Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
March 11, 2025

Administrator
Cerenity Care Center On Humboldt
512 Humboldt Avenue
Saint Paul, MN 55107

RE: CCN: 245255
Cycle Start Date: January 16, 2025

Dear Administrator:

On March 3, 2025, the Minnesota Departments of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

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

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Electronically delivered
February 3, 2025

Administrator
Cerenity Care Center On Humboldt
512 Humboldt Avenue
Saint Paul, MN 55107

RE: CCN: 245255
Cycle Start Date: January 16, 2025

Dear Administrator:

On January 16, 2025, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

DEPARTMENT CONTACT

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of

the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

If substantial compliance with the regulations is not verified by April 16, 2025 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by July 16, 2025 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 **and Minnesota Statute 144A.10 subd 15**, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to: https://forms.web.health.state.mn.us/form/NHDisputeResolution

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

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

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245255	A. BUILDING _____ B. WING _____	C 01/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CERENITY CARE CENTER ON HUMBOLDT	512 HUMBOLDT AVENUE SAINT PAUL, MN 55107

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments On 1/13/25 through 1/16/25, a survey for compliance with §483.73, Appendix Z, Emergency Preparedness Requirements for Long Term Care Facilities was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On 1/13/25 through 1/16/25, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was not in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed with no deficiencies cited: H52554545C (MN00107213), H52554540C (MN00105303), H52554546C (MN00102757), H52554543C (MN00105823), and H52554547C (MN00107559). The following complaints were reviewed: H52554541C (MN00105591) with a deficiency cited at F725, and H52554542C (MN00103967) with a deficiency cited at F677. The following complaints were reviewed: H52554544C (MN00102966). Deficient practice	F 000		

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

Electronically Signed | 02/11/2025

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

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F 000	Continued From page 1 was identified related to incidental findings F690, F677, and F725. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the	F 550		2/25/25

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F 550	Continued From page 2 provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure dignity was maintained for 2 of 4 residents (R11, R277) reviewed for dignity. Findings include: R11's Optional State Assessment (OSA) dated 1/6/25, indicated intact cognition, and did not have behaviors or reject care. R11's face sheet form in the electronic medical record indicated R11's given name, name A, along with quotations around another name, name B. R11's care plan was reviewed and lacked information R11 had a preferred name.	F 550	Plan of Correction Components: Statement of credible allegation (can use in MN, WI, MO) This plan of correction constitutes the facility's credible allegation of compliance. Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truths or facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed in accordance with federal and state law requirements.	

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F 550	Continued From page 3 R11's care sheet dated 1/13/25 at 9:08 a.m., included R11's given name A. Name B was listed in quotations. R11's physician progress notes dated 1/7/25, indicated R11 wanted to be called by name B. During interview and observation on 1/13/25 between 9:28 a.m., and 9:48 a.m., R11 had signage on her door that indicated R11's given name A. Name B was listed in quotations. R11 stated the staff were calling her name A and not her preferred name, which was name B. R11 stated it got tiring having to tell them the same thing. During interview on 1/15/25 at 11:35 a.m., nursing assistant (NA)-F stated he followed the care plan to know what cares a resident required and further stated R11 had intact cognition and called when she needed help. Further, NA-F stated R11 wanted to be called name A when asked if R11 had any preferences on what she wanted to be called. During interview on 1/15/25 at 2:52 p.m., the director of nursing (DON) reviewed R11's electronic medical record and stated R11's name B was in quotations and further stated obviously admissions knew R11 wanted to be called name B and stated it went along with dignity and staff should call someone the name the person preferred. During observation on 1/16/25 at 8:44 a.m., R11 still had the signage located on her door indicating name A. Name B was also identified on the sign in quotations.	F 550	F550 Resident Right/Exercise of Rights R11 was discharged from the facility on 1/17/2025. R277□s facial hair was shaved on 1/15/2025. All residents will be addressed by their preferred name, and preferred name will be care planned accordingly. All residents that have a preference to have facial hair shaved will be assisted by staff and/or offered the supplies to do so. Education provided to all staff regarding addressing residents by their preferred name. Education provided to social services regarding care planning resident name preferences. Education provided to nursing staff regarding offering to shave facial hair to all residents during cares. Audits related to addressing residents by their preferred name will be completed on three residents weekly for four weeks, two residents weekly for four weeks, and one resident weekly for four weeks. Audits related to female facial hair will be completed on six residents weekly for four weeks, then four residents weekly for four weeks, and two residents weekly for four weeks. Results will be brought forward to QAPI to review the need for ongoing auditing. Date of Compliance: 02/25/2025	

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F 550	Continued From page 4 During interview on 1/16/25 at 8:54 a.m., registered nurse (RN)-C stated R11's real name was name A, but R11 never wanted to be called name A and and further stated the quotations around name B in the computer indicated R11 wanted to be called name B. R277: R277's face sheet indicated R277 admitted to the facility on Friday, 1/10/25 at 11:53 a.m., and had the following diagnoses: unspecified fall, paranoid schizophrenia, depression, urinary incontinence, and type two diabetes. R277's Functional Abilities form dated 1/14/25, indicated R277 required partial to moderate assist with toileting, showering and bathing, lower body dressing, and required supervision or touching assistance with personal hygiene which included shaving. R277's Orders form indicated the following orders: 1/10/25 bath conduct a full body audit weekly skin check observation, 2., obtain a complete set of vital signs and ensure the nails are trimmed and filed (nurse if there was a diagnosis of diabetes) and complete a progress note on concerns and follow the protocol for refused baths and showers; update the "CM" with refusal. Once a day on Mondays 7:00 a.m., to 3:00 p.m. 1/10/25 bath, conduct a full body audit weekly skin check observation, obtain a complete set of vital signs and ensure nails are trimmed and filed (Nurse if there was a diagnosis of diabetes) and complete a progress note on concerns and follow	F 550		

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F 550	Continued From page 5 the protocol for refused baths and showers and update the "CM" with refusal. Once a day on Fridays 3:00 p.m., to 11:00 p.m. The orders were reviewed and lacked information regarding who should complete shaving when a resident had diabetes. R277's medication administration record (MAR) and treatment administration record (TAR) printed 1/15/25 at 8:00 a.m., indicated R277 received a bath or shower on 1/10/25, and lacked documentation on 1/13/25, that R277 received a shower or bath. R277's care plan dated 1/10/25, indicated R277 had a self care deficit with bathing, grooming, oral cares, ambulation, transferring, mobility, vision, bowel and bladder. The care plan indicated R277 could not verbally ask for assistance. The care plan lacked information regarding who should complete shaving. R277's care sheet dated 1/13/25, was reviewed and lacked information regarding shaving, but indicated R277 required assist of one with dressing, washing, oral and hair care. Further, the care sheet indicated R277 was to receive a bath on Monday a.m., and Friday p.m. R277's Point of Care history notes dated 1/1/25, through 1/15/25, lacked information for how R277 showered or bathed. R277's Weekly Skin Check form dated 1/10/25, indicated under the section, "Did the resident receive the following" included an option for marking bath, shower, or other. The circle indicated "Other" and next to "Other" indicated "New pt". The form further indicated R277 had	F 550		

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F 550	Continued From page 6	F 550		

diabetes, but lacked information whether R277 was shaved.

R277's Weekly Skin Check form dated 1/13/25, indicated R277 received a bed bath, had diabetes, and nail care was not necessary. The form lacked information whether R277 was shaved.

R277's progress notes were reviewed and lacked information R277 refused to be shaved.

During interview and observation on 1/13/25 at 9:00 a.m., R277 had a patch of chin hairs measuring approximately 1/2 inch in length and wanted someone to help her shave the chin hairs.

During observation on 1/13/25 at 1:30 p.m., R277 still had the chin hairs.

During observation on 1/14/25 at 1:08 p.m., R277 was going down the hallway in her wheelchair and still had the chin hairs located on her face measuring approximately 1/2 inch in length.

During interview on 1/15/25 at 7:36 a.m., nursing assistant (NA)-E stated she looked at the care plan to know what cares a resident required and stated shaving was completed daily or every other day and female residents were shaved usually once a week and stated they provide razors for residents and further stated some residents come with their own razor.

During interview and observation on 1/15/25 at 7:31 a.m., occupational therapist (OTR)-A entered R277's room and was going to bring R277 to the shower room. R277 still had the patch of chin hairs and verified R277 had the chin

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F 550	Continued From page 7 hairs and stated he did not know whether the facility had razors. During interview on 1/15/25 at 7:42 a.m., registered nurse (RN)-D stated the aides knew what cares a resident required because they had flow sheets that summed everything up and further stated residents were shaved on their shower days and refusals were documented in the body audit. RN-D stated R277 was very cooperative and checked the progress notes and verified no refusals were documented. RN-D stated he expected staff shave R277 on her bath day and stated they would take care of it but did not know whether they provided shavers. RN-D viewed the shower list which indicated R277 was supposed to receive a bath on Monday a.m., and Friday p.m., and stated he assumed R277 received a shower, but was not shaved and stated it would be important for R277 to look presentable. During interview on 1/15/25 at 9:32 a.m., RN-C stated R277 came to the facility on Friday, 1/10/25, at around 11:53 a.m., and stated the nurse shaves a resident who is diabetic and R277 was supposed to receive baths on Friday evenings and Monday a.m.'s. RN-C further stated they provided razors and refusals were documented in progress notes and stated it was a dignity issue for a female resident to have chin hairs and added she noticed R277 had chin hairs the night before when she was in the hallway, but did not notice when she completed a skin check on 1/10/25. During interview on 1/15/25 at 11:20 a.m., OTR-A stated he located a razor and R277 could do some shaving but required supervision and	F 550		

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F 550	Continued From page 8 assist. During interview on 1/15/25 at 2:45 p.m., the director of nursing (DON) stated she expected staff shave residents and refusals should be documented. Further, the DON stated nurses shaved diabetic residents and stated it was a dignity issue. A policy, Resident Rights and Notification of Resident Rights, revised 1/16/24, indicated the facility acts to protect and ensure the rights of residents. Resident's rights include respect and dignity.	F 550		
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the resident's ability to self-administration of medications (SAM) was assessed prior to leaving medications with the resident for 3 of 3 residents (R10, R278, R59) reviewed who had medications in their rooms. Findings include: R10's annual Minimum Data Set (MDS) dated 10/12/24, identified diagnoses of Parkinsonism (neurological condition which makes body movements difficult), mild cognitive impairment, personality disorder, bipolar disorder, depression, and arthritis. High risk medications included	F 554	Plan of Correction Components: Statement of credible allegation (can use in MN, WI, MO) This plan of correction constitutes the facility's credible allegation of compliance. Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truths or facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or	2/25/25

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CERENITY CARE CENTER ON HUMBOLDT	512 HUMBOLDT AVENUE SAINT PAUL, MN 55107

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F 554	Continued From page 9 antidepressant, antipsychotic, anticoagulant, antibiotic, hypoglycemic and anticonvulsant medications. R10 required supervision with eating meals. R10's Cognition Care Area Assessment (CAA) dated 10/22/24, was triggered and identified staff were to monitor for changes in cognition and assist with decisions. R10's Care Plan dated 10/22/24, identified she was a vulnerable adult and needed assistance to remain safe within the community. Vulnerabilities included: negative impacts of mental and physical health related to diagnoses of personality disorder, bipolar 1, fibromyalgia, hypothyroidism, DM2 (diabetes mellitus type II), ADHD (attention deficit hyperactivity disorder), history of drug and alcohol use. R10's care plan lacked a SAM assessment. R10's observations and orders dated 1/13/25 through 1/13/25, lacked a SAM assessment or orders to SAM. R10's undated Physician's Orders report included the following start dates for morning and noon medications: 1. 10/15/23, acetaminophen 1,000 milligrams (mg); oral tablet at morning, noon and bedtime. 2. 10/15/23, duloxetine (antidepressant) 60 mg oral capsule in the morning. 3. 10/15/23, gabapentin (pain medicine) 300 mg oral tablet at 8:00 a.m., 12:00 p.m., and 4:00 p.m. 4. 10/15/23, vitamin D3 25 mcg (micrograms) take 2 oral tablets at 8:00 a.m. 5. 11/9/23, ferrous gluconate (supplement) 324 mg oral tablet at 8:00 a.m.	F 554	executed in accordance with federal and state law requirements. F554 Resident Self-Admin Meds-Clinically Approp. The nurses are not self-administering medications for R10, R278, and R59. All residents have the potential to be affected. Only residents with a self-administer observation and SAM order will be allowed to self-administer. Education provided to nurses and TMA□s regarding only self-administering medications to residents with the appropriate observation and SAM order completed. Self-medication administration audits will be completed on nine residents per week for four weeks, then six residents per week for four weeks, then three residents per week for four weeks. Results will be brought forward to QAPI to review the need for ongoing auditing. Date of compliance: 02/25/2025	

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F 554	Continued From page 10 6. 3/28/24, coenzyme Q10 (supplement); 100 mg oral tablet at 8:00 a.m. 7. 8/19/24, Eliquis (anticoagulant) 5 mg oral tablet; take 2.5 mg in the morning and evening. 8. 8/20/24, lisinopril (blood pressure medication) 5 mg oral tablet at 8:00 a.m. 9. 8/29/24, metformin (lowers blood sugars) 750 mg oral tablet at 8:00 a.m., and 4:00 p.m. 10. 10/15/24, cyanocobalamin (vitamin)1,000 mcg oral tablet at 8:00 a.m. 11. 11/1/24, fexofenadine (antihistamine) 60 mg oral tablet at 8:00 a.m. and 4:00 p.m. During an observation and interview on 1/13/25 at 9:19 a.m., R10 had a pill cup with several medications inside. R10 stated she did not know specifically what the medications were for and the nurse brought them in the morning. R10 also stated technically the nurses were supposed to watch her take them but sometimes they do not. During an observation and interview on 1/13/25 at 10:04 a.m., nursing assistant (NA)-A answered R10's call light, confirmed she saw the medications in the cup on the bedside table after the nurse left the room, and R10 took the medications with breakfast. NA-A stated usually the nurse would watch R10 take the medications. During an observation and interview on 1/13/25 at 12:59 p.m., R10's pill cup on her bedside table contained two large white medications. R10 stated she was unsure if those were her noon medications. During an interview and observation on 1/13/25 at 1:02 p.m., licensed practical nurse (LPN)-A stated he recently brought R10 her medications. LPN-A stated R10 said she would take them, then LPN-A	F 554		

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F 554	Continued From page 11 said he left the room without confirming they were taken as ordered. LPN-A re-entered R10's room with surveyor and confirmed the pill cup contained two large white pills acetaminophen and one capsule of gabapentin at the bedside table. LPN-A stated in order to safely leave medications in a resident's room there should be an assessment and physician order to SAM. LPN-A reviewed R10's orders, care plans and observations; and agreed SAM had not been assessed and he should not have left the room before confirming R10 had taken her medications. R278's face sheet printed 1/13/25, indicated R278 had recently admitted to the facility and had diagnoses of kidney failure, prostate cancer, and low back pain. R278's provider order dated 1/6/25, indicated R278 required a lidocaine adhesive patch 4% applied in the morning and removed at bedtime. R278's provider orders lacked indication R278 could self-administer medications. R278's self-administration observation dated 1/10/25, indicated R278 did not want to self-administer medications. An observation on 1/13/25 at 8:26 p.m., registered nurse (RN)-E entered R278's room to administer morning medications. R278 stated he wanted to wait for the lidocaine patch as he was to painful to turn at this time. RN-E left the opened lidocaine patch on R278's tray table and left the room. When interviewed on 1/13/25 at 8:56 a.m., RN-E	F 554		

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F 554	Continued From page 12	F 554		

verified R278's lidocaine was ok to leave at the bedside as he wanted it later. RN-E further stated it was "just lidocaine" and that medication was ok to leave with residents.

R59's face sheet 1/16/24, indicated R59 had recently been admitted with a diagnosis of cellulitis of left lower limb, methicillin resistant staphylococcus aureus infection (MRSA), Type 2 diabetes mellitus, morbid obesity, chronic heart failure, and partial traumatic amputation of the left foot.

R59's provider order dated 12/30/24 to 1/23/24, indicated R59 required ceftriaxone 2 grams (G) intravenous (IV) once per day and vancomycin 1000 milligrams (mg) IV two times per day.

R59's provider orders lacked indication R59 could self-administer IV medications.

When interviewed on 01/13/25 12:55 p.m., R59 stated he has a heel injury from home, this injury has been debrided multiple times requiring IV antibiotics. R59 stated he often must disconnect his peripherally inserted central catheter (PICC) line himself; staff leave a saline flush for him. He stated the reason he does his own flush was staff just don't have time. He doesn't mind helping them with this task. Saline flush observed on R59's bedside table.

An observation on 1/15/24 at 10:27 a.m., registered nurse (RN)-F entered R59's room to administer the morning dose of vancomycin IV to infuse over 2-3 hours in his PICC line.

An observation on 1/15/24 at 1:28 p.m., R59 was observed disconnecting the vancomycin IV

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F 554	Continued From page 13 medication from his PICC line and flushing the PICC line with the saline flush. R59 did not wash his hands or perform hand hygiene prior to disconnecting the medication and flushing the PICC line. When interviewed on 01/15/25 01:25 p.m., trained medication aide (TMA)-A stated if the resident does not have a self-administration of medications (SAM), then she has to stay in the room and watch the resident take the medication; she states the same policy is required for IV medications. TMA-A verified R59 did not have a SAM for IV medications. When interviewed on 01/15/25 01:31 p.m., RN-A stated if a resident doesn't have a SAM order completed, then they can't administer their own medications; this also applies to disconnecting medications and flushing PICC lines. RN-A verified R59 did not have a SAM for IV medications. When interviewed on 01/15/25 01:42 p.m., director of nursing (DON) stated the facility policy is all residents who self-administer medication including IV medications would need an active SAM. DON verified R59 did not have a SAM for IV medications. Facility policy dated 2/2019, stated each resident must be evaluated and a SAM order placed in the electronic medical record. R59 did not have a SAM order to administer, discontinue, or flush the PICC line.	F 554		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2)	F 677		2/25/25

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F 677	Continued From page 14 §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure timely assistance with toileting for 2 of 2 (R50, R127) residents. Findings include: R50 R50's quarterly Minimum Data Set (MDS) dated11/6/24, indicated intact cognition and diagnoses of hemiplegia and hemiparesis following other cerebrovascular disease affecting left non-dominant side, chronic pain, muscle weakness, reduced mobility, and a need for assistance with personal care. It further indicated R50 required substantial assistance with toileting was dependent on staff with mobility, and was frequently incontinent of bowel and bladder. R50's care plan dated 11/25/24, indicated R50 experienced bladder and bowel incontinence due to diagnoses of cerebral vascular accident, dysphagia, hemiplegia/hemiparesis, seizures, hypertension, atrial fibrillation and history of human immunodeficiency virus (HIV). It further indicated the following interventions: -check and change brief 2-3 times per shift and as needed. -keep call light in reach. -obtain occupational therapy (OT) and physical therapy (PT) consult. -provide incontinence care after each incontinent	F 677	Plan of Correction Components: Statement of credible allegation (can use in MN, WI, MO) This plan of correction constitutes the facility's credible allegation of compliance. Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truths or facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed in accordance with federal and state law requirements. F677 ADL Care Provided for Dependent Residents R127 discharged from facility on 6/27/2024. R50 care plan and care sheets have been updated to reflect the current needs of residents. All residents with a toileting plan will be toileted per care plan. Education provided to nursing staff regarding toileting residents timely per care plan/care sheet.	

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F 677	Continued From page 15 episode. -report any signs of skin breakdown (sore, tender, red, or broken areas). -report signs of a urinary tract infection (acute confusion, urgency, frequency, bladder spasms, nocturia, burning, pain/difficulty urinating, nausea, emesis, chills, fever, low back/flank pain, malaise, foul odor, concentrated urine, blood in urine). R50's care plan also indicated R50's ability to transfer, walk in room, walk in corridor, dress, eat, toilet, maintain personal hygiene had deteriorated related to diagnoses of CVA, dysphagia, hemiplegia/hemiparesis, seizures, hypertension, atrial fibrillation, and a history of HIV with the following interventions: -toileting: incontinent. required extensive assist of 1, check and change 2-3 times per shift -transfers: total assist of 2 staff using a Hoyer lift During continuous observation on 1/15/25 from 8:41 a.m. to 1:38 p.m. the following events occurred: -8:41 a.m. R50 was sitting in his wheelchair in the dining room waiting for breakfast. -8:49 a.m. R50 received his breakfast tray, staff set up his breakfast and then walked away. -9:14 a.m. NA-L asked if he was finished eating and removed his meal tray. -9:23 a.m. sitting in his wheelchair in the dining room. -10:07 a.m. Licensed practical nurse (LPN)-D went over to R50 and started to bring him back to his room due to a fire alarm, before they got to his room maintenance stated it was just a test, so LPN-D brought him back out to the same spot in the dining room. -10:25 a.m. R50 was sitting in his wheelchair in the dining room. -10:54 a.m. same as above	F 677	Audits will be conducted on timeliness of resident toileting for nine residents per week for four weeks, then six residents per week for four weeks, then three residents per week for four weeks. Results will be brought forward to QAPI to review the need for ongoing auditing. Date of compliance: 02/25/2025	

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F 677	Continued From page 16 -11:00 a.m. the chaplain came into the dining room, greeted R50. -11:15 a.m. R50 was sitting in his wheelchair in the dining room, nodding his head in response to music. -11:18 a.m. R50 was sitting in his wheelchair in the dining room. -11:27 a.m. same as above. -11:42 sitting in his wheelchair in the dining room. Chaplain offered hand massage or scented lotion for hands, then handed out prayer cards. -11:57 a.m. Chaplain pushed R50's wheelchair up closer to the table. -12:17 p.m. sitting in his wheelchair in the dining room, waiting for lunch -12:34 p.m. same as above -12:54 p.m. same as above -1:18 p.m. same as above, R50 received his lunch tray -1:38 p.m. nursing assistant (NA)-L brought R50 back to his room to lay him down and then went to get the Hoyer lift. LPN-D entered the room to assist with transferring him to his bed. Once he was in bed, the surveyor asked NA-L to see R50's skin before they left the room. NA-L stated "I know he's been up for quite awhile." NA-L did not change R50's brief stating he was not wet. During the continuous observation, staff failed to check or change R50's brief, nor did they offer to. During interview on 1/15/25 at 1:45 p.m., nursing assistant (NA)-L verified that R50 had not been checked/changed or offered since getting him up in the morning stating "I try to get them down (lay down in bed) but when I have so many Hoyers I can't get to them all." During interview on 1/16/25 at 9:23 a.m., NA-C stated each NA was assigned a group of	F 677		

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F 677	Continued From page 17 residents but they were all expected to help each other when needed. NA-C further stated they were responsible for following each residents care plan and they generally check/change a resident's brief every 2-3 hours or at least offer to. If a resident refuses, they should try to encourage them, reapproach, and let the nurse know. During interview on 1/16/25 at 9:31 a.m., NA-M stated each nursing assistant was given a group of residents they were responsible for but everyone was expected to help each other when needed. They should be following each residents care plan but generally should be checking/changing each resident every 2-3 hours. If a resident was refusing to have their brief checked/changed, staff should try to reapproach them 3 times and if they still refuse they should report it to the nurse and the next shift. NA-M also stated there's a lot of days where it's hard to get to everyone every 2-3 hours, especially since they're a lot of residents who require the use of a Hoyer lift to transfer. During interview on 1/16/25 at 9:59 a.m., LPN-E stated residents should be checked/changed every 2 hours unless the nurse directs them differently. The NA's should also be following the residents care plan. If a resident refuses, the NA should re-approach or have someone else re-approach, notify the nurse, and document it. R127 R127's significant change Minimum Data Set (MDS) dated 5/16/24, indicated intact cognition and diagnoses of hemiplegia and hemiparesis following cerebral infarction affecting right dominant side and abnormalities of gait and	F 677		

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F 677	Continued From page 18 mobility. It further indicated R127 was frequently incontinent of bowel, bladder and required assistance with toileting. R127's care plan dated 2/1/24, indicated R127 will have less than 2 episodes of bowel incontinence per day, will be continent of bowel at all times, and will be continent of bowel during the daytime with an intervention to observe his level of incontinence and initiate toileting schedule if indicated; check and change every two hours with incontinence pad. R127's Point of Care history report for bowel/bladder dated 6/7/24, indicate R127 hadn't been assisted with toileting from 8:46 a.m. until 9:15 p.m. During interview on 1/16/24 at 8:33 a.m., (NA)-T stated she changed R127 and he had dried bowel movement (BM) and it appeared he had been sitting in it for awhile. During interview on 1/16/25 at 11:00 a.m. the director of nursing (DON) stated R50 usually sat in the dining room from breakfast until after lunch and then would lay down in bed. The DON further stated that he (and all other residents) should be offered to be toileted or checked and changed every 2-3 hours and 5 hours was too long for someone to not be toileted. It was important for residents to be toileted every 2-3 hours in order to prevent skin issues. The facility's policy on ADL's dated June 2021, indicated care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care, including	F 677		

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F 677	Continued From page 19 appropriate support and assistance with: a. Hygiene (bathing, dressing, grooming, and oral care) b. Mobility (transfer and ambulation, including walking) c. Elimination (toileting) d. Dining (meals and snacks) e. Communication (speech, language, and any functional communication systems)	F 677		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on interview, observation, and document review, the facility failed to ensure symptoms of loose stools was acted upon and assessed to determine what, if any interventions were needed to promote appropriate bowel management. Findings include: R11's admission Minimum Data Set (MDS) dated 1/6/25, indicated intact cognition, did not have behaviors, and did not reject cares. Further, R11 required substantial to maximal assistance with toileting hygiene, and transfers, did not have a catheter or ostomy, was frequently incontinent of urine and bowel and a toileting program trial had	F 684	Plan of Correction Components: Statement of credible allegation (can use in MN, WI, MO) This plan of correction constitutes the facility's credible allegation of compliance. Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truths or facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or	2/25/25

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F 684	Continued From page 20 not been attempted. Additionally, R11 had diagnoses of noninfective gastroenteritis and colitis, nausea and vomiting, The MDS indicated R11 was at risk for developing pressure ulcers and application of ointments and medications were completed other than to feet. R11's Facesheet form undated, indicated the following diagnoses: noninfective gastroenteritis and colitis, diarrhea, and other sites of candidiasis (a fungal infection) to the groin. R11's care plan dated 1/13/25, indicated R11 was continent of bladder and bowel and required assist of one for toileting. R11 was at risk for alteration in skin integrity due to nausea, vomiting, and diarrhea and required barrier cream to buttocks and sacrum area for irritation and was to be toileted every two to three hours. R11's care sheet dated 1/13/25, indicated R11 was continent of bowel and bladder and required assist of one with most activities of daily living (ADLs). R11's physician's orders indicated the following orders: 12/31/24, loperamide capsule 2 milligrams (MG) capsule. Give 2 mg four times a day PRN (as needed) for diarrhea. 12/31/24, skilled charting use template in progress notes for renal, urinary, and acute gastroenteritis twice a day. 1/2/25, barrier cream daily to buttocks and sacrum area for irritation, do not use zinc R11 is allergic daily. 1/10/25, Cavilon durable barrier (dimethicone) over the counter 1.3% cream apply twice daily.	F 684	executed in accordance with federal and state law requirements. F684 Quality of Care R11 was discharged from the facility on 1/17/2025. All residents with symptoms of loose stools will be acted upon and assessed to determine if interventions are needed. Education provided to nurses regarding acting upon symptoms of loose stools and assessing to determine if any interventions were needed to promote appropriate bowel management. The bowel report and PRN medication report will be audited to ensure symptoms of loose stools are acted upon. Audits will be completed on nine residents per week for four weeks, then six residents per week for four weeks, then three residents per week for four weeks. Results will be brought forward to QAPI to review the need for ongoing auditing. Date of compliance: 02/25/2025	

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	245255	A. BUILDING _____ B. WING _____	C 01/16/2025

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F 684	Continued From page 21 R11's medication administration record (MAR) and treatment administration record (TAR) dated 12/17/24, through 1/14/25, indicated R11 utilized PRN loperamide once on 1/1/25, 1/5/25, 1/7/25, 1/8/25, and 1/11/25. The MAR and TAR indicated R11's response to the medication was slightly effective on 1/5/25, and 1/8/25. Loperamide was not documented as administered on 12/31/24, 1/2/25, 1/3/25, 1/4/25, 1/6/25, 1/9/25, 1/10/25, 1/12/25, 1/13/25, and 1/14/25. R11's progress notes dated 12/31/24, indicated R11's groin was red, purple, and blanchable with a skin tear on the left groin and redness around the coccyx with a skin tear to the left buttocks and was blanchable due to diarrhea. R11's progress notes dated 12/31/24, through 1/14/25, were reviewed and R11 had symptoms of diarrhea on 12/31/24, 1/1/25, 1/2/25, 1/5/25, 1/10/25, 1/11/25, 1/12/25, 1/13/25, 1/14/25. The progress notes dated 1/5/25 at 12:39 p.m., indicated R11 had loperamide on 1/5/25 at 11:33 a.m. for diarrhea and was effective. R11's Bowel Movements form under Vitals dated 12/16/24, to 1/16/25, in the electronic medical record (EMR) indicated R11 had a large, loose, foamy, mucus bowel movement on 1/7/25, an additional entry on 1/7/25, indicated "None" and a large bowel movement on 1/11/25. R11's Bowel Assessment form dated 1/4/25, indicated R11 was occasionally incontinent and risk factors for incontinence included frequency of diarrhea. R11's Point of Care (POC) documentation dated	F 684		

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F 684	Continued From page 22 12/31/24, through 1/16/25, under the heading, "What is the residents level of control with bowel function?" indicated out of 51 entries, R11 was continent 26 times, incontinent 6 times, was unanswered 4 times, had no bowel movement 14 times, and had an ostomy one time. R11's physician progress note dated 1/7/25, indicated R11 had chronic diarrhea and used PRN loperamide and staff were to monitor. R11's history and physical dated 1/9/25, indicated R11 had chronic diarrhea and was admitted to the hospital 12/26/24, to 12/31/24, for dehydration associated with vomiting and diarrhea likely due to viral gastroenteritis that has largely resolved. Further, the note indicated R11 had not had diarrhea in the past 24 hours. During interview on 1/13/25 at 9:35 a.m., R11 stated she had a history of diverticulitis (an inflammation or infection of pouches that form in the colon) and stated staff give 1 Immodium (loperamide) and stated she knew her history and knew that 1 Immodium was not enough and further stated did not feel heard when telling staff. During interview on 1/15/25 at 11:35 a.m., nursing assistant (NA)-F stated he looked to the care plan to know what cares a resident required and if a resident refused, would tell the nurse and reapproach and the nurse would document if a resident still refused. NA-F stated R11 pivot transferred and used a bedside commode and was alert, and had diarrhea but not every day. During interview on 1/16/25 at 8:54 a.m., registered nurse (RN)-C stated residents with diarrhea should be monitored because they may	F 684		

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F 684	Continued From page 23 have a condition and added R11 had chronic diarrhea from a long time ago and stated R11's groin was red and had gotten worse with her diarrhea and added every time R11 ate, she had to go. RN-C stated R11 had loperamide four times a day as needed and stated if it was given and was somewhat effective staff should let the provider know and stated R11 could have another dose of loperamide and stated she would remind the staff to give the loperamide as ordered up to 8 mg per day. RN-C stated she did not think R11 refused and stated she did not want to eat because she has diarrhea. RN-C reviewed the progress notes and verified there was no note to indicate the physician was notified of R11's diarrhea and stated she expected if a medication was somewhat effective to give the additional ordered dose and further stated R11 had diarrhea every day and added that was probably why R11 had a fungal infection. During interview on 1/16/25 at 11:31 a.m., NA-E stated bowel movements were documented on POC in output under Vitals and stated staff have to document whether the stool was hard or soft and loose or liquid and the size. During interview on 1/16/25 at 11:34 a.m., RN-C stated the provider informed her nurses call about the diarrhea they just didn't document the notifications. RN-C stated NA's documented bowel movements in POC under Vitals and verified 3 entries were located. RN-C further stated the NA's should document the stool consistency and expected all bowel movements to be documented and stated she expected staff to offer Immodium if R11 had daily diarrhea and added staff was going to talk with the provider about scheduling Immodium.	F 684		

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F 684	Continued From page 24 During interview on 1/16/25 at 11:43 a.m., R11 stated staff do not offer the Immodium and further stated she had to beg for the medication. During interview on 1/16/25 at 11:50 a.m., NA-E stated the NA's are supposed to document every shift and for every bowel movement the resident has. During interview on 1/16/25 at 11:59 a.m., the director of nursing (DON) stated she expected staff follow up with the provider and stated she spoke with RN-C and they were updating the provider and was going to have staff enter a late entry. The DON further stated staff should be documenting all of the resident's bowel movements to make sure R11 didn't have a bowel impaction or a perforation and verified the three entries for bowel movements under Vitals. A policy, Bowel Management Protocol, dated September 2023, indicated the purpose was to ensure proper bowel function and management and indicated a protocol for staff if a resident does not have a bowel movement. The policy lacked direction when a resident had diarrhea.	F 684		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain.	F 690		2/25/25

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F 690	Continued From page 25 §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to implement interventions necessary to maintain continence for 1 of 1 resident (R72) reviewed for bowel and bladder. Findings include: R72's Facesheet form identified the following diagnoses: brachial plexus disorders carpal tunnel (a small passageway in the wrist that	F 690	Plan of Correction Components: Statement of credible allegation (can use in MN, WI, MO) This plan of correction constitutes the facility's credible allegation of compliance. Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truths or	

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F 690	Continued From page 26 contains the median nerve and tendons that control the thumb and fingers), encounter for surgical aftercare following surgery on the nervous system carpal tunnel release (a surgical procedure where a ligament is cut to relieve pressure on the median nerve), sepsis (a condition where the body responds improperly to an infection), severe sepsis without septic shock, malignant neoplasm of the prostate, autistic disorder (a condition related to brain development that impacts how a person perceives and socializes with others), rhabdomyolysis (a condition where muscle cells break down and release their contents into the bloodstream), legal blindness, wrist drop (paralysis of the muscles which normally raise the hand at the wrist and extend the fingers usually caused by nerve damage) to the left wrist. R72's admission Minimum Data Set (MDS) dated 12/19/24, indicated intact cognition, did not have behaviors, did not reject cares, had impaired range of motion to the upper extremity on one side, was dependent on staff for toileting hygiene, bathing, dressing, and required substantial to maximum assist with personal hygiene. Further, R72 did not have a catheter, was always incontinent of bowel and bladder, and a toileting program had not been attempted. R72's Optional State Assessment dated 12/19/24, indicated R72 required extensive assist with toilet use including using the toilet room, commode, bedpan, urinal, transferring on and off the toilet, and cleansing self after elimination. R72's care area assessment (CAA) dated 12/19/24, indicated R72 had modifiable factors that contributed to incontinence that included	F 690	facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed in accordance with federal and state law requirements. F690 Bowel/Bladder Incontinence, Catheter, UTI R72 was discharged from the facility on 1/21/2025. All residents with a toileting plan are being toileted per care plan. Education provided to nursing staff regarding toileting residents timely per care plan/care sheet. Audits will be conducted on timeliness of resident toileting for nine residents per week for four weeks, then six residents per week for four weeks, then three residents per week for four weeks. Results will be brought forward to QAPI to review the need for ongoing auditing. Date of compliance: 02/25/2025	

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F 690	Continued From page 27 pain, restricted mobility, lack of access to a toilet, and other environmental barriers such as pads or briefs. Other factors that contributed to incontinence included urinary urgency and the need for assistance with toileting, had diabetes and prostate cancer, and had functional incontinence (can't get to the toilet in time due to physical disability, external obstacles, or problems thinking or communicating). The CAA further indicated R72 was always incontinent of bowel and bladder and was dependent on staff for incontinent care, had weakness, impaired mobility, and cognitive loss and risk factors included skin breakdown, falls, and recurrent UTI's (urinary tract infections). Last, a care plan would be initiated to maintain check and change for incontinent episodes, reduction of pressure ulcer and fall risk and reduce the risk for UTI's. R72's care plan dated 12/13/24, indicated R72 required therapy services related to left wrist carpal tunnel release in splint, right arm swelling, autism, severe sepsis and legal blindness. R72's goal indicated R72 would attain and maintain the highest functional ability and included PT, OT, and speech therapy (ST). R72's care plan dated 12/13/24, indicated R72 had a self care deficit with bathing, grooming, oral cares, ambulation, transferring, mobility, vision, bowel and bladder. R72's goals included maintaining skin integrity, and regaining his ability to transfer independently. The care plan further indicated R72 was incontinent of bowel and bladder and was on a bowel and bladder plan that included being toileted every 2 to 3 hours to remain free of skin breakdown and respect R72's dignity. The plan further included every two hours; 12:00 a.m., 2:00 a.m., 4:00 a.m., 6:00	F 690		

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F 690	Continued From page 28 a.m., 8:00 a.m., 10:00 a.m., 12:00 p.m., 2:00 p.m., 4:00 p.m., 6:00 p.m., 8:00 p.m., and 10:00 p.m. Further, R72 required assist of 1 to get his toileting needs addressed and utilized incontinence pads for his current toileting needs. Additionally, R72 required assist of 1 for transfers, and bed mobility. R72's care plan dated 12/23/24, indicated R72 was legally blind and required assist to place and remove R72's glasses. R72's care plan dated 1/9/25, indicated R72 required rehabilitative services related to the carpel tunnel release surgery and required physical therapy (PT) and occupational therapy (OT) to assist with activities of daily living (ADLs). R72's care sheet indicated R72 was incontinent of bladder and bowel. Additionally, the care sheet included in red ink that R72 required toileting every 2 to 3 hours. R72 had the following physician order: 1/6/25, weight bearing as tolerated to the right upper extremity R72's Bladder Observation form dated 12/17/24 at 2:45 a.m., indicated R72 did not have a catheter, was always incontinent, did not recognize the appropriate place or time to urinate, did not feel an urge to urinate, had impaired mobility, and neurological disorders, polypharmacy (multiple medications), brachial plexus disorder (a condition that can cause weakness, numbness, or paralysis in the arm or hand), mixed incontinence and under the heading "Urinary Toileting Program" included four boxes that could be marked and included: 1., bladder	F 690		

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F 690	Continued From page 29 retraining (able to resist or delay urge), 2., scheduled toileting/habit training, 3., prompted voiding (able to say name and reliability point to 2 objects), and 4., not appropriate for toileting or retraining program, rationale. The area lacked any check boxes for a toileting program or a rationale why R72 would not be appropriate for a toileting program. Under the heading, Bladder Assessment Summary, directed staff to summarize findings and identify whether R72 was appropriate for a toileting plan and indicate why or why not. Documentation under the heading indicated, "Resident is incontinent of bladder" and lacked information whether R72 was appropriate or not for a toileting plan. R72's Bowel Observation dated 12/17/24 at 3:28 a.m., indicated R72 was always incontinent of bowel, required extensive assistance, had constipation and abdominal cramping, a systemic neurologic disease, passive incontinence (the involuntary discharge of fecal matter or flatus without any awareness), was able to recognize an appropriate time and place to defecate, did not feel an urge to have a bowel movement and under a heading, "Treatment Management Program Placement Decision" indicated R72 would be on a scheduled defecation program. R72's occupational therapy (OT) evaluation note dated 12/14/24, indicated R72's short-term goal was to be minimal assist with toileting and the purpose was to return home at his previous level of independence. Further, R72's previous level of functioning was independent with toileting and his current level of functioning was dependent. R72's OT notes dated 1/10/25, indicated R72's previous level of functioning was independent	F 690		

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F 690	Continued From page 30 with dressing, toileting, showering, grooming and hygiene, and his current level of functioning for toileting was moderate to maximum assist. The note further indicated R72's long-term goal purpose was to return home at his previous level of independence. R72's OT notes dated 1/14/25, indicated R72 was maximum assist to dependent for bed mobility, donning pants and had low effort for lower body dressing. Further, OT discussed with R72, and family R72's low participation and importance of full effort during therapy in order to make progress. R72's Point of Care (POC) documentation dated 12/17/24, through 1/16/25, under the heading, "How did the resident use the toilet?" indicated out of 330 opportunities, "unanswered" 212 times, "Activity did not occur" 32 times, "Extensive Assistance" 66 times, "Total Dependence" 14 times, "Limited Assistance" 5 times, and was documented one time as "Independent" on 12/30/24. R72's POC documentation dated 12/17/24, through 1/16/25, under the heading, "Staff support provided for toileting?" indicated out of 85 opportunities, "1 person physical assist" 57 times, "2+ persons physical assist" 27 times, and was documented one time as "No setup or physical help from staff" on 12/30/24. R72's POC documentation dated 12/17/24, through 1/16/25, under the heading, "What is the residents level of control with bladder function?" indicated out of 98 opportunities, R72 was "Incontinent" 81 times, "Continent" 3 times, "unanswered" 11 times, and "No Urine Output"	F 690		

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F 690	Continued From page 31 was documented 3 times. R72's POC documentation dated 12/17/24, through 1/16/25, under the heading, "What is the residents level of control with bowel function?" indicated out of 98 opportunities, R72 was "Incontinent" 58 times, "No Bowel Movement" 25 times, was "unanswered" 11 times, and was "Continent" 4 times. During interview and observation on 1/13/25 at 10:39 a.m., R72 stated he did not go into the bathroom and staff did not assist with using a urinal. R72 had a splint on both hands and stated he has utilized incontinence pads since he was hospitalized. During continuous observation and interview on 1/14/25 between 1:59 p.m., and 6:47 p.m., R72's door was closed at 1:59 p.m., and at 2:03 p.m., R72's visitor came out of R72's room with a walker and sat down on the walker outside R72's room. At 2:09 p.m., R72's visitor went back into R72's room. At 2:13 p.m., no staff entered R72's room since continuous observations started and a visitor came out of R72's room at 2:14 p.m. At 2:23 p.m., a staff person entered R72's room and stated they had a pain pill for R72 and at 2:24 p.m., the staff person left the room. At 2:28 p.m., a visitor went into R72's room and stated R72 would want to go to bed soon and would turn on the call light. At 2:36 p.m., R72's call light was on and R72 was sitting up in a chair. At 2:43 p.m., staff brought a bag down the hallway and entered the trash room across from R72's room and then walked down the hallway. R72's call light had been on for 15 minutes according to the monitor at the end of the hallway. At 2:47 p.m., R72's visitor stated she would go find staff and R72's	F 690		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 690	Continued From page 32 call light was unanswered. At 2:50 p.m., nursing assistant (NA)-G entered the room and at 3:12 p.m., NA-G exited the room with a bag with a brief and inquired what the code was for the trash chute. At 3:14 p.m., NA-G stated they looked at the care plan to know what cares a resident required and if a resident refused, she called for help and documented and let the nurse know. NA-G stated R72 was incontinent and did not go into the toilet and stated she just assisted R72 into bed. At 3:53 p.m., staff had not entered the room since NA-G left the room. At 4:32 p.m., registered nurse (RN)-C entered R72's room with his meal and at 4:33 p.m., left R72's room. At 4:39 p.m., a staff person checked in on R72 and at 4:40 p.m., staff left the room. At 5:13 p.m., R72's family member brought out R72's meal tray and set it in the dining room and went back into R72's room. At 5:26 p.m., R72's family left and closed R72's door. At 6:43 p.m., NA-J and NA-K entered R72's room. NA-J instructed R72 to roll towards the window and rolled a chuck pad under R72. At 6:47 p.m., NA-J checked R72's brief, but did not change it and stated the brief was dry. NA-J did not offer to take R72 into the bathroom, gave R72 water and repositioned R72 on his side. During interview on 1/14/25 at 6:51 p.m., NA-J stated she worked at the facility for seven years and usually worked the night shift on this floor and stated she looked at the care plan in her pocket to know what cares a resident required and if a resident refused she let the nurse know and stated R72 required total care and stated he did not go into the bathroom as far as she knew and did not use the urinal and stated she does not offer to toilet R72 and could not state what the care plan indicated. NA-J took out the care plan and stated R72 was incontinent of bowel and	F 690		

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	245255	A. BUILDING _____ B. WING _____	C 01/16/2025

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F 690	Continued From page 33 bladder and stated the care plan indicated to toilet R72 every 2 to 3 hours and added he usually did not get out of bed. During interview on 1/14/25 at 6:55 p.m., licensed practical nurse (LPN)-C stated R72 required an assist of one and had surgery for carpel tunnel and viewed R72's Observations forms and bladder assessment dated 12/17/24, and stated she expected staff to offer to toilet R72 and further stated R72 should have been toileted within the 2 to 3 hour time frame and was important for him to be on a toileting program to be more independent and so R72 did not get a sore on his bottom and verified R72's aide care sheet indicated R72 required toileting every 2-3 hours. During interview on 1/15/25 at 9:22 a.m., registered nurse (RN)-C stated the toileting schedule is initiated for residents who are at risk of falling and stated they completed a check and change for residents who were incontinent and further stated R72 may want to use the toilet if staff offered and stated if he was dry, staff should offer to toilet because not toileting could be a cause of falls and stated R72 should be on a toileting program. During interview on 1/15/25 at 11:15 a.m., OT-A stated PLOF stood for prior level of function, and CLOF stood for current level of function and stated they were focusing on self cares for R72 and stated pain was a factor and R72 also had a autism and added staff have to speak slower and autism can affect motivation. OT stated R72 was full assist for peri cares due to having a brace on the left hand and a wrist drop on the right. OT stated R72 was previously continent and further	F 690		

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F 690	Continued From page 34 stated it would be important to toilet R72 and have have a toileting program according to the care plan. During interview on 1/15/25 at 2:41 p.m., the director of nursing (DON) stated the expectation was staff were to follow the protocol. A policy, Activities of Daily Living, dated June 2021, indicated the purpose of the policy was to provide residents with care, treatment and services appropriate to maintain or improve their ability to carry out activities of daily living (ADLs). Care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care including appropriate support and assistance with elimination. Interventions to improve and or minimize a resident's functional abilities will be in accordance with the resident's assessed needs, preferences, stated goals and recognized standards of practice.	F 690		
F 697 SS=D	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure pain medications were administered timely in accordance with physician's orders and care plan	F 697	Plan of Correction Components: Statement of credible allegation (can use in MN, WI, MO)	2/25/25

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F 697	Continued From page 35 for 1 of 1 residents (R25) reviewed for pain management. Findings Include: R25's minimum data set (MDS) dated 11/20/24, indicated R25 had a brief interview for mental status (BIMS) of 15, showing intact cognition. R25 had a diagnosis of hypertension, diabetes, arthritis, and chronic obstructive pulmonary disease (COPD). R25 receives both scheduled and as needed pain medication related diagnosis of chronic pain syndrome and non-displaced oblique fracture of the shaft of the right fibula. R25's care area assessment (CAA) dated 1/15/25 at 12:16 p.m., indicated pain made it hard for R25 to sleep at night, day-to-day activities were limited because of pain, pain was described as "moderate" to "very severe" and occurred frequently or almost constantly daily. R25's care plan dated 11/29/24, indicated scheduled pain medications to be administered per physician order and to administer as needed pain medications upon request. R25's medication administration record (MAR) for pain medications included: 1. Acetaminophen (Tylenol) 1000 miligrams (mg) three times per day at 8am, noon, and 4pm for chronic pain a. given late on 1/2/25 at 5:13 p.m. b. given late on 1/3/25 at 5:33 p.m. c. given late on 1/6/25 at 9:27 a.m. d. given late on 1/7/25 at 1:04 p.m. e. given late on 1/8/25 at 9:21 a.m. and 5:26 p.m. f. given late on 1/9/25 at 1:12 p.m.	F 697	This plan of correction constitutes the facility's credible allegation of compliance. Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truths or facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed in accordance with federal and state law requirements. F697 Pain Management R25□s pain medication is being administered timely. All residents who receive pain medication will be administered timely. Education provided to nurses and TMAs regarding administering pain medications timely and in accordance with physician orders and care plan. Audits will be conducted on timeliness of administering pain medications on nine residents per week for four weeks, then six residents per week for four weeks, then three residents per week for four weeks. Results will be brought forward to QAPI to review the need for ongoing auditing. Date of compliance: 02/25/2025	

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F 697	Continued From page 36	F 697		

g. given late on 1/13/25 at 9:20 a.m., 1:20 p.m., 5:09 p.m.
h. given late on 1/14/25 at 9:21am, 1:00 p.m., 5:54 p.m.

2. Celebrex (Celecoxib) 100mg two times per day at 8am and 4pm for sciatica
a. given late on 1/2/25 at 5:13 p.m.
b. given late on 1/3/25 at 5:33 p.m.
c. given late on 1/6/25 at 9:27 a.m.
d. given late on 1/8/25 at 9:21 a.m. and 5:26 p.m.
e. given late on 1/13/25 at 9:20 a.m., 5:09 p.m.
f. given late on 1/14/25 at 9:21 a.m., 5:54 p.m.

3. Cyclobenzaprine (Flexeril) 10mg 3 times per day as need for muscle pain or spasm
a. given on 1/1/25 at 4:23 a.m., 1:25 p.m., 10:47 p.m.
b. given on 1/2/25 at 7:57 a.m., 6:21 p.m.
c. given on 1/4/25 at 6:25 a.m., 3:33 p.m., 11:44 p.m.
d. given on 1/5/25 at 8:49 a.m., 6:16 p.m.
e. given on 1/6/25 at 3:10 a.m., 7:04 p.m.
f. given on 1/8/25 at 5:59 a.m., 3:00 p.m.
g. given on 1/9/25 at 12:49 a.m., 8:59 a.m., 7:10 p.m.

4. Lidocaine patch 5% 3 patches, apply to painful areas, apply at noon and remove at bedtime
a. not administered, medication unavailable, 1/2/25
b. given late on 1/12/25 9:45 p.m.

5. Lyrica (Pregbalin) 50mg two times per day at 8am and 4pm for neuropathy
a. given late on 1/2/25 at 5:13 p.m.

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F 697	Continued From page 37 b. given late on 1/3/25 at 5:33 p.m. c. given late on 1/6/25 at 9:27 a.m. d. given late on 1/8/25 at 9:21 a.m. and 5:26 p.m. e. given late on 1/13/25 at 9:20 a.m., 5:09 p.m. f. given late on 1/14/25 at 9:21 a.m., 5:54 p.m. 6. Oxycodone 2.5mg every 8 hours as needed for generalized pain a. given on 1/1/25 at 4:23 a.m., 1:25 p.m., 10:47 p.m. b. given on 1/2/25 at 7:57 a.m., 6:21 p.m. c. given on 1/5/25 at 8:49 a.m., 6:16 p.m. d. given on 1/8/25 at 5:59 a.m., 3:00 p.m. e. given on 1/9/25 at 12:49 a.m., 8:59 a.m., 7:10 p.m. During interview on 1/13/25 at 10:14 a.m., R25 stated she has difficulty getting her scheduled pain medications on time; this causes her distress and increasing pain to the point she needs to ask for additional pain relief. R25 stated to get the additional pain medication could often take an additional 2-3 hours. During interview on 1/15/25 at 12:19 p.m., nursing assistant (NA)-O stated when a resident requests pain medication, it should be reported to the resident's nurse, sometimes the medications were not administered after the first request, and NA-O would have to remind the nurse. During interview on 1/15/25 at 12:27 p.m., trained medication aide (TMA)-A stated when a resident requests pain medication, it should be reported to the nurse responsible, sometimes the medications were not administered after the first	F 697		

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F 697	Continued From page 38 request, and TMA-A would have to remind the nurse. TMA-A confirmed the expectation is to give requested pain medications within 5-10 minutes of request. During interview on 1/16/25 at 11:15 a.m., the director of nursing (DON) stated the expectation is call lights will be answered in 15 minutes or less. For residents requesting additional pain management, they should receive the pain medication within 20-25 minutes from initial time of request. Facility policy dated 9/12/22, stated the interdisciplinary team (IDT) would develop and implement individualized measures to promote comfort; the facility failed to follow the implemented pain management orders developed by IDT.	F 697		
F 699 SS=D	Trauma Informed Care CFR(s): 483.25(m) §483.25(m) Trauma-informed care The facility must ensure that residents who are trauma survivors receive culturally competent, trauma-informed care in accordance with professional standards of practice and accounting for residents' experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to assess trauma history and identify potential triggers for 1 of 1 resident (R54) who had a diagnosis of post traumatic stress disorder (PTSD).	F 699	Plan of Correction Components: Statement of credible allegation (can use in MN, WI, MO) This plan of correction constitutes the	2/25/25

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F 699	Continued From page 39 Findings include: R54's quarterly Minimum Data Set dated 12/16/24, identified intact cognition and diagnoses of anxiety, depression, mild cognitive impairment and PTSD. Daily medications included an antispychotic. R54's annual Care Area Assessment (CAA) dated 6/20/24, triggered for psychosocial needs; indicating little interest or pleasure in doing things on the PHQ-9 (depression screen). R54 was seen by a therapist and care plan was established to minimize risks. R54's Behavioral Symptoms Care Plan dated 12/30/24, lacked identification of potential triggers related to PTSD. R54's LTC (long term care) Social services assessments dated 3/22/24, 6/19/24, 9/17/24 and 12/16/24 lacked assessment of PTSD and triggers. R54's Associated Clinic of Psychiatry notes dated 11/21/24, 10/24/24, 9/19/24 8/16/24, 7/11/24, and 6/26/24, identified diagnosis of PTSD but not assessment of triggers. During an interview on 1/13/25 at 2:26 p.m., R54 stated some things that triggered her PTSD were staff that were not patient with her, she would cry sometimes for no reason, loud noises and certain times of the year were also triggering to her, especially this time of year around the major holidays. During an interview on 1/13/25 at 2:26 p.m., nursing assistant (NA)-B stated she worked with	F 699	facility's credible allegation of compliance. Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truths or facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed in accordance with federal and state law requirements. F699 Trauma Informed Care R54 was assessed for trauma history and potential triggers related to Trauma informed care. All residents with a diagnosis of post-traumatic stress disorder have been assessed for trauma history. Education provided to social services staff related to the requirement of trauma informed care assessments for all residents with a diagnosis of post-traumatic stress disorder. Audits will be completed on new admissions with a diagnosis of Post Traumatic Stress Disorder (if applicable, a trauma informed care observation will be completed). All admissions will be audited each week for four weeks, then up to three admissions each week for four weeks, and then up to one admission each week for four weeks. Results will be brought forward to QAPI to review the need for ongoing auditing.	

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F 699	Continued From page 40 R54 routinely, not aware of any triggers and R54 had delusions sometimes, but was unsure why. During an interview on 1/14/25 at 5:02 p.m., NA-C stated R54 had some bad days and had some delusions but staff were able to talk to her within reason. NA-C was fairly certain she had completed trauma informed care training, but was unsure of any trauma informed care approaches for R54. During an interview on 1/14/25 at 5:06 p.m., RN-B stated she was not aware of R54's trauma history or what would be triggers. RN-B stated R54 was on psychotropic medications and thought identification of triggers could help ensure care was provided in accordance with resident's wishes. During an interview on 1/14/25 at 5:19 p.m., social services designee (SS)-A stated trauma informed care "observations" (documented assessments) were done upon admission which identified trauma history and triggers, which would guide the care plan. SS-A reviewed R54's chart and agreed a trauma assessment was not completed and should have been, and was not aware of any triggers in particular. SS-A stated the purpose of assessing trauma and care planning was to to avoid re-trauma and better inform staff so person centered care could be care planned and consistently provided. During an interview on 1/14/25 at 6:09 p.m., licensed practical nurse (LPN)-B also looked for a trauma assessment and stated one had not been completed. LPN-B stated R54 had visual hallucinations at times which was brought to the provider's attention, and she was unaware if the	F 699	Date of compliance: 02/25/2025	

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F 699	Continued From page 41 hallucinations had associated triggers. During an interview on 1/16/25 at 1:30 p.m., the director of nursing (DON) stated she would expect trauma informed care assessments to be completed in accordance with the regulations to identify any potential triggers and guide resident care. The facility's Trauma Informed Care policy dated 5/28/24, identified: 1. Each resident would be assessed by using a multi-pronged approach to identify the resident's history of trauma and cultural preferences. The resident would be asked about triggers that may be stressors or may prompt recall of previous traumatic events. Common triggers include: a. Privacy or confinement in crowded or small spaces b. Loud noises c. Bright/flashing lights d. Certain sights such as those used in abuse, sounds, smells, physical touch. After the assessment has been completed, an individualized, comprehensive care plan will be completed. Each resident's comprehensive care plan should include approaches that address the residents' cultural preferences and reflect trauma-informed care when appropriate. This includes but was not limited to interventions accounting for the residents' experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization.	F 699		
F 725 SS=F	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with	F 725		2/25/25

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F 725	Continued From page 42 the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.71. §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide sufficient staffing to ensure residents received care and assistance they needed (R127, R35, R281, R11, R25, R59) for 6 of 7 residents reviewed for staffing needs. This had the potential to affect all 85 residents who reside in the facility. Findings include: The facility's payroll-based journal (PBJ) Staffing Data Report dated 7/1/24 through 9/30/24,	F 725	Plan of Correction Components: Statement of credible allegation (can use in MN, WI, MO) This plan of correction constitutes the facility's credible allegation of compliance. Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truths or facts alleged or conclusions set forth in	

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F 725	Continued From page 43 identified excessively low weekend staffing as an area of concern. R127's significant change Minimum Data Set (MDS) dated 5/16/24, indicated intact cognition and diagnoses of hemiplegia and hemiparesis following cerebral infarction affecting right dominant side and abnormalities of gait and mobility. It further indicated R127 was frequently incontinent of bowel, bladder and required assistance with toileting. R127's care plan dated 2/1/24, indicated R127 will have less than 2 episodes of bowel incontinence per day, will be continent of bowel at all times, and will be continent of bowel during the daytime with an intervention to observe his level of incontinence and initiate toileting schedule if indicated; check and change every two hours with incontinence pad. R127's Point of Care history report for bowel/bladder dated 6/7/24, indicate R127 hadn't been assisted with toileting from 8:46 a.m. until 9:15 p.m. During interview on 1/16/24 at 8:33 a.m., (NA)-T stated she changed R127 and he had dried bowel movement (BM) and it appeared he had been sitting in it for awhile. R127's call light log dated 6/7/24, showed the following delayed call light response times: -11:30 a.m. 41 minutes and 46 seconds -12:26 p.m. 50 minutes and 30 seconds -1:56 p.m. 93 minutes and 33 seconds -3:31 p.m. 78 minutes and 56 seconds R35	F 725	the statement of deficiencies. The plan of correction is prepared and/or executed in accordance with federal and state law requirements. F725 Sufficient Nursing Staff R127 discharged from facility on 6/27/2024. R11 was discharged from the facility on 1/17/2025. R35, R25, and R59□s call lights are answered within a timely manner. R281, R25, and R59□s medications are delivered timely. R59□s PICC line is now being managed by staff. All residents have the potential to be affected. Education provided to all staff regarding the importance of assisting with resident call lights when on the floors and not turning the call light off until need is met. Education provided to nurses and TMAs regarding administering pain medications timely and in accordance with physician orders and care plan. Facility assessed location of CNAs and nurses and have reallocated per acuity needs and will continue to adjust as needed based on acuity. Call light reports will be audited on alternating shifts for nine residents per week for four weeks, then six residents per week for four weeks, and then three residents per week for four weeks.	

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F 725	Continued From page 44 R35's annual MDS dated 11/6/24, identified moderately impaired cognition, no rejection of care; and diagnoses of kidney insufficiency, high blood pressure, osteoporosis and respiratory failure. R35 used a manual wheelchair for mobility and was dependent on staff for toileting, bathing, dressing, and hygiene. R35's call light log dated 1/15/25, showed the following delayed call light response times: 12/19/24 9:19 a.m., 31 minutes and 48 seconds 12/21/24 at 9:28 a.m., 56 minutes and 41 seconds 12/24/24 at 9:46 a.m., 102 minutes and 9 seconds 12/27/24 at 9:50 a.m., 40 minutes and 48 seconds 1/3/25 at 10:37 a.m., 45 minutes and 1 second 1/9/25 at 10:45 p.m., 39 minutes and 5 seconds 1/23/25 at 8:46 p.m., 44 minutes and 54 seconds 1/13/25 at 8:25 p.m., 37 minutes and 29 seconds 1/14/25 at 9:49 a.m., 37 minutes and 31 seconds. During an interview on 1/15/24 at 11:10 a.m., R35 stated call lights were "absolutely not answered in 15 minutes". Staff had a habit of coming in and turning the call light off and say they would be back in when they are able to, but they never come back. R281 R281's quarterly MDS dated 1/8/25, identified intact cognition, no rejection of care and diagnoses of Multiple Sclerosis, heart failure and high blood pressure. R281 used a motorized wheelchair for mobility and needed substantial assistance with toileting, upper body dressing and	F 725	Medication administration reports will be audited on alternating shifts for nine residents per week for four weeks, then six residents per week for four weeks, and then three residents per week for four weeks. Results will be brought forward to QAPI to review the need for ongoing auditing. Date of compliance: 02/25/2025	

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F 725	Continued From page 45 was dependent on staff for lower body dressing and hygiene. During an interview on 1/15/24 at 11:10 a.m., R281 stated nurses will answer call lights sometimes, however they will turn it off and say, "I will let your aide know". Medications were often late and sometimes a nurse from another floor will come and help, but just at the beginning of the shift. R11's admission Minimum Data Set (MDS) dated 1/6/25, indicated intact cognition, did not have behaviors, and did not reject cares. Further, R11 required substantial to maximal assistance with toileting hygiene, and transfers, did not have a catheter or ostomy, was frequently incontinent of urine and bowel and a toileting program trial had not been attempted. Additionally, R11 had diagnoses of noninfective gastroenteritis and colitis, nausea and vomiting, The MDS indicated R11 was at risk for developing pressure ulcers and application of ointments and medications were completed other than to feet. R11's Facesheet form undated, indicated the following diagnoses: noninfective gastroenteritis and colitis, diarrhea, and other sites of candidiasis (a fungal infection) to the groin. R11's care plan dated 1/13/25, indicated R11 had a self care deficit with bathing, grooming, oral cares, ambulation, transferring, mobility, vision, bowel and bladder and was continent of bowel and bladder. Additionally, R11 had a bowel and bladder plan that included offering toileting every two to three hours at 12:00 a.m., 3:00 a.m., 6:00 a.m., 9:00 a.m., 12:00 p.m., 3:00 p.m., 6:00 p.m., and 9:00 p.m. R11 required assist of one for	F 725		

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F 725	Continued From page 46 toileting and used the toilet. R11's care sheet dated 1/13/25, indicated R11 was continent of bowel and bladder and required assist of one with most activities of daily living (ADLs). R11's Bowel Assessment form dated 1/4/25, indicated R11 was occasionally incontinent and risk factors for incontinence included frequency of diarrhea. During interview on 1/13/25 at 9:28 a.m., R11 stated she was in a room that was far away from the nurse's station and experienced problems with diarrhea and sat in diarrhea for 45 minutes before a staff person came. R11 stated the diarrhea breaks down her skin and further stated she should be seen faster than 45 minutes. R11's call light logs were reviewed and included the following reset times: 12/31/24 at 2:08 p.m., 19 minutes, 36 seconds. 1/2/25 at 4:50 a.m., 20 minutes, 36 seconds. 1/2/25 at 3:59 p.m., 23 minutes, 30 seconds. 1/3/25 at 8:39 a.m., 21 minutes, 44 seconds. 1/3/25 at 10:58 a.m., 26 minutes, 13 seconds. 1/3/25 at 7:34 p.m., 19 minutes, 25 seconds. 1/4/25 at 5:17 a.m., 50 minutes, 2 seconds. 1/6/25 at 4:52 a.m., 25 minutes, 5 seconds. 1/6/25 at 9:13 a.m., 23 minutes, 33 seconds. 1/6/25 at 2:56 p.m., 29 minutes, 43 seconds. 1/7/25 at 8:18 a.m., 63 minutes, 42 seconds. 1/7/25 at 10:09 p.m., 25 minutes, 44 seconds. 1/8/25 at 7:47 a.m., 24 minutes, 50 seconds. 1/8/25 at 8:48 a.m., 27 minutes, 34 seconds. 1/8/25 at 1:12 p.m., 20 minutes, 43 seconds. 1/10/25 at 8:34 a.m., 48 minutes, 51 seconds. 1/11/25 at 1:36 a.m., 27 minutes, 39 seconds.	F 725		

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F 725	Continued From page 47	F 725		

1/11/25 at 7:37 a.m., 28 minutes, 47 seconds.
1/11/25 at 8:14 a.m., 43 minutes, 27 seconds.
1/12/25 at 1:36 p.m., 27 minutes, 15 seconds.
1/15/25 at 12:47 p.m., 21 minutes, 48 seconds.

R25's face sheet dated 1/15/25, indicated R25 had diagnoses of generalize pain disorder, generalized muscle weakness, sciatica, morbid obesity, presbyopia, and a right fibula fracture.

R25's care plan dated 11/29/24, indicated scheduled pain medications to be administered per physician order. R25 has visual dysfunction and self-care deficit requiring additional help for activities of daily living (ADL).

R25's medication administration record (MAR) dated 1/1/25 through 1/15/25 indicated R25 received late medication 10 out of the 15 days.

R25's call light logs were reviewed and included the following reset times:
1/4/25 at 5:13 a.m., 21 minutes, 13 seconds
1/4/25 at 12:54 p.m., 33 minutes, 36 seconds
1/4/25 at 1:37 p.m., 91 minutes, 49 seconds
1/5/25 at 10:23 a.m., 67 minutes, 32 seconds
1/8/25 at 8:37 a.m., 23 minutes, 27 seconds
1/8/25 at 8:38 p.m., 26 minutes, 15 seconds
1/9/25 at 5:00 p.m., 19 minutes, 19 seconds
1/9/25 at 10:46 p.m., 39 minutes, 31 seconds

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F 725	Continued From page 48 During interview on 1/13/25 10:14 a.m., R25 stated she has difficulty getting her scheduled pain medications on time; sometimes additional pain medication could often take an additional 2-3 hours due to low staffing, especially overnight. R59's face sheet printed 1/16/24 8:56 a.m., indicated R59 had recently been admitted with a diagnosis of cellulitis of left lower limb, methicillin resistant staphylococcus aureus infection (MRSA), Type 2 diabetes mellitus, morbid obesity, chronic heart failure, and partial traumatic amputation of the left foot. R59's care plan dated 12/10/24, indicated a high risk for infections, administering intravenous medications as ordered by physician. R59 had ADL deficits requiring nursing assistance of one. R59's provider order dated 12/30/24 to 1/23/24, indicated R59 required ceftriaxone 2 grams (G) intravenous (IV) once per day and vancomycin 1000 milligrams (mg) IV two times per day. R59's MAR dated 1/1/25 through 1/6/25 indicated R59 received late medication 10 out of 15 days. When interviewed on 1/13/25 at 12:55 p.m., R59 stated he often disconnected his peripherally inserted central catheter (PICC) line; he stated the reason he does his own flush was staff just don't have time. An observation on 1/15/24 at 1:28 p.m., R59 was observed disconnecting the vancomycin IV medication from his PICC line and flushing the PICC line with the saline flush. R59 did not wash his hands or perform hand hygiene prior to disconnecting the medication and flushing the	F 725		

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F 725	Continued From page 49 PICC line. During an interview on 1/16/25 at 9:55 a.m., licensed practical nurse (LPN)-D stated she feels like they can't answer call lights fast enough. LPN-D stated they are understaffed because it can take longer to answer call lights and medications can be late. During an interview on 1/16/25 at 10:00 a.m., nursing assistant (NA)-B stated staffing could be better. NA-B stated the residents complain to her call lights take a long time to get answered; in the mornings when she comes on, the residents say they took so long to get things over night. NA-B stated some residents have yelled at her for not helping them even though she is already helping another resident. NA-B stated most days just fly by because she never sits down. During interview on 1/16/25 at 10:05 a.m., registered nurse (RN)-A stated they very rarely have enough staff. Nights and weekends have high call ins; this staff may not get replaced. RN-A stated it has been difficult to get all the meds passed on time and give the residents the attention they deserve. RN-A stated it is very difficult to get everything done in a shift if someone calls in. Residents tell her they need to hire more staff, but nothing seems to change. RN-A stated she just wishes there were more staff so things could get done on time. During an interview on 1/16/25 at 11:15 a.m., staffing Coordinator (SC) stated the staffing coordinator and administrator handle most things with staffing. SC stated daily staffing is completed using the daily census and daily budget allowances for each day. SC stated staffing is	F 725		

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F 725	Continued From page 50 done daily for the next day to make sure the right number of staff are scheduled for the number of residents. SC stated staff are required to call them as soon as they know they won't make a shift; staff who call in on weekends can be difficult to replace. SC stated all workload concerns (too many meds to pass, call lights, resident cares, etc.) are submitted to the director of nursing (DON). During interview on 1/16/25 at 12:15 p.m., administrator confirmed staffing numbers are based solely on census and budgeted hours not resident acuity or diagnosis. Administrator stated the facility does use temporary staffing; most days temporary staff make up 1-5 people of the daily staff. Administrator confirmed the facility does not perform care plan audits or task completion audits. Administrator confirmed the facility does not track late medication administration. Administrator confirmed the expected call light response time is less than or equal to 15 minutes. Administrator confirmed the facility does not routinely perform call light response time audits.	F 725		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent	F 812		2/25/25

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F 812	Continued From page 51 facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to ensure expired food items were removed from service, food items were labeled and dated, and food was stored in a manner to prevent cross contamination from resident care items. Furthermore, the facility failed to ensure follow up and maintenance of a leaking refrigerator, routine maintenance of the dishwasher and overall cleanliness of the kitchen was maintained. Findings include: A facility kitchen/kitchenette cleaning log was requested however was not received. An email recieved 1/13/25, at 2:50 p.m., the administrator stated the last work order for the 4th floor refirdgerator was on 7/16/24. A new order was placed and contractors have been notified to remedy the issue. Kitchenettes An observation on 1/13/25 at 8:56 a.m., the 4th floor kitchenette was reviewed. The refrigerator contained a container of opened Molly's Kitchen premade egg salad with a use by date was	F 812	Plan of Correction Components: Statement of credible allegation (can use in MN, WI, MO) This plan of correction constitutes the facility's credible allegation of compliance. Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truths or facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed in accordance with federal and state law requirements. F812 Food Procurement, Store/Prepare/Serve-Sanitary The expired and/or undated food in the kitchenettes on the 4th floor, 3rd floor, and 2nd floor have been removed. The single use ice packs have been removed from kitchenette freezer and away from cross contamination. The leaking refrigerator is now in working order. The main kitchen	

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F 812	Continued From page 52 1/7/25. An opened bottle of Lyons prune juice had a best by date of 12/10/24. The bottom shelf of the fridge contained food crumbs or debris. In the back of the lower shelf was a box that appeared to be frozen onto the shelf. There were several butter packets stuck to the bottom of the box and the box stuck. The freezer contained a loaf of bread that was set upon a frozen white one time use ice pack. On the counter of the kitchenette was a bottle of opened Smucker's grape jelly that indicated it required refrigeration after opening. The counter also contained an open pump bottle of Simply Thick easy mix instant food thickener with a best use by date of 12/14/24. When interviewed on 1/13/25 at 9:11 a.m., licensed practical nurse (LPN)-C verified the egg salad, prune juice, jelly, and food thickener. LPN-C stated all those items should be discarded and the jelly should be refrigerated. LPN-C stated kitchen staff would bring food items up weekly and ensure they were not out of date. LPN-C stated the ice pack was a one-time use and should be thrown away and for infection control purposes, not stored with the food. LPN-C verified the food debris and box that was stuck on the bottom shelf and was not able to remove it. An observation on 1/13/25 at 9:15 a.m., the 3rd floor kitchenette was reviewed. The refrigerator contained a container of opened Molly's Kitchen premade egg salad with a use by date was 1/7/25. The freezer contained two instant once time use ice packs on the shelf and one in the door of the freezer. The freezer contained a few ice cream containers. The bottom shelf of the freezer and the back of the freezer contained	F 812	dishwasher has been de-limed, and the kitchen overall has been cleaned. All residents have the potential to be affected. The expired and/or undated food in the kitchenettes on the 4th floor, 3rd floor, and 2nd floor have been removed. The single use ice packs and other ice packs have been removed from kitchenette freezer and away from cross contamination. The leaking refrigerator is now in working order. The main kitchen dishwasher has been de-limed, and the kitchen overall has been cleaned. Education has been provided to all culinary staff regarding the responsibility of monitoring expiration dates for food stored in the kitchenettes, ensuring all items are labeled and dated, ensuring ice packs are not stored in kitchenette freezers, ensuring the equipment within the kitchenettes are in working order (if applicable, a maintenance ticket be put in for repair), and responsibility of ensuring the main kitchen cleaning log(includes dishwasher cleaning and overall kitchen cleanliness) is followed. Education provided to nursing staff regarding the requirement of disposing of one-time use ice packs. Audits will be completed on the expiration dates of items and ice packs in the kitchenettes, and the cleanliness of the dishwasher and overall kitchen three times weekly for four weeks, then two times weekly for four weeks, and then one time weekly for four weeks. Results will be	

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F 812	Continued From page 53 spilled red sticky substance. On the counter of the kitchenette contained two opened bottles of Smucker's grape jelly that indicated it required refrigeration after opening. When interviewed on 1/13/25 at 9:39 a.m., LPN-A verified the egg salad, ice packs and red sticky substance in the freezer. LPN-A wasn't sure who stocked the refrigerator or monitors for items that are expired. He wasn't sure if nursing staff or dietary staff were responsible for cleaning the in the kitchenette. LPN-A further stated ice packs should not be stored in the kitchenette freezers and were either one time use or there was a freezer in the medication room. An observation on 1/13/25 at 9:42 a. m., the 2nd floor kitchenette was reviewed. The freezer contained two one time use ice packs. The freezer also contained a ball of dough like substance wrapped in plastic wrap. There was no label or date on it. When interviewed on 1/13/25 at 9:47 a.m., nursing assistant (NA)-B verified the ice packs and the dough like substance. NA-B was not sure what the process for ice pack storage was as she normally did not work on 2nd floor. NA-B was not sure what the dough was and what it was for, however verified there was no label or date. When interviewed on 1/103/25 at 1:30 p.m., registered nurse (RN)- F stated the culinary staff usually take care of the kitchenettes. This included checking dates on food items and cleaning. Nursing doesn't look at dates on any routine basis but can always double check when using an item. RN-F stated icepacks were one time use only and should not be stored in the	F 812	brought forward to QAPI to review the need for ongoing auditing. Date of compliance: 02/25/2025	

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F 812	Continued From page 54 freezers. Having them in the freezer could cause contamination or become an infection control issue. Main kitchen An observation on 1/13/25 at 11:26 a.m., the main kitchen was reviewed. In a stand-up refrigerator a tray of salad items was noted. The tray consisted of cut up meats, cheese, vegetables for salad building. The tray was covered in plastic wrap, however, was not labeled or dated. This was verified by the Culinary Director (CD). At 12:02 p.m., The dishwasher was reviewed, there was grime and dirt on the floors, under shelves and the dishwasher countertop. The Ecolab dishwasher had grime on top and the sides of the machine and had white flaky scale substance on the counter where clean dishes exited the machine and around the bottom of the lift door. CD wasn't sure when the machine was last de-limed and stated the bigger concerns was to ensure temperatures were in range. When interviewed on 1/13/25 at 11:26 p.m., the CD expected all food items to have a label and date, so staff know what it is and how long it is good for. CD stated the kitchen staff delivered snacks and cold salads to the floor weekly. CD stated that was when the dates of those items were checked. CD stated the egg salad dated from 1/7/25 should be tossed out. Kitchen staff reviewed only the fridge and freezer items and nursing staff were responsible for the rest of the kitchenette. CD stated all staff using the kitchen should be ensuring the dates of items if pulling to use. CD verified the 4th floor refrigerator had been leaking down the back causing the box of butter to be frozen. CD stated he had placed	F 812		

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	245255	A. BUILDING _____ B. WING _____	C 01/16/2025

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F 812	Continued From page 55 multiple work orders for this to get fixed and wasn't sure why it was not done. When interviewed on 1/15/25 at 1:11 p.m., the Director of Nursing (DON) expected ice packs to be stored separately from any food or kitchen items. DON further stated it is a group effort between the kitchen staff and nursing staff to ensure kitchen items were not expired and still ok for resident use. When interviewed on 1/15/25 at 3:06 p.m., the administrator verified there was not a cleaning schedule for the kitchen or kitchenettes and this was being worked on. The administrator further expected any expired items to be removed from service and expected the kitchen staff to be managing both the main kitchen and kitchenettes. A facility policy titled Food Storage revised 8/2019, directed staff to ensure all storage areas in refrigerated and freezer will be maintained in a clean and sanitary condition and spills should be wiped up immediately. All prepared food items should be covered labeled and dated. A facility policy titled Equipment Operation Safety revised 8/2019, directed staff to make provisions for regular inspection and assure equipment is in good working order and protected by safeguards as needed.	F 812		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and	F 880		2/25/25

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F 880	Continued From page 56 comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the	F 880		

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F 880	Continued From page 57 circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure transmission-based precautions (TBP) were followed for 1 of 1 resident (R38) who required TPB during medication administration and failed to ensure a glucose meter was disinfected per manufacturer's guidelines after resident use for 1 of 1 residents (R31) observed for glucose monitoring. Furthermore, the facility failed to ensure resident clothing was transported in a manner to ensure cleanliness and protect from dust and soil during transport. This had the potential to impact all residents residing on the 3rd floor and who the facility provides laundry services for.	F 880	Plan of Correction Components: Statement of credible allegation (can use in MN, WI, MO) This plan of correction constitutes the facility's credible allegation of compliance. Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truths or facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed in accordance with federal and	

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F 880	Continued From page 58 Findings include: R31's quarterly MDS dated 12/25/24, indicated R1 was cognitively intact and had diagnoses of diabetes. R31's provider order dated 12/17/24, indicated R31 required a blood glucose check on Sun, Tue, Thu, Sat, at 5:00 p.m. R38's admission Minimum Data Set (MDS) dated 12/16/24, indicated R38 was cognitively intact and had diagnoses of cellulitis (skin infection) of left lower limb and Methicillin resistant Staphylococcus aureus (multidrug resistant bacteria, (MRSA) infection to left extremity wound. R38's provider dated 12/10/24, indicated R38 required ceftriaxone 2grams intravenous (IV) daily for cellulitis. R38's provider and nursing orders lacked indication R38 required contact precautions. R38's care plan revised 12/23/24, indicated R38 required contact precautions related to MRSA and presence of open wounds. Interventions included to post clear signage on the door outside the resident room to indicate precautions and personal protective equipment (PPE) needed and to assure residents are encouraged to be restricted to their rooms or limited participation in group activities. Cleaning and disinfecting the Assure Platinum blood glucose monitoring system revised 9/2024, recommended cleaning and disinfecting with the following products; Clorox germicidal wipes,	F 880	state law requirements. F880 Infection Prevention & Control R31 now has their own individual glucometer. The 3rd floor laundry cart is now covered and protected from dust and soil during transport. R59 (error noted in 2567, R38) is no longer on contact precautions. Facility implementing individual glucometers for all diabetic residents. All laundry carts are now covered and protected from dust and soil during transport. Education provided to nurses regarding proper cleaning supplies and cleaning technique for shared resident equipment. Education provided to laundry staff to ensure the laundry cart is covered and protected from dust and soil during transport. Education provided to all staff related to proper PPE usage for precautions. Audits will be completed on glucometer cleaning, laundry transportation, and proper PPE usage for precautions three times weekly for four weeks, then two times weekly for four weeks, and then one time weekly for four weeks. Results will be brought forward to QAPI to review the need for ongoing auditing. Date of compliance: 02/25/2025	

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F 880	Continued From page 59 Dispatch hospital cleaner disinfectant towels with bleach, super Sani-cloth germicidal wipes, Cavi wipes, or microdot bleach wipes. A continuous observation on 1/24/25 at 4:42 p.m., LPN-F approached R31 who was seated at the dining room table with a white basket that contained an Assure Platinum glucometer, test strips, lancets, and alcohol wipes. LPN-F obtained R31's blood glucose and wrote 166 down on a piece of paper. LPN-F removed the test strip and then placed the glucometer back in the white basket, removed gloves and folded the used test strip up in the gloves, and returned to the medication cart. LPN-F removed gloves and performed hand hygiene. The white basket was placed on top of the medication cart. No sanitizing wipes were observed to be on the medication cart. Without cleaning the glucometer, LPN-F continued with medication administration. At 4:59 p.m., LPN-F obtained R38's medications to administer. R38's door was open and outside the door was a sign that stated Contact Precautions and instructed staff to perform hand hygiene, gown, and glove before entering the room. LPN-F performed hand hygiene and gloves before realizing R38 was in the dining room waiting for dinner. LPN-F stated they needed to get some supplies to administer R38's antibiotic. LPN-F still having gloves donned entered R38's room without placing a gown. LPN-F opened R38's nightstand table that was located towards the end of the bed and obtained a normal saline (NS) flush (medication used to access an IV before administering medication). LPN-F then closed the dresser drawer and left the room without removing gloves or performing hand hygiene and went back to R38 still in the dining room. With the same	F 880		

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F 880	Continued From page 60 gloves, LPN-F opened the saline flush and prepared it to administer. LPN-F then removed their gloves and without hand hygiene placed new gloves. R38 removed the cap from his IV and LPN-F then cleaned the port and gave the NS flush medication. LPN-F then primed and connected R38's ceftriaxone medication. LPN-F removed gloves and without hand hygiene, administered the remaining pills to R38. LPN-F then verified there were no other residents who required blood glucose checks or medications to be administered. When interviewed on 1/24/25 at 5:22 p.m., LPN-F verified the glucometer was used for multiple residents. LPN-F was only helping with medications and wasn't sure how many residents used the glucometer. LPN-F further stated the glucometer had to be cleaned with the purple top super-Sani-cloth disinfectant wipes and wasn't sure where they were at. LPN-F was not able to find any on either medication cart or at the nurse's desk. LPN-F then donned gloves and started to clean glucometer with an alcohol wipe as the other Sani-cloth wipes were not available. LPN-F verified R38 was on contact precautions for MRSA and acknowledged the signage directing staff to wear a gown and gloves when entering the room. LPN-F stated a gown was needed if completing cares, but it was ok to enter to obtain supplies or when not providing wound or close contact care. LPN-F acknowledged R38 should have returned to their room for the antibiotic, or a gown should have been worn when accessing it. LPN-F further stated hand hygiene should be done in-between glove changes and at when done working with the IV site.	F 880		

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F 880	Continued From page 61 When interviewed on 1/15/25 at 1:13 p.m., the Director of Nursing (DON) thought most residents had their own glucometers and those should be used. If residents shared one, the super-Sani cloth (purple top) wipes needed to be used after each use. DON was unsure of the use of alcohol wipes and would need to review policy/procedure. DON stated staff would be able to enter the room for residents on contact precautions if they were not providing cares for the resident. DON expected staff to have a gown and gloves in place when working with an IV site and to perform hand hygiene after each glove removal and upon exiting resident rooms. When interviewed on 1/15/25 at 1:23 p.m., the covering infection preventionist (IP) expected staff to follow the signs for contact precautions and should be gowning and gloving whenever entering the resident environment. Upon exit of any rooms, gloves should be removed, and hand hygiene performed. Furthermore, staff should wear gown and gloves when working with an IV of a resident and after any glove exchange hand hygiene should be completed. IP stated some of the residents have their own glucometers, however if using one for multiple residents the super-Sani cloth (purple top) wipes or an alcohol swab should be used to sanitize after each resident use. Laundry An observation on 1/14/25 at 11:45 p.m., nursing assistant (NA)-N was pushing a rack of clothing through the hallway on 2nd floor. The clothing contained resident items that were coming back from laundry. The items were hung up with hangers and uncovered. Other staff were	F 880		

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F 880	Continued From page 62 observed to be walking down same hallway, delivering meals to residents. Several staff and residents had walked by the rack of clothing. When interviewed on 1/24/25 at 11:50 a.m., NA-N stated they had just picked up shifts to help in laundry and didn't work there regularly. NA-N stated she had training and was told only sheets and linens needed to be covered when transported, and it was ok for residents clothing to be uncovered. When interviewed on 1/15/25 at 3:02 p.m., the Director of Maintenance (DM) stated resident linen should be covered during transport. Residents clean clothing was transported on an open rack and were not covered. DM further stated currently, there was not a housekeeping supervisor and he thought covering laundry during transport was intended for linens and not resident clothing. A Facility policy titled Infection Control; Hand Hygiene revised 2009, directed staff to perform hand hygiene before and after direct contact with residents, before and after handling an invasive device such as an IV, after glove removal and before and after entering isolation precaution settings. A facility policy titled Contact Precautions revised 9/2023, directed staff to use contact precautions in addition to standard precautions to prevent spread of organisms that can be transmitted by direct resident contact or by indirect contact of environmental surfaces. This includes acute infection with MRSA. A facility policy titled Environmental Cleaning,	F 880		

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F 880	Continued From page 63 Disinfection and Sterilization revised 8/2023, directed staff to clean semi-critical devises such as glucometers with a disinfectant that claims to inactivate HIV, TB, HBV, and HCV or household bleach (1 part bleach and 9 parts water). A facility policy titled Linen and Laundry revised 5/15/24, directed staff to transport linens by methods to ensure cleanliness and protection from dust and soil during transportation.	F 880		
F 919 SS=D	Resident Call System CFR(s): 483.90(g)(1)(2) §483.90(g) Resident Call System The facility must be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area from- §483.90(g)(1) Each resident's bedside; and §483.90(g)(2) Toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure call lights were accessible for 1 of 1 resident (R9) reviewed. Findings include: R9's quarterly Minimum Data Set (MDS) dated 12/4/24, indicated intact cognition and diagnoses of hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, repeated falls, chronic pain, unspecified displaced fracture of sixth cervical vertebra, need for assistance with personal care, dependence on wheelchair, and history of a traumatic brain injury	F 919	Plan of Correction Components: Statement of credible allegation (can use in MN, WI, MO) This plan of correction constitutes the facility's credible allegation of compliance. Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truths or facts alleged or conclusions set forth in the statement of deficiencies.	2/25/25

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F 919	Continued From page 64 (TBI). It further indicated R9 had an impairment on one side of his upper and lower extremites and required substantial/maximal assistance with all activities of daily living (ADL) and mobility except eating and oral hygiene. R9's care plan last reviewed on 12/16/2024, indicated R9 was at risk for falls due to Basal Ganglia stroke resulting in left hemiparesis, history of TBI, subdural hematoma, and mild degenerative retrolisthesis of C3- C4, with an intervention of call light within reach at all times. During observation on 1/13/25 at 9:20 a.m., R9 was sitting in his room in his wheelchair. His call light box was sitting on his bedside table and the cord had been removed. During observation and interview on 1/13/25 at 9:54 a.m., nursing assistant (NA)-B verified R9's call light box was sitting on his bed side table, the cord had been removed, and if he were to fall on the floor, he wouldn't be able to reach it. During interview on 1/16/24 at 9:42 a.m., LPN-B stated R9 didn't have a cord for his call light box per his preference. LPN-B verified R9 wouldn't be able to reach his call light if he fell in his room but stated even if he had a cord he wouldn't be able to access it from all areas of the rooml. LPN-B also stated resident preferences should be written in their care plan and verified R9's preference to not have a cord for his call light box was not written in his care plan and it was important to ensure he was getting his needs met and also in case it's an emergency. During interview on 1/16/25 at 9:59 a.m., LPN-E stated resident call light boxes should have a	F 919	The plan of correction is prepared and/or executed in accordance with federal and state law requirements. F919 Resident Call System R9□s care plan now reflects residents call light preference of having no cord. All residents have the potential to be affected. All residents have their call light mounted with a cord, unless it is the resident's preference to have it mobile, in which it is care planned. Education provided to nurse managers regarding care planning call light preferences for all residents. Audits related to call lights reflecting resident preference and care plan will be completed on three residents per week for four weeks, then two residents per week for four weeks, then one resident per week for four weeks. Results will be brought forward to QAPI to review the need for ongoing auditing. Date of compliance: 02/25/2025	

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F 919	Continued From page 65 cord and it was important because the resident wouldn't be able to notify anyone of being on the floor without the cord. LPN-E further stated if it was a residents preference to not have a cord, it shoudl be documented in their care plan and they should have a risk vs. benefits completed. During interview on 1/16/25 at 1:00 p.m., the director of nursing (DON) verified the call light boxes didn't have cords stating the length of the cord wouldn't reach the entire room even if they had them. The facility's policy regarding call lights dated 5/28/24, indicated the call system must be accessible to the resident at each toilet and bath or shower facility. The call system should be accessible to a resident lying on the floor.	F 919		

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	245255	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**01/14/2025**

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted on January 14, 2025, by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Cerenity Care Center on Humbolt, was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		02/11/2025

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245255	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**01/14/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CERENITY CARE CENTER ON HUMBOLDT	**512 HUMBOLDT AVENUE** **SAINT PAUL, MN 55107**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1	K 000		

Healthcare Fire Inspections
State Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101-5145, OR

By email to:
FM.HC.Inspections@state.mn.us

THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION:

1. A detailed description of the corrective action taken or planned to correct the deficiency.

2. Address the measures that will be put in place to ensure the deficiency does not reoccur.

3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained.

4. Identify who is responsible for the corrective actions and monitoring of compliance.

5. The actual or proposed date for completion of the remedy.

Building Info:
The building was constructed at 2 different times. The original building was constructed in 1960 and was determined to be of Type II(222) construction.
In 1970, an addition was constructed to the South side of the building that was determined to be of Type II(222) construction.

The building is fully sprinklered. The facility has a fire alarm system with full corridor smoke

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K 000	Continued From page 2 detection and spaces open to the corridors that is monitored for automatic fire department notification. Because the original building and the addition meet the construction type allowed for existing buildings, it was surveyed as one building. The facility has a capacity of 93 beds and had a census of 85 at the time of the survey.	K 000		
K 311 SS=F	The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by: Vertical Openings - Enclosure CFR(s): NFPA 101 Vertical Openings - Enclosure 2012 EXISTING Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least 1 hour. An atrium may be used in accordance with 8.6. 19.3.1.1 through 19.3.1.6 If all vertical openings are properly enclosed with construction providing at least a 2-hour fire resistance rating, also check this box. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to the ceiling and openings in accordance with the Life Safety Code NFPA 101 - 2012 edition (8.6, 19.3.1.1 through 19.3.1.6). These deficient findings could have a widespread impact on the residents within the facility.	K 311	K311 The ceiling panels have been reinstalled to cover the openings in the housekeeping closets on floors 2, 3, and 4.	2/25/25

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K 311	Continued From page 3 Findings Include: On 01/14/2025, between 9:30 AM and 12:00 PM, observations and staff interview revealed that there were penetrations through teh ceiling of the housekeeping closets on floors 2, 3 and 4. Ceiling access panels had been removed and not reinstalled. An interview with the Environmental Services Director verified these deficient findings at the time of discovery.	K 311	EVS Director or designee will monitor to ensure continued compliance. EVS Director or administrator is responsible for ongoing compliance. Date for completion: 2/25/2025	
K 351 SS=F	Sprinkler System - Installation CFR(s): NFPA 101 Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to install sprinkler heads per NFPA	K 351	K351	2/25/25

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K 351	Continued From page 4 101 (2012 edition), Life Safety Code, sections 19.3.5.1 and 9.7.1.1 and NFPA 13 (2010 edition), The Standard for the Installation of Sprinkler Systems, sections 8.1.1, 8.3.2.5, 8.4.9.1 and 8.4.9.2. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 01/14/2025 between 9:30 AM and 12:00 PM, it was revealed by observation that there was flex conduit in contact with the sprinkler system above the ceiling on the 3rd floor entering the West Wing. An interview with the Director of Environmental Services verified this deficient finding at the time of discovery.	K 351	Bailing wire was ordered, and flex conduit is strapped away from contact with the sprinkler system above entry way on 3rd floor. All hallway sprinkler heads have been audited to ensure there is no flex conduit in contact with sprinkler heads. EVS Director or designee will audit three sprinkler heads per week for four weeks, and then three sprinkler heads per month for two months. EVS Director or administrator is responsible for ongoing compliance Date of completion: 2/25/2025	
K 541 SS=F	Rubbish Chutes, Incinerators, and Laundry Chu CFR(s): NFPA 101 Rubbish Chutes, Incinerators, and Laundry Chutes 2012 EXISTING (1) Any existing linen and trash chute, including pneumatic rubbish and linen systems, that opens directly onto any corridor shall be sealed by fire resistive construction to prevent further use or shall be provided with a fire door assembly having a fire protection rating of 1-hour. All new chutes shall comply with 9.5. (2) Any rubbish chute or linen chute, including pneumatic rubbish and linen systems, shall be provided with automatic extinguishing protection in accordance with 9.7. (3) Any trash chute shall discharge into a trash collection room used for no other purpose and	K 541		2/25/25

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K 541	Continued From page 5 protected in accordance with 8.4. (Existing laundry chutes permitted to discharge into same room are protected by automatic sprinklers in accordance with 19.3.5.9 or 19.3.5.7.) (4) Existing fuel-fed incinerators shall be sealed by fire resistive construction to prevent further use. 19.5.4, 9.5, 8.4, NFPA 82 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain chute doors and safety measures of the laundry and bio-hazard chute systems per NFPA 101 (2012 edition), section 19.5.4, 9.5, 9.5.2 and NFPA 82 (2009 edition), section 5.2.3.3. These deficient findings could have a widespread impact on the residents within the facility. Findings include: On 01/14/2025, between 09:30 AM and 12:00 PM, it was revealed by observation in that the Trash and Linen chutes on floors 2, 3 and 4 failed to properly close and positively latch. An interview with the Environmental Services Director verified these deficient findings at the time of discovery.	K 541	K541 The Trash and Linen chutes on floors 2, 3, and 4 have been decommissioned and closed off, until proper contractor can be located to correct and ensure the chutes positively latch. Facility will utilize bins on the floors in place of the laundry and trash chutes. Trash and linen chutes will remain decommissioned unless able to find proper contractor. If the facility is able to replace the latches on the trash and linen chutes, education will be provided to EVS staff regarding the chutes needing to positively latch and close. If the facility is able to replace the latches on the trash and linen chutes, EVS Director or designee will audit linen and trash chute latches to ensure compliance. EVS Director or administrator is responsible for ongoing compliance. Date of completion: 2/25/2025	

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