Protecting, Maintaining and Improving the Health of All Minnesotans

Revised letter date

Electronically delivered
April 25, 2023

Administrator
The Emeralds At Grand Rapids LLC
2801 South Highway 169
Grand Rapids, MN 55744

RE: CCN: 245495
Cycle Start Date: January 12, 2023

Dear Administrator:

On January 24, 2023, we notified you a remedy was imposed. On February 16, 2023 the Minnesota Department(s) of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of March 24, 2023.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective April 6, 2023 did not go into effect. (42 CFR 488.417 (b))

In our letter of January 24, 2023, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from April 6, 2023 due to denial of payment for new admissions. Since your facility attained substantial compliance on March 24, 2023, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

The CMS Region V Office may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

Sarah Lane

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

Protecting, Maintaining and Improving the Health of All Minnesotans

Revised letter date

Electronically delivered

April 25, 2023

Administrator
The Emeralds At Grand Rapids LLC
2801 South Highway 169
Grand Rapids, MN 55744

Re: Reinspection Results
Event ID: LV1G12

Dear Administrator:

On March 29, 2023 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on February 10, 2023. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
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DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
March 7, 2023

Administrator
The Emeralds At Grand Rapids LLC
2801 South Highway 169
Grand Rapids, MN 55744

RE: CCN: 245495
Cycle Start Date: January 12, 2023

Dear Administrator:

On January 24, 2023, we informed you of imposed enforcement remedies.

On February 10, 2023, the Minnesota Department(s) of Health and Public Safety completed a survey and it has been determined that your facility continues to not to be in substantial compliance. The most serious deficiencies in your facility were found to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

As a result of the survey findings:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective April 6, 2023.

- Directed plan of correction, Federal regulations at 42 CFR § 488.424 Please see electronically attached documents for the DPOC.

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

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective April 6, 2023. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective April 6, 2023.

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

As we notified you in our letter of January 24, 2023, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from April 6, 2023.

ELECTRONIC PLAN OF CORRECTION (ePOC)

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

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

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

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

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));
- Per day civil money penalty (42 CFR 488.430 through 488.444).

DEPARTMENT CONTACT

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

LeAnn Huseth, RN, Unit Supervisor
Fergus Falls District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health

1505 Pebble Lake Rd., Suite 300
Fergus Falls, Mn. 56537
Email: leann.huseth@state.mn.us
Office: (218) 332-5140 Mobile: (218) 403-1100

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by July 12, 2023 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

APPEAL RIGHTS

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

Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Steven.Delich@cms.hhs.gov

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

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

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Steven Delich, Program Representative at (312) 886-5216. Information may also be emailed to Steven.Delich@cms.hhs.gov.

INFORMAL DISPUTE RESOLUTION/ INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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

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

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

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable plan of correction. A copy of the Department's informal

dispute resolution policies are posted on the MDH Information Bulletin website at:
https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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

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

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

Feel free to contact me if you have questions.

Sincerely,

Sarah Lane

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245495	A. BUILDING _____ B. WING _____	C 02/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE EMERALDS AT GRAND RAPIDS LLC	2801 SOUTH HIGHWAY 169 GRAND RAPIDS, MN 55744

(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 2/6/23, to 2/10/23, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) was conducted during a standard recertification survey. The facility was IN compliance. 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 2/6/23 - 2/10/23, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were found to be SUBSTANTIATED: MN 85454 H54953568C, with a deficiency cited at (F677, F689). MN 85366 H54953568C,with a deficiency cited at (F584, F677,F689). MN 84996 H54958237C, with a deficiency cited at (F677). MN 83905 H54958238C, with a deficiency cited at (F550). MN 89640 H54958200C, with a deficiency cited at (F689). MN 89723 H54958204C, with a deficiency cited at (F550). MN 89298 H54958202C, with a deficiency cited at (F 689).	F 000		

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

Electronically Signed | 03/15/2023

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

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F 000	Continued From page 1 AND The following complaints were found to be SUBSTANTIATED however NO deficiencies were cited due to actions implemented by the facility prior to survey: MN 85571 H54958218C MN 86095 H54958203C AND The following complaints were found to be UNSUBSTANTIATED: MN 80604 H5495139C MN 89628 H54958201C MN 89302 H54956494C MN 90815 H54958153C The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 550 SS=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	F 550		3/24/23

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F 550	Continued From page 2 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 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	F 550	Immediate Corrective Action:	

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F 550	Continued From page 3 review, the facility failed to ensure privacy of exposed body areas for 1 of 5 residents (R5) reviewed for dignity. Findings include: R5's Diagnosis Report dated 2/9/23, indicated R5's diagnoses included muscle weakness, chronic pain, bipolar disorder, depression, and panic disorder. R5's quarterly Minimum Data Set (MDS) dated 12/4/22, indicated R5 was cognitively intact, and required extensive with bed mobility, dressing, toilet use, and personal hygiene. R5's care plan revised on 12/6/22, indicated R5 had limited physical mobility related to morbid obesity and pain. The care plan directed staff to assist with all cares while resident participated to her maximum capacity. During an observation on 2/7/23, at 3:34 p.m. nursing assistant (NA)-A entered R5's room, performed hand hygiene, applied gloves, opened a brief, and laid the brief on the bed. NA-A removed R5's shirt, then using personal care wipes cleansed under her pannus (excess abdominal skin and fat that hangs over the pubic region), groin folds, and perineum wiping front to back (using a new wipe for each area). R5 rolled onto her side, her back and buttocks were exposed (no privacy curtain between the bed and the resident's door). NA-A noted the bottom sheet was wet and needed to be changed. NA-A told R5 she needed to get a sheet and pad for the bed. NA-A removed her gloves, performed hand hygiene and walked to R5's room door and was ready to open the door. NA-A was stopped prior	F 550	R5 was covered for privacy at time of incident after prompting. Corrective Action as it applies to others: The policy titled "Quality of Life - Dignity" was reviewed and remains current. All resident in shared rooms were reviewed to ensure that they have a privacy curtain in room that can be utilized. Education will be provided to direct care staff including CNA, TMA, LPN, and RN on policy titled "Quality of Life - Dignity" highlighting #10. Staff shall promote, maintain and protect resident privacy, including bodily privacy during assistance with personal care and during treatment procedures. Date of Compliance: 3/24/2023 Recurrence will be prevented by: Resident privacy during cares will be audited on 5 residents weekly x3 weeks, and monthly x2 months to ensure that residents have privacy during cares. Audits and findings will be reported to QAPI committee for further recommendations. Corrections will be monitored by: Director of Nursing or Designee	

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F 550	Continued From page 4 to exiting the room and was asked if she was going to cover the resident. NA-A went back to the bed and asked R5 if she could cover her with her clean gown. R5 agreed to be covered. During an interview on 2/7/23, at 3:40 p.m. NA-A verified she should have covered R5 before leaving the room for more supplies. During an interview on 2/9/23, at 11:20 a.m. the administrator verified she would expect staff to cover a resident prior to leaving the room for more supplies and not leave them exposed. The facility policy titled Quality of Life - Dignity revised 8/2009, directed staff to treat residents with dignity and respect at all times. "Staff shall promote, maintain and protect resident privacy, including bodily privacy during assistance with personal care and during treatment procedures."	F 550		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of	F 580		3/24/23

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F 580	Continued From page 5 treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to notify physician per orders of blood sugars and weights 2 of 5 residents (R5, R32) reviewed weights and blood sugars.	F 580	Immediate Corrective Action:¿¿¿ R5's physician¿has been notified of weight changes and blood sugars out of¿parameters.¿	

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F 580	Continued From page 6 Findings include: R5's Diagnosis Report dated 2/9/23, indicated R5's diagnoses included hypertension, chronic diastolic (congestive) heart failure, (a chronic condition in which the heart doesn't pump blood as well as it should), type two diabetes mellitus, bipolar disorder, depression, and panic disorder. R5's quarterly Minimum Data Set (MDS) assessment dated 12/4/22, indicated R5 was cognitively intact and had no rejections of care. In addition, R5's MDS indicated she required insulin four of the seven days. R5's care plan revised on 12/6/22, indicated R5 had limited physical mobility related to morbid obesity and pain. The care plan directed staff to assist with all cares while resident participated to her maximum capacity. R5's Order Summary Report dated 2/9/23, directed staff to notify physician as soon as possible if blood sugar was less than 60 or greater than 450. Document notification and resulting orders. In addition, staff were directed to call her provider for weight gain of more than two pounds per day or five pounds per week. R5's Weight and Vital Summary dated 2/9/23, indicated R5's blood sugars were as follows: 1/25/23, 7:30 a.m. 488 1/29/23, 11:09 a.m. 472 2/8/23, 11:42 a.m. 463 2/7/23, 3:59 p.m. 520 2/6/23, 7:38 a.m. 484 2/6/23, 10:52 a.m. 487	F 580	R32 has not had a blood sugar out of parameter since 1/23/23. If the resident does have a blood sugar parameter out of range, the provider will be notified. ¿ Corrective Action as it applies to others:¿¿ Policies titled “Diabetes - Clinical Protocol” and “Heart Failure – Clinical Protocol” have been reviewed and remain current.¿ All residents will be audited to determine if they need weight or blood sugar monitoring. Those residents needing monitoring will be audited to determine if proper notification to provider was completed. ¿ Nurses and TMAs will be educated on policies titled “Diabetes - Clinical Protocol” and “Heart Failure – Clinical Protocol” specifically on notification of provider if weights or blood sugars are out of range per MD order. Date of Compliance:¿ 3/24/2023¿ Recurrence will be prevented by:¿¿ Provider notification for weights or blood sugar out of parameters will be audited on 5 residents weekly x3 weeks, and monthly x2 months to ensure that provider notification has been completed if numbers are out of range. Audits and	

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F 580	Continued From page 7 R5's Weight and Vital Summary dated 2/9/23, indicated R5's weights were as follows: 1/2/23, 280 pounds 1/3/23, 283.9 pounds 1/15/23 no weight 1/16/23, 286.1 pounds 1/17/23, no weight 1/18/23, 288.3 pounds 1/20/23, 291 pounds 1/21/23, 293. 6 pounds 1/23/23, 287.9 pounds 1/24/23, 291.8 pounds R5's progress notes were reviewed from 1/1/23-2/9/23, related to the elevated blood sugar on 2/7/23, R5's record lacked documentation of provider notification of either elevated blood sugars or weight gain. During an interview on 2/9/23, at 9:41 a.m. the director of nursing (DON) stated she would expect staff to follow provider orders to as written and to call with elevated blood sugars and weight gains. The DON stated it would be important to follow provider orders as medication may have needed to be adjusted for blood sugar control and for R5's congestive heart failure. R32 R32 quarterly minimum data set (MDS) assessment completed 1/16/23 indicated moderately impaired cognition, dependent on staff for activities of daily living. R32's medical diagnosis included type 2 diabetes mellitus. R32's physician orders dated 1/1/23, indicated to	F 580	findings will be reported to QAPI committee for further recommendations.¿¿ Corrections will be monitored by:¿ Director of Nursing or Designee¿	

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F 580	Continued From page 8 check blood sugar two times a day. R32's order dated 6/28/21 indicated to notify MD (medical doctor) ASAP if blood sugar is less than 60 or greater than 400. Document notification and resulting orders every shift. Record review indicated R32 had blood sugars of: 421 on 1/4/23 410 on 1/5/23 505 on 1/14/23 426 on 1/16/23 477 on 1/18/23 431 on 1/20/23 445 on 1/23/23 During an interview on 2/9/23, at 4:16 p.m. LPN-C stated communication with NP (nurse practitioner) or MD regarding elevated blood sugars would be documented in progress notes. R32's record review lacked notification to MD or NP regarding elevated blood sugars from 1/1/23 through 1/23/23. During a phone interview on 2/9/23, at 1:50 p.m. NP confirmed lack of notification of R32's blood sugars over 400. NP stated it would have been appropriate to have been notified. During an interview on 2/9/23, at 3:40 p.m. director of nursing (DON) & (assistant) ADON stated reporting elevated blood sugars to the NP or MD was important to determine if R32 needs a change with insulin or other things happening within R32's body. The facility policy titled Diabetes - Clinical Protocol revised 11/2020, indicated "The	F 580		

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F 580	Continued From page 9 Physician will order desired parameters for monitoring and reporting information related to blood sugar management." The facility policy titled Heart Failure - Clinical Protocol revised 11/2018, indicated "The physician will review and make recommendations for relevant aspects of the nursing care plan; for example, what symptoms to expect, how often and what (weights, renal function, digoxin level, etc.) to monitor, when to report findings to the physician, etc."	F 580		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;	F 584		3/24/23

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F 584	Continued From page 10 §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure resident floors were clean and rooms were free of odors, ensue bed linens were clean, a wheelchair was safe for use and a catheter bag was emptied. This deficient practice affected 6 of 9 residents (R18, R31, R11, R2, R53, and R57) reviewed for a clean and homelike environment. Findings include: R18's Admission Record dated 2/9/23, identified diagnoses which included traumatic brain injury, depression, and anxiety, R18's quarterly Minimum Data Set (MDS) dated 1/6/23, indicated R18 was cognitively intact and rejected care four to six days in a seven day period. In addition, R18 was independent with eating.	F 584	Immediate Corrective Action: R18's floor was cleaned. R31's urinal was emptied, and odor has been addressed by housekeeping. R11's bed sheet was changed. R2's wheelchair was repaired. R53's catheter bag was emptied. R57 was discharged from the facility and CNA (F) was educated on completing resident cares in a private area. Corrective Action as it applies to others:¿¿ The Cleaning and Disinfecting Rooms Policy, Catheter Care Policy, and the Maintenance Service Policy were reviewed and remain current. All residents' floors were observed to ensure that they have been cleaned and	

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F 584	Continued From page 11 During an observation on 2/6/23, at 6:55 p.m. R18's floor was noted to have a residue about two feet in length and 10 inches in width, there were also food crumbs between his bed and his recliner on the floor. During an observation on 2/8/23, at 8:29 a.m. R18 was seated in his recliner he had just finished his breakfast, there was residue on the floor and food between his chair and his bed. During an observation on 2/9/23, at 6:38 a.m. R18 was seated in his recliner leaning to his right. R18's floor between his bed and his chair had a large area of food residue on the floor. In addition, there was a black cushion on the floor between the bed and his recliner. During an interview on 2/8/22, at 9:35 a.m. housekeeping aide (HA)-A stated she cleaned the floor between his recliner and his bed twice a day. During an interview on 2/9/23, at 9:59 a.m. the director of nursing (DON) stated she would expect staff to report a dirty floor to housekeeping to get it cleaned up. During an interview on 2/9/23, at 11:10 a.m. the administrator stated she would expect staff to notice dirty floors and get them cleaned by telling housekeeping or their care coordinator. The facility policy titled Cleaning and Disinfecting Resident Rooms revised 8/2013, directed staff to do the following; "Housekeeping surfaces (e.g., floors, tabletops) will be cleaned on a regular basis, when spills occur, and when these surfaces are visibly soiled."	F 584	rooms are free from odor. All residents who utilize urinals or have catheter urine collection bags were observed to ensure that they were emptied. All residents' bed linens were observed to ensure that they are clean and dry. All residents' wheelchairs were observed to ensure that they are in working order and safe. Education was provided to housekeeping on "Cleaning and Disinfecting Rooms Policy" specifically on keeping resident floors clean and ensuring that rooms are free from odors. Nursing staff was educated on " Catheter Care Policy" specifically on emptying urine catheter bags at a minimum every shift as well as emptying urinals regularly, ensuring that bed linens are changed when dirty, and putting work requests into TELS when an item is in disrepair to notify maintenance department to address. Date of Compliance:¿ 3/24/2023¿ Recurrence will be prevented by:¿¿ Audits will be completed on 5 residents' floors to check for cleanliness and odor weekly x3 weeks, and then monthly x2 months.	

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F 584	Continued From page 12 R31's quarterly MDS dated 1/6/23, indicated R31 had diagnoses which included heart failure (a chronic condition in which the blood doesn't pump blood as well as it should), anxiety, diabetes mellitus, and depression. In addition, R31's MDS indicated he was cognitively intact, rejected cares four to six of the seven days. During an observation on 2/7/23, at 8:16 a.m. there was a strong odor of urine, R31's urinal was hanging on the trash can next to his bedside it was empty. During an observation on 2/8/23, at 8:24 a.m. R31's door was closed, after knocking on the door and being given permission to enter a strong odor of urine was noted. R31's urinal was noted hanging on the trash can with about 100 milliliters of urine. During an interview on 2/8/23, at 7:41 a.m. licensed practical nurse (LPN)-D verified there was a strong odor of urine when she went into his room to give him his medications. LPN-D stated she thought he spilled his urinal a lot. During an interview on 2/8/23, at 9:21 a.m. housekeeper (H)-A verified there was a strong odor of urine in R31's room. She stated R31 would sometimes urinate in the trash can. She stated she would mop at least three times in a shift. During an interview on 2/9/23, at 11:10 a.m. the administrator stated odors needed to be addressed and interventions put into place to neutralize the odor. R11's Admission Record dated 2/9/23, indicated	F 584	Audits will be completed on 5 residents identifying urinal and urine catheter bag emptying, clean linen on resident beds, and wheelchair condition weekly x3 weeks, and then monthly x2 months. Audits and findings will be reported to QAPI committee for further recommendations.¿¿ Corrections will be monitored by:¿ Director of nursing or designee.	

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F 584	Continued From page 13	F 584		

R11 had diagnoses which included chronic kidney disease stage three (mild to moderate damage to kidneys and they are less able to filter waste), muscle weakness, and legal blindness.

R11's quarterly MDS dated 2/8/23, indicated R11 was cognitively intact, had no rejections of care, required supervision with toilet use, and was occasionally incontinent of urine.

During an observation on 2/6/23, at 2:41 p.m. a yellow stain approximately two feet by one foot was noted in the middle near the left edge of the bottom sheet of his unmade bed.

During an observation on 2/7/23, at 3:22 p.m. R11's bed was unmade, the yellow stain remained on the bottom sheet.

During an interview on 2/8/23, at 7:39 a.m. nursing assistant (NA)-K stated she saw the yellow stain on R11's bottom sheet that morning. NA-K verified R11 did not make his own bed and the staff should have been checking his bed daily, changing the sheets as needed, and making his bed. NA-K stated he was continent of bladder but would sometimes spill his urinal. NA-K stated someone should have made his bed over the last two days and noticed the bottom sheet needed to be changed.

During an interview on 2/9/23, at 9:57 a.m. the DON stated bed linens should be changed whenever they were soiled, on bath day, and as needed. The DON stated NAs should be checking resident's beds and making the bed and/or changing the linens as needed.

During an interview on 2/9/23, at 11:10 a.m. the

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F 584	Continued From page 14 administrator verified resident bed linens should be checked and changed when they are soiled. R2's Admission Record dated 2/9/23, indicated R2 had diagnoses which included epilepsy, chronic obstructive pulmonary disease (a group of lung diseases that block airflow and make it difficult to breathe), hypotension, age-related osteoporosis, and post-traumatic stress disorder. R2's quarterly MDS dated 12/2/22, indicated R2 was cognitively intact and had no rejections of care. In addition R2's MDS indicated he was independent with bed mobility and transfers. On 2/6/23, at 3:03 p.m. R2's wheelchair was parked next to his bed, he was seated on his bed. On the right side of R2's wheelchair there were rivets missing (two of the four rivets were torn from the rivet and being held by the underside material of the wheelchair and the front and back rivet were no longer attached to the chair seat). On 2/8/23, at 9:05 a.m. occupational therapist (OTR)-H verified R2's wheelchair seat was being held in place with two rivets. OTR-H stated he would have expected staff to notice the wheelchair seat needed repair and would have expected them to fill out a repair slip. On 2/8/23, at 9:08 a.m. nursing assistant (NA)-B, verified the wheelchair material was torn away from the rivets and the wheelchair material was no longer being held by the front and back rivets. On 2/8/23, at 9:19 a.m. regional maintenance director (RMD)-A stated he had just received a request to fix R2's wheelchair, he stated he thought it was the first request.	F 584		

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F 584	Continued From page 15 On 2/8/23, at 10:00 a.m. maintenance director (MD)-B reviewed his work orders and stated he did not see any work orders for R2's wheelchair. On 2/9/23, at 10:01 a.m. the DON stated she would expect staff to note equipment that was in need of repair and would expect them to fill out a maintenance request for repair or tell the nurse. The DON added all staff know how to fill out repair slips. On 2/9/23, at 11:10 a.m. the administrator stated she would expect staff to note resident equipment that was not safe for their use, remove it and fill out a maintenance request for repair. The facility policy titled Maintenance Service dated 12/2009, did not address how staff made work order requests. R53's diagnosis included: bacteremia, retention of urine, flaccid neuropathic bladder, nodular prostate with lower urinary tract symptoms, urinary tract infection, and chronic cystitis without hematuria. Document review of Significant change Minimum Data Set (MDS) assessment dated 11/6/22 indicated R53 had intact cognition and required assistance of staff with bowel and bladder needs. Document review of R53's care plan had a focus area of alteration in elimination for resident. Interventions included assist of 1 with toileting, provide assistance with peri-cares morning,	F 584		

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bedtime and as needed, provide incontinent products and assist to change as needed, monitor Foley catheter output, change Foley catheter per policy, Foley catheter care per policy.

During an observation on 2/6/23, at 7:00 p.m. R53's catheter bedside bag was hanging from the frame of the bed. The catheter bag was not connected to the resident and contained approximately 700 cc gold-colored urine.

During an interview on 2/6/23, at 7:02 p.m. R53 stated he asked the staff to empty the urine multiple times since he got up at noon. R53 stated bag had not been emptied since he went to bed the night before. R53 stated he independently empties his leg bag into the urinal throughout the day and the staff empty the urinal. R53 stated that there had been a delay in emptying the bedside bag several times in the previous week.

During an interview on 2/6/23, at 7:46 p.m. R53 stated nursing assistant (NA)-C emptied the urine from the bedside bag.

During an interview on 2/6/23, at 7:47 p.m. NA-C stated urine was emptied when R53 asked for it to be emptied. NA-C stated the day shift usually empties it.

During an interview on 2/6/23, at 7:48 p.m. LPN-C stated staff should be emptying the bedside catheter bag during the day for the purpose of infection control.

Document review on 2/6/23, indicated that R53 was currently being treated for a bladder infection with Bactrim DS (antibiotic) twice daily for 7 days,

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F 584	Continued From page 17 started 2/2/23. R53 also was taking Keflex (antibiotic) twice daily 500 mg indefinitely. During an interview on 2/9/23, at 3:50 p.m. director of nursing (DON) and assistant director of nursing (ADON) DON stated catheter bags should be emptied when residents get up in the morning. ADON stated reason to empty bags was for infection control. R57 During observation on 2/9/23, at 9:53 a.m. certified nursing assistant (CNA)-F was cutting R57's fingernails in the dining room, with fingernails falling to the floor. During an interview on 2/9/23, at 9:54 a.m. licensed practical nurse (LPN)-C stated residents' nail care should not be completed in the dining room. During an interview on 2/9/23, at 10:09 a.m. CNA-F stated fingernails should not be cut in the dining room. During an interview on 2/9/23, at 3:29 p.m. the director of nursing (DON) and assistant director of nursing (ADON) stated residents should receive nail care assistance in their room or in the shower room on their bath day, for dignity reasons. Review of catheter care policy, dated September 2014 indicated in the infection control section, d) empty the collection bag at least every eight hours.	F 584		
F 641 SS=D	Accuracy of Assessments	F 641		3/24/23

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F 641	Continued From page 18 CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to complete all sections on the Minimum Data Set (MDS) for 1 of 1 residents (R26) reviewed for resident assessment. Findings include: The Centers for Medicare and Medicaid (CMS) Long-Term Resident Facility Assessment Instrument (RAI) 3.0 User's Manual dated 10/2019, "OBRA-required comprehensive assessments include the completion of both the MDS and the CAA process, as well as care planning. Comprehensive assessments are completed upon admission, annually, and when a significant change in a resident ' s status has occurred or a significant correction to a prior comprehensive assessment is required." Section C: identified cognitive patterns, "Determine the resident's attention, orientation, and ability to register and recall information." Section D: identified mood, "Identify signs and symptoms of mood distress." R26's admission MDS dated 1/6/23, indicated R26 had diagnoses which included atrial fibrillation (an irregular often rapid heart rate that commonly causes poor blood flow), heart failure (a chronic condition in which the heart doesn't pump blood as well as it should), hypertension, diabetes mellitus, hyperlipidemia, arthritis, and	F 641	Immediate Corrective Action:¿¿¿ Staff member responsible for completing section C and D educated on need for timely/accurate MDS completion. Corrective Action as it applies to others:¿¿ The MDS Completion and Submission Policy was reviewed and remains current. All residents' most recent MDS will be reviewed to ensure that all sections were completed. All staff that complete sections on MDS were educated on the need to complete sections completely and timely. Date of Compliance:¿ ¿3/24/23 Recurrence will be prevented by:¿¿ 5 residents' MDS will be audited weekly x3 weeks and then monthly for 2 months to ensure that all sections of MDS were	

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F 641	Continued From page 19 anxiety. R26's admission MDS dated 1/6/23, section C-Cognitive patterns revealed the following: C0100 Should Brief Interview for Mental Status be completed? This was documented as yes. section C0200 was not completed section C0300 was not completed section C0400 was not completed section C0500 had a dash section C1310 had dashes R26's admission MDS dated 1/6/23, section D-Mood. D0100 Should resident mood interview be completed? this was documented as yes. section D0200 had only dashes section D0300 had only dashes section D0500 had only dashes section D0600 had only dashes During an interview on 2/8/23, at 3:53 p.m. the director of nursing reviewed R26's admission MDS dated 1/6/23, and verified sections C and D were not completed and should have been completed. The DON stated these should have been completed, she stated she is the person responsible for submitting the MDS but does not check to see if all staff involved in the completion of the MDS have completed their portions. During an interview on 2/9/23, at 9:14 a.m. regional social service consultant (RGSC)-A verified the team would be expected to complete sections C and D for the admission MDS and they should have been communicating with each other prior to submitting. RGSC-A stated the	F 641	completed timely and are complete. Audits and findings will be reported to QAPI committee for further recommendations.¿¿ Corrections will be monitored by:¿ Social Services Director or designee.	

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F 641	Continued From page 20 assessments were important because they drive care for the residents. The facility policy titled MDS Completion and Submission Timeframe's revised 7/2017, directed staff to do the following: "The Assessment Coordinator or designee is responsible for ensuring that resident assessments are submitted to CMS ' QIES Assessment Submission and Processing (ASAP) system in accordance with current federal and state guidelines."	F 641		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure nail care and grooming was completed for 2 of 3 residents (R26 and R60) reviewed for personal cares. Findings include: R26's admission Minimum Data Set (MDS) assessment dated 1/6/23, indicated R26 had diagnoses of atrial fibrillation (an irregular often rapid heart rate that commonly causes poor blood flow), heart failure (a chronic condition in which the heart doesn't pump blood as well as it should), hypertension, diabetes mellitus, hyperlipidemia, arthritis, and anxiety. R26's admission MDS did not address cognition or	F 677	Immediate Corrective Action:¿¿¿ F26's nails were clean and trimmed. F60's face was shaved. Corrective Action as it applies to others:¿¿ The policy titled "Assistance with Activities of Daily Living (ADLs)" has been reviewed and remains current. ¿ All residents/family members were	3/24/23

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F 677	Continued From page 21 personal hygiene. R26's care plan identified a self care deficit, interventions were for staff to assist with personal hygiene. On 2/6/23, at 6:25 p.m. R26's nails were observed to be long with a brown substance under them. On 2/8/23, at 2:22 p.m. R26 was eating his lunch, he looked at his fingernails and said they were getting long (thumb nails were about a quarter of an inch in length with brown substance under them). R26 stated they were too long and were snagging on fabric, he said he wasn't sure who was responsible for cutting his nails. During an interview on 2/8/23, at 7:34 a.m. nursing assistant (NA)-K stated the hospice aides helped R26 with his shower. During an interview on 2/8/23, at 2:24 p.m. NA-B stated the hospice aides were helping R26 with his shower and they were responsible for nail care. During an interview on 2/8/23, at 2:50 p.m. licensed practical nurse (LPN)-D, verified R26's nails were long and had a brown substance under them. During an interview on 2/9/23, at 9:55 a.m. the director of nursing (DON) stated nail care should be done weekly for residents on their bath day. The DON stated she would expect any nursing staff to perform nail care if they noted a resident's nails were long and had a brown substance under them.	F 677	reviewed to get resident preference on nail length and what their hair removal preferences are and care plan will be updated. All residents were reviewed to ensure that their nails have been cut (per preference) and cleaned. All residents were reviewed to ensure that they have received hair removal (per preference.) Education will be provided to direct care staff including CNA, TMA, LPN, and RN¿on the policy titled “Assistance with Activities of Daily Living (ADLs)”¿specifically on provider nail care including trimming and cleaning and hair removal per care plan. Date of Compliance:¿ 3/24/2023¿ Recurrence will be prevented by:¿¿ 5 residents will be audited weekly x3 weeks, and monthly x2 months to ensure residents are receiving nail and hair removal care per preference as well as nails being cleaned. Audits and findings will be reported to QAPI committee for further recommendations.¿¿	

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F 677	Continued From page 22 R60 R60's admission Minimum Data Set (MDS) assessment dated 1/12/23 indicated R60 had memory problems and severely impaired cognitive skills. MDS indicated R60 had preferences with his care and required assistance or supervision of one staff for personal grooming and hygiene needs. Document review indicated R60 had medical diagnosis of Parkinson's disease, metabolic encephalopathy, and dementia. R60's care plan indicated R60 had a self-care deficit. Interventions included assist with bathing, assist with dressing, and assist with personal hygiene. During an observation on 2/6/23, at 7:12 p.m. R60 had white facial hair on cheeks, chin, and above upper lip. During an observation on 2/7/23, at 9:31 a.m. R60 had white facial hair on cheeks, chin, and above upper lip. During an interview on 2/7/23, at 9:29 a.m. R60's wife stated R60 likes to be clean-shaven. R60's wife stated she recently had to buy R60 a new electric razor. During an observation on 2/7/23, at 3:06 p.m. R60 had facial hair on cheeks, chin, and above upper lip.	F 677	Corrections will be monitored by:¿ Director of Nursing or designee.¿	

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F 677	Continued From page 23 During an observation on 2/8/23, at 10:06 a.m. R60 had facial hair on cheeks, chin, and above upper lip. During an interview on 2/9/23, at 5:18 a.m. licensed practical nurse (LPN)-A stated cares were outlined in the care plans in each resident's chart and in the pocket care plans in the binder for the nursing assistants. During an observation on 2/9/23, at 10:55 a.m. observed R60 to have facial hair on cheeks, chin, and above upper lip. During an interview on 2/9/23, at 10:56 a.m. nursing assistant (NA)-D stated staff were responsible to shave resident or supervise R60 while he shaved himself. NA-D stated she would shave him soon. A policy on activities of daily living policy was requested but not provided.	F 677		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.	F 688		3/24/23

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F 688	Continued From page 24 §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure restorative therapy services were completed for 1 of 3 (R42) residents evaluated for limited range of motion. Findings include: R42's annual Minimum Data Set (MDS) dated 2/3/23, indicated the facility was unable to determine R42's cognitive impairment level. He required total assistance for all activities of daily living (ADL's). Diagnoses included respiratory failure, malnutrition and diabetes. R42's annual care area assessment dated 1/24/22, indicated cognitive loss, falls and feeding tube were special areas of consideration. The care area assessment is specialized areas of care that were specific to R42 and needed to be addressed to assist in specialized care he needed. Restorative orders dated 2/1/22, indicated R42 had passive range of motion (PROM) to both upper and lower extremities. R42's care plan dated 1/26/23, indicated restorative nursing with interventions included active range of motion to bilateral wrists and hands, PROM to elbows and shoulders. PROM to bilateral upper and lower extremities would be	F 688	Immediate Corrective Action:¿¿¿ R42 received his exercises as identified in his restorative program. Corrective Action as it applies to others:¿¿ The policies titled “Restorative Nursing Services” and “Resident Mobility and Range of Motion” have been reviewed and remain current.¿ All resident restorative programs will be reviewed by the clinical nursing department to ensure that the programs continue to be appropriate and referred to therapy for re-evaluation if they feel programs may need to be changed. Education will be provided to direct care staff including CNA, TMA, LPN, and RN¿on the policies titled “Restorative Nursing Services” and “Resident Mobility and Range of Motion” specifically on the need to provide any restorative nursing services as identified on their care plan. Date of Compliance:¿ 3/24/2023¿	

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F 688	Continued From page 25 completed twice a week. R42's care sheet undated, indicated restorative nursing would be completed twice a week. R42's Restorative therapy documentation from 1/11/23, to 2/9/23, was reviewed and indicated R42 received five of the eight restorative therapy sessions he was suppose to have. During an interview on 2/7/23, at 9:24 a.m. nurse assistant (NA)-F stated the facility had a restorative aide, however the facility would pull them from their restorative duties and would work the floor " all the time". The NAs already assigned to the floor would attempt to perform restorative services when they could, but restorative was not getting done like it would be ordered. As a result of this, NA-F stated many residents did not receive their restorative sessions timely. NA-F stated restorative nursing was identified on the care sheets and on the care plan. NA-F indicated she was aware R42 was to receive restorative services however some sessions were missed. During an interview on 2/8/2023, at 3:24 p.m. occupational therapist registered (OTR)-H stated nursing department had stopped the restorative therapy program due to the restorative aid was always pulled to the floor. Therapy would continue to make referrals for restorative and the NAs working the floor would attempt to perform restorative therapy treatments when there was time. OTR-H stated R42 was on restorative therapy services, but several treatments had been missed. During an interview on 2/9/23, at 10:24 a.m. physical therapist registered (PTR)-G stated she	F 688	Recurrence will be prevented by:¿¿ Restorative therapy services will be audited on 5 residents weekly x3 weeks, and monthly x2 months to ensure that residents are receiving restorative therapy per care plan. Audits and findings will be reported to QAPI committee for further recommendations.¿¿ Corrections will be monitored by:¿ Director of Nursing or designee. ¿	

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F 688	Continued From page 26 had set up a restorative program for R42 on 7/22. PTR-G indicated she was aware residents were not receiving their restorative sessions as ordered by therapy. PTR-G stated she performed an evaluation of R42 and there had been a decline in his knee movement since discontinued from therapy. During an interview on 2/9/23, at 2:00 p.m. the assistant director of nursing (ADON) stated staff were expected to perform restorative nursing as ordered to prevent decline in range of motion. Review of facility policy titled, Restorative Nursing Services dated 7/17, indicated residents would receive restorative nursing care which promoted optimal safety and independence.	F 688		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to accurately and compressively assess safe smoking practices and implement identified interventions for 1 of 1 residents (R21) reviewed for safe smoking practices. Findings include:	F 689	Immediate Corrective Action:¿¿¿ R21's was reassessed for smoking safety. Corrective Action as it applies to others:¿¿	3/24/23

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F 689	Continued From page 27 R21's Admission Minimum Data Set (MDS) dated 10/29/22, indicated R21 had moderate cognitive impairment. Diagnoses included acute renal failure, urinary tract infection, anxiety disorder and blindness in one eye, unspecified. One person assist was required for activities of daily living (ADL) except eating, which was independent. R21's admission care assessment area (CAA) indicated cognitive loss/dementia, ADL functional and falls were triggered as special care focus areas related to resident care. Review of R21's smoking evaluation form dated 10/24/22, indicated R21 did not have a history of cognitive loss, visual deficit, or dexterity problems. Identified R21 could safely light and hold her cigarette. Indicated R21 did not require any adaptive equipment such as a smoking apron, supervision or individualized care plan. The only intervention identified was R21's cigarettes would be stored in the nursing cart. R21's care plan dated 10/26/22 indicated an alteration in cognition and vision related to acute kidney failure, alcoholic hepatitis and blindness in one eye. The care plan lacked data related to resident safety when smoking. On 2/9/23, at 10:18 R 21 was observed on the outside patio smoking by herself. She did have a noted tremor to her right hand and arm, which was the hand that she held her cigarette in. During an interview on 2/7/23, at 4:26 p.m. R21 stated she was allowed to go out to smoke independently and kept her cigarettes with her at all times. R21 removed her cigarettes from her	F 689	Smoking policy was reviewed and remains current. All residents who identify as smokers will be audited to ensure their smoking assessment is current and accurate.¿Care plans will be updated if safety interventions are put into place. Education will be completed with all clinical staff that complete the smoking assessment if there is a change in smoking status. Education will be provided to direct care staff including CNA, TMA, LPN, and RN¿on the policy titled “Smoking Policy” specifically following care plan with regards to providing smoking interventions as appropriate and notifying clinical leadership team if there are concerns with a resident smoking such as burn marks on skin, burn holes in clothing, etc. Date of Compliance:¿ 3/24/2023¿ Recurrence will be prevented by:¿¿ 5 residents who smoke will be audited weekly x3 weeks, and monthly x2 months to ensure that residents have had an accurate smoking assessment completed	

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F 689	Continued From page 28 coat pocket at that time. R21 stated she was completely blind in her left eye and had 50% blindness in her right eye. R21 indicated her best vision was shadows in the left eye and blurred lines in the right eye. R21 stated she did have an occasional tremor in her right hand and arm, which she confirmed was the hand she held her cigarette in. R21 indicated she had burned her clothes recently due to the tremor. She stated the clothing was currently in the laundry. During an interview on 2/9/23, at 11:48 a.m. licensed practical nurse (LPN)-B stated residents who had restrictions such as smoking would be identified in the care plan. She stated there were no current residents who were expected to keep their cigarettes in the nursing cart. LPN-B reviewed R21's smoking assessment and confirmed R21's cigarettes should have been stored in the nursing cart however had not been. On 2/9/23, at 12:11 p.m. R21 was observed in her room holding a wine (red) colored pair of sweat pants which were folded up. R21 unfolded the sweat pants and pointed to the right inner thigh area which had five small holes present and black charring noted between two of the bigger holes. R21 confirmed the holes and charring were from dropping hot cigarette ashes on her while outside smoking in the last month. During an interview on 2/9/23, at 12:47 p.m. LPN-E stated when she completed smoking assessments, she would observe the residents smoke and if they were able to light the cigarette and hold it safely, there would be no restrictions. LPN-E stated she was unaware of R21's documented confusion and diagnosis of blindness, but it would not have made a	F 689	and staff are providing safe smoking interventions as appropriate. Audits and findings will be reported to QAPI committee for further recommendations.¿¿ Corrections will be monitored by:¿ Director of Nursing or designee. ¿	

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F 689	Continued From page 29 difference in her assessment. LPN-E reviewed R21's smoking assessment and acknowledge she had marked no on cognitive concerns and and vision deficit. They should have been marked. During an interview on 2/9/23, at 2:00 p.m. the assistant director of nursing (ADON) stated stated staff were expected to review the resident's diagnoses, MDS and observe the resident smoking when they completed the smoking assessment. ADON stated interventions would be determined based on the results of the assessment. Review of facility policy titled, Resident Smoking Policy last revised 10/22, indicated all residents who smoke would be evaluated on admission. The intent of the policy was to outline the procedure for safe resident smoking, which included evaluation to determine those who would be capable to smoke independently or who needed adaptive equipment.	F 689		
F 693 SS=D	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was	F 693		3/24/23

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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 693	Continued From page 30 clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure appropriate interventions were taken to reduce the risk of aspiration and ensure the product and equipment was not expired prior to use for 2 of 2 residents (R42 and R49) reviewed for tube feedings. Findings include: R42's annual Minimum Data Set (MDS) dated 2/3/23, indicated the facility was unable to determine R42's cognitive impairment level. Identified R42 required total assistance for all activities of daily living (ADL's). Diagnoses included respiratory failure, malnutrition and diabetes. Indicated R42 received 54% or more of his daily nutrition through tube feeding. The annual care area assessment dated 1/24/22, indicated cognitive loss, falls and feeding tube were special areas of consideration. The care area assessment is specialized areas of care that were specific to R42 and needed to be addressed to assist in specialized care he needed. R42's Order Summary Report dated 1/22/21, identified R42 was to have nothing by mouth	F 693	Immediate Corrective Action:¿¿¿ The staff that cared for R42 was educated on the need to have tube feeding stopped if lying resident flat for cares and to restart when they are in the appropriate position. F49 was provided with a fresh tube feeding formula with a catheter tip cap. Corrective Action as it applies to others: The tube feeding policy was reviewed and remains current. Residents who received tube feedings will be reviewed to ensure that their care plan is updated to have tube feeding stopped by nurse if resident has to be placed flat in bed for ADLs. All tube feeding supplies in the building will be audited to ensure that any expired	

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F 693	Continued From page 31 (NPO). Orders dated 11/25/22, indicated R42 had a tube feeding which consisted of Jevity 1.5 running at 60 milliliters (ML) per hour 24 hours a day. Orders dated 6/3/22, indicated R42's head needed to always be elevated 45 degrees due to risk of aspiration. R42's progress notes from 2/6/22, to 2/6/23, were reviewed and indicated the following: -R42 was hospitalized from 2/26/22, to 3/2/22, for aspiration pneumonia. -R42 was hospitalized from 3/23/22, to 3/25/22, for aspiration pneumonia and sepsis. -R42 was hospitalized from 4/20/22, to 4/25/22, for acute respiratory failure with hypoxia and aspiration pneumonia. -R42 was hospitalized from 8/31/22, to 9/6/22, for aspiration pneumonia and sepsis due to pseudomonas of the sputum. During an observation on 2/8/23, at 9:58 a.m. registered nurse (RN)-C entered R42's room and laid his head of the bed flat. RN-C performed trachea cares which consisted of changing trachea ties and suctioning R42. RN-C rolled R42 side to side to observe his buttocks and lifted both of R42's feet to observe his feet. RN-C proceeded to clean R42's room and removed trash from the room while R42's head remained flat. RN-C re-entered R42's room, elevated his head back to 45 degrees and exited the room at 10:21 a.m. During an interview on 2/8/23, at 10:35 a.m. RN-C stated R42's head should always be elevated. RN-C confirmed the tube feeding had still been running when R42 was laying flat. RN-C stated she was not aware staff were expected to stop tube feedings when a R42 was	F 693	formula is disposed of. All residents who receive tube feeding will be reviewed to ensure that they have feeding tube catheter tips capped when not in use. CNAs, TMAs, and Nurses will be educated on the policy titled “Tube Feeding” specifically regarding need to notify nurse to hold/stop tube feeding process if resident needs to be lied flat in bed. All nurses will be educated on the policy titled “Tube Feeding” specifically regarding the need to check the expiration date on tube feeding formula located on the package prior to administration and to dispose of any formula that is expired. They will also need to be educated on the need to mark the package with the date and time that it was opened/used to notify staff when it expires after opening and to cover container and place in fridge when not in use. They will also be educated on the need to cap the feeding tube catheter tip when not in use. Education will also need to be completed that when taking a tube feeding formula out of the fridge, staff need to check the date/time it was opened and dispose if it has been over 24 hours. If the formula was not placed in the fridge, the formula will need to be disposed of if it has been out for over 4 hours.	

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F 693	Continued From page 32 laying flat due to increased risk of aspiration. During an interview on 2/8/23, at 12:10 p.m. the nurse practitioner (NP)-F stated laying a resident flat while a tube feeding was running would increase the resident's risk of aspiration. NP-F confirmed R42 was at a high risk of aspiration. During an interview on 2/9/23, at 2:00 p.m. the assistant director of nursing (ADON) stated staff were expected to stop the tube feedings when a resident needed to be laid flat for any reason. R49 R49's quarterly Minimum Data Set (MDS) dated 1/20/23, indicated moderated cognitive deficiency. R49 required extensive assistance with all ADL's. She required mechanical lift for all transfers. Diagnoses included Hemiplegia or Hemiparesis (loss of use of one side of the body), seizure disorder and anxiety disorder. R49's care area assessment (CAA) dated 10/21/22, indicated cognitive loss/dementia, ADL functional, falls and tube feeding were triggered as special focus areas for cares. R49's Order Summary Report dated 1/24/23, indicated R49 had tube feeding Jevity 1.5 to run at 50 ml (milliliter) per hour from 7:00 p.m. to 7:00 a.m. During observation on 2/7/23, at 10:22 a.m. R49's tube feeding was disconnected and the purple catheter tip was pointed upward and uncapped. The date on the bottle indicated last changed 2/6/23, at 10:00 p.m.	F 693	Date of Compliance:¿ 3/24/2023¿ Recurrence will be prevented by:¿¿ All resident who receive tube feedings will be audited weekly x3 weeks, and monthly x2 months to ensure that tube feeding formula is not expired, packaging is marked with date/time opened, that formula is properly being stored if not in use after being opened and disposed of accordingly, that feeding tube catheter tip is capped when not in use, and that resident’s tube feeding is held/stopped if resident is every laid flat in bed. Audits and findings will be reported to QAPI committee for further recommendations.¿¿ Corrections will be monitored by:¿ Director of Nursing or designee.¿	

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F 693	Continued From page 33 During observations on 2/7/23, at 3:30 p.m. R49's tube feeding was still disconnected and the purple catheter tip was pointed upward and uncapped. The same dated bottle was hanging and 750 ml of tube feeding was left in the bottle. During observations on 2/8/23, at 7:05 a.m. R49 was laying in bed and the tube feeding catheter was connected to R49's gastric tube and tube feeding ran through the tube at 50 ml per hour. The date on the bottle that was hung at that time was dated 2/6/23, at 10:00 p.m. registered nurse (RN)-B entered room, placed on gloves, disconnected the tube feeding catheter from R49's gastric tube and hung the tube feeding catheter on the hook on the pole. The purple tip was not capped. During an interview on 2/8/23, at 7:19 a.m. RN-B stated tube feeding bottles were only good for 24 hours and then would be changed. RN-B looked at the tube feeding bottle that hung at that time and confirmed the date and time on the bottle was 2/6/23, at 10:00 p.m. She stated she should have changed the bottle before 10:00 p.m. on 2/7/23 but had not done it. RN-B stated bottles needed to be changed prior to 24 hour mark because the longer they hung after 24 hours the higher the risk of infection the resident would have. During an interview on 2/8/23, at 3:10 p.m. registered dietician (RD)-E stated tube feeding bottles had to be changed every 24 hours to decrease the risk of infection for the resident. During interview on 2/9/23, at 2:00 p.m. the assistant director of nursing stated staff should change the Tube feeding per facility protocol to	F 693		

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F 693	Continued From page 34 prevent infection. Facility policy Tube Feeding last revised 9/21 indicated all residents on tube feeding would be monitored. It did not discuss information about how long tube feeding was good for.	F 693		
F 755 SS=F	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in	F 755		3/24/23

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F 755	Continued From page 35 order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: The facility failed to ensure a system was in place for tracking and monitoring, and managing received prescription medications stored within the facility medication rooms. On 2/8/23, at 11:48 AM licensed practical nurse (LPN)-C gave a tour of Wing four medication room. There were bins with medication cards on the counter. LPN-C stated the medications were not meds for destruction, all those meds go to the director of nurse's (DON's) office and some medications get sent back to the pharmacy for a credit and some get destroyed. 2/8/23, at 12:08 p.m. during a tour of the medication room on wing three registered nurse (RN)-A stated the extra cards of prescription medications were overflow medications for residents. RN-A stated scheduled medications like narcotics would not be kept in there with the surplus medications, but other that, any medication that was not in the narcotic count, could be in surplus storage. On 2/8/23, 3:01 p.m. LPN-D entered the medication room for the 200's hallway. to LPN-D explained the bins of medications stored up to a three-month supply of extra medication cards for each resident so when a card was empty, a new one could be grabbed from the medication room to replace it. LPN-D stated she believe the pharmacy service did two runs a day to the facility with medications.	F 755	Immediate Corrective Action:¿¿¿ Pharmacy was consulted to ensure facility is only receiving 30 day supply of resident medications when ordered by staff. Medication Rooms and Carts were reorganized to ensure that current active resident medication cards were placed in med carts and overflow meds are organized by resident name in medication room. All meds that needed to be returned to pharmacy for credit were placed in specific bins/bags for floor nurse to give to pharmacy when meds are delivered. All meds that needed to be destroyed were destroyed per policy. Corrective Action as it applies to others:¿¿ The policy titled “Storage of Medications” was reviewed and remains current. Since immediate correction actions have been completed, medication rooms and carts were observed again to ensure that current active resident medication cards are being placed in med carts and overflow meds are organized by resident	

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F 755	Continued From page 36 On 2/10/23, at 09:02 a.m. trained medication aid (TMA)-C stated there is no tracking when I take a card out of the surplus supply in the medication room. If you are low on a medication, you can go into the medication administration record and see when it was last ordered. For instance, I can see this was reordered on the 25th, so I know I don't need to order it. It does not say how many cards were ordered on the 25th, just the date last ordered. If I ran out of a medication, I could check the med room for more cards, and if I attempt to order and it's too soon, the pharmacy may not let me send the reorder request in. On 2/10/23, at 9:16 a.m. the DON pulled the ADON, the administrator and the assistant administrator (AA) into an interview regarding medication management in the facility. The administrator stated the facility uses Polaris connect to order medications. The administration team and the nurse leadership team can see what has been delivered. The group shared that anyone working the cart can put a request in for medication refills. The AA stated if staff go to reorder, the pharmacy will decline the refill if something has been ordered too soon. The system tells whoever is ordering when something was last ordered but it does not tell how many cards were ordered. The administrator stated I don't know if there is a particular process to track medication non-narcotic prescription medication in the building. Regarding diversion of the surplus medications, only the ADON, the two LPN care coordinators and each staff person working the cart would have access to the medication room at any given time. The administrator stated our biggest clue would be if we tried to order something and the	F 755	name in medication room. Also, that meds that needed to be returned to pharmacy for credit were placed in specific bins/bags for floor nurse to give to pharmacy when meds are delivered and all meds that need to be destroyed were destroyed per policy. Nurses and TMAs will be educated on the policy titled “Storage of Medications” and on the need to keep as many medication cards in locked medication cart as possible and to only place overflow medications into locked med room into designated area separated by resident name to keep all residents’ medications individually separated. They will also receive education on which meds are designated to be returned for credit when pharmacy comes to building and to notify clinical leadership if there are meds to be destroyed in med room so they can be removed timely. Date of Compliance:¿3/24/2023 ¿ Recurrence will be prevented by:¿¿ Medication Carts and Medication Rooms will be audited weekly x3 weeks, and monthly x2 months to ensure meds continue to be organized and separated in med room/carts, returnable meds are sent back to pharmacy, and non-returnable meds are disposed of timely. Audits and findings will be reported to QAPI	

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F 755	Continued From page 37 pharmacy would not refill it then we would maybe know something was taken. All agreed the facility did not have a process in place to account for how many medications were in the facility for each resident, or a process to track when medications go in and out of the surplus medication supply located in the medication rooms. AA stated medications can be tracked at the entrance into the facility but after that, they do not track the prescription medications cards. The administrator stated administration and nursing leadership would all get alerts and reports from the pharmacy when medication reorder requests are made to soon and indicated the team mostly monitors for narcotics, and the facility has not had issues with narcotics refill requests being requested too soon. All agreed, that the pharmacy would give a credit on most medications sent back to the pharmacy. All also believed that the surplus medications were updated with a sticker that stated see orders new order so that staff would look at the order in the EMR and not the order on the card before dispensing medication from the card once it was pulled to the cart. On 2/10/23, at 9:30 a.m. TMA-B stated when a medication order changes, we pass it on at shift change. We also put the change of order sticker on the medication card cards. We should put the sticker on all the medications in surplus too, but it doesn't always happen. Sometimes I put the sticker on the surplus but not always. It has been my experience that when I pull a card it does not always have the order change sticker on it, so I often have to sticker cards when I pull them from surplus.	F 755	committee for further recommendations.¿ Corrections will be monitored by:¿ Director of Nursing or designee.¿	

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F 755	Continued From page 38 2/10/23, at 9:56 a.m. the administrator and AA acknowledged the facility did not have a process to track what happens to non-controlled prescription medications once they are in the building. Both indicated they watch the pharmacy notices for refills that occur too soon. The AA stated the old pharmacy system they used only sent a two-week supply of drugs at a time, but since the new pharmacy allows it, the facility has been keeping a one-to-three-month surplus supply of most prescription medications. The other difference is the new pharmacy will only package one pill per bubble tab so sometimes six cards may be needed for a 30-day supply when multiple pills equal one dose. The administrator stated we are calling our pharmacy consultant to see if we can get less medications on hand in the facility. On 2/10/23, at 9:35 a.m. the consult pharmacist stated she was not sure why the facility would have up to a three-month supply of prescription medications on hand in the medication rooms. Having medications on hand that are not tracked creates a risk for diversion. It could also create a lot of waste and expense if the patient gets discharged or dies and the medications can't be taken back for credit. More concerning, this creates a big risk for medication errors. A dose change could get missed when pulling a card from storage that still has the old orders on it. In my experience most facilities get medications in 14-, 21-, or 30-day supply and do not have additional medications on hand stored at the facility. The facility provided an inventory of drugs on hand stored on the counter in locked medication rooms: two, three, and four. The count was made	F 755		

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F 755	Continued From page 39 up of individual pill and injectable's. Based on inventory the total approximate medication surplus count for each medication room was Wing two: 4860, wing three: 1721, wing four: 2600 for a total of 9,181 pills and injectable's stored in facility medication rooms. The medication inventory contained medications from the following classes of medications: antipsychotics, antipsychotic-atypical, antidepressant SSRIs, antidepressant SARIs, bi-polar therapy agents, antianxiety, anticonvulsant's, skeletal muscle relaxants, steroids, diuretics, antihyperlipidemics, ace inhibitors, alpha beta blocker, , estrogen hormonal agents, proton pump inhibitors, angiotensin II receptor blockers, platelet aggregation inhibitors, director factor xa inhibitors, thyroid hormones, digitalis glycosides, antiarrhythmics, postherpetic neuralgia agents alzheimer's disease therapy - cholinesterase inhibitors, anticoagulants, allergy, prostatic hypertrophy agent - alpha-1-adreoceptor antagonists, vitamins, cephalosporin antibiotics, hyperuricemia therapy, migraine therapies, bone restoration inhibitors, tetracycline antibiotics, aldosterone receptor agonist, calcium channel blocker, and insulin response enhancers.	F 755		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant;	F 758		3/24/23

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F 758	Continued From page 40 (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication.	F 758		

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F 758	Continued From page 41 This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure a resident was reassessed for continued use of an as needed (PRN) antipsychotic medication (medication used for a variety of mental health disorders), beyond the 14 days for 1 of 5 residents (R33) who received an as needed antipsychotic medication reviewed for unnecessary medications. Findings include: R33's admission Minimum Data Set (MDS), dated 12/28/22, identified R33 was cognitively intact. Diagnoses included Alzheimer's disease, dementia and depression. The MDS indicated R33 received antipsychotics and antidepressants seven days a week. R33's care plan, dated 12/22/22, identified R33 was at risk for adverse reactions due to psychotropic medication use and a goal of R33 would not experience any drug reactions to current psychotropic drug regimen. Indicated R33 had behaviors which included throwing items and calling the emergency room when wanted pain medications. Interventions included redirect resident and document. R33's care plan lacked any specific nonpharmacological (NP) treatments to attempt prior to administering meds. Review of R33's Order Summary Report dated 12/22/22, indicated orders were active for Quetiapine Fumarate (Seroquel) oral tablet 25 milligrams (mg) as needed (PRN) for agitation, confusion 2 times a day. The order did not have a stop date.	F 758	Immediate Corrective Action:¿¿ R33's prn Seroquel was discontinued. Corrective Action as it applies to others:¿¿ Psychotropic Medication Use Policy was reviewed and remains current. All residents were reviewed to ensure that any resident taking prn antipsychotic medications are being reviewed by provider every 14 days either getting an order to d/c or a detailed note for ongoing use. All residents were reviewed to ensure that any resident taking prn psychotropic meds (excluding antipsychotic ones) are reviewed by provider within 14 days and either getting an order to d/c or getting a detailed note on reasons for ongoing use as well as a specific end date for the medication. Education will be provided to clinical leadership staff¿on the policy titled "Psychotropic Medication Use"¿with specifics to ensuring that residents that have prn antipsychotic medications ordered are reviewed by provider every 14 days and need to provide a detailed note on why medication continues to be needed. They will also be educated on ensuring that residents that have prn	

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F 758	Continued From page 42 Review of R33's Medication Administration Records (MAR) dated 1/1/23, to 1/31/23, indicated R33 received 26 doses of the PRN Seroquel that month. R33's progress notes from 1/1/23, to 1/30/23, were randomly compared to the MAR and indicated as follows: -1/28/23, Seroquel was administered at 8:39 a.m. however lacked any documentation of trigger behaviors displayed, NP's attempted or results from medication given. -1/25/23, Seroquel was administered at 8:40 a.m. however lacked any documentation of trigger behaviors displayed, NP's attempted or results from medication given. Progress notes at 6:51 a.m. indicated R33 was pleasant, alert and had no behaviors. -1/17/23, Seroquel was administered at 3:25 p.m. however lacked any documentation of trigger behaviors displayed, NP's attempted or results from medication given. -1/11/23, Seroquel was administered at 6:03 a.m., 3:32 p.m. and 11:03 p.m. There was a note for the 6:03 entry which identified R33 had a complaint of severe pain in his back and pulled his brief off to urinate in the bed. Review of R33's Consultant Pharmacist Medication Regimen Review dated 1/25/23, indicated the pharmacist requested the provider evaluate the appropriateness of the Seroquel and to have placed a new order with a 14 day stop date. The provider responded on the pharmacy request form "order still needed for behaviors,	F 758	psychotropic meds (excluding antipsychotics) are reviewed by provider within 14 days of start of order and either getting order to d/c or getting a detailed note on reasons for ongoing use as well as a specific end date for the medication. Date of Compliance:¿ 3/24/2023¿ Recurrence will be prevented by:¿¿ 5 residents who have prn antipsychotic and psychotropic med orders will be audited weekly x3 weeks, and monthly x2 months to ensure that residents are being reassessed for continued use of medication within timeframe (for antipsychotic meds-every 14 days) and, if not discontinued, that they have a detailed note from provider on why medication needs to be continued and if a non-antipsychotic med, needs to have a specific end date . Audits and findings will be reported to QAPI committee for further recommendations.¿¿ Corrections will be monitored by:¿ Director of Nursing or designee¿	

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F 758	Continued From page 43 continue same".The provider had not performed any face to face visit with R33 prior to this decision. During an interview on 2/9/23, at 10:18 a.m. licensed practical nurse (LPN)-B stated before PRN antipsychotic medications were administered, staff would attempt NP measures to calm the resident down. LPN-B indicated if NP measures were not effective, then medications would be administered. LPN-B confirmed the R33's progress notes lacked identification of trigger behaviors, NP measures taken and results from the medication administered. LPN-B confirmed R33 received too many doses of Seroquel on 1/11/23. LPN-B stated it was important to only use PRN antipsychotics when needed so the resident would stay at baseline as much as possible. During an interview on 2/9/23, at 2:00 p.m. the assistant director of nursing (ADON) stated PRN antipsychotics should only be used when NP measures were attempted and unsuccessful. If antipsychotics were used, staff were expected to document the target behaviors which occurred, the NP measures attempted and the response from the medication. The ADON reviewed the MAR dates and confirmed there was no documentation about why medication was administered. The ADON stated the dose administered on 1/11/23, at 6:03 a.m. was not appropriate based on what was documented. The ADON stated she was not aware PRN antipsychotic medications had to have a 14 day stop date and the provider had to complete a face to face evaluation before another 14-day order was obtained.	F 758		

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F 758	Continued From page 44 During an interview on 2/10/23, at 8:09 a.m. consultant pharmacist (CP) acknowledged she had sent a review in January which requested a revaluation of appropriateness of the prn medication and a new order with a 14 day stop date. The CP reviewed the provider response and stated the response was not appropriate for what is required for PRN antipsychotics orders. Review of the facility policy titled Provider policy Psychotropic Medication Use undated, indicated NP interventions must be attempted, unless contraindicated, and documented. The staff would observe, document, and report to the Interdisciplinary team and primary care provider, the response and effectiveness of any interventions attempted.	F 758		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for	F 761		3/24/23

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F 761	Continued From page 45 storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure medication was properly labeled for 1 of 12 residents(R43) reviewed for medication administration and medication storage. In addition, the facility failed to ensure medication creams, ointments, powders, liquids and an inhaler were properly stored to prevent cross contamination of resident medications for 8 out of 12 residents (R21, R168, R5, R39, R28, R15, R37, R20). The facility also failed to remove 2 tubes (one expired) of medication from the medication cart that were not labeled or stored in a manner to prevent cross contamination. Furthermore, the facility failed to separate biohazard from medication used for residents stored in a refrigerator. During a medication pass observation on 2/8/23, at 7:28 a.m. licensed practical nurse (LPN)-A stated R-43's inhaler did not have a medication label on the actual inhaler because the inhaler box was damaged by water from another medication on ice during transport from the pharmacy. Normally we peel the label off the box and put it directly on the inhaler but since the box was damaged it couldn't be done. LPN-A stated the label on the bag the medication was stored in was adequate labeling. On 2/9/23, at 11:20 a.m. during 200 hallway	F 761	Immediate Corrective Action:¿ R43's had a pharmacy medication label placed on the inhaler. Medication carts were cleaned out and all creams/powders and inhaler were put in separate areas in cart and were individually placed in plastic zip lock bags. Expired meds were removed and disposed per facility policy. Urine sample was removed from med fridge and disposed. Corrective Action as it applies to others:¿¿ The policies titled "Labeling of Medication Containers" and "Storge of Medication" have been reviewed and remain current. ¿ All resident medications will be audited to ensure that they are properly labeled and are being stored appropriately as well as to ensure that there are no expired medications in med carts or med rooms.	

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F 761	Continued From page 46 medication cart review, the third cart drawer had compartments that contained multiple resident's medications. Medications included Lidocaine patches in boxes, inhalers in boxes, liquid medications not in plastic bags and several topical creams and powders not stored within plastic bags or boxes. Medications that were not stored in a box or plastic bag with other resident medications included: _A tube of Diclofenac sodium topical gel with an expiration date of 7/22. The expired medication did not have a patient label on it. LPN-D confirmed that the medication was expired and did not have a patient label. LPN-D removed the medication from the cart and stated it was probably in the cart in case another resident ran out of the same medication. _An open unexpired tube of Nystatin cream 100,000 usp units did not have a patient label on it. LPN-D did not know who the medication belonged to. _R-5's vesta ointment _R-39's nystop powder with instructions apply to groin as needed for yeast _R-38's nystatin powder with instruction to apply to groin peri area as needed. _R15, R37 and R39's liquid medications were stored in the same area as the creams and powders and were not contained in plastic bags. _Multiple other powders were in the shared compartment without being contained in plastic bags. _R20's Symbicort inhaler was in the same compartment amongst the creams, powders, and liquids. The inhaler was not in a bag or box. LPN-D confirmed that powder and cream containers do go into the patient rooms for application. LPN-D agreed there was a risk for	F 761	Med Fridges have been audited to ensure that there were no biological lab specimens stored in them. Nurses and TMAs will be educated on the policies titled “Labeling of Medication Containers” and “Storage of Medication” including ensuring that there is a pharmacy label on all medications including inhalers and, if not available, to contact pharmacy to resend as well as ensuring that creams/powders and inhalers are stored in plastic zip lock bags and kept separate from each other in med cart. They were also educated to remove all expired medications from med carts/room and dispose of per facility policy and that biological lab specimens can’t be stored in med fridge. Date of Compliance:¿ 3/24/2023¿ Recurrence will be prevented by:¿¿ Medications of 5 residents will be audited weekly x3 weeks, and monthly x2 months to ensure all medications have pharmacy labels on them, that med carts have creams/powders and inhalers stored in separate areas in med carts as well as auditing creams/powders and inhalers to ensure that they are stored in plastic zip lock bags, all expired meds were removed from carts/med rooms, and that no biological lab specimens are being stored in med fridge. Audits and findings will be reported to QAPI committee for further recommendations.¿	

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F 761	Continued From page 47 cross contamination when medication was stored together without being in individual boxes or plastic bags. On 02/9/23, at 12:58 p.m. the medication cart in the 400's wing was reviewed with trained medication aide (TMA)-A. R43's Symbicort inhaler was stored in a bag with a pharmacy label on it. The inhaler did not have a label on it. TMA-A stated since a pharmacy label was on the bag the inhaler did not need to have a label on it too. Liquid medications and fiber containers in the cart were not in plastic bags. TMA-A stated liquids and bulk individual fiber supplements did not ever go in resident rooms, so they did not require plastic bags for storage. On 2/9/23, at 1:11 p.m. (LPN)-B opened cart for rooms 314-322 and stated there were two medication carts in the 300 wing, but she was the only one passing medication today. R-21's Miconazole nitrate antifungal powder was not in a plastic bag. The medication was stored in a compartment with multiple other resident medications in bags or boxes. R-168's Nystatin cream was not in a plastic bag and was in a compartment sitting on top of another resident's medication that was stored in a zip lock bag. LPN-B stated topical medications should be stored in individual plastics bag to prevent cross contamination. During an interview on 2/9/23, at 1:28 p.m. both unit coordinator LPN-C and assistant director of nursing (ADON) stated in agreement, medications should all be bagged and stored separately. Regarding the inhaler without a pharmacy label, LPN-C stated the pharmacy has not been consistent with how they send inhalers, sometimes they put it on the inhaler, sometimes	F 761	Corrections will be monitored by:¿ Director of Nursing or designee.¿	

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they put it on the baggie, or just on the box and not on the inhaler. Neither confirmed the inhaler should have a pharmacy label with patient name, medication, and dose directly on the inhaler.

On 2/9/23, at 2:40 p.m. the director of nursing (DON) stated all individual medications should be stored in plastic bags due to the risk of cross contamination. Topical medications should be removed from medication carts when no longer in use, not kept in case another resident runs out. In the case of the inhaler without a label on it in the medication cart, the don stated the label on the baggie the inhaler was stored in was sufficient labeling, the inhaler did not require a label as well. For storage, the don stated an inhaler could be in the bottom cart drawer without being stored in a baggie if it was a discharged resident's inhaler that had been pulled to destroy later. However, if the inhaler belonged to a current resident, then the inhaler should be stored in a plastic bag to prevent it from becoming contaminated by other medications in the cart.

On 2/9/23, at 2:48 p.m. during follow-up the don asked LPN-D what was done with the inhaler stored in the bottom of the cart. LPN-D stated R20's inhaler was removed from the compartment with the unbagged medications, placed it in a bag and put it in the med cart drawer where other resident inhalers were stored. The don stated, "so that is taken care of." Lastly, the don stated she had confirmed the facility weekly medication cart audits included, proper labeling, and medication storage in addition to checking for expiration dates.

During an interview on 2/10/23, at 8:08 a.m. the consulting pharmacist shared the following. It is a

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F 761	Continued From page 49 MN board of pharmacy requirement for the immediate medication container to have a pharmacy label with the resident name, medication, and dose instructions. At the least an inhaler should have a mini label on it. Medication boxes should be labeled with a big label and a little label that peels off to be placed on the inhaler when the box is opened. Medications should be stored in individual bags because the bags create the best barrier to protect medications from contamination, but a box is acceptable as well. I don't know how you could use an inhaler after it was stored in the same compartment with other resident's medicated powders and ointment/creams. Using improperly stored medications is how people can get infections. Infectious disease (referring to providers) would not approve of someone putting an inhaler stored that way into their mouth and inhaling directly into their lungs. Oral medications need to be stored in plastic bags separately from other forms of medications because the risk of infection is higher with oral medications. On 02/08/23, at 11:48 a.m. during a tour of the wing four medication room licensed practical nurse (LPN)-C opened the lab fridge that was directly below the locked medication fridge. The fridge shelf had a urine sample in a specimen cup with three boxes of Bisacodyl 10 mg stimulant laxative suppositories stacked approximately 3 inches away from the urine sample. Two boxes were sealed, and one box had several doses removed from the box. LPN-C closed the fridge and stated the suppository boxes should not be stored in the lab specimen fridge where body fluids were being stored. LPN-C then reopened the fridge, removed the 3 boxes, and stated she was going to destroy the boxes because the	F 761		

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suppositories should not be given to residents after being stored next to a urine sample.

On 2/09/23, at 2:46 p.m. the director of nursing (DON) stated suppositories should not be stored in the lab specimen fridge because of the risk for contamination. The DON stated the suppositories should be thrown away.

During an interview on 2/10/23, at 8:08 a.m. the consulting pharmacist stated medications should be stored in a fridge dedicated to medication storage only, nothing else should be stored in the fridge. The pharmacist further stated medications should be thrown out due to infection risk and unsafe storage.

A list of residents receiving suppositories was requested and not received.

Facility policy Storage of Medications directed staff to store all drugs and biologics in a safe, secure, and orderly manner. The policy did not provide direction specific to infection prevention or the storage of medications requiring refrigeration.

Facility policy Storage of Medications directed staff to store all drugs and biologics in a safe, secure, and orderly manner. Interpretation and implementation included: nursing staff are responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner. Drug containers that have missing, incomplete, improper labels should be returned to the pharmacy for proper labeling before storing and discontinued, outdated, or deteriorated drugs or biologics should be returned

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F 761	Continued From page 51 to the dispensing pharmacy or destroyed. The policy did not have instructions that directed staff on proper storage of medications to prevent medication contamination and spread of infection.	F 761		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §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 document review, the facility failed to maintain clean and sanitary equipment in the main kitchen of the facility. This deficient practice had the potential to affect 61 of 63 residents who were served food from the main kitchen. In addition, the facility failed to ensure refrigerated and dry food items were disposed of after expiration date and were properly labeled and dated when the original packaging was opened in 4 of 4 wings.	F 812	Immediate Corrective Action: The vent hood has been cleaned. Expired Thick and Easy has been disposed of. Expired and unlabeled food in wing refrigerators and personal rooms have been thrown away and cleaned. The Culinary Director educated cold food temperatures to be served. Thermometer was placed in refrigerator on wing 200.	3/24/23

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F 812	Continued From page 52 Findings include: During an observation on 2/6/23, at 1:25 p.m. kitchen hood vent over stove had brownish-gray fuzz-like material moving with air along the black metal frame. During an interview on 2/6/23, at 1:28 p.m. certified dietary manager (CDM) stated it was "probably dust". CDM stated hood vent was last cleaned in March 2022 and it was on the schedule to be cleaned March 2023. During an observation on 2/8/23, at 7:03 a.m. eight yogurt cups on three separate meal tray carts. During an interview on 2/8/23, at 7:04 a.m. with dietary aide (DA)-A stated yogurt placed on trays in kitchen at 7:00 am. During an interview on 2/8/23, at 7:04 a.m. CDM stated yogurt would be served at 7:30 a.m. During an observation on 2/8/23, at 7:35 a.m. kitchen thermometer read 80 degrees. During an observation on 2/08/23, at 07:35 a.m. prior to yogurt being served, CDM confirmed temperature of yogurt confirmed to be 50 degrees, by placing thermometer into center of yogurt.. CDM stated cold foods should be served at 41 degrees or less. During an observation on 2/8/23, at 10:53 a.m. dry food storage area observed to have Thick and Easy Hormel thickened water with expiration date of 11/16/22 and Thick and Easy Hormel honey	F 812	Build-up on the kitchen floor was cleaned. Corrective Action as it applies to others:¿ The Food Receiving and Storage Policy was reviewed and remains current. Unit resident fridges and personal resident room fridges have been reviewed to ensure that there are no expired products and that all opened items have been dated. Any open dated items that are over 3 days old will be disposed of. All unit and resident personal fridges will be reviewed to ensure that they have a working thermometer and that temps are being checked daily and documented. Housekeeping was educated on the need to check unit fridge and personal resident fridge temps daily and document on log. Temps should be 33-40 degrees. They were also educated on the need to notify maintenance immediately if temperature is over 40 degrees. All staff members were educated on checking dates of food/drinks for expiration dates and disposing if needed, labeling of opened food items with resident name and date opened on wing refrigerators as well as disposing of any opened food item that is over 3 days old.	

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	245495	A. BUILDING _____ B. WING _____	C 02/10/2023

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F 812	Continued From page 53 thickened apple juice with expiration date of 11/11/22. During an observation on 2/6/23, at 1:42 p.m. resident personal item refrigerator on 100 wing had a thermometer that did not display the temperature. Refrigerator contained Yoplait strawberry banana yogurt and Yoplait blueberry yogurt with expiration date of 1/27/23. Plastic bag labeled "MD" contained pickles and mayonnaise, without a date. Seafood snackers package was not sealed, without name. Freezer contained a box of Eggo waffles that were not sealed. Waffle expiration date of 7/30/22. Resident personal item refrigerator lacked a thermometer in operating condition on 200 wing. Plastic container contained food that was covered with a white fuzz-like matter. Plastic container was not dated. Two strawberry banana Yoplait yogurts had expiration dates of 1/9/23 and 1/27/23. Whipping cream lacking name and date, had expiration date of 1/4/23. Resident personal item fridge on 300 wing contained a Styrofoam container: lacking date. Food was covered in white and green matter. Biohazard Ziploc baggie contained a block of pepper jack cheese with dark green fuzz-like circles that had white perimeters. Cheese lacked name or date label. Soup in a jar was observed to have a name and date of 12/7/22. String cheese with expiration date of 10/29/22 observed. Bottle of Dr Pepper soda, approximately half full had an expiration date of 7/25/22. Pace picante sauce had an expiration date of 9/21/22. Picante sauce lacked name and date. Freezer observed to contain gelato with a use by date of 12/19/21 and Kemp's rainbow sherbet with use by date of	F 812	Culinary staff were educated on the need to check food/drinks for expiration dates and disposing as needed. Also, educated on need to date food/drinks when opening them and disposing items that are expired. Culinary staff were also educated on the need to keep kitchen floors swept and clean. Also, educated on the need to serve food to residents that is within acceptable temperature range. Administrator and CDM were educated on the need to ensure vent hoods are cleaned on a scheduled basis. Date of Compliance:¿3/24/2023 ¿ Recurrence will be prevented by:¿ Audits on vent hood and floor cleanliness will be completed weekly x3 weeks and monthly x2 months. Audits on cold food temperatures will be completed during each meal daily for 1 week, and then weekly x3 weeks. Audits on dry goods storage for expired foods will be completed weekly x3 weeks	

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F 812	Continued From page 54 7/27/21. Sherbet lacked name and date opened. Resident personal item refrigerator on wing 3 cul-de-sac observed to have plastic bag containing liverwurst with green matter on it, lacking name and date. Helluva brand dip observed to have expiration date or 11/30/22. Land o' Lakes butter with canola oil " had expiration date of 1/10/23. Block of pepper jack cheese in freezer dated 7/21/22, with expiration date of 12/21/22. During an interview on 2/6/23, at 1:57 p.m. CDM stated there was not a process in place to monitor the temperature of the refrigerator/freezers for resident personal item refrigerators. Resident personal item refrigerator/freezers available for residents to access freely. During an observation on 2/8/23, at 11:12 a.m. kitchen floor observed have brownish black buildup on floor under dishwashing counter to left of dishwasher and under cook prep area. During an interview on 2/8/23, at 11:13 a.m. CDM stated the kitchen floor was swept and mopped every evening.	F 812	and monthly x2 months. Wing refrigerators and common area refrigerators will be audited weekly x3 weeks and monthly x2 months to identify food items getting labeled and expired foods disposed of as well as ensuring fridge temps are being checked daily and are in the appropriate range. Corrections will be monitored by:¿ Culinary Director or Designee.	
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 comfortable environment and to help prevent the development and transmission of communicable diseases and infections.	F 880		3/24/23

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F 880	Continued From page 55 §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct	F 880		

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F 880	Continued From page 56 contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure staff were following infection control practices for equipment storage and cleaning for resident (R16) reviewed for infection control. Findings include: R16's quarterly minimum data set (MDS) dated 11/4/22 indicated R16 was cognitively intact and with diagnosis of depression, schizophrenia, rhabdomyolysis, restless leg syndrome. R16's chart review showed R16 had impaired mobility related to a 8/2/22 left ankle surgical procedure and changes in her right ankle which she was being seen by a orthopedic surgeon for. R16 was also receiving antibiotics for urinary tract infections. On 2/7/23 at 3:01 p.m. R16 stated staff do not wash my bedpan, they just dump it out and put it	F 880	Immediate Corrective Action:¿¿¿ R16's bedpan was cleaned, dried, and placed in a plastic bag with resident's name. Corrective Action as it applies to others:¿¿ The Bedpan Policy was reviewed and remains current. All residents who utilize a bedpan will be reviewed to ensure that they have a clean, dry bedpan and that it is stored in a plastic bag with the resident's name and stored	

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F 880	Continued From page 57 on the floor to dry. When they don't get it positioned right, my butt hits the bowl part and I end up sitting in my own dry pee, and other times they put the bed pan under me and it is still wet "so gross." R16's bedpan was on the floor in the shared bathroom beside the toilet. On 2/8/23, at 10:00 a.m. R16's bed pan was on partially on floor of shared bathroom leaning against the toilet. During an interview with the Unit manager LPN-C and the ADON on 2/9/23 at 1:28 p.m. both agreed with the following: it was the responsibility of nursing staff to rinse and wipe bedpans dry before storing. Once dry, bedpans should be put in spot next to the toilet, but not on the floor. For infection prevention reasons, after rinsed and dried, individual bedpans should be kept in a bag labeled with resident's name. On 2/10/23 at 9:10 a.m. R16's bed pan was in the shared bathroom partially on the floor and partially sitting on top of another bed pan sitting directly on the floor. The other bed pan had toilet paper in it. R16's bedpan was wet inside. No stool was noted on either bedpan. The facility policy Bedpan/Urinal, Offering/Removing had the outlined the following step by step instructions for staff; Wash hands, put on gloves and place gathered supplies on the bedside stand. Remove the bedpan from the bedside stand, take it to the bathroom, warm it with warm water, and dry before placing under the resident. Either have the resident lift buttocks and place pan under resident or have resident roll away and roll back onto the bedpan. Ensure bedpan is positioned correctly. Remove gloves, wash hands, and give resident privacy. When the resident is done, wash hands and apply gloves,	F 880	on a shelf in resident room. Education will be provided to direct care staff including CNA, TMA, LPN, and RN on the Bedpan Policy with regards to immediately cleaning and drying after use and placing into a plastic bag with resident's name for storage and stored on shelf in resident room. Date of Compliance:¿ 3/24/23 Recurrence will be prevented by:¿¿ 5 residents who utilize bedpans will be audited 5x/week until 100% compliance is noted, and then weekly x 2 weeks, and then monthly x2 months to ensure staff are cleaning, drying, and placing bedpans in labeled plastic bag after use. Audits and findings will be reported to QAPI committee for further recommendations. ¿ Corrections will be monitored by:¿ Director of Nursing or designee.¿	

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F 880	Continued From page 58 bring a ½ full wash basin of water and place it on the nightstand. Remove the bedpan from under the resident and place it on the floor on top of a paper towel next to the bedside stand. Cover the bed pan immediately. Use toilet paper and then soap and water to clean perineum as necessary and dry with towel. Return clothing and bedding to appropriate position and make resident comfortable. Take bedpan into bathroom. Record intake and output, empty bedpan into commode and flush. Clean the bedpan and wipe dry with a clean paper towel. Store the bedpan per facility policy. Do not leave the bedpan on the bathroom floor. Remove gloves and wash hands. Allow resident to was hands, with clean water in basin. Discard soiled linens, remove gloves, wash hands. Clean wash basin and bedside table. Wash hands thoroughly.	F 880		
F 886 SS=F	COVID-19 Testing-Residents & Staff CFR(s): 483.80 (h)(1)-(6) §483.80 (h) COVID-19 Testing. The LTC facility must test residents and facility staff, including individuals providing services under arrangement and volunteers, for COVID-19. At a minimum, for all residents and facility staff, including individuals providing services under arrangement and volunteers, the LTC facility must: §483.80 (h)((1) Conduct testing based on parameters set forth by the Secretary, including but not limited to: (i) Testing frequency; (ii) The identification of any individual specified in this paragraph diagnosed with COVID-19 in the facility; (iii) The identification of any individual specified in	F 886		3/24/23

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F 886	Continued From page 59 this paragraph with symptoms consistent with COVID-19 or with known or suspected exposure to COVID-19; (iv) The criteria for conducting testing of asymptomatic individuals specified in this paragraph, such as the positivity rate of COVID-19 in a county; (v) The response time for test results; and (vi) Other factors specified by the Secretary that help identify and prevent the transmission of COVID-19. §483.80 (h)((2) Conduct testing in a manner that is consistent with current standards of practice for conducting COVID-19 tests; §483.80 (h)((3) For each instance of testing: (i) Document that testing was completed and the results of each staff test; and (ii) Document in the resident records that testing was offered, completed (as appropriate to the resident's testing status), and the results of each test. §483.80 (h)((4) Upon the identification of an individual specified in this paragraph with symptoms consistent with COVID-19, or who tests positive for COVID-19, take actions to prevent the transmission of COVID-19. §483.80 (h)((5) Have procedures for addressing residents and staff, including individuals providing services under arrangement and volunteers, who refuse testing or are unable to be tested. §483.80 (h)((6) When necessary, such as in emergencies due to testing supply shortages,	F 886		

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F 886	Continued From page 60 contact state and local health departments to assist in testing efforts, such as obtaining testing supplies or processing test results. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to have a procedure in place to address when a staff member or resident would refuse to be tested. This deficient practice had the potential to affect all 63 residents who resided in the facility as well as staff and visitors in the facility. Findings include: Department of Health & Human Services Centers for Medicare & Medicaid Services (CMS) regulation QSO-20-38-NH (CMS nursing home testing policy) last revised 9/23/22, indicated facilities had to have procedures in place to address when a staff member or resident would refuse testing when symptoms were present or when the facility was in outbreak testing. During an interview on 2/8/23, at 2:10 p.m. the new assistant director of nursing/infection preventionist (ADON), the administrative assistant (AA) and the administrator all stated the only testing policy the facility had was a reference to QSO-20-38-NH. The administrator and the AA confirmed the facility did not have a procedure in place that addressed what the facility would do when staff and residents refused testing. ADON, AA and administrator all stated they were not aware the facility was expected to have that procedure. During a follow-up interview on 2/8/23, at 2:22	F 886	Immediate Corrective Action:¿¿¿ The COVID Policy was updated on 2/8/23 and given to surveyor. Corrective Action as it applies to others:¿¿ The COVID Policy was reviewed and remains current. All residents were reviewed to ensure that if they are refusing testing that they have interventions in place per policy. All staff were reviewed and removed from schedule if they have refused to test and remained off schedule until they are tested as appropriate per policy. Education will be provided to residents/staff on the update to the COVID policy with regards to refusal of testing. Date of Compliance:¿ 3/24/23 Recurrence will be prevented by:¿¿	

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F 886	Continued From page 61 p.m. after review of QSO-20-38-NH, ADON, AA and administrator confirmed a procedure to address staff or residents who refused to be tested needed to be in place. The administrator stated an expectation was for all polices to be created per guidelines set forth by CMS to ensure the safety of all residents, staff and visitors who reside or come into the building. Review of the facility policy titled COVID-19 Infection Prevention and Control last updated 10/14/22, indicated a reference to CMS QSO-20-38-NH revised for information regarding testing. The policy lacked information about staff or residents who refused to be tested. The Facility COVID-19 testing policy was requested however was not provided.	F 886	The policy will be reviewed and updated as needed based on COVID-19 guidance. The policy will be reviewed monthly x3 months to ensure there have been no changes in guidance that is not reflected in the policy. Audits and findings will be reported to QAPI committee for further recommendations. ¿ Corrections will be monitored by:¿ Director of Nursing or designee	
F 921 SS=D	Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i) §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to keep resident equipment clean while in use for 2 of 2 residents (R27 and R47) reviewed. During an observation on 2/8/23, at 3:44 p.m. gray fuzz material was on the vents of the oxygen concentrators for R27 and R47. During an interview on 2/8/23, at 3:44 p.m. LPN-C stated the gray fuzz material observed on the oxygen contractor vents was an infection	F 921	Immediate Corrective Action:¿¿¿ R27 and R47's oxygen concentrator vents were cleaned. Corrective Action as it applies to others:¿¿ The Infection Prevention and Control	3/24/23

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F 921	Continued From page 62 control concern. During an interview on 2/9/23, at 3:25 p.m. director of nursing (DON) and assistant director of nursing (ADON) stated gray fuzz material on the vents of oxygen concentrators was an infection control concern. ADON the filters should be changed by the nurses weekly. Review of infection prevention and control program, indicated important facets of infection control include: c) educating staff and ensuring that they adhere to proper techniques and procedures.	F 921	Program Policy was reviewed and remains current. All residents that utilize oxygen concentrators were reviewed to ensure that their concentrator vents are clean and that they are scheduled to be wiped down weekly. Education will be provided to direct care staff including Nurses and TMAs on the policy titled “Infection Prevention and Control Program” with specifics on wiping down oxygen concentrator vents weekly per schedule. Date of Compliance:¿ 3/24/23 Recurrence will be prevented by:¿¿ 5 residents who utilize oxygen concentrators will be audited weekly x3 weeks, and monthly x2 months to ensure clean resident equipment while in use. Audits and findings will be reported to QAPI committee for further recommendations.¿¿ Corrections will be monitored by:¿	

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F 921	Continued From page 63	F 921	Director of Nursing or designee.¿	

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
March 7, 2023

Administrator
The Emeralds At Grand Rapids LLC
2801 South Highway 169
Grand Rapids, MN 55744

Re: State Nursing Home Licensing Orders
Event ID: LV1G11

Dear Administrator:

The above facility was surveyed on February 6, 2023 through February 10, 2023 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

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

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

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

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

LeAnn Huseth, RN, Unit Supervisor
Fergus Falls District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
1505 Pebble Lake Rd., Suite 300
Fergus Falls, Mn. 56537
Email: leann.huseth@state.mn.us
Office: (218) 332-5140 Mobile: (218) 403-1100

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

Please feel free to call me with any questions.

Sincerely,

Sarah Lane

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00299	A. BUILDING: _____ B. WING _____	C 02/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE EMERALDS AT GRAND RAPIDS LLC	2801 SOUTH HIGHWAY 169 GRAND RAPIDS, MN 55744

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 2/6/23 - 2/10/23, a licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found NOT in compliance with the MN State Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you have reviewed	2 000		

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2 000	Continued From page 1 these orders and identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY.	2 000		

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2 000	Continued From page 2 THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES. In addition, The following complaints were found to be not in compliance: MN 85571 H54958218C, with no deficiencies. MN 86095 H54958203C,with no deficiencies. MN 85454 H54953568C, with a licensing order issued MN 85366 H54953568C, with a licensing order issued MN 84966 H54958237C, with a licensing order issued MN 83905 H54958238C, with a licensing order issued MN 89640 H54958200C, with a licensing order issued MN 89723 H54958204C, with a licensing order issued MN 89298 H54958202C, with a licensing order issued The following complaints were found to be in compliance: MN 80604 H5495139C, with no deficiencies. MN 89628 H54958201C, with no deficiencies. MN 89302 H54956494C, with no deficiencies. Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for	2 000		

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2 000	Continued From page 3 Nursing Homes. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor's findings are the Suggested Method of Correction and Time Period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		
2 265	MN Rule 4658.0085 Notification of Chg in Resident Health Status	2 265		3/24/23

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2 265	Continued From page 4 A nursing home must develop and implement policies to guide staff decisions to consult physicians, physician assistants, and nurse practitioners, and if known, notify the resident's legal representative or an interested family member of a resident's acute illness, serious accident, or death. At a minimum, the director of nursing services, and the medical director or an attending physician must be involved in the development of these policies. The policies must have criteria which address at least the appropriate notification times for: A. an accident involving the resident which results in injury and has the potential for requiring physician intervention; B. a significant change in the resident's physical, mental, or psychosocial status, for example, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications; C. a need to alter treatment significantly, for example, a need to discontinue an existing form of treatment due to adverse consequences, or to begin a new form of treatment; D. a decision to transfer or discharge the resident from the nursing home; or E. expected and unexpected resident deaths. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to notify physician per orders of blood sugars and weights 1 of 2 residents (R5	2 265	Completed.	

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2 265	Continued From page 5 and R32) reviewed. Findings include: R5's Diagnosis Report dated 2/9/23, indicated R5's diagnoses included hypertension, chronic diastolic (congestive) heart failure, (a chronic condition in which the heart doesn't pump blood as well as it should), type two diabetes mellitus, bipolar disorder, depression, and panic disorder. R5's quarterly Minimum Data Set (MDS) assessment dated 12/4/22, indicated R5 was cognitively intact and had no rejections of care. In addition, R5's MDS indicated she required insulin four of the seven days. R5's care plan revised on 12/6/22, indicated R5 had limited physical mobility related to morbid obesity and pain. The care plan directed staff to assist with all cares while resident participated to her maximum capacity. R5's Order Summary Report dated 2/9/23, directed staff to notify physician as soon as possible if blood sugar was less than 60 or greater than 450. Document notification and resulting orders. In addition, staff were directed to call her provider for weight gain of more than two pounds per day or five pounds per week. R5's Weight and Vital Summary dated 2/9/23, indicated R5's blood sugars were as follows: 1/25/23, 7:30 a.m. 488 1/29/23, 11:09 a.m. 472 2/8/23, 11:42 a.m. 463 2/7/23, 3:59 p.m. 520 2/6/23, 7:38 a.m. 484 2/6/23, 10:52 a.m. 487	2 265		

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2 265	Continued From page 6 R5's Weight and Vital Summary dated 2/9/23, indicated R5's weights were as follows: 1/2/23, 280 pounds 1/3/23, 283.9 pounds 1/15/23 no weight 1/16/23, 286.1 pounds 1/17/23, no weight 1/18/23, 288.3 pounds 1/20/23, 291 pounds 1/21/23, 293. 6 pounds 1/23/23, 287.9 pounds 1/24/23, 291.8 pounds R5's progress notes were reviewed from 1/1/23-2/9/23, related to the elevated blood sugar on 2/7/23, R5's record lacked documentation of provider notification of either elevated blood sugars or weight gain. During an interview on 2/9/23, at 9:41 a.m. the director of nursing (DON) stated she would expect staff to follow provider orders to as written and to call with elevated blood sugars and weight gains. The DON stated it would be important to follow provider orders as medication may have needed to be adjusted for blood sugar control and for R5's congestive heart failure. The facility policy titled Diabetes - Clinical Protocol revised 11/2020, indicated "The Physician will order desired parameters for monitoring and reporting information related to blood sugar management." The facility policy titled Heart Failure - Clinical Protocol revised 11/2018, indicated "The physician will review and make recommendations for relevant aspects of the nursing care plan; for	2 265		

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2 265	Continued From page 7 example, what symptoms to expect, how often and what (weights, renal function, digoxin level, etc.) to monitor, when to report findings to the physician, etc." R32 R32 quarterly minimum data set (MDS) assessment completed 1/16/23 indicated moderately impaired cognition, dependent on staff for activities of daily living. R32's medical diagnosis included type 2 diabetes mellitus. R32's physician orders dated 1/1/23, indicated to check blood sugar two times a day. R32's order dated 6/28/21 indicated to notify MD (medical doctor) ASAP if blood sugar is less than 60 or greater than 400. Document notification and resulting orders every shift. Record review indicated R32 had blood sugars of: 421 on 1/4/23 410 on 1/5/23 505 on 1/14/23 426 on 1/16/23 477 on 1/18/23 431 on 1/20/23 445 on 1/23/23 During an interview on 2/9/23, at 4:16 p.m. LPN-C stated communication with NP (nurse practitioner) or MD regarding elevated blood sugars would be documented in progress notes. R32's record review lacked notification to MD or NP regarding elevated blood sugars from 1/1/23 through 1/23/23.	2 265		

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2 265	Continued From page 8 During a phone interview on 2/9/23, at 1:50 p.m. NP confirmed lack of notification of R32's blood sugars over 400. NP stated it would have been appropriate to have been notified. During an interview on 2/9/23, at 3:40 p.m. director of nursing (DON) & (assistant) ADON stated reporting elevated blood sugars to the NP or MD was important to determine if R32 needs a change with insulin or other things happening within R32's body. The facility policy titled Diabetes - Clinical Protocol revised 11/2020, indicated "The Physician will order desired parameters for monitoring and reporting information related to blood sugar management." The facility policy titled Heart Failure - Clinical Protocol revised 11/2018, indicated "The physician will review and make recommendations for relevant aspects of the nursing care plan; for example, what symptoms to expect, how often and what (weights, renal function, digoxin level, etc.) to monitor, when to report findings to the physician, etc." SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure providers were notified of blood sugars and weight loss. The Director of Nursing or designee could educate all appropriate staff on the policies and procedures. The Director of Nursing or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one	2 265		

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2 265	Continued From page 9 (21) days.	2 265		
2 550	MN Rule 4658.0400 Subp. 4 Comprehensive Resident Assessment; Review Subp. 4. Review of assessments. A nursing home must examine each resident at least quarterly and must revise the resident's comprehensive assessment to ensure the continued accuracy of the assessment. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to complete all sections on the Minimum Data Set (MDS) for 1 of 1 residents (R26) reviewed for resident assessment. Findings include: The Centers for Medicare and Medicaid (CMS) Long-Term Resident Facility Assessment Instrument (RAI) 3.0 User's Manual dated 10/2019, "OBRA-required comprehensive assessments include the completion of both the MDS and the CAA process, as well as care planning. Comprehensive assessments are completed upon admission, annually, and when a significant change in a resident ' s status has occurred or a significant correction to a prior comprehensive assessment is required." Section C: identified cognitive patterns, "Determine the resident's attention, orientation, and ability to register and recall information." Section D: identified mood, "Identify signs and symptoms of mood distress."	2 550	Completed.	3/24/23

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2 550	Continued From page 10 R26's admission MDS dated 1/6/23, indicated R26 had diagnoses which included atrial fibrillation (an irregular often rapid heart rate that commonly causes poor blood flow), heart failure (a chronic condition in which the heart doesn't pump blood as well as it should), hypertension, diabetes mellitus, hyperlipidemia, arthritis, and anxiety. R26's admission MDS dated 1/6/23, section C-Cognitive patterns revealed the following: C0100 Should Brief Interview for Mental Status be completed? This was documented as yes. section C0200 was not completed section C0300 was not completed section C0400 was not completed section C0500 had a dash section C1310 had dashes R26's admission MDS dated 1/6/23, section D-Mood. D0100 Should resident mood interview be completed? this was documented as yes. section D0200 had only dashes section D0300 had only dashes section D0500 had only dashes section D0600 had only dashes During an interview on 2/8/23, at 3:53 p.m. the director of nursing reviewed R26's admission MDS dated 1/6/23, and verified sections C and D were not completed and should have been completed. The DON stated these should have been completed, she stated she is the person responsible for submitting the MDS but does not check to see if all staff involved in the completion of the MDS have completed their portions.	2 550		

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2 550	Continued From page 11 During an interview on 2/9/23, at 9:14 a.m. regional social service consultant (RGSC)-A verified the team would be expected to complete sections C and D for the admission MDS and they should have been communicating with each other prior to submitting. RGSC-A stated the assessments were important because they drive care for the residents. The facility policy titled MDS Completion and Submission Timeframe's revised 7/2017, directed staff to do the following: "The Assessment Coordinator or designee is responsible for ensuring that resident assessments are submitted to CMS ' QIES Assessment Submission and Processing (ASAP) system in accordance with current federal and state guidelines." SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure the MDS was completed for all sections to ensure care plans were developed for residents. The Director of Nursing or designee could educate all appropriate staff on the policies and procedures. The Director of Nursing or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 550		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General	2 830		3/24/23

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2 830	Continued From page 12 Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to accurately and compressively assess safe smoking practices and implement identified interventions for 1 of 1 residents (R21) reviewed for safe smoking practices. Findings include: R21's Admission Minimum Data Set (MDS) dated 10/29/22, indicated R21 had moderate cognitive impairment. Diagnoses included acute renal failure, urinary tract infection, anxiety disorder and blindness in one eye, unspecified. One person assist was required for activities of daily living (ADL) except eating, which was independent. R21's admission care assessment area (CAA) indicated cognitive loss/dementia, ADL functional and falls were triggered as special care focus areas related to resident care. Review of R21's smoking evaluation form dated	2 830	Completed.	

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2 830	Continued From page 13 10/24/22, indicated R21 did not have a history of cognitive loss, visual deficit, or dexterity problems. Identified R21 could safely light and hold her cigarette. Indicated R21 did not require any adaptive equipment such as a smoking apron, supervision or individualized care plan. The only intervention identified was R21's cigarettes would be stored in the nursing cart. R21's care plan dated 10/26/22 indicated an alteration in cognition and vision related to acute kidney failure, alcoholic hepatitis and blindness in one eye. The care plan lacked data related to resident safety when smoking. On 2/9/23, at 10:18 R 21 was observed on the outside patio smoking by herself. She did have a noted tremor to her right hand and arm, which was the hand that she held her cigarette in. During an interview on 2/7/23, at 4:26 p.m. R21 stated she was allowed to go out to smoke independently and kept her cigarettes with her at all times. R21 removed her cigarettes from her coat pocket at that time. R21 stated she was completely blind in her left eye and had 50% blindness in her right eye. R21 indicated her best vision was shadows in the left eye and blurred lines in the right eye. R21 stated she did have an occasional tremor in her right hand and arm, which she confirmed was the hand she held her cigarette in. R21 indicated she had burned her clothes recently due to the tremor. She stated the clothing was currently in the laundry. During an interview on 2/9/23, at 11:48 a.m. licensed practical nurse (LPN)-B stated residents who had restrictions such as smoking would be identified in the care plan. She stated there were no current residents who were expected to keep	2 830		

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2 830	Continued From page 14 their cigarettes in the nursing cart. LPN-B reviewed R21's smoking assessment and confirmed R21's cigarettes should have been stored in the nursing cart however had not been. On 2/9/23, at 12:11 p.m. R21 was observed in her room holding a wine (red) colored pair of sweat pants which were folded up. R21 unfolded the sweat pants and pointed to the right inner thigh area which had five small holes present and black charring noted between two of the bigger holes. R21 confirmed the holes and charring were from dropping hot cigarette ashes on her while outside smoking in the last month. During an interview on 2/9/23, at 12:47 p.m. LPN-E stated when she completed smoking assessments, she would observe the residents smoke and if they were able to light the cigarette and hold it safely, there would be no restrictions. LPN-E stated she was unaware of R21's documented confusion and diagnosis of blindness, but it would not have made a difference in her assessment. LPN-E reviewed R21's smoking assessment and acknowledge she had marked no on cognitive concerns and and vision deficit. They should have been marked. During an interview on 2/9/23, at 2:00 p.m. the assistant director of nursing (ADON) stated stated staff were expected to review the resident's diagnoses, MDS and observe the resident smoking when they completed the smoking assessment. ADON stated interventions would be determined based on the results of the assessment. Review of facility policy titled, Resident Smoking Policy last revised 10/22, indicated all residents	2 830		

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2 830	Continued From page 15 who smoke would be evaluated on admission. The intent of the policy was to outline the procedure for safe resident smoking, which included evaluation to determine those who would be capable to smoke independently or who needed adaptive equipment. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure residents were assessed for safe smoking practices. The Director of Nursing or designee could educate all appropriate staff on the policies and procedures. The Director of Nursing or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		
2 860	MN Rule 4658.0520 Subp. 2 F. Adequate and Proper Nursing Care; Hands-Feet Subp. 2. Criteria for determining adequate and proper care. The criteria for determining adequate and proper care include: E. per care and attention to hands and feet. Fingernails and toenails must be kept clean and trimmed. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure nail care and grooming was completed for 2 of 3 residents (R26 and R60) reviewed for personal cares.	2 860	Completed.	3/24/23

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2 860	Continued From page 16 Findings include: R26's admission Minimum Data Set (MDS) assessment dated 1/6/23, indicated R26 had diagnoses of atrial fibrillation (an irregular often rapid heart rate that commonly causes poor blood flow), heart failure (a chronic condition in which the heart doesn't pump blood as well as it should), hypertension, diabetes mellitus, hyperlipidemia, arthritis, and anxiety. R26's admission MDS did not address cognition or personal hygiene. R26's care plan identified a self care deficit, interventions were for staff to assist with personal hygiene. On 2/6/23, at 6:25 p.m. R26's nails were observed to be long with a brown substance under them. On 2/8/23, at 2:22 p.m. R26 was eating his lunch, he looked at his fingernails and said they were getting long (thumb nails were about a quarter of an inch in length with brown substance under them). R26 stated they were too long and were snagging on fabric, he said he wasn't sure who was responsible for cutting his nails. During an interview on 2/8/23, at 7:34 a.m. nursing assistant (NA)-K stated the hospice aides helped R26 with his shower. During an interview on 2/8/23, at 2:24 p.m. NA-B stated the hospice aides were helping R26 with his shower and they were responsible for nail care. During an interview on 2/8/23, at 2:50 p.m.	2 860		

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2 860	Continued From page 17 licensed practical nurse (LPN)-D, verified R26's nails were long and had a brown substance under them. During an interview on 2/9/23, at 9:55 a.m. the director of nursing (DON) stated nail care should be done weekly for residents on their bath day. The DON stated she would expect any nursing staff to perform nail care if they noted a resident's nails were long and had a brown substance under them. R60 R60's admission Minimum Data Set (MDS) assessment dated 1/12/23 indicated R60 had memory problems and severely impaired cognitive skills. MDS indicated R60 had preferences with his care and required assistance or supervision of one staff for personal grooming and hygiene needs. Document review indicated R60 had medical diagnosis of Parkinson's disease, metabolic encephalopathy, and dementia. R60's care plan indicated R60 had a self-care deficit. Interventions included assist with bathing, assist with dressing, and assist with personal hygiene. During an observation on 2/6/23, at 7:12 p.m. R60 had white facial hair on cheeks, chin, and above upper lip. During an observation on 2/7/23, at 9:31 a.m. R60 had white facial hair on cheeks, chin, and above upper lip. During an interview on 2/7/23, at 9:29 a.m. R60's	2 860		

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2 860	Continued From page 18 wife stated R60 likes to be clean-shaven. R60's wife stated she recently had to buy R60 a new electric razor. During an observation on 2/7/23, at 3:06 p.m. R60 had facial hair on cheeks, chin, and above upper lip. During an observation on 2/8/23, at 10:06 a.m. R60 had facial hair on cheeks, chin, and above upper lip. During an interview on 2/9/23, at 5:18 a.m. licensed practical nurse (LPN)-A stated cares were outlined in the care plans in each resident's chart and in the pocket care plans in the binder for the nursing assistants. During an observation on 2/9/23, at 10:55 a.m. observed R60 to have facial hair on cheeks, chin, and above upper lip. During an interview on 2/9/23, at 10:56 a.m. nursing assistant (NA)-D stated staff were responsible to shave resident or supervise R60 while he shaved himself. NA-D stated she would shave him soon. A policy on activities of daily living policy was requested but not provided. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure nail care and shaving was completed as needed. The Director of Nursing or designee could educate all appropriate staff on the policies and procedures. The Director of Nursing or designee could	2 860		

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2 860	Continued From page 19 develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 860		
2 890	MN Rule 4658.0525 Subp. 2 A Rehab - Range of Motion Subp. 2. Range of motion. A supportive program that is directed toward prevention of deformities through positioning and range of motion must be implemented and maintained. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without a limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure restorative therapy services were completed for 1 of 3 (R42) residents evaluated for limited range of motion. Findings include: R42's annual Minimum Data Set (MDS) dated 2/3/23, indicated the facility was unable to determine R42's cognitive impairment level. He required total assistance for all activities of daily	2 890	Completed.	3/24/23

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2 890	Continued From page 20 living (ADL's). Diagnoses included respiratory failure, malnutrition and diabetes. R42's annual care area assessment dated 1/24/22, indicated cognitive loss, falls and feeding tube were special areas of consideration. The care area assessment is specialized areas of care that were specific to R42 and needed to be addressed to assist in specialized care he needed. Restorative orders dated 2/1/22, indicated R42 had passive range of motion (PROM) to both upper and lower extremities. R42's care plan dated 1/26/23, indicated restorative nursing with interventions included active range of motion to bilateral wrists and hands, PROM to elbows and shoulders. PROM to bilateral upper and lower extremities would be completed twice a week. R42's care sheet undated, indicated restorative nursing would be completed twice a week. R42's Restorative therapy documentation from 1/11/23, to 2/9/23, was reviewed and indicated R42 received five of the eight restorative therapy sessions he was suppose to have. During an interview on 2/7/23, at 9:24 a.m. nurse assistant (NA)-F stated the facility had a restorative aide, however the facility would pull them from their restorative duties and would work the floor " all the time". The NAs already assigned to the floor would attempt to perform restorative services when they could, but restorative was not getting done like it would be ordered. As a result of this, NA-F stated many residents did not receive their restorative sessions timely. NA-F	2 890		

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2 890	Continued From page 21 stated restorative nursing was identified on the care sheets and on the care plan. NA-F indicated she was aware R42 was to receive restorative services however some sessions were missed. During an interview on 2/8/2023, at 3:24 p.m. occupational therapist registered (OTR)-H stated nursing department had stopped the restorative therapy program due to the restorative aid was always pulled to the floor. Therapy would continue to make referrals for restorative and the NAs working the floor would attempt to perform restorative therapy treatments when there was time. OTR-H stated R42 was on restorative therapy services, but several treatments had been missed. During an interview on 2/9/23, at 10:24 a.m. physical therapist registered (PTR)-G stated she had set up a restorative program for R42 on 7/22. PTR-G indicated she was aware residents were not receiving their restorative sessions as ordered by therapy. PTR-G stated she performed an evaluation of R42 and there had been a decline in his knee movement since discontinued from therapy. During an interview on 2/9/23, at 2:00 p.m. the assistant director of nursing (ADON) stated staff were expected to perform restorative nursing as ordered to prevent decline in range of motion. Review of facility policy titled, Restorative Nursing Services dated 7/17, indicated residents would receive restorative nursing care which promoted optimal safety and independence. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could develop, review, and/or revise policies and	2 890		

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2 890	Continued From page 22 procedures to ensure restorative therapy was completed as ordered. The Director of Nursing or designee could educate all appropriate staff on the policies and procedures. The Director of Nursing or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 890		
2 930	MN Rule 4658.0525 Subp. 7 B. Rehab - Nasogastric, Gastrostomy tubes Subp. 7. Nasogastric tubes, gastrostomy tubes, and feeding syringes. Based on the comprehensive resident assessment, a nursing home must ensure that: B. a resident who is fed by a nasogastric or gastrostomy tube or feeding syringe receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal feeding function. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure appropriate interventions were taken to reduce the risk of aspiration and ensure the product and equipment was not expired prior to use for 2 of 2 residents (R42 and R49) reviewed for tube feedings.	2 930	Completed.	3/24/23

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2 930	Continued From page 23 Findings include: R42's annual Minimum Data Set (MDS) dated 2/3/23, indicated the facility was unable to determine R42's cognitive impairment level. Identified R42 required total assistance for all activities of daily living (ADL's). Diagnoses included respiratory failure, malnutrition and diabetes. Indicated R42 received 54% or more of his daily nutrition through tube feeding. The annual care area assessment dated 1/24/22, indicated cognitive loss, falls and feeding tube were special areas of consideration. The care area assessment is specialized areas of care that were specific to R42 and needed to be addressed to assist in specialized care he needed. R42's Order Summary Report dated 1/22/21, identified R42 was to have nothing by mouth (NPO). Orders dated 11/25/22, indicated R42 had a tube feeding which consisted of Jevity 1.5 running at 60 milliliters (ML) per hour 24 hours a day. Orders dated 6/3/22, indicated R42's head needed to always be elevated 45 degrees due to risk of aspiration. R42's progress notes from 2/6/22, to 2/6/23, were reviewed and indicated the following: -R42 was hospitalized from 2/26/22, to 3/2/22, for aspiration pneumonia. -R42 was hospitalized from 3/23/22, to 3/25/22, for aspiration pneumonia and sepsis. -R42 was hospitalized from 4/20/22, to 4/25/22, for acute respiratory failure with hypoxia and aspiration pneumonia. -R42 was hospitalized from 8/31/22, to 9/6/22, for aspiration pneumonia and sepsis due to pseudomonas of the sputum.	2 930		

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2 930	Continued From page 24 During an observation on 2/8/23, at 9:58 a.m. registered nurse (RN)-C entered R42's room and laid his head of the bed flat. RN-C performed trachea cares which consisted of changing trachea ties and suctioning R42. RN-C rolled R42 side to side to observe his buttocks and lifted both of R42's feet to observe his feet. RN-C proceeded to clean R42's room and removed trash from the room while R42's head remained flat. RN-C re-entered R42's room, elevated his head back to 45 degrees and exited the room at 10:21 a.m. During an interview on 2/8/23, at 10:35 a.m. RN-C stated R42's head should always be elevated. RN-C confirmed the tube feeding had still been running when R42 was laying flat. RN-C stated she was not aware staff were expected to stop tube feedings when a R42 was laying flat due to increased risk of aspiration. During an interview on 2/8/23, at 12:10 p.m. the nurse practitioner (NP)-F stated laying a resident flat while a tube feeding was running would increase the resident's risk of aspiration. NP-F confirmed R42 was at a high risk of aspiration. During an interview on 2/9/23, at 2:00 p.m. the assistant director of nursing (ADON) stated staff were expected to stop the tube feedings when a resident needed to be laid flat for any reason. R49 R49's quarterly Minimum Data Set (MDS) dated 1/20/23, indicated moderated cognitive deficiency. R49 required extensive assistance with all ADL's. She required mechanical lift for all transfers. Diagnoses included Hemiplegia or	2 930		

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2 930	Continued From page 25 Hemiparesis (loss of use of one side of the body), seizure disorder and anxiety disorder. R49's care area assessment (CAA) dated 10/21/22, indicated cognitive loss/dementia, ADL functional, falls and tube feeding were triggered as special focus areas for cares. R49's Order Summary Report dated 1/24/23, indicated R49 had tube feeding Jevity 1.5 to run at 50 ml (milliliter) per hour from 7:00 p.m. to 7:00 a.m. During observation on 2/7/23, at 10:22 a.m. R49's tube feeding was disconnected and the purple catheter tip was pointed upward and uncapped. The date on the bottle indicated last changed 2/6/23, at 10:00 p.m. During observations on 2/7/23, at 3:30 p.m. R49's tube feeding was still disconnected and the purple catheter tip was pointed upward and uncapped. The same dated bottle was hanging and 750 ml of tube feeding was left in the bottle. During observations on 2/8/23, at 7:05 a.m. R49 was laying in bed and the tube feeding catheter was connected to R49's gastric tube and tube feeding ran through the tube at 50 ml per hour. The date on the bottle that was hung at that time was dated 2/6/23, at 10:00 p.m. registered nurse (RN)-B entered room, placed on gloves, disconnected the tube feeding catheter from R49's gastric tube and hung the tube feeding catheter on the hook on the pole. The purple tip was not capped. During an interview on 2/8/23, at 7:19 a.m. RN-B stated tube feeding bottles were only good for 24 hours and then would be changed. RN-B looked	2 930		

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2 930	Continued From page 26 at the tube feeding bottle that hung at that time and confirmed the date and time on the bottle was 2/6/23, at 10:00 p.m. She stated she should have changed the bottle before 10:00 p.m. on 2/7/23 but had not done it. RN-B stated bottles needed to be changed prior to 24 hour mark because the longer they hung after 24 hours the higher the risk of infection the resident would have. During an interview on 2/8/23, at 3:10 p.m. registered dietician (RD)-E stated tube feeding bottles had to be changed every 24 hours to decrease the risk of infection for the resident. During interview on 2/9/23, at 2:00 p.m. the assistant director of nursing stated staff should change the Tube feeding per facility protocol to prevent infection. Facility policy Tube Feeding last revised 9/21 indicated all residents on tube feeding would be monitored. It did not discuss information about how long tube feeding was good for. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure precautions to prevent aspiration and infection control were followed. The Director of Nursing or designee could educate all appropriate staff on the policies and procedures. The Director of Nursing or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 930		

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21095	Continued From page 27	21095		
21095	MN Rule 4658.0650 Subp. 4 Food Supplies; Storage of Nonperishable food Subp. 4. Storage of nonperishable food. Containers of nonperishable food must be stored a minimum of six inches above the floor in a manner that protects the food from splash and other contamination, and that permits easy cleaning of the storage area. Containers may be stored on equipment such as dollies, racks, or pallets, provided the equipment is easily movable and constructed to allow for easy cleaning. Nonperishable food and containers of nonperishable food must not be stored under exposed or unprotected sewer lines or similar sources of potential contamination. The storage of nonperishable food in toilet rooms or vestibules is prohibited. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to maintain clean and sanitary equipment in the main kitchen of the facility. This deficient practice had the potential to affect 61 of 63 residents who were served food from the main kitchen. In addition, the facility failed to ensure refrigerated and dry food items were disposed of after expiration date and were properly labeled and dated when the original packaging was opened in 4 of 4 wings. Findings include: During an observation on 2/6/23, at 1:25 p.m. kitchen hood vent over stove had brownish-gray fuzz-like material moving with air along the black metal frame.	21095	Competed.	3/24/23

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21095	Continued From page 28 During an interview on 2/6/23, at 1:28 p.m. certified dietary manager (CDM) stated it was "probably dust". CDM stated hood vent was last cleaned in March 2022 and it was on the schedule to be cleaned March 2023. During an observation on 2/8/23, at 7:03 a.m. eight yogurt cups on three separate meal tray carts. During an interview on 2/8/23, at 7:04 a.m. with dietary aide (DA)-A stated yogurt placed on trays in kitchen at 7:00 a.m.. During an interview on 2/8/23, at 7:04 a.m. CDM stated yogurt would be served at 7:30 a.m. During an observation on 2/8/23, at 7:35 a.m. kitchen thermometer read 80 degrees. During an observation on 2/08/23, at 07:35 a.m. prior to yogurt being served, CDM confirmed temperature of yogurt confirmed to be 50 degrees, by placing thermometer into center of yogurt.. CDM stated cold foods should be served at 41 degrees or less. During an observation on 2/8/23, at 10:53 a.m. dry food storage area observed to have Thick and Easy Hormel thickened water with expiration date of 11/16/22 and Thick and Easy Hormel honey thickened apple juice with expiration date of 11/11/22. During an observation on 2/6/23, at 1:42 p.m. resident personal item refrigerator on 100 wing had a thermometer that did not display the temperature. Refrigerator contained Yoplait strawberry banana yogurt and Yoplait blueberry	21095		

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21095	Continued From page 29 yogurt with expiration date of 1/27/23. Plastic bag labeled "MD" contained pickles and mayonnaise, without a date. Seafood snackers package was not sealed, without name. Freezer contained a box of Eggo waffles that were not sealed. Waffle expiration date of 7/30/22. Resident personal item refrigerator lacked a thermometer in operating condition on 200 wing. Plastic container contained food that was covered with a white fuzz-like matter. Plastic container was not dated. Two strawberry banana Yoplait yogurts had expiration dates of 1/9/23 and 1/27/23. Whipping cream lacking name and date, had expiration date of 1/4/23. Resident personal item fridge on 300 wing contained a Styrofoam container: lacking date. Food was covered in white and green matter. Biohazard Ziploc baggie contained a block of pepper jack cheese with dark green fuzz-like circles that had white perimeters. Cheese lacked name or date label. Soup in a jar was observed to have a name and date of 12/7/22. String cheese with expiration date of 10/29/22 observed. Bottle of Dr Pepper soda, approximately half full had an expiration date of 7/25/22. Pace picante sauce had an expiration date of 9/21/22. Picante sauce lacked name and date. Freezer observed to contain gelato with a use by date of 12/19/21 and Kemp's rainbow sherbet with use by date of 7/27/21. Sherbet lacked name and date opened. Resident personal item refrigerator on wing 3 cul-de-sac observed to have plastic bag containing liverwurst with green matter on it, lacking name and date. Helluva brand dip observed to have expiration date or 11/30/22. Land o' Lakes butter with canola oil " had expiration date of 1/10/23. Block of pepper jack	21095		

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21095	Continued From page 30 cheese in freezer dated 7/21/22, with expiration date of 12/21/22. During an interview on 2/6/23, at 1:57 p.m. CDM stated there was not a process in place to monitor the temperature of the refrigerator/freezers for resident personal item refrigerators. Resident personal item refrigerator/freezers available for residents to access freely. During an observation on 2/8/23, at 11:12 a.m. kitchen floor observed have brownish black buildup on floor under dishwashing counter to left of dishwasher and under cook prep area. During an interview on 2/8/23, at 11:13 a.m. CDM stated the kitchen floor was swept and mopped every evening. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure procedures were followed to maintain clean and sanitary equipment in the kitchen. The Director of Nursing or designee could educate all appropriate staff on the policies and procedures. The Director of Nursing or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21095		
21620	MN Rule 4658.1345 Labeling of Drugs Drugs used in the nursing home must be labeled in accordance with part 6800.6300.	21620		3/24/23

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21620	Continued From page 31 This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure medication was properly labeled for 1 of 12 residents(R43) reviewed for medication administration and medication storage. In addition, the facility failed to ensure medication creams, ointments, powders, liquids and an inhaler were properly stored to prevent cross contamination of resident medications for 8 out of 12 residents (R21, R168, R5, R39, R28, R15, R37, R20). The facility also failed to remove 2 tubes (one expired) of medication from the medication cart that were not labeled or stored in a manner to prevent cross contamination. Furthermore, the facility failed to separate biohazard from medication used for residents stored in a refrigerator. During a medication pass observation on 2/8/23, at 7:28 a.m. licensed practical nurse (LPN)-A stated R-43's inhaler did not have a medication label on the actual inhaler because the inhaler box was damaged by water from another medication on ice during transport from the pharmacy. Normally we peel the label off the box and put it directly on the inhaler but since the box was damaged it couldn't be done. LPN-A stated the label on the bag the medication was stored in was adequate labeling. On 2/9/23, at 11:20 a.m. during 200 hallway medication cart review, the third cart drawer had compartments that contained multiple resident's medications. Medications included Lidocaine patches in boxes, inhalers in boxes, liquid medications not in plastic bags and several topical creams and powders not stored within	21620	Completed.	

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21620	Continued From page 32 plastic bags or boxes. Medications that were not stored in a box or plastic bag with other resident medications included: _A tube of Diclofenac sodium topical gel with an expiration date of 7/22. The expired medication did not have a patient label on it. LPN-D confirmed that the medication was expired and did not have a patient label. LPN-D removed the medication from the cart and stated it was probably in the cart in case another resident ran out of the same medication. _An open unexpired tube of Nystatin cream 100,000 usp units did not have a patient label on it. LPN-D did not know who the medication belonged to. _R-5's vesta ointment _R-39's nystop powder with instructions apply to groin as needed for yeast _R-38's nystatin powder with instruction to apply to groin peri area as needed. _R15, R37 and R39's liquid medications were stored in the same area as the creams and powders and were not contained in plastic bags. _Multiple other powders were in the shared compartment without being contained in plastic bags. _R20's Symbicort inhaler was in the same compartment amongst the creams, powders, and liquids. The inhaler was not in a bag or box. LPN-D confirmed that powder and cream containers do go into the patient rooms for application. LPN-D agreed there was a risk for cross contamination when medication was stored together without being in individual boxes or plastic bags. On 02/9/23, at 12:58 p.m. the medication cart in the 400's wing was reviewed with trained medication aide (TMA)-A. R43's Symbicort inhaler was stored in a bag with a pharmacy label	21620		

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21620	Continued From page 33 on it. The inhaler did not have a label on it. TMA-A stated since a pharmacy label was on the bag the inhaler did not need to have a label on it too. Liquid medications and fiber containers in the cart were not in plastic bags. TMA-A stated liquids and bulk individual fiber supplements did not ever go in resident rooms, so they did not require plastic bags for storage. On 2/9/23, at 1:11 p.m. (LPN)-B opened cart for rooms 314-322 and stated there were two medication carts in the 300 wing, but she was the only one passing medication today. R-21's Miconazole nitrate antifungal powder was not in a plastic bag. The medication was stored in a compartment with multiple other resident medications in bags or boxes. R-168's Nystatin cream was not in a plastic bag and was in a compartment sitting on top of another resident's medication that was stored in a zip lock bag. LPN-B stated topical medications should be stored in individual plastics bag to prevent cross contamination. During an interview on 2/9/23, at 1:28 p.m. both unit coordinator LPN-C and assistant director of nursing (ADON) stated in agreement, medications should all be bagged and stored separately. Regarding the inhaler without a pharmacy label, LPN-C stated the pharmacy has not been consistent with how they send inhalers, sometimes they put it on the inhaler, sometimes they put it on the baggie, or just on the box and not on the inhaler. Neither confirmed the inhaler should have a pharmacy label with patient name, medication, and dose directly on the inhaler. On 2/9/23, at 2:40 p.m. the director of nursing (DON) stated all individual medications should be stored in plastic bags due to the risk of cross	21620		

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21620	Continued From page 34 contamination. Topical medications should be removed from medication carts when no longer in use, not kept in case another resident runs out. In the case of the inhaler without a label on it in the medication cart, the don stated the label on the baggie the inhaler was stored in was sufficient labeling, the inhaler did not require a label as well. For storage, the don stated an inhaler could be in the bottom cart drawer without being stored in a baggie if it was a discharged resident's inhaler that had been pulled to destroy later. However, if the inhaler belonged to a current resident, then the inhaler should be stored in a plastic bag to prevent it from becoming contaminated by other medications in the cart. On 2/9/23, at 2:48 p.m. during follow-up the don asked LPN-D what was done with the inhaler stored in the bottom of the cart. LPN-D stated R20's inhaler was removed from the compartment with the unbagged medications, placed it in a bag and put it in the med cart drawer where other resident inhalers were stored. The don stated, "so that is taken care of." Lastly, the don stated she had confirmed the facility weekly medication cart audits included, proper labeling, and medication storage in addition to checking for expiration dates. During an interview on 2/10/23, at 8:08 a.m. the consulting pharmacist shared the following. It is a MN board of pharmacy requirement for the immediate medication container to have a pharmacy label with the resident name, medication, and dose instructions. At the least an inhaler should have a mini label on it. Medication boxes should be labeled with a big label and a little label that peels off to be placed on the inhaler when the box is opened. Medications should be stored in individual bags because the	21620		

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21620	Continued From page 35 bags create the best barrier to protect medications from contamination, but a box is acceptable as well. I don't know how you could use an inhaler after it was stored in the same compartment with other resident's medicated powders and ointment/creams. Using improperly stored medications is how people can get infections. Infectious disease (referring to providers) would not approve of someone putting an inhaler stored that way into their mouth and inhaling directly into their lungs. Oral medications need to be stored in plastic bags separately from other forms of medications because the risk of infection is higher with oral medications. On 02/08/23, at 11:48 a.m. during a tour of the wing four medication room licensed practical nurse (LPN)-C opened the lab fridge that was directly below the locked medication fridge. The fridge shelf had a urine sample in a specimen cup with three boxes of Bisacodyl 10 mg stimulant laxative suppositories stacked approximately 3 inches away from the urine sample. Two boxes were sealed, and one box had several doses removed from the box. LPN-C closed the fridge and stated the suppository boxes should not be stored in the lab specimen fridge where body fluids were being stored. LPN-C then reopened the fridge, removed the 3 boxes, and stated she was going to destroy the boxes because the suppositories should not be given to residents after being stored next to a urine sample. On 2/09/23, at 2:46 p.m. the director of nursing (DON) stated suppositories should not be stored in the lab specimen fridge because of the risk for contamination. The DON stated the suppositories should be thrown away. During an interview on 2/10/23, at 8:08 a.m. the	21620		

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21620	Continued From page 36 consulting pharmacist stated medications should be stored in a fridge dedicated to medication storage only, nothing else should be stored in the fridge. The pharmacist further stated medications should be thrown out due to infection risk and unsafe storage. A list of residents receiving suppositories was requested and not received. Facility policy Storage of Medications directed staff to store all drugs and biologics in a safe, secure, and orderly manner. The policy did not provide direction specific to infection prevention or the storage of medications requiring refrigeration. Facility policy Storage of Medications directed staff to store all drugs and biologics in a safe, secure, and orderly manner. Interpretation and implementation included: nursing staff are responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner. Drug containers that have missing, incomplete, improper labels should be returned to the pharmacy for proper labeling before storing and discontinued, outdated, or deteriorated drugs or biologics should be returned to the dispensing pharmacy or destroyed. The policy did not have instructions that directed staff on proper storage of medications to prevent medication contamination and spread of infection. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure medications were properly labeled and stored. The Director of Nursing or designee could	21620		

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21620	Continued From page 37 educate all appropriate staff on the policies and procedures. The Director of Nursing or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21620		
21695	MN Rule 4658.1415 Subp. 4 Plant Housekeeping, Operation, & Maintenance Subp. 4. Housekeeping. A nursing home must provide housekeeping and maintenance services necessary to maintain a clean, orderly, and comfortable interior, including walls, floors, ceilings, registers, fixtures, equipment, lighting, and furnishings. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure resident floors were clean and rooms were free of odors, ensue bed linens were clean, a wheelchair was safe for use and a catheter bag was emptied. This deficient practice affected 5 of 9 residents (R18, R31, R11, R2, R53 and R57) reviewed for a clean and homelike environment. Findings include: R18's Admission Record dated 2/9/23, identified diagnoses which included traumatic brain injury, depression, and anxiety, R18's quarterly Minimum Data Set (MDS) dated 1/6/23, indicated R18 was cognitively intact and	21695	Completed.	3/24/23

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21695	Continued From page 38 rejected care four to six days in a seven day period. In addition, R18 was independent with eating. During an observation on 2/6/23, at 6:55 p.m. R18's floor was noted to have a residue about two feet in length and 10 inches in width, there were also food crumbs between his bed and his recliner on the floor. During an observation on 2/8/23, at 8:29 a.m. R18 was seated in his recliner he had just finished his breakfast, there was residue on the floor and food between his chair and his bed. During an observation on 2/9/23, at 6:38 a.m. R18 was seated in his recliner leaning to his right. R18's floor between his bed and his chair had a large area of food residue on the floor. In addition, there was a black cushion on the floor between the bed and his recliner. During an interview on 2/8/22, at 9:35 a.m. housekeeping aide (HA)-A stated she cleaned the floor between his recliner and his bed twice a day. During an interview on 2/9/23, at 9:59 a.m. the director of nursing (DON) stated she would expect staff to report a dirty floor to housekeeping to get it cleaned up. During an interview on 2/9/23, at 11:10 a.m. the administrator stated she would expect staff to notice dirty floors and get them cleaned by telling housekeeping or their care coordinator. The facility policy titled Cleaning and Disinfecting Resident Rooms revised 8/2013, directed staff to do the following; "Housekeeping surfaces (e.g., floors, tabletops) will be cleaned on a regular	21695		

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	00299	A. BUILDING: _____ B. WING _____	C 02/10/2023

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THE EMERALDS AT GRAND RAPIDS LLC	2801 SOUTH HIGHWAY 169 GRAND RAPIDS, MN 55744

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21695	Continued From page 39 basis, when spills occur, and when these surfaces are visibly soiled." R31's quarterly MDS dated 1/6/23, indicated R31 had diagnoses which included heart failure (a chronic condition in which the blood doesn't pump blood as well as it should), anxiety, diabetes mellitus, and depression. In addition, R31's MDS indicated he was cognitively intact, rejected cares four to six of the seven days. During an observation on 2/7/23, at 8:16 a.m. there was a strong odor of urine, R31's urinal was hanging on the trash can next to his bedside it was empty. During an observation on 2/8/23, at 8:24 a.m. R31's door was closed, after knocking on the door and being given permission to enter a strong odor of urine was noted. R31's urinal was noted hanging on the trash can with about 100 milliliters of urine. During an interview on 2/8/23, at 7:41 a.m. licensed practical nurse (LPN)-D verified there was a strong odor of urine when she went into his room to give him his medications. LPN-D stated she thought he spilled his urinal a lot. During an interview on 2/8/23, at 9:21 a.m. housekeeper (H)-A verified there was a strong odor of urine in R31's room. She stated R31 would sometimes urinate in the trash can. She stated she would mop at least three times in a shift. During an interview on 2/9/23, at 11:10 a.m. the administrator stated odors needed to be addressed and interventions put into place to neutralize the odor.	21695		

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21695	Continued From page 40 R11's Admission Record dated 2/9/23, indicated R11 had diagnoses which included chronic kidney disease stage three (mild to moderate damage to kidneys and they are less able to filter waste), muscle weakness, and legal blindness. R11's quarterly MDS dated 2/8/23, indicated R11 was cognitively intact, had no rejections of care, required supervision with toilet use, and was occasionally incontinent of urine. During an observation on 2/6/23, at 2:41 p.m. a yellow stain approximately two feet by one foot was noted in the middle near the left edge of the bottom sheet of his unmade bed. During an observation on 2/7/23, at 3:22 p.m. R11's bed was unmade, the yellow stain remained on the bottom sheet. During an interview on 2/8/23, at 7:39 a.m. nursing assistant (NA)-K stated she saw the yellow stain on R11's bottom sheet that morning. NA-K verified R11 did not make his own bed and the staff should have been checking his bed daily, changing the sheets as needed, and making his bed. NA-K stated he was continent of bladder but would sometimes spill his urinal. NA-K stated someone should have made his bed over the last two days and noticed the bottom sheet needed to be changed. During an interview on 2/9/23, at 9:57 a.m. the DON stated bed linens should be changed whenever they were soiled, on bath day, and as needed. The DON stated NAs should be checking resident's beds and making the bed and/or changing the linens as needed.	21695		

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21695	Continued From page 41 During an interview on 2/9/23, at 11:10 a.m. the administrator verified resident bed linens should be checked and changed when they are soiled. R2's Admission Record dated 2/9/23, indicated R2 had diagnoses which included epilepsy, chronic obstructive pulmonary disease (a group of lung diseases that block airflow and make it difficult to breathe), hypotension, age-related osteoporosis, and post-traumatic stress disorder. R2's quarterly MDS dated 12/2/22, indicated R2 was cognitively intact and had no rejections of care. In addition R2's MDS indicated he was independent with bed mobility and transfers. On 2/6/23, at 3:03 p.m. R2's wheelchair was parked next to his bed, he was seated on his bed. On the right side of R2's wheelchair there were rivets missing (two of the four rivets were torn from the rivet and being held by the underside material of the wheelchair and the front and back rivet were no longer attached to the chair seat). On 2/8/23, at 9:05 a.m. occupational therapist (OTR)-H verified R2's wheelchair seat was being held in place with two rivets. OTR-H stated he would have expected staff to notice the wheelchair seat needed repair and would have expected them to fill out a repair slip. On 2/8/23, at 9:08 a.m. nursing assistant (NA)-B, verified the wheelchair material was torn away from the rivets and the wheelchair material was no longer being held by the front and back rivets. On 2/8/23, at 9:19 a.m. regional maintenance director (RMD)-A stated he had just received a request to fix R2's wheelchair, he stated he thought it was the first request.	21695		

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21695	Continued From page 42 On 2/8/23, at 10:00 a.m. maintenance director (MD)-B reviewed his work orders and stated he did not see any work orders for R2's wheelchair. On 2/9/23, at 10:01 a.m. the DON stated she would expect staff to note equipment that was in need of repair and would expect them to fill out a maintenance request for repair or tell the nurse. The DON added all staff know how to fill out repair slips. On 2/9/23, at 11:10 a.m. the administrator stated she would expect staff to note resident equipment that was not safe for their use, remove it and fill out a maintenance request for repair. The facility policy titled Maintenance Service dated 12/2009, did not address how staff made work order requests. R53's diagnosis included: bacteremia, retention of urine, flaccid neuropathic bladder, nodular prostate with lower urinary tract symptoms, urinary tract infection, and chronic cystitis without hematuria. Document review of Significant change Minimum Data Set (MDS) assessment dated 11/6/22 indicated R53 had intact cognition and required assistance of staff with bowel and bladder needs. Document review of R53's care plan had a focus area of alteration in elimination for resident. Goal indicated resident will be free from signs/symptoms of urinary tract infection (UTI). Interventions included assist of 1 with toileting,	21695		

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21695	Continued From page 43 provide assistance with peri-cares morning, bedtime and as needed, provide incontinent products and assist to change as needed, monitor Foley catheter output, change Foley catheter per policy, Foley catheter care per policy. During an observation on 2/6/23, at 7:00 p.m. R53's catheter bedside bag was hanging from the frame of the bed. The catheter bag was not connected to the resident and contained approximately 700 cc gold-colored urine. During an interview on 2/6/23, at 7:02 p.m. R53 stated he asked the staff to empty the urine multiple times since he got up at noon. R53 stated bag had not been emptied since he went to bed the night before. R53 stated he independently empties his leg bag into the urinal throughout the day and the staff empty the urinal. R53 stated that there had been a delay in emptying the bedside bag several times in the previous week. During an interview on 2/6/23, at 7:46 p.m. R53 stated nursing assistant (NA)-C emptied the urine from the bedside bag. During an interview on 2/6/23, at 7:47 p.m. NA-C stated urine was emptied when R53 asked for it to be emptied. NA-C stated the day shift usually empties it. During an interview on 2/6/23, at 7:48 p.m. LPN-C stated staff should be emptying the bedside catheter bag during the day for the purpose of infection control. Document review on 2/6/23, indicated that R53 was currently being treated for a bladder infection with Bactrim DS (antibiotic) twice daily for 7 days,	21695		

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21695	Continued From page 44 started 2/2/23. R53 also was taking Keflex (antibiotic) twice daily 500 mg indefinitely. During an interview on 2/9/23, at 3:50 p.m. director of nursing (DON) and assistant director of nursing (ADON) DON stated catheter bags should be emptied when residents get up in the morning. ADON stated reason to empty bags was for infection control. Review of catheter care policy, dated September 2014 indicated in the infection control section, d) empty the collection bag at least every eight hours. R57 During observation on 2/9/23, at 9:53 a.m. certified nursing assistant (CNA)-F was cutting R57's fingernails in the dining room, with fingernails falling to the floor. During an interview on 2/9/23, at 9:54 a.m. licensed practical nurse (LPN)-C stated residents' nail care should not be completed in the dining room. During an interview on 2/9/23, at 10:09 a.m. CNA-F stated fingernails should not be cut in the dining room. During an interview on 2/9/23, at 3:29 p.m. the director of nursing (DON) and assistant director of nursing (ADON) stated residents should receive nail care assistance in their room or in the shower room on their bath day, for dignity reasons. During an observation on 2/8/23, at 3:44 p.m. gray fuzz material was on the vents of the oxygen concentrators for R27 and R47.	21695		

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21695	Continued From page 45 During an interview on 2/8/23, at 3:44 p.m. LPN-C stated the gray fuzz material observed on the oxygen contractor vents was an infection control concern. During an interview on 2/9/23, at 3:25 p.m. director of nursing (DON) and assistant director of nursing (ADON) stated gray fuzz material on the vents of oxygen concentrators was an infection control concern. ADON the filters should be changed by the nurses weekly. Review of infection prevention and control program, indicated important facets of infection control include: c) educating staff and ensuring that they adhere to proper techniques and procedures. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure resident care areas were clean and free of odors. In addition, the facility could ensure bed linens were checked and changed when soiled. Furthermore, staff should check equipments and resident supplies to keep clean. The Director of Nursing or designee could educate all appropriate staff on the policies and procedures. The Director of Nursing or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21695		

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21850	Continued From page 46	21850		
21850	MN St. Statute 144.651 Subd. 14 Patients & Residents of HC Fac.Bill of Rights Subd. 14. Freedom from maltreatment. Residents shall be free from maltreatment as defined in the Vulnerable Adults Protection Act. "Maltreatment" means conduct described in section 626.5572, subdivision 15, or the intentional and non-therapeutic infliction of physical pain or injury, or any persistent course of conduct intended to produce mental or emotional distress. Every resident shall also be free from non-therapeutic chemical and physical restraints, except in fully documented emergencies, or as authorized in writing after examination by a resident's physician for a specified and limited period of time, and only when necessary to protect the resident from self-injury or injury to others. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure privacy of exposed body areas for 1 of 5 residents (R5) reviewed for dignity. Findings include: R5's Diagnosis Report dated 2/9/23, indicated R5's diagnoses included muscle weakness, chronic pain, bipolar disorder, depression, and panic disorder. R5's quarterly Minimum Data Set (MDS) dated 12/4/22, indicated R5 was cognitively intact, and required extensive with bed mobility, dressing, toilet use, and personal hygiene.	21850	Completed.	3/24/23

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21850	Continued From page 47 R5's care plan revised on 12/6/22, indicated R5 had limited physical mobility related to morbid obesity and pain. The care plan directed staff to assist with all cares while resident participated to her maximum capacity. During an observation on 2/7/23, at 3:34 p.m. nursing assistant (NA)-A entered R5's room, performed hand hygiene, applied gloves, opened a brief, and laid the brief on the bed. NA-A removed R5's shirt, then using personal care wipes cleansed under her pannus (excess abdominal skin and fat that hangs over the pubic region), groin folds, and perineum wiping front to back (using a new wipe for each area). R5 rolled onto her side, her back and buttocks were exposed (no privacy curtain between the bed and the resident's door). NA-A noted the bottom sheet was wet and needed to be changed. NA-A told R5 she needed to get a sheet and pad for the bed. NA-A removed her gloves, performed hand hygiene and walked to R5's room door and was ready to open the door. NA-A was stopped prior to exiting the room and was asked if she was going to cover the resident. NA-A went back to the bed and asked R5 if she could cover her with her clean gown. R5 agreed to be covered. During an interview on 2/7/23, at 3:40 p.m. NA-A verified she should have covered R5 before leaving the room for more supplies. During an interview on 2/9/23, at 11:20 a.m. the administrator verified she would expect staff to cover a resident prior to leaving the room for more supplies and not leave them exposed. The facility policy titled Quality of Life - Dignity revised 8/2009, directed staff to treat residents	21850		

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21850	Continued From page 48 with dignity and respect at all times. "Staff shall promote, maintain and protect resident privacy, including bodily privacy during assistance with personal care and during treatment procedures." SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure staff ensure privacy with personal cares. The Director of Nursing or designee could educate all appropriate staff on the policies and procedures. The Director of Nursing or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21850		

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	245495	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/07/2023**

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 02/07/2023. At the time of this survey, The Estates At Grand Rapids 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		03/13/2023

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

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K 000	Continued From page 1 Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. The Emeralds At Grand Rapids is a 1-story building with a partial basement and was constructed at 4 different times. The original building was constructed in 1963, is 1 story with a partial basement, and was determined to be of Type II(111) construction. In 1968 a one story addition, without a basement, was constructed south and west of the original building, and was determined to be of Type II (111) construction. In 1980 a one story addition was constructed to the north of the original building, was determined to	K 000		

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THE EMERALDS AT GRAND RAPIDS LLC	**2801 SOUTH HIGHWAY 169** **GRAND RAPIDS, MN 55744**

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K 000	Continued From page 2 be a type V (111) construction, and is separated with a 2-hour fire barrier. This building is no longer used by residents and is staff only. In 2001 two other one story additions were built, one north of the west wing (a chapel) and one south of the west wing (special cares unit) which were determined to be Type II (111) construction and separated with 2-hour fire barriers. The building is divided into 8 smoke compartments by 30-minute and 2-hour fire barriers. The facility is fully sprinkler protected and has a fire alarm system with smoke detection in the corridor system and in all sleeping rooms that is monitored for automatic fire department notification. The facility has a capacity of 95 beds and had a census of 63 at the time of the survey. The requirements at 42 CFR, Subpart 483.70(a), are NOT MET as evidenced by:	K 000		
K 511 SS=F	Utilities - Gas and Electric CFR(s): NFPA 101 Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 This REQUIREMENT is not met as evidenced	K 511		3/14/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245495	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/07/2023**

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K 511	Continued From page 3 by: Based on observation and staff interview, the facility failed to secure electrical panels per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.3.2.2.1.3. These deficient findings could have a widespread impact on the residents within the facility. Findings include: 02/07/2023, between 9:30am and 12:30pm, it was revealed by observation that the electrical panels located on the 401 wing, 201 wing and 101 wing were not locked. An interview with the Maintenance Director, Regional Maintenance Director and Facility Administrator verified this deficient finding at the time of discovery.	K 511	Immediate Corrective Action: Electrical panels on 400, 200, and 100 wing were locked on 2/7/23. Corrective Action as it applies to others: Education will be provided to the Maintenance director and maintenance assistants to ensure that electrical panels are locked. Date of Compliance: 3/14/23 Recurrence will be prevented by: Audits will be conducted to ensure electrical panels are locked. Audits will be completed weekly for 3 weeks, and then monthly for 2 months. Audits and findings will be reported to QAPI committee for further recommendations.¿ Corrections will be monitored by: Maintenance Director or Designee	
K 712 SS=F	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted	K 712		3/14/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 712	Continued From page 4 between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to conduct fire drills per NFPA 101 (2012 edition), Life Safety Code, sections 19.7.1.6, 4.7.4, and 4.6.1.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 02/07/2023, between 9:30am and 12:30pm, it was revealed by a review of available documentation that fire drills were not completed: 1) First quarter (January - March) missing fire drills during first and second shifts. 2) Third quarter (July - September) missing fire drills during first and third shifts. 3) Fourth quarter (October - December) missing fire drill during third shift. An interview with the Maintenance Director, Regional Maintenance Director and Facility Administrator verified this deficient finding at the time of discovery.	K 712	Immediate Corrective Action: Fire drills have been completed 2/27 during 2nd shift, and 3/3 during 3rd shift. Corrective Action as it applies to others: Education provided to maintenance director on frequency of conducting fire drills and NFPA 101, Life Safety Code sections 19.7.16, 4.7.4, and 4.6.1.1. Date of Compliance: 3/14/23 Recurrence will be prevented by: Audits will be conducted on fire drill completion ensuring fire drills are compliant with NFPA 101, Life Safety Code sections 19.7.16, 4.7.4, and 4.6.1.1. . Audits will be completed monthly for 3 months, and then quarterly for 2 quarters. Audits and findings will be reported to QAPI committee for further recommendations.¿ Corrections will be monitored by: Maintenance Director or Designee	