| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245236 | A. BUILDING _____ B. WING _____ | R-C 09/21/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **BENEDICTINE HEALTH CENTER** | **935 KENWOOD AVENUE DULUTH, MN 55811** |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| {E 000} | Initial Comments<br><br>No Appendix Z, Emergency Preparedness, deficiencies were noted at the time of the recertification survey, 6/21/21. | {E 000} | | |
| {F 000} | INITIAL COMMENTS<br><br>On 9/21/21, an offsite revisit was conducted to follow up on deficiencies issued related to an onsite PCR survey exited on 8/19/21, and the standard recertification survey prior to that, exited on 6/21/21. Your facility was IN compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities.<br><br>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, the facility must acknowledge receipt of the electronic documents. | {F 000} | | |

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

Electronically Signed | 10/12/2021

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.

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

**MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL**

ID: L435

**PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY**

Facility ID: 00861

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245236**
2.STATE VENDOR OR MEDICAID NO.
(L2) **819240500**

3. NAME AND ADDRESS OF FACILITY
(L3) **BENEDICTINE HEALTH CENTER**
(L4) **935 KENWOOD AVENUE**
(L5) **DULUTH, MN** (L6) **55811**

4. TYPE OF ACTION: **7** (L8)
**1. Initial** **2. Recertification**
**3. Termination** **4. CHOW**
**5. Validation** **6. Complaint**
**7. On-Site Visit** **9. Other**
**8. Full Survey After Complaint**

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **08/19/2021** (L34)

8. ACCREDITATION STATUS: __ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

| | | | | |
|---|---|---|---|---|
| **01 Hospital** | **05 HHA** | **09 ESRD** | **13 PTIP** | **22 CLIA** |
| **02 SNF/NF/Dual** | **06 PRTF** | **10 NF** | **14 CORF** | |
| **03 SNF/NF/Distinct** | **07 X-Ray** | **11 ICF/IID** | **15 ASC** | |
| **04 SNF** | **08 OPT/SP** | **12 RHC** | **16 HOSPICE** | |

FISCAL YEAR ENDING DATE: (L35)
**06/30**

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **96** (L18)
13.Total Certified Beds **96** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC
**X** B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

| 18 SNF | 18/19 SNF | 19 SNF | ICF | IID |
|---|---|---|---|---|
| | 96 | | | |
| (L37) | (L38) | (L39) | (L42) | (L43) |

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE Date :
Susan Frericks, Unit Supervisor 10/01/2021 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Joanne Simon, Enforcement Specialist 10/01/2021 (L20)

**PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY**

19. DETERMINATION OF ELIGIBILITY
**X** 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION
**11/17/1980**
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
**03001**
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
**09/02/2021**
(L33)

DETERMINATION APPROVAL

Electronically delivered
September 8, 2021

Administrator
Benedictine Health Center
935 Kenwood Avenue
Duluth, MN 55811

RE: CCN: 245236
Cycle Start Date: June 21, 2021

Dear Administrator:

On July 9, 2021, we informed you of imposed enforcement remedies.

On August 19, 2021, the Minnesota Department of Health completed a revisit and it has been determined that your facility continues to not to be in substantial compliance. The most serious deficiencies in your facility were found to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

The deficiency(ies) not corrected is/are as follows:

F0755 -- S/S: D -- 483.45(a)(b)(1)-(3) -- Pharmacy Srvcs/procedures/pharmacist/records

As a result of the revisit findings:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective June 21, 2021, will remain in effect.

This Department continues to recommend that CMS impose a civil money penalty. (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective June 21, 2021. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective June 21, 2021.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

As we notified you in our letter of July 9, 2021, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from June 21, 2021.

## ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable plan of correction (ePOC) for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

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

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

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:

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

- Per day civil money penalty (42 CFR 488.430 through 488.444).

## DEPARTMENT CONTACT

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

Susan Frericks, Unit Supervisor
Duluth District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health

Duluth Technology Village
11 East Superior Street, Suite 290
Duluth, Minnesota 55802-2007
Email: susan.frericks@state.mn.us
Mobile: (218) 368-4467

## PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

## VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by December 21, 2021 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. 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.

## APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40,

et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Tamika.Brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

INFORMAL DISPUTE RESOLUTION/ INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245236 | A. BUILDING _____ B. WING _____ | R-C 08/19/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **BENEDICTINE HEALTH CENTER** | **935 KENWOOD AVENUE DULUTH, MN 55811** |

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|---|---|---|---|---|
| {E 000} | Initial Comments<br><br>No Appendix Z, Emergency Preparedness, deficiencies were noted at the time of the recertification survey, 6/21/21. | {E 000} | | |
| {F 000} | INITIAL COMMENTS<br><br>On 8/18/21, and 8/19/21, an onsite revisit was conducted to follow up on deficiencies related to a standard recertification survey exited on 6/21/21. The facility was found to be NOT in compliance with the requirements of 42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities.<br><br>The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form.<br><br>Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained. | {F 000} | | |
| {F 755} SS=D | Pharmacy Srvcs/Procedures/Pharmacist/Records<br>CFR(s): 483.45(a)(b)(1)-(3)<br><br>§483.45 Pharmacy Services<br>The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.<br><br>§483.45(a) Procedures. A facility must provide | {F 755} | | 9/10/21 |

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

Electronically Signed | 09/10/2021

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| {F 755} | Continued From page 1<br>pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.<br><br>§483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-<br><br>§483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility.<br><br>§483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and<br><br>§483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, and document review, the facility failed to ensure crushed medications were not combined and crushed together to be administered together through a gastrostomy tube (GTube-a tube surgically inserted into the stomach for nutrition, hydration, and medication administration) without a physician's order to combine medications for 1 of 3 residents (R78) reviewed for crushing and combining of medications for administration. In addition, the facility failed to ensure medications were administered by the same nursing staff who prepared medications for administration to prevent medication errors and diversion for 1 of 3 residents (R78) observed during medication administration. | {F 755} | R 78's medications have been reviewed by pharmacy and primary MD for appropriateness to crush and combine medications and administered through G-tube. MD orders reflect ok to crush and combined medications. MAR updated to reflect MD orders.<br><br>All residents who receive medications via G-tube have been reviewed for appropriateness to crush and combine per pharmacy and MD review/orders.<br><br>All licensed nurses and Trained Medical Assistance (TMA) have been re-educated on their scope of practice and job | |

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| {F 755} | Continued From page 2<br><br>Findings include:<br><br>R78's face sheet printed 8/19/21, indicated R78's diagnoses included epilepsy (seizures), pneumonitis due to inhalation of food and vomit, and dysphagia (swallowing difficulty).<br><br>R78's physician's orders updated 8/20/21, included:<br><br>-OK to crush and administer medications through GTube dated 7/7/21<br>-acetaminophen 1000 milligrams (mg) gastric tube, three times a day.<br>-Banzel suspension; 40 mg/milliliter (ml); 20 ml=800; gastric tube four times a day<br>-levocarnitine 330 mg; gastric tube three times a day<br>-valproic acid solution; 250 mg/5 ml; 10 ml=500 mg; gastric tube four times a day<br>-lamotrigine tablet; 200 mg; gastric tube three times a day<br>-Lasix tablet; 20 mg gastric tube once a morning<br>-primidone tablet; 50 mg; gastric tube twice a day<br>-vitamin D3; 2000 units; gastric tube once a day<br>-zinc tablet; 50 mg once an evening<br>-OK to crush and administer medications together through GTube dated 8/18/21.<br><br>R78's Medication Administration Record (MAR) and Treatment Administration Record (TAR) for 8/1/21 to 8/19/21, directed to "Crush meds and give through G-tube" at the top of each page. R78's MAR and TAR lacked directives to combine crushed medications together.<br><br>On 8/18/21, at 11:20 a.m. trained medication aide (TMA)-B was observed to be preparing | {F 755} | descriptions which includes TMA's not preparing medications for G-Tube administration and following MD orders, training completed on 08/27/2021 if staff were unable to attend a training session a personal one on one education was completed. Observations/audits for medication administration via G-tube haven been conducted following training of licensed staff and TMAs to verify understanding of the expectations. Observations/audits completed since training have indicated through understanding of the administration process and expectations.<br><br>We will conduct 5 audits per week of medication administrations that consist of crushed medications and or with G-tube medications administration to include all shifts until our quality council deems, we are 100% compliance. DON or designee is responsible. | |

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| {F 755} | Continued From page 3 | {F 755} | | |

medications to be administered to R78. TMA had placed medications in different medication cups. Licensed practical nurse (LPN)-G approached the medication cart from the nurse's station area, picked up a medication cup with tablets in it, put the tablets into a small plastic sleeve, and crushed the tablets together. LPN-G put the crushed medications into a medication cup, and walked away from the medication cart. TMA-B continued to prepare medications for administration for R78. TMA-B stated she had placed tablets in one medication cup, acetaminophen in a separate cup, liquid medications in separate medication cups, and the zinc was in a separate cup. TMA-B stated the zinc could not be crushed so would be added later. TMA-B stated R78's medications were crushed to be given through the GTube by the nurse. TMA-B stated she usually crushed and prepared the medications and the nurse administered them, as she was unable to administer medications through the GTube. TMA-B verified R78 had orders to crush medication and give through the GTube, but did not have orders to crush medications together or combine crushed medications.

On 8/18/21, at 11:25 a.m. LPN-G approached the medication cart to review R78's medications and prepare to bring them to R78's room for administration. LPN-G verified R78 did not have orders to combine crushed medications for administration and when to check with RN-D. LPN-G returned to the medication cart and stated they had been crushing medications together and giving them together, but on this day, they would not do that. LPN-G stated she would reprint the medications for the pharmacy and new medications would be set up in separate

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|---|---|---|---|---|
| {F 755} | Continued From page 4<br>medication cups.<br><br>On 8/18/21, at 11:32 a.m. TMA-B began to set up new medications in separate medication cups and crushed each tablet separately.<br><br>On 8/18/21, at 11:36 a.m. TMA-B verified the nurse was not usually present during preparation of R78's medications, but the nurse would administer the medications. LPN-G returned to the medication cart as TMA-B was finishing the medication preparation. LPN-G verified she would verify each medication individually to ensure they were the correct medications, but would be unable to identify medications that had been crushed. LPN-G stated she would normally prepare medications herself if she was going to give them. TMA-B then told LPN-G what medication was in each medication cup, as LPN-G verified each on the package it had been taken from and on the electronic medication administration record (eMAR).<br><br>On 8/18/21, at 11:43 am. LPN-G took the medications into R78's room, and mixed each medication with a small amount of water. LPN-G administered each medication in R78's GTube and flushed the GTube with approximately 20 ml of water between each medication. At 12:21 pm R78's last medication was administered and R78's GTube was flushed as ordered.<br><br>On 8/19/21, at 1:52 p.m. LPN-G verified she should not have administered medications that were set up by someone else. LPN-G verified there would need to be physician's orders to crush and combine medications for administration. | {F 755} | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245236 | A. BUILDING _____ B. WING _____ | R-C 08/19/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **BENEDICTINE HEALTH CENTER** | **935 KENWOOD AVENUE DULUTH, MN 55811** |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| {F 755} | Continued From page 5<br>On 8/19/21, at 3:15 p.m. the interim director of nursing (DON) verified there must be an order to crush medications and combine medications. Interim DON verified a nurse should not administer medication that they did not prepare the medications, so the one who prepares the medications is the one who should give the medications.<br><br>The facility policy and procedure for Enteral Tube Medication Administration, revised 8/14, directed nurses to administer medications in accordance with the provider orders, and directed that crushing medications required an order by the provider. The facility policy and procedure directed nurseng to crush each immediate-release tablets one at a time, and to administer each medication separately and flush the tubing between each medication.<br><br>The facility policy and procedure for Administering Medications dated 2018, , directed nurses to administer medications in accordance with the provider orders, and directed that crushing medications required an order by the provider. The facility policy and procedure lacked directives to ensure the nurse or TMA who prepared the medications for administration, was the same person who administered the medications to prevent medication errors and diversion. | {F 755} | | |

Electronically Delivered

September 14, 2021

Administrator
Benedictine Health Center
935 Kenwood Avenue
Duluth, MN 55811

RE: CCN: 245236
Cycle Start Date: August 12, 2021

**Life Safety and Health survey's were processed seperately. This letter corrects only the Life Safety Survey.**

Dear Administrator:

On August 31, 2021, the Minnesota Department of Public Safety, completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

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

**MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL**

ID: L435

**PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY**

Facility ID: 00861

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245236**
2.STATE VENDOR OR MEDICAID NO.
(L2) **819240500**

3. NAME AND ADDRESS OF FACILITY
(L3) **BENEDICTINE HEALTH CENTER**
(L4) **935 KENWOOD AVENUE**
(L5) **DULUTH, MN** (L6) **55811**

4. TYPE OF ACTION: **2** (L8)
**1. Initial** **2. Recertification**
**3. Termination** **4. CHOW**
**5. Validation** **6. Complaint**
**7. On-Site Visit** **9. Other**
**8. Full Survey After Complaint**

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **06/21/2021** (L34)

8. ACCREDITATION STATUS: __ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

| | | | | |
|---|---|---|---|---|
| **01 Hospital** | **05 HHA** | **09 ESRD** | **13 PTIP** | **22 CLIA** |
| **02 SNF/NF/Dual** | **06 PRTF** | **10 NF** | **14 CORF** | |
| **03 SNF/NF/Distinct** | **07 X-Ray** | **11 ICF/IID** | **15 ASC** | |
| **04 SNF** | **08 OPT/SP** | **12 RHC** | **16 HOSPICE** | |

FISCAL YEAR ENDING DATE: (L35)
**06/30**

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **96** (L18)
13.Total Certified Beds **96** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC
**X** B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

| 18 SNF | 18/19 SNF | 19 SNF | ICF | IID |
|---|---|---|---|---|
| | 96 | | | |
| (L37) | (L38) | (L39) | (L42) | (L43) |

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE Date :
Colleen Johnson HFE - NE II 08/25/2021 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Joanne Simon, Enforcement Specialist 09/02/2021 (L20)

**PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY**

19. DETERMINATION OF ELIGIBILITY
**X** 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION
**11/17/1980**
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
**03001**
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Electronically Submitted
July 9, 2021

Administrator
Benedictine Health Center
935 Kenwood Avenue
Duluth, MN 55811

RE: CCN: 245236
Cycle Start Date: June 21, 2021

**Please Note: The health and life safety code survey findings will be processed under separate enforcement cycles.**

Dear Administrator:

On June 21, 2021, survey was completed at your facility by the Minnesota Department of Health 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.

Your facility was not in substantial compliance with the participation requirements and the conditions in your facility constituted both substandard quality of care and immediate jeopardy to resident health or safety. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted immediate jeopardy (Level J) whereby corrections were required. The Statement of Deficiencies (CMS-2567) is being electronically delivered.

## REMOVAL OF IMMEDIATE JEOPARDY

On June 17, 2021, the situation of immediate jeopardy to potential health and safety cited at F678 was removed. However, continued non-compliance remains at the lower scope and severity of D.

## REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy listed below to the CMS Region V Office for imposition: The CMS Region V Office concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective July 24, 2021.

- Directed plan of correction (DPOC), Federal regulations at 42 CFR § 488.424. Please see

electronically attached documents for the DPOC.

This Department is also recommending that CMS impose a civil money penalty (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective July 24, 2021, (42 CFR 488.417 (b)). They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective July 24, 2021 (42 CFR 488.417 (b)).

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

## NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $11,160; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

Therefore, your agency is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective June 21, 2021. This prohibition is not subject to appeal. Under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

## SUBSTANDARD QUALITY OF CARE

Your facility's deficiencies with with one or more of the following: §483.10, Residents Rights, §483.12, Freedom from Abuse, Neglect, and Exploitation, §483.15, Quality of Life and §483.25, Quality of Care, 483.40 Behavioral Health Services, §483.45 Pharmacy Services, §483.70 Administration, or §483.80 Infection control has been determined to constitute substandard quality of care as defined at §488.301. Sections 1819(g)(5)(C) and 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) require that the attending physician of each resident who was found to have received substandard

quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.

Please note that, in accordance with 42 CFR 488.325(g), your failure to provide this information timely will result in termination of participation in the Medicare and/or Medicaid program(s) or imposition of alternative remedies.

Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, Benedictine Health Center is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective June 21, 2021. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

## ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable plan of correction (ePOC) for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

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

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

## DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by a "F" tag), and emergency preparedness deficiencies (those preceded

by an "E" tag), i.e., the plan of correction should be directed to:

Terri Ament, Unit Supervisor
Duluth District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Duluth Technology Village
11 East Superior Street, Suite 290
Duluth, Minnesota 55802-2007
Email: teresa.ament@state.mn.us
Office: (218) 302-6151 Mobile: (218) 766-2720

## 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 their respective deficiencies (if any) is acceptable.

## VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by December 21, 2021 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. 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.

## APPEAL RIGHTS DENIAL OF PAYMENT

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Tamika.Brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

## APPEAL RIGHTS NURSE AIDE TRAINING PROHIBITION

Pursuant to the Federal regulations at 42 CFR Sections 498.3(b)(13)(2) and 498.3(b)(15), a finding of substandard quality of care that leads to the loss of approval by a Skilled Nursing Facility (SNF) of its NATCEP is an initial determination. In accordance with 42 CFR part 489 a provider dissatisfied with an initial determination is entitled to an appeal. If you disagree with the findings of substandard quality of care which resulted in the conduct of an extended survey and the subsequent loss of approval to conduct or be a site for a NATCEP, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40, et. Seq.

A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to the Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration) at the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201

A request for a hearing should identify the specific issues and the findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. You do not need to submit records or other documents with your hearing request. The Departmental Appeals Board (DAB) will issue instructions regarding the proper submittal of documents for the hearing. The DAB will also set the location for the hearing, which is likely to be in Minnesota or in Chicago, Illinois. You may be represented by counsel at a hearing at your own expense.

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

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

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245236 | A. BUILDING _____ B. WING _____ | C 06/21/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **BENEDICTINE HEALTH CENTER** | **935 KENWOOD AVENUE DULUTH, MN 55811** |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| E 000 | Initial Comments<br><br>On 6/14/21, through 6/21/21, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) was conducted during a standard recertification survey. The facility was IN compliance.<br><br>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<br><br>On 6/14/21, through 6/21/21, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities.<br><br>The survey resulted in an Immediate Jeopardy (IJ) at F678 when a resident had requested a change from do not resuscitate (DNR) status to full code status. The health unit coordinator (HUC) made a copy and gave it to the nurse manager. Neither the HUC, nor the nurse manager transcribed the order into the electronic medical record (EMR). The EMR indicated the resident was DNR. The IJ began on 6/16/21, and the immediacy was removed on 6/17/21.<br><br>In addition, an extended survey was completed on 6/21/21 related to the substandard quality of care findings.<br><br>The complaint H5236073C (MN73185) was found | F 000 | | |

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

Electronically Signed | 07/16/2021

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245236 | A. BUILDING _____ B. WING _____ | C 06/21/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **BENEDICTINE HEALTH CENTER** | **935 KENWOOD AVENUE DULUTH, MN 55811** |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 000 | Continued From page 1<br>to be UNSUBSTANTIATED:<br><br>The complaint H5236072C (MN73099 & MN73127) was found to be UNSUBSTANTIATED; however, related a deficiency was cited at F755.<br><br>The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance.<br><br>Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained. | F 000 | | |
| F 554 SS=D | Resident Self-Admin Meds-Clinically Approp<br>CFR(s): 483.10(c)(7)<br><br>§483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, and document review, the facility failed to assess safety with self-administration of medication (SAM) for 1 of 1 residents (R44) reviewed for SAM.<br><br>Findings include:<br><br>R44's Face Sheet printed 6/21/21, indicated R44's diagnoses included unspecified dementia without behavioral disturbance, rheumatoid | F 554 | R44 is no longer in the building<br><br>Self-administration of medication assessments and orders reviewed for all residents with self-administration of medication preference and updated if needed.<br><br>Immediate education provided to nurse involved regarding policy and procedure | 8/4/21 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245236 | A. BUILDING _____ B. WING _____ | C 06/21/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **BENEDICTINE HEALTH CENTER** | **935 KENWOOD AVENUE DULUTH, MN 55811** |

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| F 554 | Continued From page 2<br>arthritis, and chronic pain syndrome.<br><br>R44's quarterly Minimum Data Set (MDS) dated 4/26/21, indicated R44 was cognitively intact and had impaired vision. R44's MDS further indicated that she was on scheduled pain medication, antipsychotic, antianxiety and antidepressant medications.<br><br>R44's care plan initiated on 1/19/21, indicated the pharmacy would review the medications as indicated and directed nursing to monitor for side effects of medications and target behaviors. R44's care plan lacked orders for self administration of medications.<br><br>R44's SAM assessment dated 1/19/21, indicated R44 did not wish to self-administer her medications. The assessment further indicated nursing was to store and dispense all medications when due.<br><br>R44's Physician Order Report dated 5/28/21, indicated the following orders:<br><br>1. Arthritis Pain Relief (pain reliever) tablet extended release 650 milligrams (mg), every 8 hours. put how often she is to receive each of these<br>2. Percocet (narcotic pain reliever tablet 10-325 mg, four times a day.<br>3. Premarin (hormone) tablet 0.3 mg, once a day.<br>4. Protonix (treats certain stomach problems) tablet, delayed release (DR/EC) 40 mg, twice a day.<br>5. Cymbalta (duloxetine, antidepressant) capsule delayed release 60 mg, once a day.<br>6. ferrous sulfate (iron supplement) 325 mg, once a day. | F 554 | for resident self-administration of medications.<br><br>Education will be provided to licensed nurses/TMAs to review order instructions to verify that resident has instructions for self-administer medications.<br><br>Self-Administration of Medications policy has been reviewed and remains appropriate.<br><br>Audits for will be completed on 4 residents per week for (3) weeks, then 2 residents per week for an additional (3) weeks to ensure SAM assessments are completed with appropriate nursing orders present stating "okay to self-administer medications dispensed by licensed nurse/TMA. Audit findings will be presented to facility's Quality Council by DON or designee. | |

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| F 554 | Continued From page 3 | F 554 | | |

7. Flonase Allergy Relief (fluticasone propionate, steroid, allergy relief) spray suspension 50 microgram (mcg), once a day.
8. gabapentin (seizure medication) 600 mg, three times a day.
9. quetiapine (atypical antipsychotic)100 mg, once a day.
10. Slow-Mag (magnesium chloride tablet, once a day.
12. hydroxyzine HCl (antihistamine) tablet 25 mg, every 8 hours as needed.
13. lorazepam (antianxiety) 0.5 mg, three times a day.
R44's physician orders lacked orders for a SAM.

On 6/15/21, at 10:59 a.m. R44 was observed sitting on her bed bed with multiple medications including in a medication cup on the bedside table. R44 was able to identify the medications she had in the medication cup. R44 stated, "They trust me." R44 stated some staff trust her to take her medications, so they will leave them with her, and some don't.

On 6/15/21, at 2:35 p.m. trained medication aide (TMA)-B stated R44 could take her medications herself. TMA-B verified she left R44's medications with her that morning, and stated she could take her medications herself and was good about taking them. TMA-B verified R44 did not have an order for SAM. TMA-B stated she had left the following medications: Percocet, arthritis pill, gabapentin, Protonix, and sucralfate. TMA-B stated she was supposed to go back and check to make sure R44 had taken her medications, and if R44's 8 a.m. medications were still sitting there, she would discard them and document. TMA-B stated she should not leave the medications with R44 if she had not assessed to

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| F 554 | Continued From page 4<br>be safe with SAM.<br><br>On 6/18/21, at 9:21 a.m. registered nurse (RN)-D stated R44 lacked an order and assessment for SAM. RN-D stated she did not know staff was leaving R44's medications in her room for her to take independently. At 9:30 a.m. RN-D stated she would have expected a SAM assessment to be completed before allowing R44 to self-administer her medications.<br><br>On 6/21/21, at 10:07 a.m. the director of nursing (DON) stated she would have expected a SAM assessment to be completed prior to leaving the medications in R44's room.<br><br>The facility policy Self-Administration of Medications dated 2017, directed nursing would assess and determine whether SAM was appropriate with consideration of each resident's mental and physical ability the facility assessment further directed the SAM assessment to be documented in the electronic health record (EHR). | F 554 | | |
| F 583 SS=D | Personal Privacy/Confidentiality of Records<br>CFR(s): 483.10(h)(1)-(3)(i)(ii)<br><br>§483.10(h) Privacy and Confidentiality.<br>The resident has a right to personal privacy and confidentiality of his or her personal and medical records.<br><br>§483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. | F 583 | | 8/4/21 |

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| F 583 | Continued From page 5<br><br>§483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service.<br><br>§483.10(h)(3) The resident has a right to secure and confidential personal and medical records.<br>(i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws.<br>(ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, and document review, the facility failed to ensure privacy and confidentiality was maintained for 2 of 4 residents (R37, R18) reviewed for privacy who had signs posted in public view regarding personal care restrictions.<br><br>Findings include:<br><br>R18's Face Sheet printed 6/21/21, indicated R18's diagnoses included major depressive disorder, schizoaffective disorder, intellectual disabilities, and neurofibromatosis type 1 (the growth of tumors along nerves in the skin, brain, and other parts of the body). | F 583 | R18 □ Signage was removed from resident□s door.<br>R37 □ Sign was removed from resident□s wheelchair.<br><br>100% audit completed of any signage placed in public viewing of protected medical information. Any signage seen from public space removed.<br><br>Education will be provided to all staff indicating that we cannot post signs regarding individual care plans in public view. All care needs are outlined in the resident's care plan. | |

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| F 583 | Continued From page 6<br><br>R18's quarterly Minimum Data Set (MDS) dated 3/26/21, indicated R18 had a moderate cognitive impairment, usually understood others, usually was understood by others, and had no symptoms of delirium or psychosis during the assessment period. R18's MDS further indicated R18 had no behaviors, but did have mild mood symptoms.<br><br>R18's care plan initiated 6/25/20, indicated R18 had a developmental disability, was impulsive, had mild signs and symptoms of depression, and was vulnerable to abuse from others and was at risk for abusing others. R18's care plan lacked identification of self-harm behaviors, suicidal ideation, or physical aggression toward others, and lacked interventions to restrict access to sharp objects.<br><br>R18's progress notes dated 5/2/21, indicated R18 was combative with staff and refused cares, but lacked any indication of use of sharp objects toward self or others.<br><br>R18's progress note regarding R18's care conference dated 4/6/21, indicated R18 had no changes in cognition or mood and R18's resident representative had no concerns.<br><br>A review of R18's progress notes since 3/22/21, lacked evidence of inappropriate use of sharp objects.<br><br>R18's undated nursing assistant group sheet lacked evidence of R18's inappropriate use of sharp objects or directives to restrict access to sharp objects.<br><br>R18's physician progress notes dated 5/7/21, | F 583 | Resident Rights and Notification of Resident Rights policy has been reviewed and remains appropriate.<br><br>Audit 4 resident rooms/week for (3) weeks then 2 resident rooms/week for an additional (3) weeks to ensure no private information is publicly displayed. Audit findings will be presented to facility's Quality Council by DON or designee | |

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| F 583 | Continued From page 7 | F 583 | | |

indicated R18 had aggressive behaviors toward staff sometimes, but lacked indication of inappropriate use of sharp objects.

On 6/15/21, at 1:49 p.m. a handwritten sign was observed on the outside of R18's door, visible to all who walked past or entered R18's room. The handwritten signs directed, "No knives or sharp objects please!!!"

On 6/18/21, at 12:00 p.m. nursing assistant (NA)-G. stated she was able to calm R18 down when he was agitated, and did not know why he had a sign on the outside of his door regarding sharp objects.

On 6/18/21, at 3:50 p.m. registered nurse (RN)-D stated she was not sure, but thought the sign on R18's door was due to R18's family being concerned that R18 was having suicidal ideation around August of 2020. RN-D verified it was privacy issue and the outside of his door was not a good place for that sign.

On 6/18/21, at 4:03 p.m. the director of nursing (DON) verified a sign posted on the outside of R18's door regarding sharp objects was a privacy concern and should not be posted for others to see.

R37's Face Sheet printed 6/21/21, indicated R37's diagnoses included vascular dementia and dysphagia (swallowing difficulties).

R37's quarterly MDS dated 4/14/21, indicated R37 had a significant cognitive impairment, usually understood others and was usually understood, and had no signs or symptoms of a swallowing disorder.

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| F 583 | Continued From page 8 | F 583 | | |

R37's care plan initiated 10/10/19, directed staff to provide nectar thick liquids to R37.

R37's speech therapy discharge summary dated 1/7/21, indicated R37 was treated for dysphagia (difficulty swallowing) from 12/24/20, through 1/7/21, and directed R37 to continue on a regular textured diet with MT2 (nectar-thick) liquids.

On 6/15/21, at 11:16 a.m. R37 was observed to be sitting in her wheelchair in her room. A handwritten note was visible on the right arm of her wheelchair indicating, "Nectar."

On 6/15/21, at 2:42 p.m. trained medication assistant (TMA)-H verified R37 was to receive nectar thickened liquids, as it was posted on the arm of R37's wheelchair.

On 6/16/21, at 2:57 p.m. R37 was sitting in her wheelchair in her room. R37 had a handwritten sign on the arm of her wheelchair that said, "Nectar." R37 stated she did not think her liquids were thickened.

On 6/18/21, at 12:00 p.m. NA-G stated R37 was to have thickened liquids, and verified she had a note that said, "Nectar" on her wheelchair arm.

On 6/18/21, at 3:46 p.m. RN-D stated she would have to ask if it was a privacy issue to have "nectar" posted on the arm of R37's wheelchair where it was visible to the public, and questioned whether it was a concern and whether the public would understand what that meant.

On 6/18/21, at 4:03 p.m. DON verified the posting of the sign, "Nectar" on the arm of R37's

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| F 583 | Continued From page 9<br>wheelchair could be a privacy concern.<br><br>The facility Notice of Privacy Practices document reviewed/revised 12/2020, failed to address the public posting of health or personal information, though directed disclosures of health information otherwise not described would be made only with the resident's written authorization. | F 583 | | |
| F 584 SS=D | Safe/Clean/Comfortable/Homelike Environment<br>CFR(s): 483.10(i)(1)-(7)<br><br>§483.10(i) Safe Environment.<br>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.<br><br>The facility must provide-<br>§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.<br>(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.<br>(ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft.<br><br>§483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;<br><br>§483.10(i)(3) Clean bed and bath linens that are in good condition;<br><br>§483.10(i)(4) Private closet space in each | F 584 | | 8/4/21 |

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| F 584 | Continued From page 10<br>resident room, as specified in §483.90 (e)(2)(iv);<br><br>§483.10(i)(5) Adequate and comfortable lighting levels in all areas;<br><br>§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<br><br>§483.10(i)(7) For the maintenance of comfortable sound levels.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, and document review, the facility failed to ensure a wheelchair armrest was in good repair for 1 of 6 residents (R19) reviewed for equipment.<br><br>Findings include:<br><br>R19's Face Sheet printed 6/21/21, indicated R19's diagnoses included hemiplegia (severe or complete loss of strength or paralysis on one side of the body) and hemiparesis (slight weakness in leg, arm, or face), aphasia (loss of ability to understand or express speech), and gastrostomy status (a surgical opening into the stomach from the abdominal wall for the introduction of food).<br><br>R19's quarterly Minimum Data Set (MDS) dated 3/25/21, indicated R19 was severely cognitively impaired.<br><br>R19's care plan printed on 6/21/21, indicated R19 was non-ambulatory, and required the use of a wheelchair to navigate her environment.<br><br>On 6/15/21, at 8:30 a.m. R19 was observed in | F 584 | R19 - specialty wheelchairs require the vendor to complete maintenance through therapy evaluation. Evaluation has been completed and issue corrected.<br><br>100% audit of all wheelchairs to ensure all are in appropriate repair has been completed.<br><br>Wheelchair inspection outlined in facility maintenance TELS system to be utilized monthly to ensure each resident wheelchair is inspected. Any repair needs identified will be corrected for wheelchair owned by facility, DME company will be contacted for any repair needs identified for resident owned wheelchairs. Any repair items identified outside of the monthly inspection will be reported to maintenance department through the facilities maintenance TELS system.<br><br>Education to all associates regarding how to report repair needs for resident DME. | |

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| F 584 | Continued From page 11<br>her wheelchair. The wheelchair arm rest was noted to have approximately 4 inches of wood and foam exposed with the cover torn.<br><br>On 6/15/21, at 8:35 a.m. nursing assistant (NA)-C was interviewed. NA-C stated she had not really noticed the arm rest with the torn cover. NA-C stated it should be reported to maintenance or therapy.<br><br>On 6/15/21, at 10:24 a.m. registered nurse (RN)-D was interviewed. RN-D verified she would expect staff to alert her to equipment that needs to be repaired.<br><br>On 6/15/21, at 10:55 a.m. the director of nursing (DON) was interviewed. The DON verified she would expect the nursing assistants to put repairs on the maintenance board or tell the nurse manager.<br><br>A policy for equipment cleaning and maintenance was requested but not provided. | F 584 | Resident Equipment policy has been reviewed and remains appropriate.<br><br>4 audits of the inspection documentation per week for (3) weeks, then 2 audits of the inspection documentation for an additional (3) weeks. Audit findings will be presented to facility's Quality Council by ED or designee. | |
| F 656 SS=D | Develop/Implement Comprehensive Care Plan<br>CFR(s): 483.21(b)(1)<br><br>§483.21(b) Comprehensive Care Plans<br>§483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -<br>(i) The services that are to be furnished to attain | F 656 | | 8/4/21 |

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| F 656 | Continued From page 12<br>or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and<br>(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).<br>(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.<br>(iv)In consultation with the resident and the resident's representative(s)-<br>(A) The resident's goals for admission and desired outcomes.<br>(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.<br>(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, and document review, the facility failed to timely develop a comprehensive care plan to reflect individualized goals, and interventions for 1 of 3 residents (R198) reviewed for care planning. In addition, the facility failed to implement the care plan to provide thickened liquids according to physician orders for liquid consistency during medication administration for 1 of 6 residents (R37) observed | F 656 | R198 □ Comprehensive care plan has been completed<br><br>R37 - Entered liquid type in administration notes on MAR and on care guide, order for thickened liquids is present and reflected in the care plan.<br><br>All residents' care plans have been | |

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| F 656 | Continued From page 13<br>during medication administration.<br><br>Findings include:<br><br>R198's Face Sheet printed 6/21/21, indicated R198 was admitted on 6/3/21. R198's diagnoses included syncope and collapse, dysphagia (difficulty swallowing) and lumbar disc disease.<br><br>R198's admission Minimum Data Set (MDS) dated 6/10/21, indicated R198 had mild cognitive impairment, required limited assistance from staff with transfers, dressing, toileting, and required supervision with personal hygiene, eating and bed mobility. R198's MDS further indicated R198 required a therapeutic, mechanically altered diet, and received speech, occupational, and physical therapies.<br><br>R198's care plan dated 6/3/21, lacked individualized goals and interventions for activities of daily living (ADLs), pain, psychotropic drug use, falls, behaviors, and skin.<br><br>R198's care guide sheets updated 6/11/21, indicated R198 bath was on Wednesday evenings, Ate a low protein pureed level four diet (a soft smooth consistency), had daily weights until 6/15/21, and staff was to document compliance with meals. R198's care guide sheet lacked ADL, transfer, ambulation, and mobility needs.<br><br>On 6/18/21, at 11:22 a.m. licensed practical nurse (LPN)-A-stated R198 was suppose to be on a gluten free diet, and was not always compliant with her diet choices. LPN- A stated, " We just educate and remind her what her diet orders are." | F 656 | audited and reviewed for current interventions.<br><br>Training for nurse managers, nurse transition coordinators, admission nurse, DON and QMC provided regarding care planning completed on 6/29/2021.<br><br>Care plans continue to be reviewed at least quarterly at care conference and as needed to ensure accuracy and appropriateness.<br><br>Comprehensive Assessments and Care Planning policy reviewed and remains appropriate.<br><br>Audit 4 care plans/week for (3) weeks, then 2 care plans/week for an additional (3) weeks. Audit findings will be presented to facility's Quality Council by DON or designee. | |

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| F 656 | Continued From page 14<br><br>On 6/21/21, at 9:24 a.m. nursing assistant (NA)-A stated she would refer to the dry erase board located in each of the resident's rooms to know how to care for them. NA-A verified R198's careguide sheet lacked R198's ADL , transfer, and mobility needs.<br><br>On 6/21/21, at 12:23 p.m. the director of nursing (DON) stated a temporary care plan should be completed within 48 hours of admission, and the completed comprehensive care plan was expected to be completed within a week of admission. The DON verified R198 did not have a completed individualized comprehensive care plan, and stated R198's current care plan was a template, and the care plan had not been completed.<br><br>On 6/21/21, 1:45 p.m. registered nurse (RN)-A stated it was important to develop an individualized comprehensive plan of care to identify any concerns, set goals, and put interventions in place. RN-A stated care plans direct care for the resident, and verified R198's care plan had not been completed.<br><br>The facility policy Comprehensive Assessments and Care Planning revised 7/2/18, directed the completion of a comprehensive assessment to be completed within 14 calendar days after admission. | F 656 | | |

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| F 656 | Continued From page 15 | F 656 | | |

R37's Face Sheet printed 6/21/21, indicated R37's diagnoses included vascular dementia and dysphagia.

R37's quarterly MDS dated 4/14/21, indicated R37 had a significant cognitive impairment, usually understood others and was usually understood, and had no signs or symptoms of a swallowing disorder.

R37's care plan initiated 10/10/19, directed staff to provide nectar thick liquids to R37.

R37's undated nursing assistant group sheet directed to provide R37 with a regular diet and mildly thick liquids.

R37's Medication Administration Record for 6/21, lacked directives to provide R37 with nectar-thick liquids.

R37's speech therapy discharge summary dated 1/7/21, indicated R37 was treated for dysphagia from 12/24/20, through 1/7/21, and directed R37 to continue on a regular textured diet with MT2 (nectar-thick) liquids.

On 6/15/21, at 11:16 a.m. R37 was observed to be sitting in her wheelchair in her room. A handwritten note on the right arm of the wheelchair indicated, "Nectar." Trained Medication Aide (TMA)-B administered medications to R37 crushed in pudding, and provided R37 with regular water. R37 coughed slightly following medications and regular water. R37 readily cleared her throat without difficulty. R37 had nectar-thick water in a glass on her tray table, in her room.

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| F 656 | Continued From page 16<br><br>On 6/15/21, at 2:42 p.m. TMA-B verified R37 was to receive nectar thickened liquids, said it was on the arm of her wheelchair and in the computer. TMA-B verified she should have given R37 nectar-thick liquids with her medications.<br><br>On 6/16/21, at 2:57 p.m. R37 was sitting in her wheelchair in her room. R37 stated she did not think her liquids were thickened.<br><br>On 6/18/21, at 12:00 p.m. NA-G stated R37 was to have thickened liquids, and verified she had a note that indicated, "Nectar" on her wheelchair arm.<br><br>On 6/18/21, at 3:40 p.m. RN-D verified R37 should have nectar-thick liquids and staff should follow the physician's order to provide nectar-thick liquids.<br><br>On 6/18/21, at 4:03 p.m. DON verified nectar-thick liquids should be given when it is ordered.<br><br>The facility policy Safe Delivery of Food and Beverages, dated 2/2018, directed beverages to be delivered to the resident as ordered for diet and diet modification as ordered by the provider, dietitian, or speech therapist. | F 656 | | |
| F 657 SS=D | Care Plan Timing and Revision<br>CFR(s): 483.21(b)(2)(i)-(iii)<br><br>§483.21(b) Comprehensive Care Plans<br>§483.21(b)(2) A comprehensive care plan must be-<br>(i) Developed within 7 days after completion of the comprehensive assessment. | F 657 | | 8/4/21 |

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| F 657 | Continued From page 17<br>(ii) Prepared by an interdisciplinary team, that includes but is not limited to--<br>(A) The attending physician.<br>(B) A registered nurse with responsibility for the resident.<br>(C) A nurse aide with responsibility for the resident.<br>(D) A member of food and nutrition services staff.<br>(E) To the extent practicable, the participation of the resident and the resident's representative(s).<br>An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.<br>(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.<br>(iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and document review, the facility failed to ensure a care plan was revised to address preference for an essential caregiver for 1 of 4 residents (R45) reviewed for care plans.<br><br>Findings include:<br><br>R45's Face Sheet printed 6/21/21, identified R45's diagnoses included hemiplegia (slight weakness in a leg, arm, or face) and hemiparesis (severe or complete loss of strength or paralysis on one side of the body), and dysphagia (difficulty swallowing).<br><br>R45's annual Minimum Data Set (MDS) dated | F 657 | R45 □ Care Plan has been corrected<br><br>All Resident care plans have been audited and updated if necessary.<br><br>Training for nurse managers, nurse transition coordinators, admission nurse, DON and QMC provided regarding care planning completed on 6/29/2021.<br><br>Care plans continue to be reviewed at least quarterly at care conference and as needed to ensure accuracy and appropriateness. | |

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| F 657 | Continued From page 18<br>4/27/21, indicated R45 had moderately intact cognition, and required extensive assistance with bed mobility, transfers, dressing, toilet use, and personal hygiene.<br><br>R45's care plan dated 8/19/20, indicated R45's preference for his essential caregiver was his wife. In addition, R45's care plan dated 9/26/20, indicated R45 would not have increased verbal or non-verbal signs of increased depression related to the recent loss of his wife.<br><br>On 6/21/21, at 9:40 a.m. licensed practical nurse (LPN)-B was interviewed. LPN-B stated R45's care plan still included his deceased wife as his essential caregiver, and was not current.<br><br>On 6/21/21, at 10:29 a.m. registered nurse (RN)-D was interviewed. RN-D stated care plans should be updated quarterly with the MDS. RN-D verified R45's care plan was not current and that his essential caregiver, his wife, died in September of 2020.<br><br>On 6/21/21, at 10:59 a.m. the director of nursing (DON) was interviewed. The DON verified R45's care plan was not current related to his essential caregiver. The DON stated care plans should be updated at the care conference quarterly.<br><br>The facility policy Comprehensive Assessments and Care Planning dated 7/2/18, directed changes to the care plan would be made when a resident experiences a significant change to reflect the new approaches. | F 657 | Comprehensive Assessments and Care Planning policy reviewed and remains appropriate.<br><br>Audit 4 care plans/week for (3) weeks, then 2 care plans/week for an additional (3) weeks. Audit findings will be presented to facility's Quality Council by DON or designee. | |
| F 677 SS=D | ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) | F 677 | | 8/4/21 |

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| F 677 | Continued From page 19<br>§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;<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, and document review, the facility failed to ensure oral care was completed for 1 of 2 residents (R21) reviewed for activities of daily living (ADLs), and who were dependent on staff for ADL assistance.<br><br>Findings include:<br><br>R21's Face Sheet printed 6/21/21, indicated R21's diagnoses included Parkinson's disease (a disorder of the central nervous system that affects movement, often including tremors), dementia, osteoarthritis, Bell's palsy (sudden weakness in the muscles on one half of the face), difficulty in walking, and mild cognitive impairment.<br><br>R21's annual Minimum Data Set (MDS) dated 3/26/21, indicated R21 was moderately cognitively impaired. In addition, R21's MDS indicated R21 required extensive assistance with ADLs.<br><br>R21's Care Area Assessment (CAA) dated 3/30/21, indicated R21 had impaired ADLs, and required extensive assistance with all personal cares including bathing, dressing, oral cares, and grooming due to impaired mobility.<br><br>R21's care plan dated 6/23/20, indicated R21 had a self deficit with ADLs including oral care. The care plan lacked information on oral care. | F 677 | R21 - care plan reflects expectation of oral care BID and documentation of refusal if he chooses not to receive assistance with oral care.<br><br>All residents needing assistance with oral care have been identified. Level of care assistance reviewed for all residents using admission assessment and/or MDS coding data.<br><br>New ADL policy was established and all nursing staff have been trained on the policy.<br><br>Auditing of oral care completion to be completed on 4 residents/week for (3) weeks than 2 residents for an additional (3) weeks. Audit findings will be presented to facility's Quality Council by DON or designee. | |

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| F 677 | Continued From page 20 | F 677 | | |

R21's care guide undated, directed staff to set up and assist R21 with oral cares morning and night, and as needed.

On 6/15/21, at 9:39 a.m. R21 was interviewed. R21 stated the staff tell him they will help him brush his teeth after breakfast, but then they're too busy and they don't do it.

On 6/21/21, at 8:30 a.m. R21 was wheeled back to his room by dietary staff. R21 was interviewed, and stated no one had helped him brush teeth since, "Saturday," 6/19/21. R21 went on to say no one had offered to help him brush his teeth yet that morning.

On 6/21/21, at 9:00 a.m. nursing assistant (NA)-E was observed to assist R21 to the bathroom. After R21 was done using the toilet, NA-E did not offer to set R21 up for oral cares.

On 6/21/21, at 9: 10 a.m. NA-F was interviewed. NA-F verified R21 had not been offered oral care yet that morning. NA-F verified he was aware R21 wanted to brush his teeth after breakfast.

On 6/21/21, at 9:42 a.m. licensed practical nurse (LPN)-B was interviewed. LPN-B stated she would expect residents to be offered oral care when they were assisted with morning cares.

On 6/21/21, at 10:34 a.m. registered nurse (RN)-D was interviewed. RN-D verified she would expect staff to offer oral care to residents twice daily. RN-D went on to say she would expect staff to offer oral cares with the morning cares, if they refused she would expect staff to go back after breakfast and offer again.

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| F 677 | Continued From page 21<br>On 6/21/21, at 11:05 a.m. the director of nursing (DON) was interviewed. The DON stated she would expect staff to offer oral care to residents twice a day. If a resident wanted to brush their teeth after breakfast she would expect staff to do this.<br><br>The facility policy titled Activities of Daily Living dated 2021, directed staff to assist residents who are unable to carry out ADLs independently, this included oral care. If a resident refuses care staff were directed to approach at a different time or have another staff approach. | F 677 | | |
| F 678 SS=J | Cardio-Pulmonary Resuscitation (CPR)<br>CFR(s): 483.24(a)(3)<br><br>§483.24(a)(3) Personnel provide basic life support, including CPR, to a resident requiring such emergency care prior to the arrival of emergency medical personnel and subject to related physician orders and the resident's advance directives.<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and document review, the facility failed to ensure a system to identify a resident's Physician Orders for Life Sustaining Treatment (POLST) to initiate cardio-pulmonary resuscitation (CPR) was accurate in the event breathing and heart beat ceased for 1 of 91 residents (R45) who wanted CPR initiated. This resulted in an immediate jeopardy (IJ) situation placing the resident at risk for death in the event his heart stopped beating, and his breathing ceased.<br><br>The IJ began on 6/14/21, when R45 requested a change from a Do Not Resuscitate (DNR status, | F 678 | R45: code status was updated on June 15th.<br><br>A whole house audit was completed by 1900 on 6/15/2021 to ensure the physician order and POLST matched what was in the resident's EMR and paper chart. All records were verified to match.<br><br>The policy for Medical Orders (POLST, TROPP and OHDNR) and Comprehensive Assessment and Care Planning were reviewed and remain appropriate. | 8/4/21 |

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| F 678 | Continued From page 22<br>if a person's heart stopped beating a natural death would be allowed to occur) code status to a full code status (full code status, if a person's heart stopped beating CPR would be initiated). A POLST was filled out on 6/14/21, and given to the health unit coordinator (HUC)-C. HUC-C made a copy and gave it to the nurse manager, registered nurse (RN)-D. Neither the HUC-C nor RN-D transcribed the order into R45's electronic medical record (EMR). The administrator was informed of the IJ on 6/16/21, at 11:40 a.m. The IJ was removed on 6/17/21, at 10:51 a.m. but noncompliance remained at a lower severity of a D, no actual harm, with potential for more than minimal harm.<br><br>Findings include:<br><br>The facility policy Initiation of CPR/Automated external defibrillator (AED) and Basic Life Support (BLS) Associate Training Expectations dated 2017, directed CPR would be initiated on a resident who is found unresponsive, except when: 1) a Provider medical order states a code status of DNR; 2) a resident Declination of CPR Form is present; or 3) there are signs of obvious long standing death of the resident present. The policy lacked direction on where staff would obtain code status information.<br><br>R45's Face Sheet printed 6/21/21, identified R45's diagnoses included hemiplegia (slight weakness in a leg, arm, or face) and hemiparesis (severe or complete loss of strength or paralysis on one side of the body) following nontraumatic intracranial hemorrhage affecting left non-dominant side.<br><br>R45's annual Minimum Data Set (MDS) dated | F 678 | On 6/16/2021, staff currently working, and oncoming staff, were educated that going forward the source for a resident's code status will be the electric health record.<br><br>All LN/TMA/NAR associates have been educated on where to find code status Licensed nurses and HUC's currently or oncoming have been educated to ensure they know that POLST form is to be treated like orders and it is a Physician Order for Life Sustaining Treatment and needs to be processed immediately.<br><br>Whole house weekly audit: to ensure banner, order, upload and no paper in chart X 4 weeks and reassess. Audit findings will be presented to facility's Quality Council by DON or designee. | |

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| F 678 | Continued From page 23 | F 678 | | |

4/27/21, indicated R45 had moderately intact cognition, and required extensive assistance with bed mobility, transfers, dressing, toilet use, and personal hygiene.

On 6/15/21, at 1:39 p.m. R45's POLST dated 6/14/21, indicated R45's wishes were to attempt CPR, full treatment.

On 6/15/21, at 1:53 p.m. R45's EMR indicated his code status was DNR, and his MD orders also indicated DNR status.

On 6/15/21, at 1:55 p.m. R45 was interviewed. R45 stated the day before, he signed a paper to indicate he wanted CPR if his heart stopped.

On 6/15/21, at 2:16 p.m. trained medication aide (TMA)-A was interviewed. TMA-A stated she would check a resident's code status in the physical chart or the EMR, then stated the physical chart would be the most accurate.

On 6/15/21, at 2:19 p.m. TMA-B was interviewed. TMA-B stated she would look in the computer for a resident's code status.

On 6/15/21, at 2:22 p.m. registered nurse (RN)-B was interviewed. RN-B stated he would look for a resident's code status depending on which was closer the physical chart, or the EMR.

On 6/15/21, at 2:26 p.m. RN-C was interviewed. RN-C stated she would look in the computer for a resident's code status.

On 6/15/21, at 2:30 p.m. HUC-C was interviewed. HUC-C stated the RN's transcribe the POLST orders and they update the EMR.

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| F 678 | Continued From page 24<br><br>On 6/15/21, at 3:38 p.m. licensed practical nurse (LPN)-C was interviewed. LPN-C stated she would look in the resident's physical chart for code status.<br><br>On 6/15/21, at 3:40 p.m. RN-G was interviewed. RN-G stated the process for changing code status is for the HUC to update the order in the EMR and change the banner in the EMR to reflect the change. The HUC would put the new POLST in the chart, and bring the chart to the clinical manager to verify the order. After hours, the order would be verified by the supervisor or the medication nurse.<br><br>On 6/15/21, at 3:44 p.m. RN-E was interviewed. RN-E stated she would look in the computer if she was in a resident room, if she was at the nurse's station she would look in the physical chart for a resident's code status.<br><br>On 6/15/21, at 3:50 p.m. the director of nursing (DON) was interviewed. The DON stated a POLST was handled the same way any other order was processed. The DON went on to state the RN nurse managers were responsible to update the resident's code status in the EMR. The DON stated the failure to transcribe the code status order could have resulted in death for R45 if his heart would have stopped between the time the order was written on 6/14/21, and the time the discrepancy in the physical chart and the EMR was discovered on 6/15/21.<br><br>The immediate jeopardy that began on 6/14/21, was removed on 6/17/21, at 10:51 a.m. when the facility completed an audit of all resident records to ensure the physician order and POLST were | F 678 | | |

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| F 678 | Continued From page 25<br>consistent with what was in the resident's EMR and physical chart, staff was educated on where to look for a resident's code status, and the procedure for order transcription for POLST/Code status orders was updated. These actions were verified through interview and record review. | F 678 | | |
| F 686 SS=G | Treatment/Svcs to Prevent/Heal Pressure Ulcer<br>CFR(s): 483.25(b)(1)(i)(ii)<br><br>§483.25(b) Skin Integrity<br>§483.25(b)(1) Pressure ulcers.<br>Based on the comprehensive assessment of a resident, the facility must ensure that-<br>(i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and<br>(ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, and document review, the facility failed to ensure care planned interventions were timely implemented for 1 of 1 residents (R193) with worsening of current pressure ulcer and development of new pressure ulcers. This resulted in actual harm when R193's right hip Stage 2 pressure ulcer worsened to unstageable, and he developed an unstageable pressure ulcer to the right heel, an unstageable pressure ulcer to the left heel, a Stage 2 pressure ulcer to the right lower coccyx, a Stage 2 pressure ulcer to the left lower coccyx, an unstageable pressure ulcer to the sacrum, and a | F 686 | R193 □ Resident is no longer in the facility<br><br>All current residents with wounds' skin risk assessment and care plans have been reviewed and updated as needed. All new admissions have a skin risk assessment completed and will be followed by wound nurse/wound team if needed.<br><br>All licensed nurses will be educated regarding wound care procedure, which includes notifying provider, resident and | 8/4/21 |

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| F 686 | Continued From page 26<br>deep tissue injury on the left great toe.<br><br>Findings include:<br><br>Pressure Ulcer stages defined by the National Pressure Ulcer Advisory Panel (NPUAP):<br><br>Stage 2 Pressure Injury: Partial-thickness skin loss with exposed dermis Partial-thickness loss of skin with exposed dermis. The wound bed is viable, pink or red, moist, and may also present as an intact or ruptured serum-filled blister. Adipose (fat) is not visible and deeper tissues are not visible. Granulation tissue, slough (yellow devitalized tissue, that can be stringy or thick and adherent on the tissue bed) and eschar (black, dry, and leathery dead tissue and may form a thick covering) are not present.<br><br>Stage 3 Pressure Injury: Full-thickness skin loss Full-thickness loss of skin, in which adipose (fat) is visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present. Slough and/or eschar may be visible. The depth of tissue damage varies by anatomical location; areas of significant adiposity can develop deep wounds. Undermining and tunneling may occur. Fascia, muscle, tendon, ligament, cartilage and/or bone are not exposed. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury.<br><br>Unstageable Pressure Injury: Obscured full-thickness skin and tissue loss Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar. If slough or eschar is removed, a Stage 3 or Stage 4 pressure injury will be revealed. Stable eschar | F 686 | family of worsening or no improvement. All nursing assistants will be educated regarding the need to document all refusals as well as the need to re-approach in the event of a refusal and report refusals to the licensed nurse.<br><br>Current wound process has been reviewed and remains appropriate<br><br>IDT will review resident refusals of care weekly<br><br>Prevention and Treatment of Skin Breakdown/Pressure Injury policy has been reviewed and remains appropriate.<br><br>Audit 4 resident wound prevention interventions in place/week x (3) weeks, then 2/week x an additional (3) weeks. Audit findings will be presented to facility's Quality Council by DON or designee. | |

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(i.e., dry, adherent, intact without erythema or fluctuance) on the heel or ischemic limb should not be softened or removed.

Deep Tissue Pressure Injury: Persistent non-blanchable deep red, maroon or purple discoloration Intact or non-intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration or epidermal separation revealing a dark wound bed or blood filled blister. Pain and temperature change often precede skin color changes. Discoloration may appear differently in darkly pigmented skin. This injury results from intense and/or prolonged pressure and shear forces at the bone-muscle interface. The wound may evolve rapidly to reveal the actual extent of tissue injury, or may resolve without tissue loss.

R193's Face Sheet printed 6/21/21, indicated R193 was admitted to the facility on 5/27/21. R193's diagnoses included anemia, myelofibrosis (a type of bone marrow cancer that disrupts your body's normal production of blood cells), chronic kidney disease, atrial fibrillation, and a head injury.

R193's admission Minimum Data Set (MDS) dated 6/3/21, indicated R193 had severe cognitive impairment, required assistance with bed mobility, extensive assist with transfers, was occasionally incontinent of urine, and frequently incontinent of bowel. R193's MDS further indicated R193 was at risk for pressure ulcers, and had one Stage 2 pressure ulcer upon admission. R193's MDS also indicated R193 had a pressure reducing device in chair and bed, and pressure ulcer care interventions in place.

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R193's care plan initiated 5/57/21, indicated R193 was at risk for alteration of skin, required extensive assist of one for bed mobility, and extensive assist of two for transfers. R193's goal was not to develop any skin alterations. The care plan also included interventions for an alternating pressure mattress. R193's care plan further indicated R193 required special attention when positioning related to right hip pressure ulcer and red blanchable heels. R193's care plan was revised 6/21/21, to include Prevalon boots (pressure relieving boots) while in bed, and if R193 refused Prevalon boots to float heels with a pillow. In addition, if R193 refused care, staff were to explain risk vs benefits of the refusal, re-approach in 15 minutes, try a different care giver, and report refusal to licensed nurse (LN). R193's care plan further directed if R193 continued to refuse, the LN was to document the refusal and notify social services, family, and provider.

R193's care guide updated 6/14/21, indicated R193's bath was on Monday during the day, R193 was to be up in his wheelchair at mealtimes, required toileting and reposition every two hours, and directed staff to float heels with pillows and report noncompliance to the nurse.

R193's Admission Skin Risk Assessment dated 5/28/21, inaccurately identified R193 was not at risk for the development of pressure ulcers, had advanced age and cardiac diagnoses which elevated R193's risk for impaired skin integrity. The assessment further indicated R193 was admitted with a small Stage 2 pressure ulcer to right hip with surrounding skin a Stage 1 area of pressure-non blanchable 2.0 centimeters (cm) x 3.0 cm. R193's heels were red and blanching,

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nursing were to float heels and encourage every two hours repositioning, and offload right hip from pressure.

R193's Medical Administration Record (MAR) dated 6/1/21, through 6/29/21, indicated orders for Prevalon boots on when R193 was in bed, and to float heels. From 6/1/21, through 6/22/21, R193's MAR lacked indication staff were monitoring and ensuring R193's Prevalon boots were put on, and heels were floated while in bed. The MAR further lacked frequency of monitoring.

On 6/4/21, a progress note indicated R193 had developed new skin issues on both sides of the coccyx (tailbone). A larger area noted on left side with lighter spots of purplish color with a non-blanching wound bed. No drainage was noted. A large foam border dressing was applied after cleansing and applying skin prep. The note further indicated R193 experienced anxiety during turning. R193 complained of overall body pain and refused repositioning.

On 6/5/21, a progress note indicated R193's right heel had skin breakdown with a dark area approximately the size of a quarter. R193's feet were placed in soft boots on pillows to take pressure off heels, and he was to be repositioned often due to skin breakdown on coccyx and right hip. The note further indicated R193 was noncompliant and required much encouragement.

On 6/6/21, a progress note indicated R193 refused to turn to the side to relieve pressured areas. R193 was educated, and R193 continued decline to offload the coccyx area.

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| F 686 | Continued From page 30<br>On 6/18/21, a progress note indicated R193 had a new deep tissue injury to left great toe measuring 1.2 cm x 2.0 cm. The area was purplish red in color, on the tip of toe, and was related to his shoes.<br><br>R193's Wound Management Detail Report indicated documentation on the following six pressure ulcers:<br><br>R193's right heel pressure ulcer:<br>On 6/7/21, measured 1.5 cm x 3.0 (unstageable)<br>On 6/15/21, measured 1.8 cm x 2 cm (unstageable)<br><br>R193's left heel pressure ulcer:<br>On 6/7/21, measured 4.0 cm x 3.5 cm (unstageable) note indicated area not present on 6/6/21<br>On 6/15/21, measured 4.0 cm x 2.5 cm (unstageable)<br><br>R193's coccyx (right lower) pressure ulcer:<br>On 6/7/21, measured 3.0 cm x 2.5 Stage II with 70% dark purplish/red appearance and 30% epithelial with sanguineous (bright red) drainage<br>On 6/15/21, measured 1.2 cm x 0.5 cm Stage II with 100% epithelial tissue<br><br>R193's coccyx (left lower) pressure ulcer<br>On 6/7/21, measured 1.0 cm x 2.2 Stage 2<br>On 6/15/21, measured 1.2 cm x 1.2 cm<br><br>R193's sacrum (right upper coccyx) pressure ulcer:<br>On 6/7/21, measured 2.2 cm x 1.5 cm of 60% of wound unstageable deep tissue, and 40% unstageable yellow slough, with light amount of sanguineous drainage | F 686 | | |

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| F 686 | Continued From page 31<br>On 6/15/21, measured 2.0 cm x 1.7 cm covered 100% yellow slough<br><br>R193's right hip pressure ulcer:<br>On 5/27/21 measured 2.0 cm x 3.0 stage I and stage II with non blanching peri-wound<br>On 6/7/21 measured 2.6 cm x 0.5 cm deep tissue injury<br>On 6/15/21 measured 2.1 cm x 0.5 cm (unstageable)<br><br>R193's Wound Management Detail Report dated 6/18/21, indicated a new deep tissue injury on left great toe measured 1.2 cm x 2.0 cm and was suspected from wearing shoes. Foot cradle was ordered (to keep bedding off of foot), R193 was to avoid wearing shoes, and a request for a wound clinic referral due to multiple areas of skin break down since admission.<br><br>On 6/15/21, at 2:43 p.m. R193 was observed in bed with his Prevalon boots on both feet. R193 stated he had to wear the heel boots while he was in bed because he had sores on his heels that were acquired during his stay at the facility.<br><br>On 6/17/21, at 1:12 p.m. R193 was not in his room and his Prevalon boots where on his bed.<br><br>On 6/18/21, at 7:58 p.m. R193 was up in bed eating breakfast, his Prevalon boots were not on, and R193's heels were lying directly on the mattress.<br><br>On 6/18/21, at 8:26 a.m. R193 was observed in bed and Prevalon boots remained off, and heels were lying directly on the mattress.<br><br>On 6/18/21, at 9:00 a.m. NA-K and NA-L exited | F 686 | | |

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R193's room. NA-L verified R198 continued to not wear his Prevalon boots presently and did not have them on that morning when NA-L started the shift. NA-L stated during morning shift change, there was no report R198 refused to wear his Prevalon boots from the previous shift. NA-L stated R193 was supposed to wear the Prevalon boots while in bed.

On 6/18/21, at 9:03 a.m. NA-K stated NA-K and NA-L had repositioned R193 and verified R193 did not have his Prevalon boots nor were his heels floated off the bed. NA-K stated R193 was to be turned, repositioned, and offered toileting every 2 hours. NA-K stated R193 preferred to be in bed and sometimes would refuse to wear his Prevalon boots or change position. NA-K stated if R193 refused to wear his Prevalon boots or refused to be repositioned staff we report to the nurse. NA-K stated NA-K was not aware if R193 refused to have his Prevalon boots on.

On 6/18/21, at 9:25 a.m. R193 was escorted to therapy in his wheelchair. R193 did not have his Prevalon boots on, and both feet and heels were observed resting directly on the wheelchair pedals.

On 6/18/21, at 11:25 a.m. licensed practical nurse (LPN)-H stated R193 was admitted with a pressure area to his right hip, which had healed. LPN-H stated R193 had developed new pressure ulcers to his coccyx and heels, and LPN-H was about to complete R193's wound care. R198's dressing changes to his four pressure ulcers on his coccyx, and Betadine treatments to blackened areas on the out outside of both heels were observed. During these treatments, LPN-H noted a new pressure ulcer to the top of R198's left

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great toe. LPN-H summoned registered nurse (RN)-F, who measured the new pressure ulcer at 2.1 cm x 2 cm. RN-F stated R193 mostly likely developed the new pressure area from wearing shoes, even though he had an order for Prevalon boots.

On 6/21/21, at 8:26 a.m. R193 was observed sitting up in bed eating breakfast, R193's heels were observed resting directly on the bed. Two Prevalon boots were observed in R193's chair in his room. When asked if he was supposed to have his Prevalon boots on while in bed R193 stated, "I have no idea, sometimes they are put on and other times they are not."

On 6/21/21, at 8:42 a.m. RN-I was unsure when R193 was supposed to wear his Prevalon boots. RN-I checked R193's EMAR and stated she did not see the Prevalon Boots on the MAR or TAR. RN-I further stated the Prevalon boots would be an order and should be on the TAR for the nurse to sign off. RN-I stated if R193 refused to wear his Prevalon boots or reposition, staff were to reproach, notify the nurse and document the refusal. RN-I stated since the start of her shift, there had been no reports R193 refused to wear his Prevalon boots or declined to change position.

On, 6/21/21, at 9:10 a.m. RN-I exited 193's room and verified R193 did not have his Prevalon boots on and his heels were not floated off the bed. RN-I stated R193 allowed RN-I to put on his Prevalon boots without any hesitation.

On 6/21/21, at 9:12 a.m. NA-M stated she started her shift at 6:00 a.m. that morning. NA-M stated she assisted R193 that morning and verified R193 did not have his Prevalon boots on.

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NA-M stated R193 would ask to have his boots taken off or refuse to wear them. NA-M stated when R193 first was admitted to the facility, R193 refused a lot and overtime R193 became more accepting and was more compliant and refused less. NA-M stated she did not put R193's Prevalon boots on because R193 was scheduled for shower that morning. NA-M stated R193 refused to get up for breakfast that morning and agreed to get up and take his shower after breakfast. NA-M stated if a resident refused, NA-M would reproach and if continued to refuse, notify the nurse.

On 6/21/21, at 12:23 p.m. the director of nursing (DON) stated if a resident refused any treatments or services, she would expect staff to reproach, try a different caregiver, offer a different time of the day if appropriate, and notify the nurse. The DON stated she would expect the nurse to provided education on the risk vs benefits, update the physician and document. The DON stated it was important to follow the interventions on the care plan to promote wound healing and prevent skin concerns.

The facility policy Prevention and Treatment of Skin Breakdown/Pressure dated 2018, directed if a resident was admitted with impaired skin integrity or new pressure injury or lower extremity ulcers develop, the licensed nurse implements the following items:
-Evaluate current pressure reductions interventions and revise resident centered care plan.
-Educate resident/resident representative on skin impairment and care plan interventions.
-Notify the attending provider, resident/resident representative and supervisor if the skin injury

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| F 686 | Continued From page 35<br>has not shown progress in two weeks and/or is deteriorating unexpectedly. Re-evaluate plan of care as appropriate. | F 686 | | |
| F 688 SS=D | Increase/Prevent Decrease in ROM/Mobility<br>CFR(s): 483.25(c)(1)-(3)<br><br>§483.25(c) Mobility.<br>§483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and<br><br>§483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.<br><br>§483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, and document review, the facility failed to ensure an exercise program was followed for 1 of 2 residents (R45) reviewed for restorative care.<br><br>Findings include:<br><br>R45's Face Sheet printed 6/21/21, identified R45's diagnoses included hemiplegia (slight weakness in a leg, arm, or face) and hemiparesis (severe or complete loss of strength or paralysis on one side of the body) following nontraumatic | F 688 | R45 - restorative program was reviewed and updated for resident.<br>All residents' restorative programs were reviewed and updated as necessary.<br><br>All nursing and restorative staff will be educated on the Restorative Nursing Policy. Restorative Nursing policy was reviewed and remains current.<br><br>4 audits of completion of restorative program per week for (3) weeks, then | 8/4/21 |

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| F 688 | Continued From page 36<br>intracranial hemorrhage affecting left non-dominant side, mild cognitive impairment, dysphagia (difficulty swallowing), and difficulty walking.<br><br>R45's annual Minimum Data Set (MDS) dated 4/27/21, indicated R45 had moderately intact cognition, and required extensive assistance with bed mobility, transfers, dressing, toilet use, and personal hygiene.<br><br>R45's care plan dated 5/12/20, indicated R45 required therapy services. In addition, R45's care plan dated 5/12/20, indicated R45 was to ambulate with physical therapy (PT) only. The care plan directed staff to transfer R45 with a stand aide with the extensive assist of one.<br><br>R45's Therapy Communication to Wellness/Nursing Form dated 5/19, identified R45's program recommendations:<br>NuStep (a recumbent cross trainer which simulates the motion of walking) for 15 minutes three times a week.<br><br>On 6/15/21, at 10:06 a.m. R45 was interviewed. R45 stated his goal was to be able to walk again. R45 stated therapy had not worked with him in a long time. R45 stated no one was walking with him. A walker was observed at the foot of R45's bed.<br><br>On 6/18/21, at 9:36 a.m. R45 was invited to join group wheelchair exercises, he agreed to attend. R45 did not use the NuStep.<br>On 6/21/21, at 9:21 a.m. R45 attended the group exercise program. He did not use the NuStep.<br><br>On 6/18/21, at 3:31 p.m. physical therapist (PT)-D | F 688 | 2/week for an additional (3) weeks. Audit findings will be presented to facility's Quality Council by DON or designee. | |

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| F 688 | Continued From page 37 | F 688 | | |

was interviewed. PT-D stated R45 was not strong enough, steady enough, or able to follow cues to walk safely with anyone but therapy. PT-D stated R45's current therapy program was to use the NuStep for 15 minutes three times per week.

On 6/18/21, at 3:35 p.m. occupational therapist (OT)-E was interviewed. OT-E stated nursing was responsible for ensuring R45 used the NuStep for 15 minutes three times a week.

On 6/21/21, at 9:40 a.m. licensed practical nurse (LPN)-B was interviewed. LPN-B stated she was not aware R45 should be using the NuStep three times a week, or that nursing was responsible for ensuring it was done. R45's care guide for nursing assistants lacked any information regarding use of the NuStep.

On 6/21/21, at 10:29 a.m. registered nurse (RN)-D was interviewed. RN-D stated nursing assistant (NA)-B was responsible for ensuring residents participate in their exercise program. RN-D stated she would expect NA-B to document residents participation, or let her know if it wasn't being done.

On 6/21/21, at 10:46 a.m. NA-B was interviewed. NA-B stated he had not getting R45 to the NuStep for quite awhile. NA-B stated he was not sure when he last helped him to the NuStep, stating he was, "Only one person."

On 6/21/21, at 10:49 a.m. the director of nursing (DON) was interviewed. The DON stated she would expect staff to follow therapy programs including the exercise program. The DON stated if they were not able to do this, she would expect them to tell the director of therapy.

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| F 688 | Continued From page 38<br><br>On 6/21/21, at 12:27 p.m. the director of therapy stated she was not aware R45 was not using the NuStep three times a week.<br><br>The facility Hospitality Guide dated 3/2016, described the wellness program as a way for residents to improve and maintain their strength, flexibility, and balance. The description directed each resident is assessed by an Exercise Physiologist who would establish the proper weights and measures for strength for a baseline. The guide directed the resident would be reassessed quarterly to verify improvement and determine if an increase in resistance was needed. | F 688 | | |
| F 693 SS=D | Tube Feeding Mgmt/Restore Eating Skills<br>CFR(s): 483.25(g)(4)(5)<br><br>§483.25(g)(4)-(5) Enteral Nutrition<br>(Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident-<br><br>§483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and<br><br>§483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding | F 693 | | 8/4/21 |

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| F 693 | Continued From page 39<br>including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, and document review, the facility failed to ensure tube feeding formula was used for only 24 hours to prevent contamination of tube feeding for 1 of 1 residents (R19) reviewed for tube feeding (TF).<br><br>Findings include:<br><br>R19's Face Sheet printed 6/21/21, indicated R19 had diagnoses which included dysphagia oropharyngeal phase (swallowing problems), aphasia (loss of ability to understand or express speech) following cerebral infarction, and gastrostomy status (surgical opening in the stomach used for feeding).<br><br>R19's quarterly Minimum Data Set (MDS) dated 3/25/21, indicated R19 had unclear speech, and was severely cognitively impaired. R19's MDS further indicated R19 was totally dependent on tube feedings for nutrition.<br><br>R19's Care Area Assessment (CAA) dated 12/29/20, indicated R19 was to receive nothing per mouth (NPO). R19 was receiving nutrition via percutaneous endoscopic gastrostomy (PEG).<br><br>R19's care plan dated 6/11/21, indicated R19 received nutrition via a feeding tube. The care plan lacked indication of how long the formula could be used.<br><br>R19's Physician Order Report 6/18/21, indicated Jevity (formula) 1.5 calorie tube feed at 95 | F 693 | R19 □ tube feeding orders verified to remain accurate and appropriate. Tube feeding and tubing changed and verified to be running appropriately.<br><br>All residents with enteral feeding were identified, all enteral feeding nutrition and tubing was verified and found to be appropriate.<br><br>All licensed nurses have been trained on the tube feeding policy<br><br>Gastrostomy "G" Tube Use policy reviewed and remains appropriate.<br><br>4 residents with enteral feeding will be audited/week for (3) weeks, then 2/week for an additional (3) weeks to ensure all feedings are changed within 24 hours and running appropriately. Audit findings will be presented to facility's Quality Council by DON or designee. | |

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| F 693 | Continued From page 40 | F 693 | | |

milliliters (ml) for 12 hours (flush with 100 ml of water before and after). Start at 7:00 p.m., stop and disconnect at 7:00 a.m.

On 6/16/21, at 2:20 p.m. the TF was observed hanging on an intravenous (IV) pole dated and timed 6/16/21, at 5:50 a.m. The container appeared full of formula.

On 6/17/21, at 1:35 p.m. the TF was observed hanging on the IV pole dated and timed 6/18/21, at 5:50 a.m. The container appeared approximately one third full of formula.

On 6/18/21, at 8:33 a.m. the TF was observed hanging on the IV pole dated and timed 6/18/21, at 2:00 a.m. The container appeared full of formula.

On 6/18/21, at 8:52 a.m. licensed practical nurse (LPN)-B was interviewed. LPN-B verified the TF should have been half empty if it ran all night as ordered. LPN-B stated she did not receive any information from the night nurse that there were any interruptions with the TF.

On 6/18/21, at 9:51 a.m. registered nurse (RN)-D was interviewed. RN-D verified if the TF ran from 2:00 a.m. to 7:00 a.m. it should have been about half empty. RN-D verified TF could only remain hanging for 24 hours once the bottle of formula was opened.

On 6/21/21, at 8:27 a.m. LPN-B was interviewed. LPN-B verified if the TF was hung at 7:15 p.m. on 6/20/21, as timed and dated, it should have been empty. LPN-B verified the formula was only half gone. LPN-B verified TF can only hang for 24 hours once the formula bag has been opened.

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| F 693 | Continued From page 41<br><br>On 6/21/21, at 10:55 a.m. the director of nursing (DON) was interviewed. The DON verified TF formula should only be used for 24 hours after it had been opened.<br><br>The facility policy Gastrostomy "G" Tube Use dated 2018, directed staff to hang the TF for 24-72 hours per Manufacturer's recommendation. In addition, the policy directed staff to change the administration set every 24 hours or per Manufacturer's recommendations. | F 693 | | |
| F 755 SS=D | Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3)<br><br>§483.45 Pharmacy Services<br>The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.<br><br>§483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.<br><br>§483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-<br><br>§483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. | F 755 | | 8/4/21 |

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| F 755 | Continued From page 42<br>§483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and<br><br>§483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, and document review, the facility failed to ensure medications were not crushed and combined without a physician's order for 1 of 6 residents (R20) observed during medication administration. In addition, the facility failed to ensure a medication in capsule form opened was not administered against recommendations without a physician order for R20.<br><br>Findings include:<br><br>R20's Face Sheet printed 6/21/21, indicated R20's diagnoses included hemiplegia following a cerebral infarction (stroke), diabetes, chronic kidney disease, chronic kidney disease, epilepsy (seizures), dysphagia (swallowing difficulties), chronic pain, major depressive disorder, hyperlipidemia, hyperparathyroidism (parathyroid glands release too much parathyroid hormone, causing calcium levels in your blood to rise).<br><br>R20's Physician Order Report dated 6/16/21, included orders for:<br>-Gabapentin capsule 300 milligrams (mg) twice a day.<br>-sertraline 50 mg once a morning<br>-clopidogrel 75 mg once a morning<br>-amlodipine 5 mg twice daily | F 755 | R20 - medication review completed by facility pharm D to identify medications appropriate for crushing. Review sent to provider to obtain order for "okay to crush all medications as identified through pharmacy review"<br><br>All residents requiring or currently requesting medications to be crushed have been reviewed and updated appropriately if necessary.<br><br>Licensed nurses and TMAs will be educated on the identified process; cannot crush medications without order present. Lists of medications that can/cannot be crushed have been provided to all licensed nurses and TMAs, and are available in clinical work areas.<br><br>Medication Administration Policy has been reviewed and revised. All licensed nurses and TMAs have received the education regarding this change.<br><br>4 resident's medication administrations will be audited per week for (3) weeks, then 2/week for an additional (3) weeks to ensure compliance with these orders. | |

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| F 755 | Continued From page 43<br>-metoprolol succinate tablet extended release 24 hour 100 mg once a morning<br>-furosemide tablet 80 mg once a morning<br>-calcium acetate 667 mg tablet, 2 tablets with meals,<br>-levetiracetam tablet 750 mg twice daily<br>-allopurinol tablet 200 mg once a day<br>-aspirin delayed release (DR/EC) 325 mg once a morning<br>-terazosin capsule 1 mg once a morning<br>-vitamin D3 4000 international units once a morning<br>-regular diet texture<br><br>R20's Physician Orders lacked orders to crush medications, crush medications together, or open capsules for administration.<br><br>R20's Medication Administration Record (MAR) for May 2021, lacked directions to crush medications. R20's MAR lacked special instructions for opening capsules for administration.<br><br>On 6/16/21, at 8:24 a.m. during observation of medication administration, licensed practical nurse (LPN)-B was observed to crush all oral tablet form medications together, and put into chocolate pudding. LPN-B opened all capsule form medications (calcium acetate, gabapentin and terazosin) and put into the chocolate pudding with the other medications. LPN-B stated R20's MAR had directions to crush medications with chocolate pudding, but LPN-B stated she could not crush the capsules, so opened them instead. LPN-B verified there were no orders to put the crushed medications together. LPN-B stated they did not separate the medications, but gave them all together in pudding. LPN-B administered all | F 755 | Audit findings will be presented to facility's Quality Council by DON or designee. | |

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| F 755 | Continued From page 44<br>oral medications together in chocolate pudding. R20's eMAR was observed to direct, "Meds crushed with chocolate pudding."<br><br>On 6/18/21, at 4:21 p.m. the director of nursing (DON) stated they should get an order from the physician to crush and combine medications, and open capsules.<br><br>The facility policy Medication Administration-General Guidelines revised 8/14, directed crushing tablets may require a physician's order, long-acting or enteric-coated capsules should not be crushed. The policy directed consultation with a pharmacist before opening any capsules. The policy further directed the best practice for oral administration would be to crush and administer each medication separately, and the attending physician or consultant pharmacist should determine the most appropriate method for administering crushed medications with consideration of the residents safety, needs, medication schedule, preferences and functional ability. The need for crushing medications should be indicated on the resident's orders and the MAR. | F 755 | | |
| F 756 SS=D | Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5)<br><br>§483.45(c) Drug Regimen Review.<br>§483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.<br><br>§483.45(c)(2) This review must include a review of the resident's medical chart.<br><br>§483.45(c)(4) The pharmacist must report any | F 756 | | 8/4/21 |

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| F 756 | Continued From page 45<br>irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon.<br>(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.<br>(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.<br>(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.<br><br>§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.<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and document review, the facility failed to follow up on consultant pharmacist's recommendations timely for 3 of 6 residents (R18, R37, and R44) reviewed for unnecessary medications.<br><br>Findings include:<br><br>R18's Face Sheet printed 6/21/21, indicated | F 756 | R18 □ AIMS assessment has been reviewed and completed.<br><br>R37 - psychotropic side effect monitoring implemented. Gradual dose reduction has been attempted and failed. AIMs assessment has been completed.<br><br>R44 □ No longer in facility | |

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| F 756 | Continued From page 46<br>R18's diagnoses included major depressive disorder, anxiety disorder, schizoaffective disorder, insomnia, intellectual disabilities, hyperlipidemia, and neurofibromatosis type 1(the growth of tumors along nerves in the skin, brain, and other parts of the body).<br><br>R18's quarterly Minimum Data Set (MDS) assessment dated 3/26/21, indicated R18 had a moderate cognitive impairment, usually understood others, usually was understood by others, and had no symptoms of delirium or psychosis during the assessment period. R18's MDS further indicated R18 had no behaviors, though had mild mood symptoms. R18's MDS indicated R18 received insulin, antipsychotic, antianxiety, antidepressant, diuretic, and opioid medications.<br><br>R18's care plan initiated 6/25/20, indicated R18 had a developmental disability, was impulsive, had mild signs and symptoms of depression, and was vulnerable to abuse from others and was at risk for abusing others. R18's care plan further addressed R18's diagnosis of schizoaffective disorder, major depression, anxiety, insomnia, and intellectual disability and indicated R18 received an antipsychotic medication for schizophrenia. R18's care plan indicated the pharmacy would review medications as indicated, and directed nursing to monitor for side effects of medications and target behaviors. R18's care plan lacked directives to monitor for side effects of the antipsychotic use with an Abnormal Involuntary Movement Scale (AIMS) assessment (tool for assessing severity of dyskinesias-specifically, orofacial movements and extremity and truncal movements related to neuroleptic medications). | F 756 | All residents on psychotropic medications have been identified and all AIMS have been reviewed and revised as necessary.<br><br>RN Clinical managers and DON received education on AIMS completion process<br><br>Policy for AIMS and MRR assessment has been reviewed and remains appropriate<br><br>4 residents requiring AIMS will be audited per week for (3) weeks, then 2/week for an additional (3) weeks for follow up completion. Audit findings will be presented to facility's Quality Council by DON or designee<br><br>DON or designee will audit pharmacist recommendations monthly to ensure recommendations have been followed up on. | |

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Physician Orders through 6/21/21, indicated R18's medication orders included the following psychotropic medications:
-escitalopram oxalate (antidepressant)
-Abilify (atypical antipsychotic mood stabilizer) for Schizoaffective disorder
-lorazepam (antianxiety)
-haloperidol (antipsychotic)
-hydroxyzine (antihistamines, miscellaneous antianxiety, sedative and hypnotic)
-depakote (treat complex partial seizures as well as a mood stabilizer)

A physician progress note dated 5/7/21, indicated R18 had a neuroleptic induced Parkinson (difficulty initiating movements, slow movements, tremors and rigidity of muscles related to neuroleptic medications, such as antipsychotics).

A consultant pharmacist review dated 7/25/20, indicated R18 received an antipsychotic and antidepressant medication and an AIMS assessment was completed on 7/2/20 with a score of 1, or at low risk for a movement disorder.

A consultant pharmacist review dated 1/26/21, indicated R18 had been due for an AIMS assessment on 1/2/21, and recommended completion of an AIMS assessment for Abilify.

A consultant pharmacist review dated 2/26/21, repeated a recommendation for the completion of an AIMS assessment.

A consultant pharmacist review dated 3/28/21, repeated a recommendation for the completion of an AIMS assessment.

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A consultant pharmacist review dated 4/26/21, repeated a recommendation for the completion of an AIMS assessment.

A pharmacy consultant review dated 5/28/21, repeated a recommendation for the completion of an AIMS assessment.

An AIMS assessment was not completed for R18 until 6/18/21, with a score of 0.

R18's progress note regarding R18's care conference dated 4/6/21, indicated R18 had no changes in cognition or mood, and R18's resident representative had no concerns.

R37's Face Sheet printed 6/21/21, indicated R37's diagnoses included vascular dementia, anxiety disorder, and hallucinations.

R37's quarterly MDS dated 4/14/21, indicated R37 had a significant cognitive impairment, usually understood others and was usually understood, had no signs or symptoms of delirium, psychosis such as hallucinations, mood or behaviors. R37's MDS further indicated R37 had received antianxiety, antipsychotic, and diuretic medications daily.

R37's care plan initiated 10/10/19, indicated R37 received psychotropic or mood-altering medications, and directed nursing to monitor for potential medication side effects, and to follow up on the monthly pharmacist review recommendations. R37's care plan lacked directives to monitor for side effects of the antipsychotic use with an AIMS assessment or assessment of dyskinesias.

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R37's Medication Administration Record dated 6/14/21, through 6/21/21, indicated R37 received the following psychotropic medications:
-lorazepam
-Seroquel (antipsychotic)

A consultant pharmacist review dated 8/29/20, indicated R37 had a diagnosis of dementia with behavioral disturbance and received Seroquel. R37's review indicated R37 had an AIMS assessment on 5/26/20 with a score of 1.

A consultant pharmacist review dated 10/26/20, indicated R37 was due for a gradual dose reduction (GDR) of the Seroquel in 11/20.

A consultant pharmacist review dated 11/28/20, indicated R37 needed a GDR or risk versus benefit documentation of the use of Seroquel.

A consultant pharmacist review dated 12/29/20, repeated a recommendation for a GDR or risk versus benefit documentation of the use of Seroquel.

A consultant pharmacist review dated 1/26/21, repeated the recommendation for a GDR or risk versus benefit documentation for the use of Seroquel. In addition, the recommendation indicated a need for the completion of an AIMS assessment for Seroquel use.

A consultant pharmacist review dated 2/26/21, repeated the recommendation for an AIMS assessment for the use of Seroquel. The consultant pharmacist review further indicated R37's Seroquel dose had been increased related to hallucinations, and the GDR was rejected by the provider on 2/11/21.

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A consultant pharmacist review dated 3/28/21, indicated R37 continued to need an AIMS assessment for Seroquel.

A consultant pharmacist review dated 4/26/21, repeated the recommendation for an AIMS assessment for R37's use of Seroquel.

A consultant pharmacist review dated 5/28/21, included a recommendation for a duration of R37's lorazepam as needed order, as R37's lorazepam was changed on 2/25/21, to include 0.5 mg every 4 hours as needed (PRN), in addition to the scheduled lorazepam order of 0.5 mg twice daily.

A nursing progress note dated 6/17/21, indicated R37's AIMS assessment was reviewed and remained the same with no changes since the last review. A full AIMS assessment was not completed.

On 6/18/21, at 3:50 p.m. registered nurse (RN)-D stated they do AIMS assessments yearly, and stated the consultant pharmacist reviews are provided to the provider to follow up on recommendations. When asked about recommendations for nursing to address, RN-D stated they do the AIMS assessments annually, but would try to follow up on recommendations as soon as possible, though has been difficult to keep up this year. RN-D verified she had done an AIMS assessment on someone, she thought on 6/17/21. R18 and R37's AIMS assessments had been completed following the request for R18's and R37's consultant pharmacist reviews. RN-D stated Hospice managed R37's medications. RN-D stated the provider and

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consultant pharmacist reviews and tracks the use of PRN medications for the 14-day limits for psychotropic medications.

On 6/18/21, at 4:03 p.m. director of nursing (DON) stated the consultant pharmacist recommendations should be followed up on by at least the second request.

On 6/21/21, at 12:59 p.m. the consultant pharmacist stated she expected the facility or provider to respond to her recommendations within 30 days, but allowed 60 days during the pandemic. Consultant pharmacist stated if the recommendation was very urgent, she would email the nurse manager. Consultant pharmacist stated the providers had not been cooperative with responding to the 14 day follow up for PRN psychotropic medications, and had discussed this in quality assurance meetings.

The facility policy Psychotropic Medication Use dated 2017, directed a review of psychotropic medications for a GDR yearly, adequate monitoring, and a limit of the use of PRN psychotropic medications to 14 days unless the provider evaluates and documents the rationale for renewal of the 14-day use of the PRN psychotropic medication. The facility policy and procedure lacked the required monthly consultant pharmacist review, the follow-up of consultant pharmacist recommendations, and the monitoring for and assessments of dyskinesias, such as an AIMS assessment.

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R44's Face Sheet printed 6/21/21, indicated R44's diagnoses included toxic encephalopathy, unspecified dementia without behavioral disturbance, gastrointestinal hemorrhage-recurrent, iron deficiency- chronic, gastro-esophageal reflux with esophagitis with bleeding, anxiety, and major depressive disorder.

R44's quarterly MDS dated 4/26/21, indicated R44 was cognitively intact. The MDS also indicated R44 was on scheduled pain medication, antipsychotic, antianxiety and antidepressant medications.

R44's care plan initiated 1/19/21, indicated pharmacy would review the medications as indicated and directed nursing to monitor for side effects of medications and target behaviors. R44's care plan lacked directives to monitor for side effects of the antipsychotic use with an AIMS assessment.

R44's Physician Order report dated 5/28/21 indicated R44's medication orders included the following psychotropic medications:
-quetiapine (antidepressant) 100 mg, once a day
-hydroxyzine (antianxiety) 25 mg, every 8 hours as needed
-duloxetine (antianxiety, antidepressant) 60 mg once a day

A consultant pharmacist review dated 4/26/21,

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| F 756 | Continued From page 53<br>indicated a recommendation for an AIMS assessment due to an increase in quetiapine on 4/6/21.<br><br>A consultant pharmacist review dated 5/28/21 repeated a recommendation for the completion of an AIMS assessment.<br><br>On 6/21/21, at 10:02 a.m. RN-D stated she would send the pharmacy recommendations to the physician immediately. R44's physician resigned one month ago, and R44 was having difficulty choosing a new provider. RN-D was unaware R44's AIMS assessment was not completed.<br><br>On 6/21/21, at 10:07 a.m. the DON stated the pharmacy recommendations should be sent to the physician immediately when the Pharmacist Drug Regimen Review was completed.<br><br>On 6/21/21, at 12:59 p.m. the consultant pharmacist (CP)-F was interviewed and stated she would expect the AIMS assessment would be completed on admission. CP-F stated the facility was notoriously late in getting back to her on the recommendations. CP-F stated she has told the nurses they need to put the recommendations in the folder, and need to get the providers to address the concerns. CP-F stated she gives the provider 30 days to respond, and at the next month review she would email the nurse manager. | F 756 | | |
| F 758 SS=D | Free from Unnec Psychotropic Meds/PRN Use<br>CFR(s): 483.45(c)(3)(e)(1)-(5)<br><br>§483.45(e) Psychotropic Drugs.<br>§483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental | F 758 | | 8/4/21 |

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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.

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| F 758 | Continued From page 55<br>§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.<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and document review the facility failed to ensure psychotropic medications used on an "as needed" basis were reviewed for continued use by the provider every 14 days for 1 of 6 residents (R18) reviewed for unnecessary medications. In addition, the facility failed to ensure medication orders included a specific appropriate diagnosis for 1 of 6 residents (R18) reviewed for unnecessary medications. Further, the facility failed to ensure a care plan was developed and implemented, and monitoring for target behaviors and side effects to determine efficacy of psychotropic medications for 1 of 6 residents (R198) reviewed for unnecessary medications.<br><br>Findings include:<br><br>R18's face sheet printed 6/21/21, indicated R18's diagnoses included major depressive disorder, anxiety disorder, schizoaffective disorder, insomnia, intellectual disabilities, hyperlipidemia, and neurofibromatosis type 1(the growth of tumors along nerves in the skin, brain, and other parts of the body).<br><br>R18's quarterly Minimum Data Set (MDS) assessment dated 3/26/21, indicated R18 had a moderate cognitive impairment, usually understood others, usually was understood by others, and had no symptoms of delirium or psychosis during the assessment period. R18's | F 758 | R18: PRN psychotropic medications reviewed for appropriateness of use.<br><br>R198: - care plan developed and implemented to include monitoring for target behaviors and side effects to determine efficacy of psychotropic medications<br><br>All residents receiving psychotropic medications orders have been reviewed and updated if necessary.<br><br>RN clinical managers will establish a tracking system for their resident's with PRN psychotropic medications for 14 day reviews<br><br>All licensed nurses and trained medication aides will be educated on the Psychotropic Medication Use policy and associated documentation<br><br>Psychotropic Medication Use policy has been reviewed and remains current.<br><br>4 PRN psychotropic orders will be audited for appropriate supporting documentation for (3) weeks, then 2/week for an additional (3) weeks to ensure compliance with process. Audit findings will be presented to facility's Quality Council by | |

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MDS further indicated R18 had no behaviors, though had mild mood symptoms. R18's MDS indicated R18 received insulin, antipsychotic, antianxiety, antidepressant, diuretic, and opioid medications.

R18's care plan initiated 6/25/20, indicated R18 had a developmental disability, was impulsive, had mild signs and symptoms of depression, and was vulnerable to abuse from others and was at risk for abusing others. R18's care plan further addressed R18's diagnosis of schizoaffective disorder, major depression, anxiety, insomnia, and intellectual disability and indicated R18 received an antipsychotic medication for schizophrenia. R18's care plan indicated the pharmacy would review medications as indicated, and directed nursing to monitor for side effects of medications and target behaviors. R18's care plan lacked direction to review and document rationale and risk versus benefit for continuation of PRN psychotropic medications.

R18's Physician Order Report dated 6/14/21 through 6/21/21, indicated R18's medication orders included the following as needed (PRN) psychotropic medications:

-haloperidol lactate syringe (antipsychotic); 5 milligrams (mg)/milliliter (ml); 0.5 mg/0.1 ml; intramuscular for anxiety once daily as needed (PRN). R18's haloperidol order was started 5/17/21, and open ended (no stop date). R18's physician orders lacked target behaviors and side effect monitoring.

-hydroxyzine (antihistamines, miscellaneous antianxiety, sedative and hypnotic) tablet; 25 mg oral for anxiety every 8 hour PRN. R18's

DON or designee.

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hydroxyzine order was started 2/15/21, and was open ended.

R18's Physician Order Report dated 6/14/21, included the following psychotropic medications without an associated diagnosis:
-escitalopram oxalate (antidepressant) 30 mg once a morning, started
-lorazepam (antianxiety) 0.5 mg once an evening
- Depakote (used for seizures or as a mood stabilizer) delayed release (DR/EC) 500 mg once an evening

R18's Medication Administration Record (MAR) for 5/21, indicated R18 received the PRN hydroxyzine 3 times and did not receive the PRN haloperidol.

A physician progress note by neurology dated 4/14/21, indicated R18 had been treated with antipsychotics for schizophrenia for years and had a neuroleptic induced parkinsonism, and R18 reported his shaking gets in his way sometimes. R18's progress note indicated nursing staff felt that his shaking and mobility had not changed much, and his shaking had not worsened since starting the Depakote. R18's Risperdal (antipsychotic) had been discontinued. R18's progress note did not address PRN psychotropic medication use.

A physician progress note dated 5/7/21, indicated R18 had a neuroleptic induced parkinsonism (difficulty initiating movements, slow movements, tremors and rigidity of muscles related to neuroleptic medications, such as antipsychotics). R18's physician progress note lacked addressing continuation of R18's PRN psychotropic medication use. The physician's plan included

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| F 758 | Continued From page 58 | F 758 | | |

contacting psychiatry to inquire about possible PRN Haldol and concerns about neuroleptic malignant syndrome and rigidity with R18 receiving so many antipsychotics.

On 6/18/21, at 3:50 p.m. registered nurse (RN)-D stated PRN psychotropic medications should be reviewed every 14 days. RN-D stated she did not keep track or notify the physician or nurse practitioner on the 14-day reviews. RN-D stated she relied on the pharmacist recommendations and the provider to track and review the use of PRN psychotropic medications for the 14 -day limits for PRN psychotropic medications orders. RN-D stated Hospice managed R37's medications.

On 6/18/21, at 4:03 p.m. director of nursing (DON) verified the PRN psychotropic medications should be reviewed by the provider for continued use after 14 days. DON stated there should be an end date on orders so the MD has to review it and re-order the medication. DON confirmed medication orders should include an appropriate diagnosis.

On 6/21/21, at 12:59 p.m. the consultant pharmacist (CP)-F stated the providers had not been cooperative with responding to the 14 day follow up for PRN psychotropic medications, and stated she had discussed this in quality assurance meetings.

The facility policy Psychotropic Medication Use dated 2017, directed a review of psychotropic medications for a gradual dose reduction (GDR) yearly, adequate monitoring, and a limit of the use of PRN psychotropic medications to 14 days unless the provider evaluates and documents the

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| F 758 | Continued From page 59<br>rationale for renewal of the 14-day use of the PRN psychotropic medication. The facility policy further directed each resident's drug regimen must be free from unnecessary drugs, and must not be used without adequate indications for use, for an excessive duration and without adequate indications for use.<br><br>R198's Face Sheet printed 6/21/21, indicated R198's diagnoses included anxiety, and depression.<br><br>R198's admission MDS dated 6/10/21, indicated R198 was mildly cognitive impaired, had mild depression, and was prescribed antianxiety and antidepressant medications.<br><br>R198's care plan dated 6/3/21, lacked the identification of prescribed psychotropic medications, individualized goals to include adverse reactions, and interventions to identify target behaviors and non pharmacological interventions.<br><br>R198's Physician Order Report dated 5/21/21 through 6/21/21, included lorazepam (antianxiety medication) one milligram (mg) twice a day, Prozac (antidepressant medication) 80 mg every morning, and trazodone (antidepressant | F 758 | | |

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| F 758 | Continued From page 60<br>medication) 50 mg every evening.<br><br>R198's MAR dated 6/1/19, thought 6/21/21, lacked target behavior monitoring for Prozac 80 mg every a.m., trazadone 50 mg every p.m., and lorazepam 1 mg twice a day. R198's treatment administration record (TAR) further lacked non pharmalogical interventions.<br><br>On 6/21/21, 12:23 p.m. the DON stated target behavior monitoring should be completed for Ativan, trazadone, and Prozac, and should be identified on the MAR. The DON verified R198's MAR did not include target behavior monitoring for R198's prescribed psychotropic medications.<br><br>On 6/21/21, at 12:59 p.m. consultant pharmacist (CP)-F stated she would expect residents who are on psychotropic medications to have target behavior monitoring in place, and resident care plans to reflect the use of psychotropic medications to identify and monitor possible signs, symptoms, and side effects for each of those medications.<br><br>On 6/21/21, at 1:45 p.m. RN-A stated monitoring target behaviors were important for attempts to do GDRs, and to monitor for any side effects and efficacy of the medications. RN-A stated it was important to talk with the resident to find out symptoms, monitor for those signs and symptoms, side effects, and put non-pharmalogical interventions in place. RN-A verified R198's MAR and care plan lacked target behavior monitoring and non-pharmalogical interventions.<br><br>On 6/21/21, at 3:40 p.m. the Quality Management Coordinator stated she was unable to provide a | F 758 | | |

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| F 758 | Continued From page 61<br>mood/behavior monitoring sheets for R198 because it was never were completed. The Quality Management Coordinator further stated mood and monitoring sheets should have been initiated and completed as part of the admission process.<br><br>The facility policy Psychotropic Medication Use undated, directed when psychotropic medications are ordered, interdisciplinary team (IDT) identifies target behaviors, medication side effects to be monitored and implements a resident centered care plan with both non pharmacological and pharmacological interventions. | F 758 | | |
| F 880 SS=D | Infection Prevention & Control<br>CFR(s): 483.80(a)(1)(2)(4)(e)(f)<br><br>§483.80 Infection Control<br>The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.<br><br>§483.80(a) Infection prevention and control program.<br>The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:<br><br>§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following | F 880 | | 8/4/21 |

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| F 880 | Continued From page 62<br>accepted national standards;<br><br>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:<br>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;<br>(ii) When and to whom possible incidents of communicable disease or infections should be reported;<br>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;<br>(iv)When and how isolation should be used for a resident; including but not limited to:<br>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and<br>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.<br>(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<br>(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.<br><br>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.<br><br>§483.80(e) Linens.<br>Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. | F 880 | | |

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| F 880 | Continued From page 63<br><br>§483.80(f) Annual review.<br>The facility will conduct an annual review of its IPCP and update their program, as necessary.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, and document review, the facility failed to ensure hand hygiene was performed between assisting residents or touching soiled surfaces and serving food or beverages for 4 of 19 residents on Harbor Light unit (R39, R7, R65, R31) during meal service. In addition, the facility failed to ensure hand hygiene and glove changes were performed between a dressing change and administration of eye drops for 1 of 1 residents (R28) observed for eye drop administration. In addition, the facility failed to ensure oxygen tubing was changed and dated for 3 of 4 residents (R16, R18, and R37) reviewed for respiratory services.<br><br>Findings include:<br><br>On 6/14/21, at 1:33 p.m. lunch service to resident rooms was observed. Nursing assistant (NA)-N left R39's room after setting his meal tray up, she moving the garbage can near him, and then moved the meal cart down to R7's room. NA-N did not wash or sanitize hands upon leaving R39's room and before moving the cart. NA-N removed R7's tray from the cart, and brought it into the room, and set her meal up for her. NA-N exited R7's room and did not wash or sanitize his hands. NA-N grabbed the top of R65's orange juice glass, brought in the tray to the room, moved the beverages on R65's tray table, and put R65's meal tray on the tray table. NA-N unwrapped R65's silverware, put it on the tray, unwrapped the cord on the call light, put the call | F 880 | R39, R7, R65, and R31 - verified to not have current infection as a result of non-compliance with hand hygiene during tray pass<br><br>R28: assessed for infection r/t noncompliance with hand hygiene prior to eye drop administration following changing split sponge on G-tube no infection present.<br><br>R18: - supplemental oxygen tubing was changed, order implemented in TAR to change tubing weekly<br><br>R37: - supplemental oxygen tubing was changed, order implemented in TAR to change tubing weekly<br><br>R16: - supplemental oxygen tubing was changed, order implemented in TAR to change tubing weekly<br><br>All residents with orders for supplemental oxygen were identified and reviewed to ensure nursing order to change tubing weekly was present, and current tubing was verified to be in compliance with manufacture recommendations.<br><br>Training will be provided to licensed nurses and TMAs regarding O2 tubing policy and procedure. | |

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| F 880 | Continued From page 64<br>light back on the tray table, then put a napkin on R65's neck, and removed the cover from her entree. NA-N returned to the meal tray cart to get glasses, held 2 glasses by the top drinking rim, and put them on R65's tray. NA-N opened containers, poured milk into one glass, and poured a pink supplement beverage into the other. NA-N picked up garbage off the floor, put it into the garbage can near R65, and moved the garbage can closer to R65. NA-N opened R65's straw, put the straw into the pink beverage, and then did the same with a straw for R65's milk. NA-N left R65's room. NA-N did not wash or sanitize his hands before going to the meal tray cart. NA-N went to the cart, removed another tray, grabbed a glass by the top of the drinking rim, and delivered it to R31. NA-N moved beverages on the tray to the window sill, but R31 wanted them back. NA-N removed the lid from the mug, and put the lid back on, and then removed the cover from the plate. NA-N left R31's room, without sanitizing or washing his hands.<br><br>On 6/14/21, at 1:44 p.m. NA-N verified he should have washed his hands between residents, verified he touched the top drinking rim of the glasses, and said it was not sanitary. NA-N stated he was a little busy. NA-N stated he should get R31 a new cup and sanitized his hands.<br><br>On 6/18/21, at 4:28 p.m. the director of nursing (DON) stated staff should wash or sanitize their hands between residents when passing meal trays. | F 880 | Policy and procedure for oxygen has been reviewed and remains appropriate<br><br>100% of residents with O2 tubing will be audited weekly. Audit findings will be presented to facility's Quality Council by DON or designee, audit frequency and volume to be adjusted based on results.<br><br>Refer to DPOC for items related to hand hygiene. | |

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| F 880 | Continued From page 65<br>Medication Administration:<br><br>R28's face sheet printed 6/21/21, indicated R28's diagnoses included anoxic brain damage, persistent vegetative state, and gastrostomy status.<br><br>R28's Physician Order Report dated 5/21/21 through 6//21/21, indicated R28's physician orders included:<br>-NPO (nothing by mouth) Tube feeding<br>-dorzolamide-timolol drops , one drop to left eye once a morning<br>-clean GT stoma daily with mild soap and water. Allow to air dry and no need to apply dressing..<br><br>On 6/16/21, at 8:44 a.m. licensed practical nurse (LPN)-B entered R28's room to administer medications. LPN-B sanitized her hands and gloved, and properly administered an injection of heparin and disposed of the sharps, removed her gloves, sanitized her hands, and donned clean gloves. LPN-B checked for proper placement of the gastrostomy feeding tube (tube through the abdominal and stomach wall through which nutrition, hydration, and medications are received), appropriately administered medications and water flushes through the GT. LPN-B removed R28's GT site dressing, and stated the GT site was slightly red with a small amount of bloody drainage. After removing the dressing, LPN-B administered one drop of R28's dorzolamide-timolol (lowers pressure in the eye) eye drop to the left eye while positioning R28's left eye lid and face in a position for eye drop administration, while wearing the same gloves used to remove R28's GT dressing. LPN-B removed gauze from the package on R28's table and dabbed around R28's left eye. LPN-B did | F 880 | | |

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| F 880 | Continued From page 66 | F 880 | | |

not remove gloves or complete appropriate hand hygiene prior to administering eye drops. LPN-B then grabbed more gauze, cleansed around R28's GT with normal saline, dabbed it dry and replaced the sponge dressing around the GT. LPN-B then removed her gloves and sanitized her hands.

On 6/16/21, at 9:16 a.m. LPN-B verified she did not change her gloves and sanitize or wash her hands between removing the GT dressing and administration of eye drops to R28, which could have caused cross contamination.

On 6/18/21, at 4:21 p.m. DON verified nursing should wash their hands and change gloves between dressing changes and administration of eye drops.

Oxygen Tubing:

R18's face sheet printed 6/21/21, indicated R18's diagnoses included diabetes.

R18's Physician Order Report dated 6/14/21, indicated R18's physician orders included supplemental oxygen at 2 liters per minute (LPM) per nasal cannula as needed (PRN) for dyspnea (oxygen saturation of less than 88%).

R18's care plan indicated R18 was at risk for COVID infection.

R18's Treatment Administration History for 4/21, indicated R18 used oxygen every night, and was

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| F 880 | Continued From page 67 | F 880 | | |

applied at 8:00 a.m. and taken off at 8:00 a.m. R18's Treatment Administration History lacked direction and documentation of changing oxygen tubing.

R18's Treatment Administration History for 5/21, indicated R18 used oxygen 4 nights through 5/4/21, and was applied at 8:00 a.m. and taken off at 8:00 a.m. R18's Treatment Administration History lacked direction and documentation of changing oxygen tubing.

R18's Medication Administration Record lacked direction and documentation of changing oxygen tubing.

On 6/14/21, at 7:01 p.m. R18's undated O2 tubing was lying on the floor, with the concentrator running. R18 stated he used the oxygen at night and reported the nursing staff did not change the tubing.

On 6/18/21, at 12:10 p.m. R18 was sitting in his wheelchair and no oxygen on.

R37's face sheet printed 6/21/21, indicated R37's diagnoses included chronic respiratory failure with hypoxia (low oxygen levels), heart failure, and a pleural effusion (build up of fluids in the layers on the outside of the lungs).

R37's Medication Administration Record for 4/21, indicated R37 had an order for oxygen 2 liters via nasal cannula for comfort PRN, and used oxygen daily. R37's MAR lacked directives to change oxygen tubing

R37's Medication Administration Record for 5/21,

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| F 880 | Continued From page 68 | F 880 | | |

indicated R37 had an order for oxygen 2 liters via nasal cannula for comfort PRN, and used oxygen daily. R37's MAR lacked directives to change oxygen tubing.

R37's Medication Administration Record for 6/21, indicated R37 had an order for oxygen 2 liters via nasal cannula for comfort PRN, and used oxygen daily. R37's MAR included directives to change oxygen tubing and nasal cannula on Mondays, initiated on 6/15/21.

R37's Physician Order Record dated 6/14/21, indicated R37 had an order for oxygen at 2 liters per nasal cannula PRN for comfort, initiated 1/8/21.

On 6/15/21, at 11:27 a.m. R37's oxygen concentrator was running but tubing was not connected. R37 had an oxygen tank on the back of her wheelchair and was running at 1.5 liters and on per nasal cannula. R37's oxygen tubing was not dated.

On 6/16/21, at 2:57 p.m. R37 was sitting in her wheelchair with her oxygen on, though the full tubing was not visible to see if the tubing was dated.

On 6/17/21, at 3:23 p.m. R37 was in her room with her oxygen tubing in her pocket and not connected to the tank, so not visible to see if the tubing was dated. R37 had the nasal cannula on.

On 6/18/21, at 3:50 p.m. DON stated oxygen tubing should be changed weekly and dated.

The facility policy and procedure for Hand Hygiene dated 6/17, directed hand hygiene to be

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| F 880 | Continued From page 69<br>completed before and after direct resident contact, before and after performing invasive procedures, before and after handling food or assisting residents with meals, and before and after changing a dressing, upon and after coming in contact with a residents skin.<br><br>The facility policy and procedure for Safe Delivery of Food and Beverages dated 2019, directed staff to wash hands prior to delivering food and to refrain from touching any unclean surfaces during food delivery.<br><br>The facility policy and procedure for Oxygen Therapy dated 2017, lacked directives for changing oxygen tubing.<br><br>R16's Face Sheet printed 6/21/21, indicated diagnoses included chronic obstructive pulmonary disease (COPD), chronic respiratory failure with hypoxia, and anxiety.<br><br>R16's admission Minimum Data Set (MDS) dated | F 880 | | |

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3/23/21, indicated R16 was cognitively intact, and received oxygen.

R16's care plan dated 3/16/21, indicated R16 had special treatments of continuous oxygen therapy, R16's care plan directed oxygen to be administered at 10 liters per minute (LPM) per medical administration record (MAR) and assess O2 sats as indicated on R16's treatment medical record (TAR).

R16's TAR for the month of April indicated oxygen per nasal cannula at 10 LPM, and lacked directions to change O2 tubing. R16's MAR dated 5/18/21, to 6/17/21, indicated oxygen per nasal cannula at 4-10 LPM, and lacked directions to change the oxygen tubing.

R16's Physician Order Report dated 5/17/21, through 6/17/21, included an order for oxygen at 4-10 LPM. On 6/15/21, orders were put in place to change O2 tubing and clean filter with soap and water weekly.

On 6/15/21, at 9:01 a.m. R16's oxygen tubing from both of the running oxygen concentrators were dated 4/7/21, and R16's nasal cannula tubing and nebulizer tubing were undated. R16 stated his oxygen tubing and nebulizer mask and tubing had not been changed for at least two months.

On 6/15/21, at 10:58 a.m. licensed practical nurse (LPN)-A stated oxygen tubing was changed weekly on the night shift. LPN-A verified R16's oxygen tubing was dated 4/7/21, on both of his oxygen concentrators, and R16's nasal cannula tubing, nebulizer tubing and mask were not dated. LPN-A verified R16's MAR and TAR

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245236 | A. BUILDING _____ B. WING _____ | C 06/21/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **BENEDICTINE HEALTH CENTER** | **935 KENWOOD AVENUE DULUTH, MN 55811** |

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| F 880 | Continued From page 71<br>lacked direction when to change oxygen tubing or nebulizer mask and tubing.<br><br>On 6/15/21, at 3:53 p.m. registered nurse (RN)-A stated oxygen tubing should be changed weekly, and oxygen concentrator filters should be cleaned with soap and water weekly. RN-A verified R16's oxygen tubing was not being changed weekly, and R16's MAR and TAR lacked direction on changing oxygen and nebulizer tubing.<br><br>On 6/21/21, at 12:23 p.m. the DON stated the oxygen tubing should be changed every week on the night shift. The DON further stated she would expect staff to follow facility policy on changing oxygen tubing, and make sure the information is on the TAR.<br><br>A facility policy on changing oxygen tubing was requested and not provided. | F 880 | | |

Electronically delivered
August 5, 2021

Administrator
Benedictine Health Center
935 Kenwood Avenue
Duluth, MN 55811

RE: CCN: 245236
Cycle Start Date: July 12, 2021

Dear Administrator:

On July 12, 2021, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

## ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

## DEPARTMENT CONTACT

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

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

## 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 October 12, 2021 (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 January 12, 2022 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

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

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

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245236 | A. BUILDING **01 - MAIN BUILDING 01**<br>B. WING _____ | **07/12/2021** |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **BENEDICTINE HEALTH CENTER** | **935 KENWOOD AVENUE**<br>**DULUTH, MN 55811** |

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| K 000 | INITIAL COMMENTS<br><br>FIRE SAFETY<br><br>A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Benedictine Health Center was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code.<br><br>THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENTS ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE.<br><br>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.<br><br>IF OPTING TO USE AN EPOC, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.<br><br>PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K TAGS) TO: | K 000 | | |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| Electronically Signed | | 08/13/2021 |

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<br><br>HEALTH CARE FIRE INSPECTIONS<br>STATE FIRE MARSHAL DIVISION<br>445 MINNESOTA STREET, SUITE 145<br>ST. PAUL, MN 55101-5145, or<br><br>By e-mail to:<br>FM.HC.Inspections@state.mn.us<br><br>THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION:<br><br>1. A detailed description of the corrective action taken or planned to correct the deficiency.<br><br>2. Address the measures that will be put in place to ensure the deficiency does not reoccur.<br><br>3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained.<br><br>4. Identify who is responsible for the corrective actions and monitoring of compliance.<br><br>5. The actual or proposed date for completion of the remedy.<br><br>Benedictine Health Center is a three story building with no basement. The original building was constructed in 1980 with an addition in 1990. Both buildings are of type II(111) construction. Because the original building and the addition are of the same type of construction allowed for existing buildings, the facility was surveyed as one building. | K 000 | | |

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| K 000 | Continued From page 2<br>The building is fully fire sprinkler protected. The facility has a complete fire alarm system with smoke detection in the corridors and spaces open to the corridor, that is monitored for automatic fire department notification.<br><br>The facility has a licensed capacity of 96 beds and had a census of 93 at the time of the survey.<br><br>The requirements at 42 CFR, Subpart 483.70(a) are NOT MET. | K 000 | | |
| K 321<br>SS=D | Hazardous Areas - Enclosure<br>CFR(s): NFPA 101<br><br>Hazardous Areas - Enclosure<br>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.<br>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.<br>Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door.<br>Describe the floor and zone locations of hazardous areas that are deficient in REMARKS.<br>19.3.2.1, 19.3.5.9<br><br>Area Automatic Sprinkler Separation N/A<br>a. Boiler and Fuel-Fired Heater Rooms<br>b. Laundries (larger than 100 square feet)<br>c. Repair, Maintenance, and Paint Shops<br>d. Soiled Linen Rooms (exceeding 64 gallons) | K 321 | | 8/13/21 |

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| K 321 | Continued From page 3<br>e. Trash Collection Rooms (exceeding 64 gallons)<br>f. Combustible Storage Rooms/Spaces (over 50 square feet)<br>g. Laboratories (if classified as Severe Hazard - see K322)<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations and staff interview, it was revealed that the facility has failed to provide proper protection for 1 of several hazardous areas located throughout the facility in accordance with NFPA 101 "The Life Safety Code" 2012 edition (LSC) section 19.3.2.1. This deficient condition could have an isolated impact on the residents within the facility.<br><br>Findings include:<br><br>On 07/12/2021, at 12:27 PM during the facility tour observations revealed that the door to the electrical/mechanical on the first floor did not have a self-closing device ensuring that the door positivity latches into the door frame.<br><br>This deficient conditions were verified by the Maintenance Director. | K 321 | Door closure installed 7/13/21<br><br>Maintenance staff will review all doors to verify if it is appropriate that a door closure is needed.<br><br>Photo is attached | |
| K 345 SS=F | Fire Alarm System - Testing and Maintenance<br>CFR(s): NFPA 101<br><br>Fire Alarm System - Testing and Maintenance<br>A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system | K 345 | | 8/13/21 |

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| K 345 | Continued From page 4<br>acceptance, maintenance and testing are readily available.<br>9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72<br>This REQUIREMENT is not met as evidenced by:<br>Based on a review of available documentation and staff interview, the facility failed to test and maintain the fire alarm per NFPA 101 (2012 edition), Life Safety Code, section 9.6.1.3, and NFPA 72 (2010 edition) National Fire Alarm Code, sections 14.5.3. and 14.6.2.4. This deficient condition could have a widespread impact on the residents within the facility.<br><br>Findings include:<br><br>On 07/12/2021 at 11:15 AM, it was revealed that the facility could not provide any current documentation verifying that a semiannual inspection of all initiating devices had been completed.<br><br>This deficient conditions were verified by the Maintenance Director. | K 345 | Visual inspection was completed on 8/9-8/10 by Chad Brenna. Following in the guidance under NFPA72(10), Table 14.3.1 Visual inspection Semiannually.<br><br>The semiannual inspection has been added to our electronic work order system to ensure timely completion in the future.<br><br>Paper work filed in Fire Marshall Documentation Binder | |
| K 353 SS=F | Sprinkler System - Maintenance and Testing<br>CFR(s): NFPA 101<br><br>Sprinkler System - Maintenance and Testing<br>Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available.<br>a) Date sprinkler system last checked | K 353 | | 8/13/21 |

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| K 353 | Continued From page 5<br>_____<br>b) Who provided system test<br>_____<br>c) Water system supply source<br>_____<br>Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system.<br>9.7.5, 9.7.7, 9.7.8, and NFPA 25<br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interview and a review of the available fire sprinkler test and inspection documentation, the automatic sprinkler system is not maintained in accordance with NFPA 25 the Standard for the Inspection, Testing, and Maintenance of Water Based Fire Protection Systems 2011 edition section 5.2.5 and 5.3.2.1. This deficient condition could have a widespread impact on the residents within the facility.<br><br>Findings include:<br><br>On 07/12/2021, at 12:45 p.m., the gauges that are on the main fire sprinkler riser in the mechanical room are older than 5 years and the gauge did not have any annotation that it had been re-calibrated within the last 5 years.<br><br>This deficient conditions were verified by the Maintenance Director. | K 353 | Viking Sprinkler was contracted to replace the pressure gauges that were missed during last sprinkler company inspection.<br><br>Task for the pressure gauges replacements have been added to our electronic work order to provide us a reminder that the sprinkler company needs to have them replaced.<br><br>Photo is attached | |