 a.m., NA-B stated she was familiar with R59 and pointed to his bed mattress. "[R59] is tall and a big guy. That mattress does not fit him. I haven't noticed it or said anything to anyone about it and I haven't heard anyone saying or doing anything about it." During observation and interview with RN-C on 1/28/25 at 1:10 p.m., RN-C stated she was familiar with R59. RN-C pointed out "no footboard. I would expect it to be there. All beds should have headboards and foot boards. I don't know why it is like that. " RN-C identified the unsecured mattress as a safety risk. During interview with the maintenance director (MD) on 1/28/25 at 1:21 p.m., MD stated, "[R59] should have footboard. He kicked it off. [Facility] don't have bed extenders for these beds. We don't have alternatives, and I haven't looked for any." MD stated he was aware of R59's unsecured mattress sliding down past the bedframe and was not responsible for assessing the appropriateness of the mattress and bedframe. MD stated, "no I have not asked [R59] for alternatives or options to the overhanging mattress". During interview with R59 pm 1/28/25 at 1:28 p.m., R59 stated he "kicked off" the footboard. R59 stated, "[mattress] is uncomfortable. I was not told about any alternative to the mattress or bed." R59 stated facility staff were aware of the missing footboard because staff "put it in my closet." During interview with licensed practical nurse (LPN)-C on 1/28/25 at 2:06 p.m., LPN-B stated he was also the nurse manager for the resident	21665		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00169	A. BUILDING: _____ B. WING _____	C 01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ESTATES AT BLOOMINGTON LLC	9200 NICOLLET AVENUE SOUTH BLOOMINGTON, MN 55420

(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
21665	Continued From page 26 wing R59 resided on. LPN-B stated he was told that R59's missing footboard and slipping mattress "was his preference. The staff removed the foot board. Since then, I did not visit back with him about it." LPN-B stated, "I think [R59] would benefit from an extension to the mattress or bed[frame]. He is at risk for pressure ulcers to feet." LPN-B stated the electronic medical record (EMR) failed to address the footboard and his unsecured mattress sliding down past the frame of the bed. During observation and interview with assistant director of nursing (ADON) on 1/28/25 at 2:30 p.m., ADON and surveyor walked to R59's room. ADON stated R59 "would rest his feet on top of the footboard and it is not appropriate and [R59] said he likes to hang his feet over it. [R59] did not want the footboard. He slides down in the bed. I don't know if maintenance addressed the mattress or bed. As far as I know, we do have extensions for beds. [R59] is very much alert and oriented and knows what his wants and needs are." ADON stated, "it is awkward" and facility did not have documentation of assessing [R59's] bed frame and unsecured mattress. During interview with MD on 1/28/25 at 3:10 p.m., MD stated, "[facility] do[sic] have extensions and longer mattresses and bed[frames]. I do not document or have anything about offering alternatives for extending the bed frame or mattress." MD stated R59 "slides down". During interview with ADON on 1/30/25 at 11:17 a.m., ADON stated, "[facility] did not assess and reassess for the mattress to stay secured on the bed frame. The mattress does slide down off the foot of the bed without the foot board and his feet do dangle off the mattress at times."	21665		

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21665	Continued From page 27 Facility policy on Bed Safety was requested and not received. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could educate staff regarding the importance of a safe, clean, functional and homelike environment. The DON or designee, could coordinate with maintenance and housekeeping staff to conduct periodic audits of areas residents frequent to ensure a safe, clean, functional and homelike environment is maintained to the extent possible. Time Period for Correction: Twenty-one (21) days.	21665		
21685	MN Rule 4658.1415 Subp. 2 Plant Housekeeping, Operation, & Maintenance Subp. 2. Physical plant. The physical plant, including walls, floors, ceilings, all furnishings, systems, and equipment must be kept in a continuous state of good repair and operation with regard to the health, comfort, safety, and well-being of the residents according to a written routine maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the facility failed to ensure a comfortable and homelike environment for 2 of 2 residents (R19, R23) who shared a room with a large area of the wall patched but left unfinished, unsanded, and unpainted.	21685	Corrected.	3/10/25

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21685	Continued From page 28 Findings include: R19's quarterly Minimum Data Set (MDS) dated 12/10/24, identified R19 had intact cognition. R23's annual MDS dated 12/9/24, identified had intact cognition. During observation and interview on 1/27/25 at 6:01 p.m., a shared wall of R19 and R23's room had an area of white joint compound that measured one hundred and three inches long by thirty-seven inches tall spanning most of the wall. The area was not sanded, smoothed out, or painted to match the rest of the wall and room. R23 stated, "the wall has been like this since [sic] moved to this room in October of 2024." During interview with registered nurse (RN)-B on 1/28/25 at 10:01 a.m., RN-B stated she was familiar with all the residents. RN-B stated there was an expectation of staff to notify the maintenance staff for repair work through an email request form. "All staff can do it." RN-B denied noticing the unfinished wall repair in R19 and R23's room or submitting a maintenance request to complete the sanding and painting. During interview with nursing assistant (NA)-A on 1/28/25 at 10:25 a.m., NA-A stated she was familiar with all the residents. NA-A stated staff were expected to notify the maintenance staff for repair work, "online. If [maintenance director] is not here, I may talk to the nurse manager." NA-A denied noticing the unfinished wall repair in R19 and R23's room or submitting a maintenance request to complete the sanding and painting. During interview on 1/28/25 at 10:44 a.m., R23's stated, "I don't like it because it tells me the place	21685		

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21685	Continued From page 29 has not been totally taken care of and not necessarily clean. I would never stand for that in my own home." During interview with NA-B on 1/28/25 at 11:00 a.m., NA-B stated she was familiar with the residents. NA-B stated expectation of staff to notify the maintenance staff for repair work "in the computer". NA-B denied noticing the unfinished wall repair in R19 and R23's room or submitting a maintenance request to complete the sanding and painting. During interview with NA-C on 1/28/25 at 11:12 a.m., NA-C stated she was familiar with all the residents. NA-A stated expectation of staff to notify the maintenance staff for repair work through an email request form. NA-C denied noticing the unfinished wall repair in R19 and R23's room or submitting a maintenance request to complete the sanding and painting. During observation and interview on 1/28/25 at 11:26 a.m., LPN-B looked at R19 and R23's shared wall and stated, "I don't know when they [maintenance staff] did that work on the wall but it is not finished. It does not look good. I have not noticed that before." At 2:02 p.m., LPN-B stated staff was expected to use a communication system with the maintenance department if a repair was needed, "like for painting a hallway or resident room." During observation and interview with the maintenance director (MD) on 1/28/25 at 12:14 p.m., MD looked at R19's and R23's bedroom wall and stated, "I have patched this. In order for me to paint, I have to pull everyone out of their rooms, and we have been full lately. And we don't have the colors in here anymore. We don't have	21685		

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21685	Continued From page 30 rooms to put [R19 and R23] in. If I had extra room to put these residents in while I fix the paint, then I would be able to do something about it." MD stated he could not remember when he patched their wall. MD stated he did not have a work order or documentation of ever working on the wall but that he was aware of it needing to be "fixed". During interview with R19 and R23 on 1/30/25 at 9:25 a.m., R19 stated, "it [wall patch] has been here since I got here. I think at one point [maintenance] was fixing something on the wall over there [pointing to R23's side of the room] and he did this. Looking at it makes me think it is dirty, not cared for. I don't like it. I would like it painted." R23 stated, "I am embarrassed by it." During interview with assistant director of nursing (ADON) on 1/30/25 at 10:50 a.m., ADON stated, "the wall should be painted. Don't know how long that is has been there. It is not appealing." Facility policy on building maintenance and repair was requested and not received. SUGGESTED METHOD OF CORRECTION: The administrator, maintenance supervisor, or designee could ensure a preventative maintenance program was developed to accurately reflect ongoing preventative maintenance scheduled or needed in the facility on a routine basis. The facility could create policies and procedures, educate staff on these changes and perform environmental rounds/audits periodically to ensure preventative maintenance is adequately completed. The facility could report those findings to the quality assurance performance improvement (QAPI) committee for further recommendations to ensure ongoing compliance.	21685		

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21685	Continued From page 31 TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21685		

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	245324	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**01/28/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ESTATES AT BLOOMINGTON LLC	**9200 NICOLLET AVENUE SOUTH** **BLOOMINGTON, MN 55420**

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 01/28/2025. At the time of this survey, The Estates At Bloomington was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		02/24/2025

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

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K 000	Continued From page 1	K 000		

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.

The Estates at Bloomington is a 1-story building with a partial basement. The building was constructed at 3 different times with original building being constructed in 1957 and was determined to be of Type II (111) construction. In 1963, an addition was constructed and was determined to be of Type II (111) construction. Then in 1999, an addition was constructed and was determined to be Type II (111) construction. The facility is fully protected throughout by an automatic fire sprinkler system and has a fire

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K 000	Continued From page 2 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 68 beds and had a census of 64 at the time of the survey. The requirements at 42 CFR, Subpart 483.70(a), are NOT MET as evidenced by:	K 000		
K 222 SS=E	Egress Doors CFR(s): NFPA 101 Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release	K 222		2/26/25

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K 222	Continued From page 3 upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to install the delayed egress system per NFPA 101 (2012 edition), Life Safety Code	K 222	Appropriate signs were placed on delayed egress exit doors at end of 300 hall and sunshine room.	

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K 222	Continued From page 4 sections 19.2.1 and 7.2.1.6.1.1 (4). These deficient findings could have a patterned impact on the residents within the facility. Findings include: 1. On 01/28/2025 at 10:59 AM, it was revealed by observation that the exit door near resident room 312 had a delayed egress system installed and did not have a sign saying "PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS" on it. 2. On 01/28/2025 at 11:06 AM, it was revealed by observation that the exit door in the sunshine room had a delayed egress system installed and did not have a sign saying "PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS" on it. An interview with the Regional Maintenance Director and the Maintenance Director verified these deficient findings at the time of discovery.	K 222	All other delayed egress doors have appropriate signage. Audit of delayed egress doors to ensure signage remains intact is completed weekly x 4 weeks. The results of these audits will be reviewed at the facility QAPI meeting for input on the need to increase, decrease, or discontinue the audits Corrections will be monitored by: Maintenance Director/ Designee	
K 321 SS=E	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches	K 321		2/26/25

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K 321	Continued From page 5 from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain hazardous rooms per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.2.1.2, 19.3.2.1.3, 19.3.2.1.5, 8.4.3.5, 8.3.3.1, and 7.2.1.8.1. These deficient findings could have a patterned impact on the residents within the facility. Findings include: 1. On 01/28/2025 at 10:33 AM, it was revealed by observation that the laundry room door B5 in the basement did not positively latch. 2. On 01/28/2025 at 10:37 AM, it was revealed by observation that the boiler room door B7 in the basement would not positively latch. An interview with the Regional Maintenance Director and the Maintenance Director verified	K 321	Laundry door B5 and boiler room door B7 positively latch per Life Safety Code. All other hazardous doors audited and latch appropriately. Completed education with maintenance director on routine maintenance to ensure all hazardous doors latch per Life Safety Code. Audit of hazardous doors to ensure they positively latch is completed weekly x4 weeks. The results of these audits will be reviewed at the facility QAPI meeting for input on the need to increase, decrease, or discontinue the audits. Corrections will be monitored by:	

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	245324	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**01/28/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ESTATES AT BLOOMINGTON LLC	**9200 NICOLLET AVENUE SOUTH** **BLOOMINGTON, MN 55420**

(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 321	Continued From page 6 these deficient findings at the time of discovery.	K 321	Maintenance Director/ Designee	
K 355 SS=E	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain access to 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, section 6.1.3.3.1. These deficient findings could have a patterned impact on the residents within the facility. Findings include: 1. On 01/28/2025 at 10:51 AM, it was revealed by observation that two walkers blocked the fire extinguisher in physical therapy. 2. On 01/28/2025 at 11:07 AM, it was revealed by observation that a patient lift blocked the fire extinguisher near resident room 110. An interview with the Regional Maintenance Director and the Maintenance Director verified these deficient findings at the time of discovery.	K 355	Walkers were moved and do not block fire extinguisher. Patient lift was moved and does not block fire extinguisher. All other fire extinguishers free of hazards. Education with all staff per Life Safety Code to ensure that no equipment is in front or blocks fire extinguishers. Audit fire extinguishers to be free of hazards daily for 5 days, then weekly x 4 weeks. The results of these audits will be reviewed at the facility QAPI meeting for input on the need to increase, decrease, or discontinue the audits. Corrections will be monitored by: Maintenance Director/ Designee	2/26/25
K 363 SS=D	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors	K 363		2/26/25

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K 363	Continued From page 7 Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 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	K 363	Door of room 208 has positive latching	

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K 363	Continued From page 8 facility failed to maintain corridor doors per NFPA 101 (2012 edition), Life Safety Code, section 19.3.6.3.5 and 19.3.6.3.10. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 01/28/2025 at 11:15 AM, it was revealed by observation that the door to resident room 208 would not fully close and latch. An interview with the Regional Maintenance Director and the Maintenance Director verified this deficient finding at the time of discovery.	K 363	hardware per Life Safety Code. All other corridor doors audited and latch appropriately. Maintenance Director educated on routine maintenance to ensure all corridor doors latch per Life Safety Code. Staff educated on submitting work orders through TELS. Audit 10 resident room doors to ensure they latch appropriately weekly x 4 weeks. The results of these audits will be reviewed at the facility QAPI meeting for input on the need to increase, decrease, or discontinue the audits. Corrections will be monitored by: Maintenance Director/ Designee	
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. (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	K 541		2/26/25

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K 541	Continued From page 9 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 01/28/2025 at 11:13 AM, it was revealed by observation that the latch on the laundry chute door near room 200B would get stuck causing the door to not latch. An interview with the Regional Maintenance Director and the Maintenance Director verified this deficient finding at the time of discovery.	K 541	Laundry chute door maintained and positively latches per Life Safety Code. Maintenance Director educated on routine maintenance to ensure laundry chute positively latches. Staff educated on submitting work orders through TELS. Audit laundry chute to ensure it latches weekly x 4 weeks. The results of these audits will be reviewed at the facility QAPI meeting for input on the need to increase, decrease, or discontinue the audits. Corrections will be monitored by: Maintenance Director/ Designee	
K 912 SS=D	Electrical Systems - Receptacles CFR(s): NFPA 101 Electrical Systems - Receptacles Power receptacles have at least one, separate, highly dependable grounding pole capable of maintaining low-contact resistance with its mating plug. In pediatric locations, receptacles in patient rooms, bathrooms, play rooms, and activity rooms, other than nurseries, are listed	K 912		2/26/25

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K 912	Continued From page 10 tamper-resistant or employ a listed cover. If used in patient care room, ground-fault circuit interrupters (GFCI) are listed. 6.3.2.2.6.2 (F), 6.3.2.2.4.2 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to maintain electrical outlets per NFPA 99 Standards for Health Care Facilities 2012 edition, section 6.3.2.1, and NFPA 70, (2011 edition), National Electrical Code, section 110.12. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 01/28/2025 at 11:10 AM, it was revealed by observation that the electrical outlet located above the nurse's station desk at the beginning of the 200 wing had a ground prong broken off and stuck in it. An interview with the Regional Maintenance Director and the Maintenance Director verified this deficient finding at the time of discovery.	K 912	Electrical outlet at nurses station was repaired per Life Safety Code. Audited all other electrical outlets to ensure in good condition. All staff educated on submitting work orders through TELS. Audit 5 electrical outlets to ensure it is in good condition weekly x 4 weeks. The results of these audits will be reviewed at the facility QAPI meeting for input on the need to increase, decrease, or discontinue the audits. Corrections will be monitored by: Maintenance Director/ Designee	