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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: MKWH

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00942

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245270**

2.STATE VENDOR OR MEDICAID NO.
(L2) **823957600**

3. NAME AND ADDRESS OF FACILITY
(L3) **WHITEWATER HEALTH SERVICES**
(L4) **525 BLUFF AVENUE**
(L5) **ST CHARLES, MN** (L6) **55972**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **03/01/2017**

6. DATE OF SURVEY **12/07/2021** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **45** (L18)

13.Total Certified Beds **45** (L17)

10.THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* Code: **A*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	45			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Karen Aldinger, Unit Supervisor 01/05/2022 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Melissa Poepping, Enforcement Specialist 01/05/2022 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
01/01/1985
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00454
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
12/21/2021
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
January 5, 2022

CMS Certification Number (CCN): 245270

Administrator
Whitewater Health Services
525 Bluff Avenue
St Charles, MN 55972

Dear Administrator:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective December 16, 2021 the above facility is certified for:

45 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 45 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status. If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and/or Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
January 5, 2022

Administrator
Whitewater Health Services
525 Bluff Avenue
St Charles, MN 55972

RE: CCN: 245270
Cycle Start Date: October 18, 2021

Dear Administrator:

On November 10, 2021, we notified you a remedy was imposed. On December 7, 2021 the Minnesota Departments 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 December 16, 2021.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective November 25, 2021 be discontinued as of December 16, 2021. (42 CFR 488.417 (b))

However, as we notified you in our letter of November 10, 2021, 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 is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from November 25, 2021. 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,

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: MKWH

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3. Termination **4. CHOW**
5. Validation **6. Complaint**
7. On-Site Visit **9. Other**
8. Full Survey After Complaint

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(L9) **03/01/2017**

6. DATE OF SURVEY **10/18/2021** (L34)

8. ACCREDITATION STATUS: __ (L10)
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2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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02 SNF/NF/Dual	**06 PRTF**	**10 NF**	**14 CORF**	
03 SNF/NF/Distinct	**07 X-Ray**	**11 ICF/IID**	**15 ASC**	
04 SNF	**08 OPT/SP**	**12 RHC**	**16 HOSPICE**	

FISCAL YEAR ENDING DATE: (L35)
12/31

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From (a) :
To (b) :

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X B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	45			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Ruth Furan, HFE NE II 12/06/2021 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Melissa Poepping, Enforcement Specialist 12/10/2021 (L20)

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

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

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3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION
01/01/1985
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
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05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
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07-Provider Status Change
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(L28)

29. INTERMEDIARY/CARRIER NO.
00454
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Electronically Submitted
November 10, 2021

Administrator
Whitewater Health Services
525 Bluff Avenue
St Charles, MN 55972

RE: CCN: 245270
Cycle Start Date: October 18, 2021

Dear Administrator:

On October 18, 2021, survey was completed at your facility by the Minnesota Department of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

REMOVAL OF IMMEDIATE JEOPARDY

On October 13, 2021, the situation of immediate jeopardy to potential health and safety cited at F0578 was removed. However, continued non-compliance remains at the lower scope and severity of E.

REMEDIES

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

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective November 25, 2021.

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

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective November 25, 2021, (42 CFR 488.417 (b)). They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective November 25, 2021, (42 CFR 488.417 (b)).

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

NURSE AIDE TRAINING PROHIBITION

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

Therefore, your agency is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective November 25, 2021. This prohibition is not subject to appeal. Under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

ELECTRONIC PLAN OF CORRECTION (ePOC)

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

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

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same

deficient practice.

- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

DEPARTMENT CONTACT

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

Karen Aldinger, Unit Supervisor
St. Cloud A District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: karen.aldinger@state.mn.us
Office: (651) 201-3794 Mobile: (320) 249-2805

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

SURVEY

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by April 18, 2022 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

APPEAL RIGHTS DENIAL OF PAYMENT

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

Tamika.Brown@cms.hhs.gov

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

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

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

APPEAL RIGHTS NURSE AIDE TRAINING PROHIBITION

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

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

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

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

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

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

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

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at:

https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

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

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

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,

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245270	A. BUILDING _____ B. WING _____	C 10/18/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITEWATER HEALTH SERVICES	**525 BLUFF AVENUE ST CHARLES, MN 55972**

(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 10/11/21, 10/12/21, 10/13/21, 10/14/21, 10/15/21 and 10/18/21, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) was conducted during a standard recertification survey. The facility was NOT in compliance. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulation has been attained.	E 000		
E 007 SS=C	EP Program Patient Population CFR(s): 483.73(a)(3) §403.748(a)(3), §416.54(a)(3), §418.113(a)(3), §441.184(a)(3), §460.84(a)(3), §482.15(a)(3), §483.73(a)(3), §483.475(a)(3), §484.102(a)(3), §485.68(a)(3), §485.625(a)(3), §485.727(a)(3), §485.920(a)(3), §491.12(a)(3), §494.62(a)(3). [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following:] (3) Address [patient/client] population, including, but not limited to, persons at-risk; the type of services the [facility] has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession	E 007		12/1/21

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

Electronically Signed | 11/19/2021

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245270	A. BUILDING _____ B. WING _____	C 10/18/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITEWATER HEALTH SERVICES	**525 BLUFF AVENUE ST CHARLES, MN 55972**

(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 007	Continued From page 1 plans.** *[For LTC facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do all of the following: (3) Address resident population, including, but not limited to, persons at-risk; the type of services the LTC facility has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans. *NOTE: ["Persons at risk" does not apply to: ASC, hospice, PACE, HHA, CORF, CMCH, RHC/FQHC, or ESRD facilities.] This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to address their resident population including the persons at risk, in their emergency operations plan. This had the potential to affect all 34 residents residing at the facility. Findings include: The facility's Emergency Operations Plan, undated, failed to include an assessment of their population to include persons at risk. During interview on 10/18/21, at 10:04 a.m. the executive director verified the facility emergency plan did not address the population of persons served.	E 007	Assessment of current resident population conducted on 11/19/2021. Assessment tool placed in emergency evacuation kit at each nurse's station for use by staff in the event of an emergency. Assessment will be updated weekly. Audits will be conducted weekly to ensure compliance. Audit findings will be reviewed at QAPI meeting.	
E 015 SS=C	Subsistence Needs for Staff and Patients CFR(s): 483.73(b)(1)	E 015		12/1/21

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	245270	A. BUILDING _____ B. WING _____	C 10/18/2021

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E 015	Continued From page 2 §403.748(b)(1), §418.113(b)(6)(iii), §441.184(b)(1), §460.84(b)(1), §482.15(b)(1), §483.73(b)(1), §483.475(b)(1), §485.625(b)(1) [(b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following: (1) The provision of subsistence needs for staff and patients whether they evacuate or shelter in place, include, but are not limited to the following: (i) Food, water, medical and pharmaceutical supplies (ii) Alternate sources of energy to maintain the following: (A) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (B) Emergency lighting. (C) Fire detection, extinguishing, and alarm systems. (D) Sewage and waste disposal. *[For Inpatient Hospice at §418.113(b)(6)(iii):] Policies and procedures. (6) The following are additional requirements for hospice-operated inpatient care facilities only. The policies and procedures must address the following: (iii) The provision of subsistence needs for	E 015		

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E 015	Continued From page 3 hospice employees and patients, whether they evacuate or shelter in place, include, but are not limited to the following: (A) Food, water, medical, and pharmaceutical supplies. (B) Alternate sources of energy to maintain the following: (1) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (2) Emergency lighting. (3) Fire detection, extinguishing, and alarm systems. (C) Sewage and waste disposal. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to include in their emergency operations plan (EOP) how to obtain pharmaceutical supplies and how to maintain sewage and waste disposal during an emergency. This had the potential to affect 34 residents at the facility. Findings include: Review of the facility's undated EOP reviewed 10/18/21, the facility failed to address how they would obtain pharmaceutical supplies and how they would maintain sewage and waste disposal during an emergency. During interview on 10/18/21, at 10:22 a.m., the executive director verified this information.	E 015	Shelter in place and evacuation procedures updated in emergency preparedness plan to reflect how we would ensure delivery of medication in either situation. Agreement with Kimo's obtained in the event our sewage system fails. In this situation, Kimo's would bring portable bathrooms and we would empty commodes and sewage into the portable bathrooms, keeping a few designated for staff use. Agreement has been added to emergency preparedness plan. Will ensure compliance upon annual review of emergency preparedness plan.	
E 023 SS=C	Policies/Procedures for Medical Documentation CFR(s): 483.73(b)(5) §403.748(b)(5), §416.54(b)(4), §418.113(b)(3),	E 023		12/1/21

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E 023	Continued From page 4 §441.184(b)(5), §460.84(b)(6), §482.15(b)(5), §483.73(b)(5), §483.475(b)(5), §484.102(b)(4), §485.68(b)(3), §485.625(b)(5), §485.727(b)(3), §485.920(b)(4), §486.360(b)(2), §491.12(b)(3), §494.62(b)(4). [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:] [(5) or (3),(4),(6)] A system of medical documentation that preserves patient information, protects confidentiality of patient information, and secures and maintains availability of records. *[For RNHCIs at §403.748(b):] Policies and procedures. (5) A system of care documentation that does the following: (i) Preserves patient information. (ii) Protects confidentiality of patient information. (iii) Secures and maintains the availability of records. *[For OPOs at §486.360(b):] Policies and procedures. (2) A system of medical documentation that preserves potential and actual donor information, protects confidentiality of potential and actual donor information, and secures and maintains the availability of records.	E 023		

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E 023	Continued From page 5 This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to develop a policy and procedure for preservation of medical documents. This had the potential to affect all 34 residents residing in the facility. Findings include: The facility's emergency operations plan reviewed 10/18/21, was reviewed with the executive director. The facility had no system in place that would preserve patient information, protect confidentiality of patient information, and secure and maintain availability of records in the event of an emergency. During an interview on 10/18/21, at 10:32 a.m. the executive director verified there was not a policy or procedure to preserve medical documents.	E 023	Resident demographic pages, including physician and contact information, placed in the center's emergency evacuation kit by 12/1/2021 and will be updated on a weekly basis. Audits will be conducted weekly to ensure compliance. Audit findings will be reviewed at QAPI meeting.	
E 026 SS=C	Roles Under a Waiver Declared by Secretary CFR(s): 483.73(b)(8) §403.748(b)(8), §416.54(b)(6), §418.113(b)(6)(C)(iv), §441.184(b)(8), §460.84(b)(9), §482.15(b)(8), §483.73(b)(8), §483.475(b)(8), §485.625(b)(8), §485.920(b)(7), §494.62(b)(7). [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years	E 026		12/1/21

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E 026	Continued From page 6 [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:] (8) [(6), (6)(C)(iv), (7), or (9)] The role of the [facility] under a waiver declared by the Secretary, in accordance with section 1135 of the Act, in the provision of care and treatment at an alternate care site identified by emergency management officials. *[For RNHCIs at §403.748(b):] Policies and procedures. (8) The role of the RNHCI under a waiver declared by the Secretary, in accordance with section 1135 of Act, in the provision of care at an alternative care site identified by emergency management officials. This REQUIREMENT is not met as evidenced by: Based on document review and interview, the facility failed to develop policies and procedures in its emergency plan describing the facility's role in providing care and treatment at alternate care sites under section 1135 act waiver. This had the potential to affect all 34 residents currently residing in the facility. Findings Include: The facility emergency operations plan reviewed did not contain information of a policy describing the facility's role in providing care and treatment at alternate care sites under an 1135 waiver. During an interview on 10/18/21, at 10:40 a.m. the executive director confirmed the lack of a policy and procedure, which specifically identified the facility's role in providing care and treatment at alternate care sites under an 1135 waiver.	E 026	Information regarding 1135 Waiver placed in emergency preparedness plan on 11/17/2021. Will ensure compliance upon annual review of emergency preparedness plan.	

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E 030 SS=C	Names and Contact Information CFR(s): 483.73(c)(1) §403.748(c)(1), §416.54(c)(1), §418.113(c)(1), §441.184(c)(1), §460.84(c)(1), §482.15(c)(1), §483.73(c)(1), §483.475(c)(1), §484.102(c)(1), §485.68(c)(1), §485.625(c)(1), §485.727(c)(1), §485.920(c)(1), §486.360(c)(1), §491.12(c)(1), §494.62(c)(1). [(c) The [facility must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities]. The communication plan must include all of the following:] (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians (iv) Other [facilities]. (v) Volunteers. *[For Hospitals at §482.15(c) and CAHs at §485.625(c)] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians (iv) Other [hospitals and CAHs]. (v) Volunteers. *[For RNHCIs at §403.748(c):] The communication plan must include all of the following:	E 030		12/1/21

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E 030	Continued From page 8 (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Next of kin, guardian, or custodian. (iv) Other RNHCIs. (v) Volunteers. *[For ASCs at §416.45(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Volunteers. *[For Hospices at §418.113(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Hospice employees. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Other hospices. *[For HHAs at §484.102(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Volunteers. *[For OPOs at §486.360(c):] The communication plan must include all of the following:	E 030		

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E 030	Continued From page 9 (2) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Volunteers. (iv) Other OPOs. (v) Transplant and donor hospitals in the OPO's Donation Service Area (DSA). This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility's communication plan failed to include the required information including facility staff names and contact numbers and names and contact information for physicians. This had the potential to affect all 34 residents in the facility. Findings include: During interview on 10/18/21, at 10:46 a.m. the executive director acknowledged there was not a list of physicians and their contact numbers or staff names and their contact numbers information in the emergency operations plan.	E 030	Physician information and contact information is included on resident demographic sheets which were placed at the nurses stations in the evacuation kits by 12/1/2021. Audits will be conducted weekly to ensure compliance. Findings will be reviewed at QAPI meeting.	
E 031 SS=C	Emergency Officials Contact Information CFR(s): 483.73(c)(2) §403.748(c)(2), §416.54(c)(2), §418.113(c)(2), §441.184(c)(2), §460.84(c)(2), §482.15(c)(2), §483.73(c)(2), §483.475(c)(2), §484.102(c)(2), §485.68(c)(2), §485.625(c)(2), §485.727(c)(2), §485.920(c)(2), §486.360(c)(2), §491.12(c)(2), §494.62(c)(2). [(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every	E 031		12/1/21

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E 031	Continued From page 10 2 years [annually for LTC facilities]. The communication plan must include all of the following: (2) Contact information for the following: (i) Federal, State, tribal, regional, and local emergency preparedness staff. (ii) Other sources of assistance. *[For LTC Facilities at §483.73(c):] (2) Contact information for the following: (i) Federal, State, tribal, regional, and local emergency preparedness staff. (ii) The State Licensing and Certification Agency. (iii) The Office of the State Long-Term Care Ombudsman. (iv) Other sources of assistance. *[For ICF/IIDs at §483.475(c):] (2) Contact information for the following: (i) Federal, State, tribal, regional, and local emergency preparedness staff. (ii) Other sources of assistance. (iii) The State Licensing and Certification Agency. (iv) The State Protection and Advocacy Agency. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure their Emergency Operations Plan (EOP) included contact information for federal emergency preparedness staff and contact information for the Ombudsman. This had the potential to affect all 34 residents currently residing in the facility. Findings include: The facility's EOP was reviewed with the executive director. The plan-included	E 031	Ombudsman contact information added to emergency preparedness plan on 11/17/2021. Will ensure compliance upon annual review of emergency preparedness plan.	

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E 031	Continued From page 11 components of a communication plan however, lacked documentation of contact information for federal emergency preparedness staff and contact information for the Ombudsman. On 10/18/21, at 10:50 a.m. the executive director verified this information.	E 031		
E 035 SS=C	LTC and ICF/IID Sharing Plan with Patients CFR(s): 483.73(c)(8) §483.73(c)(8); §483.475(c)(8) *[For LTC Facilities at §483.73(c):] [(c) The LTC facility must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually. The communication plan must include all of the following:] *[For ICF/IIDs at §483.475(c):] [(c) The ICF/IID must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years. The communication plan must include all of the following:] (8) A method for sharing information from the emergency plan, that the facility has determined is appropriate, with residents [or clients] and their families or representatives. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the Emergency Operations Plan (EOP) was communicated to residents and/or representatives. This had the potential to	E 035	Emergency preparedness information shared with residents and representatives by 12/1/2021 including information on how to obtain additional details. New residents	12/1/21

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E 035	Continued From page 12 affect all 34 residents who resided at the facility. Findings include: The facility's EOP plan reviewed 10/18/21, lacked documentation of a method for sharing information from the emergency plan the facility had determined appropriate with residents and their families or representatives. During an interview on 10/19/21, at 2:20 p.m. the executive director confirmed the facility had not developed a method for sharing information from the emergency plan with residents and their families.	E 035	and representatives will be provided with emergency preparedness information upon admission via the new admission packet. Training provided to social services director regarding the requirement to include in the admissions packet.	
E 037 SS=C	EP Training Program CFR(s): 483.73(d)(1) §403.748(d)(1), §416.54(d)(1), §418.113(d)(1), §441.184(d)(1), §460.84(d)(1), §482.15(d)(1), §483.73(d)(1), §483.475(d)(1), §484.102(d)(1), §485.68(d)(1), §485.625(d)(1), §485.727(d)(1), §485.920(d)(1), §486.360(d)(1), §491.12(d)(1). *[For RNCHIs at §403.748, ASCs at §416.54, Hospitals at §482.15, ICF/IIDs at §483.475, HHAs at §484.102, "Organizations" under §485.727, OPOs at §486.360, RHC/FQHCs at §491.12:] (1) Training program. The [facility] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of all emergency	E 037		12/1/21

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preparedness training.
(iv) Demonstrate staff knowledge of emergency procedures.
(v) If the emergency preparedness policies and procedures are significantly updated, the [facility] must conduct training on the updated policies and procedures.

*[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following:
(i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles.
(ii) Demonstrate staff knowledge of emergency procedures.
(iii) Provide emergency preparedness training at least every 2 years.
(iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others.
(v) Maintain documentation of all emergency preparedness training.
(vi) If the emergency preparedness policies and procedures are significantly updated, the hospice must conduct training on the updated policies and procedures.

*[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following:
(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their

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E 037	Continued From page 14	E 037		

expected roles.
(ii) After initial training, provide emergency preparedness training every 2 years.
(iii) Demonstrate staff knowledge of emergency procedures.
(iv) Maintain documentation of all emergency preparedness training.
(v) If the emergency preparedness policies and procedures are significantly updated, the PRTF must conduct training on the updated policies and procedures.

*[For PACE at §460.84(d):] (1) The PACE organization must do all of the following:
(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, contractors, participants, and volunteers, consistent with their expected roles.
(ii) Provide emergency preparedness training at least every 2 years.
(iii) Demonstrate staff knowledge of emergency procedures, including informing participants of what to do, where to go, and whom to contact in case of an emergency.
(iv) Maintain documentation of all training.
(v) If the emergency preparedness policies and procedures are significantly updated, the PACE must conduct training on the updated policies and procedures.

*[For LTC Facilities at §483.73(d):] (1) Training Program. The LTC facility must do all of the following:
(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their

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expected role.
(ii) Provide emergency preparedness training at least annually.
(iii) Maintain documentation of all emergency preparedness training.
(iv) Demonstrate staff knowledge of emergency procedures.

*[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following:
(i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.
(ii) Provide emergency preparedness training at least every 2 years.
(iii) Maintain documentation of the training.
(iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment.
(v) If the emergency preparedness policies and procedures are significantly updated, the CORF must conduct training on the updated policies and procedures.

*[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following:
(i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and

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E 037	Continued From page 16 cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the CAH must conduct training on the updated policies and procedures. *[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least every 2 years. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to conduct annual training of the Emergency Operations Plan (EOP) plan with staff. This had the potential to affect all 34 residents and staff. Findings include: During an interview on 10/18/21, at 11:09 a.m. the executive director confirmed EOP training was completed upon hire however, lacked	E 037	All staff were provided training on emergency preparedness by 12/1/2021. Annual training will be provided on an ongoing basis. Compliance with emergency preparedness training will be monitored at QAPI meetings.	

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E 037	Continued From page 17 documentation to indicate the facility had annual training based on the emergency plan and risk assessment completed by the facility. The executive director verified the facility was not completing annual training on the EOP.	E 037		
F 000	INITIAL COMMENTS On 10/11/21, 10/12/21, 10/13/21, 10/14/21 10/15/21 and 10/18/21, a standard recertification survey was conducted at your facility. Complaint investigations were 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: H5270031C (MN73537), with a deficiency cited at F661 and F622. The following complaints were found to be UNSUBSTANTIATED: H5270032 (MN55823), H5270033 (MN54134), and H5270034 (MN53307), H5270035 (MN53097), H5270036 (MN48867). The IJ began on 8/11/21, when R13 was admitted to the facility and the facility failed to address code status, therefore considering him to be Full Code status, when R13 wished not to be resuscitated if his heart were to stop. R10 had returned from the hospital on 9/30/21, and had both Full Code and DNR (Do Not Resuscitate) directions in the medical record. R32 had directions for Full Code on a POLST (provider orders for life sustaining treatment) dated 4/20/21, a physician order dated 9/21/21 indicating DNR, a care plan dated 9/7/21	F 000		

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F 000	Continued From page 18 indicating the code status was on hold. The administrator and director of nursing (DON) were notified of the IJ on 10/12/21, at 2:35 p.m. The IJ was removed on 10/13/21, at 4:30 p.m. but noncompliance remained at the lower scope and severity of an E- pattern scope and severity level, which indicated no actual harm with potential for more than minimal harm that is not immediate jeopardy. The above findings constituted substandard quality of care and an extended survey was conducted 10/18/21. 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 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and	F 561		12/1/21

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F 561	Continued From page 19 waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on interview, and document review, the facility failed to ensure assessed and identified preferences for frequency of bathing was honored for 1 of 1 resident (R86) reviewed for choices. Finding include: During an interview on 10/11/21, at 1:56 p.m. R86 stated he got one shower a week, "I would like to have two and they know this." R86 stated, "They even interviewed me and asked me how many I would like, and I told them two and I get one a week." R86's baseline care plan indicated R86 was alert and orientated and was admitted to the facility on 9/24/21.	F 561	R86 interviewed and care plan updated to reflect bathing preferences. Facility residents have the potential to be affected. Residents interviewed for bathing preferences; care plans updated to reflect those preferences. Residents will be interviewed on admission and as requested for bathing preferences which will be reflected in the care plan, and bath schedule. Interdisciplinary team and nursing staff were educated by Director of Clinical Services starting on11/12/21on the	

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F 561	Continued From page 20 R86's bathing preference form dated 9/27/21, indicated resident's preference for a morning shower and indicated twice a week would be acceptable. During an interview on 10/13/21, at 12:45 p.m. nursing assistant (NA)-A stated R86 had a bath on Mondays, and he was just scheduled for once a week. NA-A showed surveyor the bath schedule that indicated room (R86's room number) was on the bath schedule for Monday only. During an interview on 10/13/21, at 12:51 p.m. licensed practical nurse (LPN)-B stated she was not sure what the process was to determine how many times a week a resident wanted a bath and stated she would find out and get back to surveyor. LPN-B returned to surveyor and stated upon admission the admitting nurse asked the resident how often they would like a bath, what type of bath and they were to put it on the bath schedule. During a subsequent interview at 1:04 p.m. LPN-B verified she was the nurse who had completed R86's bathing preference form and stated she did not know where she placed the form after she completed it upon admission. LPN-B stated she was unaware the form was to be placed in the box on the director of nursing's (DON) door for the DON to update the bath schedule. During an interview on 10/13/21, at 12:56 p.m. the DON stated the bath schedules were updated by LPN-A or herself. The DON stated the bathing preference sheet was to be placed in the mailbox on their door, then they update the bath sheet, and the form is filed in the resident chart. This was missed for R86.	F 561	Resident Rights Policy which includes bathing preferences, and showers, baths, and nail care education. Task was added to the revised Admission/Re-admission checklist. Director of Nursing/Designee will audit care plans once weekly x 8 weeks to ensure bathing preferences are honored and care plans are up to date. The results of the audits will be reviewed by the QAPI committee for trends and any needs for adjustment of audit schedules or content, as well as any further educational needs. The Executive Director is responsible to ensure this action occurs.	

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F 561	Continued From page 21 A policy was requesting on resident bathing preferences and was not provided.	F 561		
F 565 SS=E	Resident/Family Group and Response CFR(s): 483.10(f)(5)(i)-(iv)(6)(7) §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other	F 565		12/1/21

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F 565	Continued From page 22 residents in the facility. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure concerns raised at the resident council meetings were documented and presented back to the council, for 5 of 5 resident (R26, R21, R4, R23, and R186) who were present during the resident council meeting with survey team. Findings include: The resident council meeting minutes were reviewed for the months of 7/23/21, 8/27/21 and 9/30/21. The meeting minutes revealed the following concerns were shared. The meeting minutes from the resident council meeting held 7/23/21, included concerns with quality of food and food being cold, the attitude of the nursing assistants, the need for better communication between staff and residents would like to be introduced to new staff. Residents also voiced housekeeping concerns and missing clothing concerns. The meeting minutes from the resident council meeting held on 8/27/21, included concerns with housekeeping resident room and bathroom dirty, need better ramps for going inside and outside front lobby doors, the social work office is small and is hard for residents to get wheelchairs in her office to talk to her, if need be, making sure resident meal tickets are accurate with preferences, short staffed on weekends and shower days seem to be the worst. Staff talking outside of resident rooms about stuff they do not need to hear, sometimes snacks and ice water	F 565	Resident Council meeting held on 10/28/21 R26, R21, R4, R23 in attendance. R186 discharged. Grievances concerns documented appropriately and followed up on with resolution. Resolutions will be shared with individuals involved with specific concerns and will be shared with resident council group at next meeting in November. Facility residents have the potential to be affected. Activity Director, Executive Director, and other invited Interdisciplinary team members will document grievances from the Resident Council meetings and ensure follow up is complete per policy. Current staff educated by Executive Director starting on 11/12/21 to the Grievance policy and procedure and the Resident Council policy and procedure. Executive Director/Designee will audit the Grievance binder weekly x 8 weeks to ensure all grievances were addressed and complete. The results of the audits will be reviewed by the QAPI committee for trends and any needs for adjustment of audit schedules or content, as well as any further educational needs. The Executive Director is responsible to ensure this action occurs.	

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are not being passed, lack of communication between staff all staff should be on the same page and if you do not know find out.

The meeting minutes from the resident council meeting held 9/30/21, included concerns dusting of large furniture in common areas needs to be completed, request for all windowsills to be cleaned. Would like all activities to last an hour.

On 10/13/21, at 10:00 a.m. a resident council meeting was held with R26, R21, R4, R23 and R186 and one surveyor. When asked the following questions: Does the facility consider the views of the resident or family groups and act promptly upon grievances and recommendations? Does the Grievance Official respond to the resident or family group's concerns? If the facility does not respond to concerns, does the Grievance Official provide a rationale for the response? The residents responded no. The resident's shared they have had concerns with the food being cold and stated they had shared these concerns in resident council meetings in the past. R186 stated 99% of the time her food was cold and stated she eats in her room. The residents stated the facility did not follow-up on concerns shared during the resident council meetings.

During an interview on 10/13/21, at 1:28 p.m. licensed social worker (LSW)-A stated, "To be honest I was not aware the facility needed to process resident council grievances the same as any other grievance needed to be done, but obviously in the future that will change." LSW-A stated there was only one response to the resident council concerns that was in writing for the last three months of resident council meeting

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F 565	Continued From page 24 minute concerns. LSW-A stated, "Its like the residents have the same concerns that do not get resolved." During an interview on 10/14/21, at 11:05 a.m. the executive director stated he expected concern shared in the resident council meeting to be documented in the meeting minutes, the social worker to share the concern with the department responsible and that it was that staff members job to follow up to address the concern and follow up with the resident. The executive director stated he would expect the follow-up and the resolution with the residents to be documented. A policy and procedure for resident council grievances was requested and not provided.	F 565		
F 576 SS=C	Right to Forms of Communication w/ Privacy CFR(s): 483.10(g)(6)-(9) §483.10(g)(6) The resident has the right to have reasonable access to the use of a telephone, including TTY and TDD services, and a place in the facility where calls can be made without being overheard. This includes the right to retain and use a cellular phone at the resident's own expense. §483.10(g)(7) The facility must protect and facilitate that resident's right to communicate with individuals and entities within and external to the facility, including reasonable access to: (i) A telephone, including TTY and TDD services; (ii) The internet, to the extent available to the facility; and (iii) Stationery, postage, writing implements and the ability to send mail.	F 576		12/1/21

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F 576	Continued From page 25 §483.10(g)(8) The resident has the right to send and receive mail, and to receive letters, packages and other materials delivered to the facility for the resident through a means other than a postal service, including the right to: (i) Privacy of such communications consistent with this section; and (ii) Access to stationery, postage, and writing implements at the resident's own expense. §483.10(g)(9) The resident has the right to have reasonable access to and privacy in their use of electronic communications such as email and video communications and for internet research. (i) If the access is available to the facility (ii) At the resident's expense, if any additional expense is incurred by the facility to provide such access to the resident. (iii) Such use must comply with State and Federal law. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to ensure mail was delivered to residents on Saturdays. This had the potential to affect all residents in the facility who received personal mail, including but not limited to 5 of 5 residents (R26, R21, R4, R23, and R186) at the resident council meeting, who verbally confirmed not receiving mail on Saturdays. This has the potential to affect all 34 residents living in the facility. Findings include: On 10/13/21, at 10:00 a.m. a group of residents met to discuss the resident council. When asked whether residents received their mail on Saturdays, all five residents voiced they did not	F 576	Facility residents have the potential to be affected. Weekend manager task list update to include delivery of mail on Saturdays if a manager is not available, nursing staff to deliver mail. Interdisciplinary team and nursing staff educated by the Director of Clinical Services starting on 11/12/21 on the Residents Rights policy and procedures which includes the right to send and receive mail and the Mail policy and procedures. Executive Director/Designee will be	

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F 576	Continued From page 26 receive their mail on Saturdays. The residents shared the staff do not deliver mail on Saturdays. The residents shared they only received mail when the activity director (AC) was working. During an interview on 10/14/21, at 4:24 p.m. activity director (AD) stated she was the staff member that delivered the mail. The AD stated on Saturday, the manager on duty was supposed to deliver the mail. The AD stated she had come in to work on a Monday and the mail had not been delivered and stated this has been frustrating. The AD was not sure if the mail was delivered during the week if she was not at work. During an interview on 10/14/21, at 4:29 p.m. the executive director stated the facility had a manager on duty on Saturdays and it was their responsibility to pass the mail. A policy on resident mail was requested and not provided. The Combined Federal and State Bill of Rights revised 6/18/19 included, "The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service."	F 576	responsible to ensure manager on duty schedule is complete monthly for Saturdays with nursing staff back-up as needed. Executive Director/Designee will audit the Manager on duty task list for completion and check off of the mail pass task weekly for 8 weeks. The results of the audits will be reviewed by the QAPI committee for trends and any needs for adjustment of audit schedules or content, as well as any further educational needs. The Executive Director is responsible to ensure this action occurs.	
F 578 SS=J	Request/Refuse/Dscntnue Trmnt;FormIte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse	F 578		12/1/21

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F 578	Continued From page 27 to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by:	F 578		

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F 578	Continued From page 28 Based on interview and document review, the facility failed to ensure a system was in place to clearly identify resident wishes for code status, cardiopulmonary resuscitation (CPR), for 6 of 34 residents (R13, R10, R32, R184, R26 and R86) reviewed for advanced directives. This failure resulted in an immediate jeopardy (IJ) for R13, R10, and R32, when their medical records failed to identify the residents wishes accurately. In addition to the residents in immediate jeopardy, the facility failed to ensure R184, R26, and R86's code status wishes were addressed with the resident or ordered by the physician. The IJ began on 8/11/21, when R13 was admitted to the facility and the facility failed to address code status, therefore considering him to be Full Code status, when R13 wished not to be resuscitated if his heart were to stop. R10 had returned from the hospital on 9/30/21, and had both Full Code and DNR (Do Not Resuscitate) directions in the medical record. R32 had directions for Full Code on a POLST (provider orders for life sustaining treatment) dated 4/20/21, a physician order dated 9/21/21 indicating DNR, a care plan dated 9/7/21 indicating the code status was on hold. The administrator and director of nursing (DON) were notified of the IJ on 10/12/21, at 2:35 p.m. The IJ was removed on 10/13/21, at 4:30 p.m. but noncompliance remained at the lower scope and severity of an E- pattern scope and severity level, which indicated no actual harm with potential for more than minimal harm that is not immediate jeopardy. Findings include:	F 578	Residents R13, R10, and R32 Advance Directives reviewed and updated, to reflect accurate information. Physician updated. R184, R26, and R86 Advance Directives addressed with the resident, Physician updated, and care plan updated. Facility residents have the potential to be affected. Resident orders in electronic charting system, care plans and hard charts audited and updated with accurate, complete, signed, and dated CPR/code status and POLST for each resident (10/11/2021 and 10/12/2021). Any errors or conflicting information detected on the forms were corrected and sent to Physician for review and signature on 10/12/2021. If not already completed prior to admission and provided to facility, residents will be asked to complete an Advance Directive. Residents will be given the opportunity to complete the POLST (Physician Orders for Life-Sustaining Treatment). The admitting nurse will be responsible to enter this information into the resident's chart, resident's orders in PCC, and care plan. The admitting nurse will verify upon admission that Advanced Directive wishes are current prior to processing. Clear identification will be available for staff regarding CPR/code status and POLST in PCC (resident orders), in residents' hard chart, and in resident care plan.	

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F 578	Continued From page 29 R13's admission MDS dated 8/11/21, included cognitively intact with diagnoses of lung disease and heart failure. R13's physician's orders in the EHR on 10/11/21 failed to include any order for advanced directives or code status. The code status banner in the EHR did not indicate a wish for CPR or DNR. R13's paper medical chart contained a POLST which was signed by the facility's medical director (MD)-A on 8/5/21, but the form was blank and not filled out. R13's wishes were not expressed on the physician signed form. When interviewed on 10/11/21, at 2:35 p.m. R13 stated, nobody at the facility has asked about code status, but R13 would want to be considered DNR. R10's quarterly Minimum Data Set (MDS) dated 7/30/21, included moderate cognitive impairment with diagnoses including Alzheimer's disease and heart failure. R10 had a discharge, return anticipated MDS which indicated he had an unplanned discharge to an acute care hospital on 9/23/21. An entry tracking MDS indicated he had returned to the facility from the hospital on 9/30/21. R10's care plan dated 5/24/21, with a date initiated of 2/3/18, identified, "[R10] has an advanced directive. Full Code, Long term artificial nutrition, IV/IM [intravenous/intramuscular] antibiotics." The goal was listed as, "Resident wishes will be honored." Staff were directed, "Full Code [CPR] Long term artificial nutrition, IV/IM antibiotics. Follow facility protocol for identification of code status. Review code status at least	F 578	Interdisciplinary team and licensed staff educated by the Director of Clinical Services starting on 11/12/21 on Living Will/Advance Directives/Life-sustaining treatment orders policy and procedure, including CPR/code status and POLST Policy and procedure, and default code status of “full code” if POLST documentation is undecided. Director of Nursing/Designee will audit admission checklist for completion of admission tasks during next days clinical meeting. If advance directive/CPR/POLST documentation is absent, incomplete, or contains conflicting instructions. Director of Nursing/designee will follow up to determine status of documentation and/or resident’s wishes. If resident has yet to make decisions as to advanced care planning, the default status of “full code” will be entered/verified and follow up will be completed with resident until decisions are made. Advance Directives will be reviewed with resident/representative during care plan meetings, with changes in resident condition, and as requested by resident/representative. Executive Director/Designee will complete random audits of Advance Directive, POLST documentation three x weekly for 12 weeks. The results of the audits will be reviewed by the QAPI committee for trends and any needs for adjustment of audit schedules or content, as well as any further educational needs. The Executive Director is responsible to ensure this action occurs.	

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quarterly and as directed by resident's/responsible party's wishes."

R10's physician orders in the electronic health record (EHR) did not include any order for code status when reviewed on 10/11/21. The banner in the EHR also did not identify if R10's wishes were for full code (cardiopulmonary resuscitation) or for DNR (do not resuscitate).

When interviewed on 10/11/21, at 4:44 p.m. licensed practical nurse (LPN)-B stated in the event of cardiac arrest, they nurse locates the residents desired code status by going to the paper medical record and locating a POLST (Provider Orders for Life-Sustaining Treatment). LPN-B retrieved R10's paper medical record and located a POLST in the front of the chart. This POLST was dated 1/31/18, and identified R10 wished to have cardiopulmonary resuscitation (CPR) and full medical treatment, additional preferences were checked off as long-term artificial nutrition by tube and use of IV/IM antibiotic treatment. The POLST indicated a discussion was held with R10 and his health care agent and was signed by the health care agent - family member (FM)-D. The provider had signed this form on 1/31/18. A second POLST was also located, this one was signed by the social worker (SW)-B and R10 on 7/21/19. However, there was a note scribbled next to cardiopulmonary resuscitation (CPR) and the note included, "Discussed with PT [patient] with daughter 12/1/202 [unknown which year]. The box for "Attempt Resuscitation" had an X in it, which was crossed off, and the box for "Do Not Attempt resuscitation/DNR (allow natural death)" also had an X in it and was circled. Under additional preferences, both the box for Use IV/IM antibiotic

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treatment and Oral antibiotics only (no IV/IM) both had an X in them. LPN-B stated the POLST's were conflicting and staff would not know what to do in the event of cardiac arrest, "A mistake is going to happen, we are going to do CPR when we are not supposed to." LPN-B stated if she noted any conflicting orders, she would report it to the director of nursing (DON). On 10/12/21, at 2:35 p.m. R10's medical record was reviewed and remained unchanged with the conflicting POLST's and no physician order addressing code status was located.

R32's annual MDS dated 9/10/21, severe cognitive impairment with diagnoses including heart failure and lung disease.

R32's order summary dated 10/12/21, included an order for DNR/DNI [do not intubate] dated 9/7/21.

On 10/12/21, R32's paper medical record contained a POLST dated 4/20/21, which indicated R32 wished to have CPR performed.

R32's care plan dated 9/7/21, included, "Code Status: Changed again from Full CODE to DNR/DNI per MD and POA [power of attorney] as of 9/7/2021." However, listed under interventions directed staff, "ON HOLD: DNR/DNI, Comfort Cares, No artificial nutrition, IV/IM ATB [antibiotics]." It was unclear if the full code or DNR/DNI status was on hold.

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R184's admission MDS dated 10/7/21, included moderate cognitive impairment with diagnoses including heart and lung disease.

When reviewed on 10/11/21, R184's EMR and paper medical record failed to include any advanced directives or POLST.

When interviewed on 10/11/21, at 5:42 p.m. R184 stated, if was found with no pulse and was not breathing they would like CPR performed.

When interviewed on 10/11/21, at 7:22 p.m. R184's family member (FM)-E stated R184 would like to have CPR performed. The facility had not addressed this with either R184 or FM-E.

R26's admission MDS dated 9/1/21, included cognitively intact with diagnosis including heart failure.

R26's Physician Orders in the EHR on 10/11/21, included an order for, "Full Code," which was dated 9/17/21. However, there was no apparent written or verbal order from the physician.

R26's paper medical record contained a POLST dated 9/21/21. The POLST was blank/not filled out, however MD-A and LPN-B had signed the POLST and dated it with 9/21/21. Even though the POLST was signed by the physician, R26's wishes were not on the form.

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When interviewed on 10/11/21, at 7:01 p.m. licensed practical nurse (LPN)-C she stated she was going around trying to find the orders for all of the POLST's and getting information for the residents. LPN-C stated she had to fill out some of them (the POLST's) herself as it was so important to have those. LPN-C stated most of the time when the POLST's were in a resident's chart they were not filled out. LPN-C stated she did her best to update them but could not get to everybody. LPN-C stated she'd previously shared her concerns with the DON, executive director, and the social worker. LPN-C stated it caused her anxiety because staff would not know what to do in an emergency. LPN-C stated if no code status was found in a medical record, the staff would be expected to perform CPR if they were found to have no pulse and no respirations.

When interviewed on 10/11/21, at 4:19 p.m. LPN-A stated, it was not the facility's policy to put the resident's code status into the electronic record in point click care (PCC). LPN-A said she became aware that LPN-C had entered, "verbal orders" for code status in a number of residents' charts but was unsure when this had happened. LPN-A also stated there was a, "system issue" for code status of residents. LPN-C verified R26's current POLST was blank and had been signed by the physician and nurse. LPN-C stated the facility staff would need to initiate CPR if needed, "as you can't ask an unresponsive resident their code status."

When interviewed on 10/10/21, at 3:21 p.m. LPN-B stated, she was the admission nurse that completed the POLST upon admission with R26 but did not recall what R26 has said. LPN-B verified the POLST did not indicate R26's code

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status as the form was blank. LPN-B stated she would look in the hard (paper) chart for the POLST and if the POLST was blank, she would have needed to look in the computer and verified there was a verbal order that indicated full code. LPN-B stated she would have started CPR as the EHR had indicated R26 was full code.

When interviewed on 10/11/21, at 4:12 p.m. LPN-D stated she would look at the POLST in the front of the resident's medical record for a resident's code status. LPN-D stated, if the POLST was blank, "you should initiate CPR until you know their CPR status." LPN-D stated the charge nurse completed the POLST upon admission.

When interviewed on 10/12/21, at 1:37 p.m. the DON stated, "In the state of Minnesota, we would do CPR if we do not have a signed POLST." The DON stated the POLST was reviewed with the resident or representative upon admission and, "We need to make sure we are checking what they want for code status." The DON stated the nurse that prepares the POLST document with the resident wishes is supposed to sign it on the back, and then route it to the physician for signature. The physician should not sign a blank POLST form prior the resident wishes added to the form.

R86's baseline care plan indicated R86 was alert and orientated and was admitted to the facility on 9/24/21.

R86's POLST in the paper medical record dated 9/27/21, indicated R86 wished to have an Attempt Resuscitation (CPR) order in the case of cardiac

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arrest with selective treatment. This form was signed by LPN-B and R86 on 9/27/21. There was no signature from a physician.

When interviewed on 10/12/21, at 8:53 a.m. DON stated the admitting nurse meets with the resident to discuss the POLST, educate the resident and determine what their wishes were. The DON stated once that was completed, "the physician has a book we put the POLST in for it to be signed." The DON stated the physician comes to the facility on Tuesdays and Thursday and will sign items placed in a book. The DON verified R86 was admitted on 9/24/21, and did not have the POLST signed as of yet.

When interviewed on 10/13/21, at 1:15 p.m. the facility medical director (MD-A) and R10's physician, stated in the case of newly admitted residents, the facility should first review to see if the resident had come to the facility with a pre-existing POLST. If not, the facility should review any medical orders, or orders from a recent hospital stay for an indication of what has previously been ordered. MD-A stated an expectation for the facility to discuss any pre-existing POLST or pre-existing medical orders with the new resident to ensure their current wishes, and contact the provider of any new orders needed following admission. MD-A stated, she had been receiving a POLST for signature from a nurse or social worker, but thought it was usually the admitting nurse who would send it for review. MD-A stated she was in her office three days per week so any form coming to the office might take 24-48 hours to come to her attention, but said more recently, the POLST forms were not being sent to the office, but were being placed in a "doctor's rounds" book

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at the facility and would not be available for her review until the next date she made rounds. MD-A confirmed that a physician may not sign a blank POLST and allow the facility to fill it in after it was signed. MD-A confirmed that she had done so and stated, "that is my error. That is on me."

The facility policy titled, Living Will/Advance Directives/Life-Sustaining Treatment Orders dated 6/1/2017, identified residents would be offered an option of completing a Living Will or Advance Directive if they have not already done so, upon admission. A POLST is a set of medical orders that are developed and documented following a resident's (or the resident's designated decision-maker) conversation with his/her physician. The POLST form provides for communication to all health care professionals as tot he resident's wishes.

The immediate jeopardy that began on 8/11/21 was removed on 10/13/21, when it could be determined that the facility had implemented an appropriate removal plan including correcting/clarifying the orders for R10, R13, R26, R32, R86, R184 and all other residents currently residing in the building. Additionally, the facility reviewed it's policy and identified that going forward, code status orders would be reviewed upon admission, but if a resident was not willing or able to make a decision upon admission, their code status would default to perform CPR in the case of cardiac arrest, but resident wishes would be reviewed again within 48-72 hours and then weekly until a decision had been made. The facility reviewed all current resident's codes status wishes with residents or responsible parties and obtained a physician's order which was placed in the resident charts, and ensured

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F 578	Continued From page 37 any POLST form was accurate, complete and signed. As well as any conflicting information was clarified and corrected. Facility staff were educated in the policy and procedures for code status and POLST, and a plan was in place to educate any staff prior to working their next shift if not available during initial training. An audit system was designed and the medical director was instructed and updated.	F 578		
F 607 SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure a criminal background check was obtained and verified prior to employment for 1 of 1 practical nurse (PN)-A reviewed for employee licensure. Findings include: Review of licensed practical nurse (PN)-A's employee file lacked evidence a criminal background study had been obtained and verified upon hire at the facility as PN-A had been working	F 607	PN-A removed from schedule until background check completed and valid license obtained. Facility residents have the potential to be affected. Audit of current employees to verify background check, license, and certification documentation complete 10/17/21	12/1/21

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WHITEWATER HEALTH SERVICES	**525 BLUFF AVENUE ST CHARLES, MN 55972**

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F 607	Continued From page 38 in the facility as an unlicensed practical nurse. During an interview on 10/11/21, at 7:23 p.m. the director of nursing (DON) stated PN-A was a brand-new nurse and working under a temporary license. The DON stated PN-A's license was held up by her criminal background check. The DON stated PN-A had made her aware of the concern with her criminal background check. During an interview on 10/12/21, at 4:41 p.m. the business office manager (BOM) stated there was an issue with the finger printing for PN-A's criminal background check and verified PN-A had been working as an unlicensed practical nurse without a completed criminal background check since her first date of orientation on 8/16/21. During an interview on 10/12/21, at 5:17 p.m. the executive director stated he was unaware the facility had an unlicensed nurse working in the building. The executive director stated the expectation was the facility to have a copy of the license in the personal file and to check the Minnesota Board of Nursing registry. The executive director stated he would want to be in the loop if the DON and BOM were hiring a staff member under any abnormal circumstances where the staff member was not licensed yet. The executive director stated a copy of background checks should be kept in employee personal files. The Background Checks policy and procedure dated August 2017 included, "Upon hire and as required, the B.O.M. [business office manager] (or designee) will ensure that background checks will be completed to include ...Criminal History: includes review of criminal convictions and probation consistent with the State background	F 607	Employees will have on file complete background check information, current and validated license information, and credential documentation prior to working with residents. Interdisciplinary team educated by Director of Clinical Services starting on 10/18/21 on the Background Check policy and procedure, Abuse prevention policy and procedure and state of Minnesota regulations. Executive Director/Designee will audit new hires for 8 weeks for complete documentation. Audit tracking tool developed. The results of the audits will be reviewed by the QAPI committee for trends and any needs for adjustment of audit schedules or content, as well as any further educational needs. The Executive Director is responsible to ensure this action occurs.	

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F 607	Continued From page 39 check requirements." The Abuse Prevention Program dated March 2018 included: 1) Screening: Abuse Policy Requirement: It is the policy of this facility to screen employees, medical directors, contractors, volunteers and students (in nurse aide programs and affiliated academic institutions, including nursing, therapy, social and activity programs) prior to working with our residents. Screening components include verification of references, licenses, certifications and background checks. Procedures: Employee screening - Before new employees are permitted to work with residents, references will be verified as well as certifications, licenses, credentials, and criminal background checks. The facility will not employ or otherwise engage individuals who have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a Court of law. The facility will not employ or otherwise engage any nursing assistant with a finding entered into the State registry concerning abuse, neglect, exploitation, misappropriation of resident property, or mistreatment of residents. The facility will also not employ or otherwise engage a licensed professional who has a disciplinary action in effect against his/her professional license as a result of a finding of abuse, neglect, exploitation of resident property, or mistreatment of a resident. A criminal background check will be conducted on all prospective employees as per the policy. A significant finding will result in denied employment consistent with the policy, the permanent and 5-year bars to employment per State and Federal regulations.	F 607		
F 622 SS=D	Transfer and Discharge Requirements CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii)	F 622		12/1/21

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§483.15(c) Transfer and discharge-
§483.15(c)(1) Facility requirements-
(i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless-
(A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility;
(B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility;
(C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident;
(D) The health of individuals in the facility would otherwise be endangered;
(E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or
(F) The facility ceases to operate.
(ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health

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F 622	Continued From page 41	F 622		

or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose.

§483.15(c)(2) Documentation.
When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider.
(i) Documentation in the resident's medical record must include:
(A) The basis for the transfer per paragraph (c)(1)(i) of this section.
(B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s).
(ii) The documentation required by paragraph (c)(2)(i) of this section must be made by-
(A) The resident's physician when transfer or discharge is necessary under paragraph (c)(1)(A) or (B) of this section; and
(B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section.
(iii) Information provided to the receiving provider must include a minimum of the following:
(A) Contact information of the practitioner responsible for the care of the resident.
(B) Resident representative information including contact information
(C) Advance Directive information
(D) All special instructions or precautions for

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F 622	Continued From page 42 ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure medical information, including skin conditions, medications and contact information were provided to a home health agency, for 1 of 1 residents (R36) reviewed for discharge who was to receive home health services. Findings include: R36's admission record identified an admission date of 4/7/21 with diagnoses of multiple sclerosis, mild cognitive impairment and muscle contractures. R36's admission Minimum Data Set (MDS) dated 4/16/21, indicated R36 was an assist of one with bed mobility, transfers, locomotion on/off unit, dressing, toileting and personal hygiene and had no skin issues. R36's discharge MDS dated 6/2/21 indicated R36 was an assist of one with bed mobility, transfers, locomotion on/off unit, dressing, toileting and personal hygiene. The MDS also indicated R36 had a stage 3 pressure ulcer in unknown location. On 10/14/21 a review of R36's record was performed and the last progress note entered in R36's medical record was dated 6/1/21 at 3:24	F 622	R36 discharged Facility discharged residents have the potential to be affected. Transfer/Discharge checklist and folder implemented for nursing staff when a transfer/discharge is initiated. Interdisciplinary team and licensed staff educated by the Director of Clinical Services starting on 11/12/21 on Discharge-Transfer of Resident policy and procedure including discharge documentation, required discharge information provided to resident or representative, documentation and communication education, discharge care information and the Change of Condition of the Resident policy and procedure. Executive Director/Designee will complete audits of discharged resident documentation weekly as they occur for 8 weeks. The results of the audits will be reviewed by the QAPI committee for trends and any needs for adjustment of audit schedules or content, as well as any further	

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F 622	Continued From page 43 A.M. and was titled Daily Skilled Note. The medical record revealed no evidence that R36 was discharged, where R36 was discharged to, and what information was sent with resident or communicated to receiving agency. During an interview on 10/14/21, at 9:36 A.M. the director of nursing (DON) stated the expectation was for the social worker to document in a progress note the discharge summary, recap of stay and any conversations with home care agency. During an interview on 10/14/21, at 9:52 A.M. the social worker (SW) stated it was the SW's job to make sure home care is set up, including transportation and depending on cognition, a list of resources if they have other needs. SW stated discharge paperwork is printed off from the medical record and would have admission info, diagnoses, med list, prescriptions for controlled substances and if there is rehab or wound care that information is also included. Furthermore, SW stated, "I have not been documenting as well the last few months, but we have been really busy and I am working 10-12 hour days so some things fall through the cracks, I'll be honest." Facility policy titled Discharge - Transfer of Resident dated June 2017 indicated to complete a discharge summary and post discharge plan of care form which should include the following: A list of medications with instructions in simple terms. Do not use medical terms or abbreviations. Include instructions for post discharge care. Review with the resident and/or representative. Have resident and/or representative or person responsible for care sign discharge summary and post discharge care	F 622	educational needs. The Executive Director is responsible to ensure this action occurs.	

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F 622	Continued From page 44 form. This includes release of medications. Give copy of form to the resident and/or representative or person(s) responsible for care. Place signed original of form in the medical record.	F 622		
F 636 SS=D	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information	F 636		12/1/21

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F 636	Continued From page 45 regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts. §483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.) (iii)Not less than once every 12 months. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to complete, encode an admission Minimum Data Set (MDS) assessment for 2 of 2 residents (R84 and R86) reviewed who were new admissions. Findings include: R84's admission record printed 10/14/21 identified an admission date to facility of 9/21/21.	F 636	R84 and R86 admission MDS complete and submitted. Facility residents have the potential to be affected. MDS schedule reviewed for current resident to ensure MDS timely submission. MDS schedule will be reviewed at each	

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F 636	Continued From page 46 R84's admission MDS indicated, "in progress." Review of R84's electronic health record (EHR) lacked evidence of a completion, or transmission, of an admission MDS. R86's admission record printed 10/13/21 identified an admission date to facility of 9/24/21. Review of R86's electronic health record (EHR) lacked evidence of a completion, or transmission, of an admission MDS. During an interview on 10/14/21, at 9:36 a.m. licensed practical nurse (LPN)-A stated, admissions MDS's were to be completed within 14 days of admission to the facility. LPN-A verified R84's and R86's admission MDS were still in progress and had not been completed. LPN-A stated she was the only one that completed MDS assessments in the building and stated she was behind. LPN-A stated she had shared her concern with the executive director, stated she was to be going downstairs to work 4 hours a day on MDS assessments and that was to start last week and that did not happen. LPN-A stated she had a lot of work to do, and she did not get any help. LPN-A stated she was working 12 hours a day and stated she wound not do it anymore and now she was behind. A policy was requested on MDS completion and was not provided. The Centers for Medicare and Medicare Services (CMS) Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual dated 10/2019, identified the RAI MDS and CAA's primary purpose was to identify resident care	F 636	morning meeting. MDS nurse educated by Regional Reimbursement Director on 10/18/21 to The Centers for Medicare and Medicaid Services (CMS) Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 user's manual completion dates requirements. Executive Director/Designee to audit MDS completion and submission at morning meetings for 8 weeks. Regional Reimbursement Director to audit closing and submission of MDS assessments off-site weekly-on-going. The results of the audits will be reviewed by the QAPI committee for trends and any needs for adjustment of audit schedules or content, as well as any further educational needs. The Executive Director is responsible to ensure this action occurs.	

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F 636	Continued From page 47 problems which would be addressed in an individualized care plan. Further, data collected from MDS assessments was also used for the Skilled Nursing Facility Prospective Payment System (SNF PPS) Medicare reimbursement system, many State Medicaid reimbursement systems, and for monitoring the quality of care provided to nursing home residents. The manual identified comprehensive "assessment completion is defined as completion of the CAA process in addition to the MDS items, meaning that the RN [registered nurse] assessment coordinator has signed and dated both the MDS (item Z0500) and CAA(s) (item V0200B) completion attestations." In addition, the manual instructed the MDS, and CAA(s) admission (comprehensive) completion date(s) (items Z0500 and V0200B2) were to be no later than the "14th calendar day of the resident's admission (admission date + [plus] 13 calendar days)."	F 636		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and	F 656		12/1/21

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F 656	Continued From page 48 (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to develop a care plan for anticoagulation for 1 of 1 resident (R26) reviewed for anticoagulation management. Findings include: R26's Admission Record printed 10/14/21, indicated R26 was admitted to the facility on 8/26/21 with diagnoses that included personal history of pulmonary embolism (blood clot).	F 656	R26 anticoagulant care plan completed. Facility residents prescribed anticoagulant medication have the potential to be affected. Residents with anticoagulant orders audited for complete comprehensive care plan. Care plan schedule will be reviewed at each morning meeting.	

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F 656	Continued From page 49 R26's admission Minimum Data Set (MDS) dated 9/1/21, indicated R26 required anticoagulant medications. R26's care plan printed 10/14/21 did not identity a plan of care for R26's risk for bleeding, goals, and interventions for anticoagulation management R26's physician orders included: Coumadin (anticoagulant medication) 4 milligram (mg) by mouth at bedtime for Chronic Atrial Fibrillation related to chronic kidney disease stage 5 until 10/15/21. (Order start date 10/11/2021). During an interview on 10/14/21, at 12:11 p.m. licensed practical nurse (LPN)-A stated coumadin was a high-risk medication and if a resident was on coumadin they should have a care plan for being at risk for bleeding. LPN-A stated R26's comprehensive care plan was not finished yet and stated it should be. LPN-A stated she was behind on completing care plans for new admissions. LPN-A stated R26's comprehensive care plan should have been complete on 9/15/21. During an interview on 10/18/21, at 8:43 a.m. the director of nursing (DON) stated the baseline care plan was done for the first 72 hours and the comprehensive care plan should be completed within 72 hours of admission. The DON stated she would expect a care plan for coumadin as it was a risk medication and residents need to be monitoring for bleeding. The DON stated she was not aware LPN-A was behind in completing care plans. The Comprehensive care Planning Policy dated 8/23/21 included, A comprehensive care plan for each resident is developed within seven (7) days	F 656	Coumadin orders, PT/INR checks calendar implemented. Interdisciplinary team and licensed staff educated by Director of Clinical Services starting on 11/12/21 on the Comprehensive Care Planning policy and procedure, including baseline care plan requirements, and comprehensive care plan requirements. Licensed staff educated on the Warfarin policy and procedure. Director of Nursing/Designee to audit coumadin calendar daily weekly for 8 weeks. Director of Nursing/Designee to audit admissions for complete care plan if receiving anticoagulant medications. The results of the audits will be reviewed by the QAPI committee for trends and any needs for adjustment of audit schedules or content, as well as any further educational needs. The Executive Director is responsible to ensure this action occurs.	

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F 656	Continued From page 50 of completion of the resident comprehensive assessments (MDS).	F 656		
F 661 SS=D	Discharge Summary CFR(s): 483.21(c)(2)(i)-(iv) §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). (iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services. This REQUIREMENT is not met as evidenced by: Based on interviews and record review the facility failed to complete a comprehensive discharge summary including a recapitulation of	F 661	R36 discharged Facility discharged residents have the	12/1/21

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F 661	Continued From page 51 stay for 1 of 1 residents (R36) reviewed for discharge. Findings include: R36's admission record identified an admission date of 4/7/21 with diagnoses of multiple sclerosis, mild cognitive impairment and muscle contractures. R36's admission Minimum Data Set (MDS) dated 4/16/21, indicated R36 was an assist of one with bed mobility, transfers, locomotion on/off unit, dressing, toileting and personal hygiene and had no skin issues. R36's discharge MDS dated 6/2/21 indicated R36 was an assist of one with bed mobility, transfers, locomotion on/off unit, dressing, toileting and personal hygiene. The MDS also indicated R36 had a stage 3 pressure ulcer in unknown location. On 10/14/21 a review of R36's record was performed and the last progress note entered in R36's medical record was dated 6/1/21 at 3:24 A.M. and was titled Daily Skilled Note. The medical record revealed no evidence that a discharge summary or recapitulation of stay was completed. During an interview on 10/14/21 at 9:36 A.M., DON stated the expectation was for the social worker to document in a progress note the discharge summary, recap of stay and any conversations with home care agency. During an interview on 10/14/21 at 9:52 A.M., facility social worker (SW) stated discharge summary notes and recapitulation of stay should	F 661	potential to be affected. Transfer/Discharge checklist and folder implemented for nursing staff when a transfer/discharge is initiated. Interdisciplinary team and licensed staff educated by Director of Clinical Services starting on 11/12/21 on Discharge-Transfer of Resident policy, the Discharge Planning policy, the Change of Condition of the Resident policy and procedure including discharge documentation, required discharge information, discharge summary, and recapitulation of stay. Director of Nursing/Designee will complete audits of discharged resident documentation weekly as they occur for 12 weeks. The results of the audits will be reviewed by the QAPI committee for trends and any needs for adjustment of audit schedules or content, as well as any further educational needs. The Executive Director is responsible to ensure this action occurs.	

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F 661	Continued From page 52 be documented in the medical record in a progress note. SW then stated that the discharge summary note in the medical record should be completed by the staff member that saw the resident out the door. SW then verified that there was no discharge note or recapitulation of stay for R36. Furthermore, SW stated, "I have not been documenting as well the last few months, but we have been really busy and I am working 10-12 hour days so some things fall through the cracks, I'll be honest." Facility policy titled Discharge - Transfer of Resident dated June 2017 indicated to complete a discharge summary and post discharge plan of care form which should include the following: A list of medications with instructions in simple terms. Do not use medical terms or abbreviations. Include instructions for post discharge care. Review with the resident and/or representative. Have resident and/or representative or person responsible for care sign discharge summary and post discharge care form. This includes release of medications. Give copy of form to the resident and/or representative or person(s) responsible for care. Place signed original of form in the medical record.	F 661		
F 686 SS=G	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition	F 686		12/1/21

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F 686	Continued From page 53 demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to notify the medical provider and obtain wound care orders when 1 of 1 residents (R10) reviewed for pressure ulcers, had developed a new coccyx pressure ulcer, and failed to transcribe and follow orders from a provider for a newly developed heel ulcer. This failure resulted in actual harm when R10's coccyx pressure ulcer became larger and the heel ulcer deteriorated from a stage 2 to a stage 3 ulcer. Findings include: Pressure Ulcer stages defined by the Minimum Data Set (MDS) per Center Medicare/Medicaid Services: Stage I pressure ulcer (An observable, pressure-related alteration of intact skin, whose indicators as compared to adjacent or opposite area on the body may include changes in one or more of the following parameters: skin temperature (warmth or coolness); tissue consistency (firm or boggy); sensation (pain, itching); and/or a defined area of persistent redness in lightly pigmented skin, whereas in darker skin tones, the ulcer may appear with persistent red, blue, or purple hues.) Stage II pressure ulcers (Partial thickness loss of dermis presenting as a shallow open ulcer with a	F 686	R10 wounds measured and assessed, MD updated, new treatment orders obtained and care plan updated. Facility residents have the potential to be affected. Skin assessments completed for current residents on 10/13/21 and 10/14/21. Skin checks will be completed weekly with bath/shower. Wound rounds will be completed every 7 days per policy, wound binder developed to assist with wound tracking. Licensed staff educated by Director of Clinical Services starting on 11/12/21 on Skin Management policy and Pressure and Non-pressure Injury policy and procedures including identification of a new wound requirements, assessment requirements, notification requirements, and monitoring requirements. Licensed staff educated on Physicians orders policy and procedure. Director of Nursing/Designee to audit resident consultation notes for new orders after appointments, hospital stays, and MD rounds 3 times weekly for 12 weeks.	

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F 686	Continued From page 54 red-pink wound bed, without slough. May also present as an intact or open/ ruptured blister.) Stage III pressure ulcers (Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining or tunneling.) R10's quarterly Minimum Data Set (MDS) dated 7/30/21, included moderate cognitive impairment with diagnoses including, diabetes, Alzheimer's disease and peripheral vascular disease. R10's diagnoses list included a recent nondisplaced comminuted (where the bone breaks in 3 or more places) fracture of the right fibula and tibia (calf and shin bones). R10's MDS indicated he required extensive assistance with most activities of daily living (ADL's) and rejected cares 1-3 days during the 7 day assessment period. R10 was at risk for pressure ulcers, but did not have any current pressure ulcers. R10's care plan dated 9/1/21, included, "[R10] has skin breakdown related to immobility, incontinence and decreased sensation." R10's goal was, "Resident will develop clean and intact skin." Staff were instructed, "Apply protective or barrier lotion after incontinence, .Assist resident to turn and reposition every 2-3 hours. May refuse at times. Staff are to educate [R10] and reapproach. Change incontinence product ASAP after voiding or a bowel movement. Will refuse at times. Staff are to educate and reapproach. Increase out of bed activity as tolerated. Inspect skin integrity every day. Keep bed linen, clean, dry, and free of wrinkles. Keep skin clean and dry. Maintain adequate nutrition and hydration. Provide measure to decrease pressure/irritation	F 686	Director of Nursing/Designee to audit weekly wound rounds for measurements, assessments, notifications, and treatment orders for 12 weeks. The results of the audits will be reviewed by the QAPI committee for trends and any needs for adjustment of audit schedules or content, as well as any further educational needs. The Executive Director is responsible to ensure this action occurs.	

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to skin: 1)pressure reduction mattress. 2)pressure reduction chair cushion." The care plan lacked identification or staff direction for actual pressure ulcers.

R10's progress note dated 10/5/21, identified R10 had been to the, "cast room," and was to continue with no weight bearing on the right side and to elevate leg for edema control. The note also identified R10 had some loose stools soiling the cast and a call was placed to advise if needs to return to cast room for new cast.

According to a "wound tracker document" in R10's EHR dated 10/6/21, R10 had an open pressure ulcer on his coccyx (lower part of spine/tailbone). No previous documentation in the medical record was found. The wound measurements were written as 2.5 cm by 1 cm with 0.1 cm depth, identified as a stage II. The document indicated R10's pressure ulcer as having both, "slough and granulation tissue" (Slough is necrotic tissue that does not occur in superficial wounds and is part of the inflammatory process generally seen in chronic wounds. Granulation tissue is a sign of tissue regeneration not generally seen in superficial wounds). The form indicated R10's family was notified of the wound, but did not indicate the physician was notified.

R10's Cast Visit provider note dated 10/7/21, R10 had been to the Department of Orthopedic Surgery and was seen by a certified nurse practitioner (CNP)-A in order to remove a soiled cast on his right leg. CNP-A wrote, "the skin about the lower extremity has one very small superficial skin tear anterior and a developing heel ulcer. The heel ulcer is stable and improving since the

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last visit." The document included the following directions for care: "today patient was placed into a stockinette [dressing similar to a thin sock to provide skin protection] and knee immobilizer, a Mepilex heel dressing with a multi-Podus boot [a product that lifts the heel to prevent pressure]. I recommend that they remove the knee immobilizer and stockinette and check his skin twice daily. They are also to remove the multi-Podus boot twice daily to check his skin. The facility can change the Mepilex heel dressing once weekly. He is to have no pressure on his heel."

R10's physician Order Summary Sheet from the electronic health record (EHR) on 10/11/21, did not include any direction or treatment for a pressure ulcer on heel, or pressure ulcer on buttocks. R10's treatment administration record (TAR) and medication administration records (MAR) from 10/6/21 to 10/11/21, failed to identify any treatment for R10's pressure ulcers on heel or on buttocks.

R10's TAR had an order for, "Weekly skin review," and directed staff if new skin area is identified to follow protocol and notify physician. This was initialed as being completed on 10/4/21 and 10/11/21.

According to a "wound tracker document" in R10's EHR dated 10/12/21, the coccyx wound was measured at being 2.2 cm by 2.5 cm with a depth of 0.2 cm, still rated as a, "stage II" pressure ulcer, but condition listed as, "worsening." The document did not provide any indication of the cares being provided, but did include, R10 should lay down after meals. The document did not indicate the medical provider

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was notified of R10's condition.

During an observation of morning cares 10/13/21, 7:14 a.m. a nursing assistant (NA)-C and an unidentified NA came into R10's room to provide morning cares. He was laying on his back in his bed. R10 had a scab on his left shin, and had a large plastic leg immobilizer on his right leg, held in place with straps, and a stocking type dressing covered his leg so the skin could not be visualized at that time. There was nothing in place to prevent pressure to R10's right leg except for the splint itself. NAs both stated the immobilizer was not to be removed as he had a fractured leg. NAs assisted R10 to turn towards his right, affected side, so they could wash his buttocks. A square foam dressing, approximately 3 inches by 3 inches and 1/4 inch thick was observed on R10's coccyx, but was not adhered to the skin along the edges and was quite loose along the bottom edge. During cares, R10 began to have a bowel movement which oozed up under the loose edge of the dressing and the unidentified NA removed the dressing. R10's entire left buttock was observed to be slightly pink and mottled. A shallow ulcer about the size of a quarter was observed after removal of the foam dressing. The wound was situated between the left ischium and the coccyx. The top layers of skin were missing and the wound bed was a bright red color. The dressing had a small amount of bloody drainage soaked into the foam. After the NAs finished washing R10's buttocks, they returned him to his previous position on his back. The unidentified NA threw away the soiled dressing, and NA-C said they would need to report to the nurse that R10 needed a new dressing on his wound. Neither NA knew how long he had had the wound on his buttocks. Neither one knew of any other

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F 686	Continued From page 58 wounds except for the small scab on R10's left shin. When interviewed on 10/13/21, at 8:26 a.m. licensed practical nurse (LPN)-B stated R10 had had the long splint on his leg for approximately a week or more, and said they were not to remove the splint even though it was merely held in place by Velcro straps. LPN-B stated R10 was at risk for skin breakdown due to the application of the splint and it was important to monitor his condition, but said they were only able to check the skin that was not covered by the straps or splint. LPN-B stated she was aware that R10 had a wound on his buttocks and had seen it several days before. LPN-B said she was unable to find a physician's order for the care of the wound, but stated they had been applying a "Mepilex" dressing to R10's open wound near his coccyx (Mepilex is a trade name and can mean a variety of dressing types, the most common are a foam dressing meant to be held in place with some other type of dressing, or a self-adhesive, occlusive foam dressing). LPN-B stated that when a new wound is identified, or a wound is getting worse, the nurse should report it to the director of nursing (DON) and call the medical provider to get an order for care. If an NA notices a new wound or a wound that requires a new dressing, the NA is to report to the nurse on duty. LPN-B stated the removal of R10's dressing that morning, and need for wound care had not been reported to her and she would have been the nurse it should have been reported to. When interviewed on 10/13/21, at 8:51 a.m. a registered nurse consultant (NC) confirmed that R10's physician orders did not include any order for the care of the wound on his buttocks. NC	F 686		

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stated the expected process for nurses to follow in the event of a newly identified pressure ulcer were to notify the medical provider for wound care orders, and add new interventions to the resident's care plan. The resident's name should be added to the facility "wound list" and initial measurements should be taken, followed by weekly measurements to monitor the efficacy or the treatment order. NC confirmed that recommendations for care of a right heel ulcer provided by the orthopedic services cast room on 10/7/21, including removal of the splint for observation and skin care, for care of a right heel pressure ulcer and for no pressure to the right heel had not been transcribed from the paper note into R10's physician's orders and thus these recommendations for care had not been communicated to nursing staff through the EHR, and could not be confirmed to have been provided.

According to an interview 10/13/21, 9:17 a.m. DON stated immediately prior to interview DON and NC had gone to R10's room, removed his "boot" and the dressing applied on 10/7/21. DON stated she had not known about the right heel pressure ulcer prior to 10/13/21 and had not read the recommendations from CNP-A before that day. DON confirmed CNP-A's documentation indicated the wound had been "just developing" and was "healing" on 10/7/21, but confirmed the condition of the wound had deteriorated. DON said, "It's a stage III by now" (pressure ulcers are graded from stage I, superficial redness that does not go away, to stage IV, a deep tissue injury involving tendons, ligament and bone. A stage III wound extends through all layers of the skin into the subcutaneous tissue, but not to tendons or bone). DON stated an expectation for nurses to

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review any papers accompanying a resident from any medical appointment upon their return to the facility. DON was unable to confirm that CNP-A's recommendations for care were actual orders, but said the nurse on duty should have contacted their medical director (MD)-A who is also R10's physician to verify orders following the appointment. DON stated the nurse should have then entered the orders into the EHR and should also have reported to the nurse manager and the DON, but said this had not occurred. DON stated she had replaced the soiled Mepilex on R10's heel, but had not removed the brace or replaced the stockinette due to "pain", saying, "I am going to be in touch with (MD)-A about how to proceed." During the 10/13/21, 9:17 a.m. interview, DON described expectations of nursing staff when a new pressure ulcer or wound were identified. DON said the nurse in charge at the time the wound was found was responsible to take measurements of the wound and document this information and a description of the wound in a progress note. DON said the facility did not have any standing orders for wound care so the nurse on duty would need to notify the medical provider in order to get treatment orders for the wound. DON said the nurse should also notify the DON who was responsible to monitor and assess the wound weekly, and document in their "pressure injury tracker." DON stated she had become aware of R10's wound on his bottom and had applied a Mepilex dressing; however, DON confirmed she had not notified the physician and did not have an order for treatment.

When interviewed on 10/13/21, at 1:15 p.m. R10's physician and the facility's medical director MD-A stated she was aware that R10 had a pressure ulcer on his right heel and stated the

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F 686	Continued From page 61 documentation from CNP-A during the visit to the Orthopedic Surgery Cast Room should have been considered as medical provider orders, and should have been transcribed and followed as orders. MD-A stated there was no problems with the recommendations written by CNP-A and no reason for the facility to contact the facility medical director to review or confirm those orders. MD-A stated she had not seen R10's heel wound, but said, according to CNP-A's description on 10/7/21 and the DON's description on 10/13/21, the condition of the pressure ulcer had worsened since he was seen by CNP-A. MD-A stated an expectation for the facility to notify the medical provider if a resident's pressure wounds were not improving, were worsening or if a new pressure ulcer developed. MD-A confirmed she had not been notified of R10's change in condition until that morning but had previously received a copy of his 10/7/21 cast room visit notes from the Orthopedic Services. Facility did not provide a policy related to notification of wounds to provider, or transcribing and following physician orders.	F 686		
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:	F 689		12/1/21

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F 689	Continued From page 62 Based on observations, interviews and record review, facility failed to conduct a thorough investigation and analysis to determine the causative factors of a resident's fall that resulted in a significant injury, or update the resident's care-plan with appropriate interventions to reduce the likelihood of similar incidents for 1 of 2 residents (R10) reviewed for falls. Findings include: According to the electronic health record (EHR) Admission Record/diagnoses sheet, R10 had the following diagnoses, among other co-morbidities, Alzheimer's disease, generalized muscle weakness, difficulty walking, not elsewhere classified, and history of falling. R10's quarterly Minimum Data Set (MDS) dated 7/30/2021, R10 required extensive assistance of one person to walk and transfer. The MDS indicated R10 was unsteady and required assistance for balance and turning. Furthermore, R10 required the assistance of two persons to use the toilet. His cognitive status was marked as moderately impaired and R10 was assessed as sometimes exhibiting behaviors of rejecting care. R10 had no falls since the prior assessment. According to R10's EHR care plan, R10 had a focus problem area dated 4/4/2018 that indicated R10 had a self-care deficit related to difficulty in walking. An intervention dated 12/10/2019 indicated: allow [R10] to direct cares. He may choose to transfer, move, etc. with minimal help. Be patient and assist as he directs, but an intervention dated 4/20/20 indicated: transfers-assist of two with gait belt and a walker. At times he will not transfer due to behaviors. Staff are to	F 689	R10 wounds measured and assessed, MD updated, new treatment orders obtained and care plan updated. Facility residents have the potential to be affected. Skin assessments completed for current residents on 10/13/21 and 10/14/21. Skin checks will be completed weekly with bath/shower. Wound rounds will be completed every 7 days per policy, wound binder developed to assist with wound tracking. Licensed staff educated by Director of Clinical Services starting on 11/12/21 on Skin Management policy and Pressure and Non-pressure Injury policy and procedures including identification of a new wound requirements, assessment requirements, notification requirements, and monitoring requirements. Licensed staff educated on Physicians orders policy and procedure. Director of Nursing/Designee to audit resident consultation notes for new orders after appointments, hospital stays, and MD rounds 3 times weekly for 12 weeks. Director of Nursing/Designee to audit weekly wound rounds for measurements, assessments, notifications, and treatment orders for 12 weeks. The results of the audits will be reviewed by the QAPI committee for trends and any	

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F 689	Continued From page 63 leave him in a safe environment and reapproach after a short while. An additional focus problem dated 2/06/2018 indicated the following: [R10] has the potential for injury-fall risk related to: unsteady gait, impaired safety awareness, use of psychotropic medications, impaired mobility as evidenced by his inability to transfer/ambulate without assistance. Corresponding interventions for this focus problem indicated staff should: ensure resident is wearing appropriate footwear shoes, gripper socks, or slippers) (date initiated 2/6/2018 and revised 10/25/20); grip strips in front of recliner, side of bed, in bathroom in front of toilet (1/30/20); maintain room free of clutter and ensure adequate lighting (2/03/20);review information on fast falls and attempt to determine cause of falls or risk factors as indicated (2/6/18, revised 2/3/20). According to an interview 10/11/21, 1:19 p.m. R10 stated he had recently been hospitalized with a "broken hip" following a fall, but he was not able to relate any other information regarding the fall or the injury. According to a phone interview 10/14/21,1:52 p.m. a certified nursing assistant NA-D stated she had been assisting R10 to the bathroom by herself on 9/22/21 using a mechanical "sit to stand" lift rather than the two assist as indicated in his careplan. When R10's cares were complete in the bathroom, NA-D said he did not want to get off the toilet, but otherwise seemed his usual self. NA-D reported she moved R10 from the bathroom to his bed, using the lift. When NA-D got R10 as far as the bed, NA-D realized the lift would not fit under the bed and NA-D was only able to seat R10 on the very edge of the bed. NA-D stated both she and R10 were "scared" and	F 689	needs for adjustment of audit schedules or content, as well as any further educational needs. The Executive Director is responsible to ensure this action occurs.	

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she called for help. A practical nurse (PN-A) was working nearby and came to assist. NA-D stated she asked PN-A to help move R10 to his recliner. Then they put a transfer belt on R10 and asked him to walk to the bed. They started towards the bed, and R10 said, "I'm going to sit right now" and he went down onto PN-D's knees and NA-D's foot. NA-D was unable to say if R10 appeared to have twisted his leg at that time. She went to get a Hoyer lift that did not require him to stand, and they lifted him into bed using that equipment. NA-D recalled that R10 stated he had pain in his right leg, but she thought it was caused by the use of the Hoyer lift. NA-D said she reported this pain to PN-A, and later to the registered nurse (RN-B) working the overnight shift. NA-D reported that later she noticed "his leg looked extended, like he couldn't straighten it, kind of to the right and I told [PN-A] there was something really wrong with it. She was going off duty so she reported to the night nurse who followed up."

According to a phone interview with PN-A on 10/14/21, 2:03 p.m. she had graduated from college in May of 2021, and had never worked as a nurse before. PN-A stated she had taken her nursing board exams in July, but did not yet have a nursing license. When R10 suffered his fall on 9/22/21, PN-A stated she was working at that time, and it was the first fall that she had to respond to as a nurse. PN-A was unable to describe what she had learned in nursing school about what to do if a resident had fallen. PN-A said her experience with falls was from when she was a nursing assistant, but said an assessment should be done by the nurse, including a set of vital signs , the nurse should document findings and notify the DON and the physician. PN-A could not recall if she had written a progress note (no

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progress note was found). PN-A said she had called the DON and asked what paperwork she had to do, but said the DON told her she did not have to do anything because R10 was "lowered to the floor" and did not fall. PN-A asked if she needed to call the physician, but said the DON said she "would take care of it." PN-A said "I found out the next day things were worse and I felt horrible, and asked what I needed to do." PN-A said she was told by the DON that the over-night nurse had charted everything, and she did not have to do anything else.

According to a progress note in R10's EHR dated 9/23/21, 6:54 a.m. "Report from evening nurse that resident was lowered to the floor while trying to get into bed. CNA notified nurse that resident was in significant pain around 23:15 [11:15 p.m.] Assessed resident at approx 23:30 [11:30 p.m.]. Observed right leg turned outward. Swelling and bruising noted approx 1 inch below right knee ..."(progress note continued to describe R10's condition, pain level, notification to physician and update to director of nursing/DON at 5:00 a.m. R10 agreed to a transfer to hospital at 7:00 a.m.) Progress note did not include information about R10 prior to the fall, what happened during the transfer to bed or any immediate interventions to prevent further falls.

According to a Risk Management Report (incident report) for 9/22/21 the description of the incident stated R10 was being transferred from his chair to the bed using a walker and gait belt when he was suddenly weak and leaned back on a nurse and sat on her knees. The immediate action taken was listed as lowering R10 to the floor and assisting to bed via Hoyer lift without mention of additional fall prevention interventions

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specific to the incident initiated. The report indicated no injuries were observed and he did not go to the hospital. No pain level, level of consciousness were reported. Mental status was not documented. The form included 33 check list items of predisposing environmental factors, including equipment issues, but nothing was marked. The form provided a checklist of 48 predisposing physiological factors to choose from including a recent change in condition, illness, weakness, infection, various medications, but only gait imbalance was marked. The form included 47 checklist items of predisposing situation factors including footwear, use of assistive devices, whether assistance was being provided and also the opportunity to choose "other" and describe. No predisposing situation factors were checked including any information related to whether or not care plan interventions were present and followed, or why a mechanical sit to stand lift was used when not indicated on R10's care plan.

According to a progress note dated 10/12/2021, 11:52 a.m. the interdisciplinary team (IDT) found: the root cause to be that R10 had an undiagnosed respiratory infection which "may" have made him weak. The response to this was to choose an intervention of a Hoyer lift and two assist for transfers. The progress note indicated R10's care plan was updated; however, a review of his care plan did not reveal a change to include the use of a Hoyer lift. Care plan did not address a response to the "undiagnosed respiratory infection."

A review of R10's progress notes in the EHR did not indicate any notes related to respiratory symptoms for several days prior to fall; however,

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nurses had provide R10 cough syrup on several occasions without notation on his condition.

A request was made for the hospital discharge summary for R10 following his admission on 9/23/21. Facility only provided R10's hospital labs, radiology reports and diagnoses list, but no physician progress notes. R10's principle diagnosis for hospital admission was "fracture fibula shaft comminuted nondisplaced closed initial right, and fracture tibia shaft comminuted nondisplaced closed initial right." A diagnosis of sepsis was given three days after admission. Lab studies indicated a urinary tract infection with a specimen collected 9/26/21. A viral panel detected antibodies to respiratory syncytial virus on 9/27/21. Unknown if either infection was present prior to hospitalization.

According to an interview 10/14/21, 10:42 a.m. DON explained the procedure for a nurse to follow when a resident falls. DON said first the nurse was to assess the resident for injury, review a possible cause of the incident, and based on those findings, either use a Hoyer lift with additional help, to place the resident into bed, or call for emergency assistance up to and including transfer to the hospital. Following the fall, DON stated a nurse is expected to document in "risk management" (incident report) in the EHR which triggers post-fall observation documentation to be done by nurses on the up-coming shifts. DON confirmed PN-A had not done this, nor had PN-A written a progress note. DON confirmed she was the one to initiate the report, but had not been present during the incident. Although DON was the person to initiate the risk management incident report, DON was unable to state whether PN-A had asked R10 any

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questions about the fall or his condition, or if PN-A had tried to figure out why the incident had happened (root cause) to initiate any new and appropriate intervention. DON said, "(PN-A) said it wasn't a fall, but of course we know it is considered a fall, but she said he looked fine." DON indicated the persons completing the risk management report were to get witness statements from any staff who were present to best determine the cause of the fall, and were to completely fill out the report so that the IDT could best determine appropriate interventions to prevent further incidents, but DON confirmed the risk management report did not include any assessment or evaluation of the R10's condition prior to the fall; did not contain information related to environmental factors or problems with equipment and witness statements did not include the names or titles of the staff, and provided only a very brief account of the actual fall and no other information or evaluation. DON confirmed the report did not contain evidence of any immediate interventions to provide for safety or further injury at the time of the fall.

Facility provided a document titled Fall Prevention and Management Guidelines dated as effective February of 2017 and revised 3/10/2021. The policy stated they would maintain a fall prevention and management program for resident determined to be at risk for falls in order to better manage any risk factor and prevent and/or manage as much as is possible the resident from falling and/or sustaining injuries related to falling. The policy statement included a definition "a fall refers to unintentionally coming to rest on the ground, floor or other lower level but not as a result of an overwhelming external force."
The policy indicated that following a fall, a post

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F 689	Continued From page 69 fall evaluation should be completed including a physical assessment with vital signs, resident and witness statement regarding the fall, environmental assessment, contributing factors to the fall, medication changes, mental status changes and any new diagnoses. An update to the physician and responsible party was indicated as an expectation. The policy also indicated "upon initial review, investigation and assessment, nurse to update the care plan as to (1) any new intervention put in place to try to prevent additional falls, and (2) removal of any interventions determined to be no longer appropriate. The policy also indicated the IDT should review the fall the following morning to determine the potential root cause of the fall, and review updates to the plan of care, and add additional revisions as needed.	F 689		
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, facility failed to adequately and comprehensively monitor the pre-and post-treatment stability of 1 of 1 resident (R11) reviewed for dialysis; also, the facility failed to evaluate R11's fluid intake or daily weights on a regular basis to ensure stability while receiving hemodialysis treatments.	F 698	R11 PCC orders updated to include parameters for weight changes per Physician order and fluid intakes for each 24 hours. Current weight and daily fluid intake reviewed with Physician. Facility residents on Dialysis have the potential to be affected.	12/1/21

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F 698	Continued From page 70 Findings include: According to R11's electronic health record (EHR) Admission Record/diagnosis sheet, R11 has the following diagnoses among other co-morbidities: hypertensive chronic kidney disease with stage 5 chronic kidney disease or end stage renal disease, dependence on renal dialysis and acute on chronic diastolic (congestive) heart failure, and hypertensive heart failure. According to a minimum data set (MDS) assessment dated 8/6/21, R11 was assessed to have a 13/15 BIMS (brief interview for mental status) showing she was cognitively intact. According to R11's physician orders in the EHR, on 11/09/2020 the following was entered: Dialysis at [site] every day shift every Mon, Wed, Fri related to dependence on renal dialysis. An order 11/07/2020 directed nurses to monitor the dialysis catheter site every evening for "redness, drainage or warmth and notify MD if any of these symptoms present." An order stating "staff are to complete dialysis UDA and send with [R11] to dialysis every evening shift every Mon, Wed, Fri for dialysis monitoring" was entered 5/14/21. An order for vital signs to be completed on R11's bath day, once weekly on Sundays had been entered on 11/08/20. Weight prior to breakfast every day shift was entered on 11/08/20; weight order did not include any directions for staff on reporting vacillations in weigh findings. On 11/07/20 an order for Fluid restriction 1.5 to 2 liters per 24 hours was entered in the EHR. Recommended breakdown: 360cc/meal, 340cc AM/PM shifts, 240cc at night. Order failed to instruct on when to tally daily intake, or how to determine if R11 should receive 1.5 liters or 2	F 698	Morning meeting form updated to include review of residents on dialysis including weight, fluid intake, and dialysis UDA. Licensed staff educated by the Director of Clinical Services starting on 11/12/21 on the Hemodialysis Communication policy and procedure including the User Defined Assessment communication tool and procedures and required monitoring for dialysis residents. Director of Nursing/Designee to complete audit 3 x weekly for 8 weeks of residents on dialysis for completion of weights, User Defined Assessment, and fluid monitoring. The results of the audits will be reviewed by the QAPI committee for trends and any needs for adjustment of audit schedules or content, as well as any further educational needs. The Executive Director is responsible to ensure this action occurs	

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liters daily, or how to decide if R11 had exceeded the fluid restriction given the ordered range. On 8/23/21 the order was updated to read "fluid restriction 1.5 liters per 24 hours. Recommended breakdown 240cc/meal; 300 cc AM/PM shifts; 180cc nights." The order still failed to instruct on a daily total, assessment or report to be made.

A review of R11 treatment administration record (TAR) for August, September and October 2021 showed that nurses were documenting they had completed the Dialysis UDA tool; however, a review of the assessment portion of the EHR failed to show this form had been completed. R11's fluid intake was documented, but not totaled. No corresponding assessment or note related to R11's intake was found indicating if she was within her designated fluid intake, or had exceeded or had not met her allotted fluid amount. A review of R11's daily weights in August showed a generally stable weight with slow vacillations, except 8/29/21 when R11's weight was 5.8 pounds higher than the day prior without reweigh noted or other documentation. On 9/1/21 weight remained elevated, 9/2/21 weight was not done, and 9/3/21 weight had dropped only one pound from the 9/1/21 weight; 9/4/21 weight was not documented. On9/5/21 the weight order was moved from the TAR to the medication administration record (MAR) and no weight was documented 9/5/21. The first weight documented on the MAR was 195.8 pounds and the following day was 201 pounds, a difference of 5.2 pounds, with no evidence of reweigh, further assessment or report. On 9/12/21 R11's weight was 198. 6, the next day 203.6, up 5lbs, and no weight documented on 9/14/21. According to R11's October 2021 MAR, R11's weight on 10/10/21 was 194.4 lbs and on 10/11/21 it was 202lbs, or a

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7.6 lb increase without reweigh or other assessment. On 10/12/21 weight was 196.8 and on 10/13/21 it was 202, an increase of 5.2 lbs.

A review of R11's EHR assessment list was done and only one Dialysis Communication UDA was found to have been completed (date 9/15/21) between August and October of 2021. The document did not include pre-treatment information except for a set of vital signs from 9/13/21, two days prior, and the same set of vital signs upon return. No other information was documented including a nurse signature.

According to an interview 10/11/21, 3:43 p.m. R11 stated she went to dialysis three times weekly. She said the facility usually weighed her before she left for dialysis and they were to check her port site to make sure there were no problems. R11 also said staff were supposed to be monitoring how much fluid she had to drink, and showed me she had soda cans in her room, but felt the staff were writing down how much she had to drink. She was unable to state her current fluid restriction.

According to an interview 10/13/21, 12:10 p.m. a licensed practical nurse stated a nurse should assess a dialysis patient's vital signs, including temperature and oxygen saturation level before sending them to a dialysis treatment, but stated that information was not sent with R11 to dialysis. LPN-B stated the facility nurse would send a copy of R11's "face sheet", medication list and a "consult sheet," but that dialysis was the ones who would send information on R11's condition to them. LPN-B was unable to confirm that information on weight changes or fluid intake were sent to dialysis, and said information on

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what to do with signs of fluid overload, such as weight changes should be listed in a resident's physician orders. LPN-B said usually they were to notify a physician if a resident had a change of 3 to 5 pounds in a day. LPN-B stated she believed a dialysis patient's port (where dialysis would access the venous system) site should be assessed every shift for signs of redness, swelling or leaking.

During an interview 10/13/21, 12:27 p.m. the director of nursing (DON) stated an expectation for nurses to monitor a dialysis patient's port site to make sure the dressing was intact and there were no signs of infection. DON was unable to state how often this should be done. DON also stated an expectation for staff to be monitoring a dialysis patient's weight and stated a change in three pounds in one day should be reported to the physician by the nurse working with that resident on that day. DON stated an expectation for nurses to document R11's fluid intake, including the amount consumed from what the kitchen provided. The DON said they were able to calculate what the facility offered R11, but R11 often went out of the building with family and because she was "her own person" could consume what she wanted and they would not know how much she had had when she was out of the building; however, DON, confirmed that R11 was their responsibility even when out of the building and they could have asked her about her intake upon return. The documentation of the 24 hour fluid total was the responsibility of the overnight nurse and any excess fluid intake should be documented in a progress note according to the DON. The DON confirmed that any dialysis patient is considered at high risk for fluid imbalance and the risks include such things

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F 698	Continued From page 74	F 698		

as pulmonary complications, but DON was unable to state any additional complications. The DON explained the facility had a document in the EHR called the Dialysis UDA that was to be completed prior to R11 leaving for dialysis and upon her return. The Dialysis UDA contains all the expected assessments for monitoring a dialysis patients stability prior to and after hemodialysis. DON stated after completing in the morning before treatment, the form could be printed out and sent with R11 when she went for her dialysis treatment. DON confirmed that the Dialysis UDA had rarely been completed in R11's EHR, although the order for completion had been signed by nurses as having been done. DON also confirmed that the order instructed nurses to complete in the evening and then to send to dialysis with R11 even though she was actually returning to the facility from dialysis in the evening. DON stated the facility had not provided any nursing staff education specific to dialysis, and had not discussed the care of a dialysis patient within at least the last year.

According to an interview 10/13/21, 1:15 p.m. with R11's physician and facility medical director (MD-A), complications of hemodialysis include fluid overload which could result in heart failure or conversely, problems with dehydration and also electrolyte imbalance. MD-A stated facility should monitor R11's daily weights and intake of fluids to ensure stability. Failure to monitor or report changes could result in a failure to identify complications. MD-A also said R11 should have her blood pressure monitored on a regular basis, at least daily. MD-A said she was unsure how often the facility was checking R11's blood-pressure but confirmed that once a week would not be adequate for a dialysis patient.

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A request was made for a policy related to the care of a dialysis patient. Facility provided a document titled Hemodialysis dated 4/13/21. The policy statement is as follows: The center has designed and implemented a process which strives to ensure the comfort, safety, and appropriate management of a hemodialysis resident regardless if the procedure is performed at the dialysis center or at the center. The center [facility] will utilize the "Dialysis Communication UDA" for continuity of care between the facility and dialysis unit.
Clinical responsibilities of the facility included: assure daily assessment and documentation of fistula or graft site (policy fails to include description of monitoring of a port); document post-dialysis (dry weight) obtained by the dialysis cneter in the Dialysis Communication UDA after each dialysis treatment; monitor fluid status of resident and maintain fluid restriction as ordered by Provider/dialysis center. If resident chooses to not follow ordered fluid restrictions, educate resident/responsible part on the risk of their choice, document this education and response to education and notify the provider and dialysis center. Complete the Risk vs Benefit UDA in the electronic medical record.
Further responsibilities listed include: manage fluid restrictions as ordered by provider/dialysis center; manage special dietary regime and dietary restrictions as ordered. In addition, the policy listed the following: assess and manage post-dialysis complications which may include, but are not limited to, the following: bleeding, fatigue, signs/symptoms of infection, hypotension (low blood-pressure), chest pain, unsteady gait, electrolyte imbalance, seizures, leg cramps, fluid imbalance and headache. The policy instructs in

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F 698	Continued From page 76 the use of the Dialysis Center Communication UDA for continuity of care. A request was made for a policy related to monitoring residents for fluid imbalance, but facility did not provide such a document.	F 698		
F 726 SS=F	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c) §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident	F 726		12/1/21

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F 726	Continued From page 77 assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure a newly graduated, unlicensed practical nurse (PN-A) received adequate training and demonstrated competency skills related to identifying and responding to changes in condition, and documenting resident assessment and nursing response for continuity of care specifically related to falls and injury. A resident (R10) suffered a fall resulting in a fractured fibula/tibia without a knowledgeable or timely response post-fall by (PN-A). This lack of competency training and assessment had the potential to affect all 34 residents in the facility. Findings include: According to education documents provided by the facility, PN-A received general employee orientation on 8/10/2021. Eighteen general topics with multiple sub-topics were covered in an 8 hour period. A competency test for hand hygiene was completed and a post-test for all staff related to understanding falls and infection control were completed. A test related to compliance was completed, but no evidence of competency test-outs for any specific nursing skills completed on that date or any other date were provided. Facility reported PN-A completed a half hour computer training module on general documentation 9/9/2021. Facility provided PN-A's college transcript showing that PN-A had completed 14 didactic and 10 clinical credit hours, totaling only 24 credit hours specific to nursing process, disease knowledge, patient care and documentation. Facility was unable to provide evidence of a nursing license for PN-A.	F 726	Facility residents have the potential to be affected. Current staff to have competency checkoff complete per policy annually. Director of Nursing/Designee to complete a competency checklist for licensed and certified staff per policy on hire and annually. Interdisciplinary team educated by the Director of Clinical Services starting on 11/12/21 to the MN Board of Nursing license requirements, the Employee orientation policy and procedure and the annual competency check off policy and procedure. Executive Director/Designee to audit new hire documentation weekly as new staff are hired and annually for complete reviews. The results of the audits will be reviewed by the QAPI committee for trends and any needs for adjustment of audit schedules or content, as well as any further educational needs. The Executive Director is responsible to ensure this action occurs.	

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According to documentation in R10's electronic health record (EHR), a progress note dated 9/23/21, 6:54 a.m. indicated the registered nurse (RN-B) writing the note, had received report from the evening nurse [PN-A] that R10 was "lowered to the floor while trying to get into bed" [9/22/21]. RN-B wrote that R10's lower right leg was rotated outward, was swollen and bruised, and R10 was complaining of significant pain. The progress note indicated RN-B assessed and responded to R10's condition and sent him to the hospital in the morning, notifying family and physician. No previous note was found in R10's EHR describing R10's condition or cares provided prior to or after the incident on 9/22/21 during the time PN-A was responsible for R10's care. No vital signs for R10 were found documented by PN-A following the incident on 9/22/21.

According to a document, an incident report related to the 9/22/21 fall, it had been completed by the director of nursing (DON) who was not present at the time of the fall, and PN-A, the nurse responsible for R10 at the time of the fall did not document in the report. No predisposing environmental factors were documented, no predisposing situation factors were documented and of predisposing physiological factors, only gait imbalance was marked.

According to an interview 10/14/21, 10:42 a.m. DON explained the procedure for a nurse to follow when a resident falls. DON said first the nurse was to assess the resident for injury, review a possible cause of the incident, and based on those findings, either use a Hoyer lift with additional help, to place the resident into bed, or call for emergency assistance up to and

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including transfer to the hospital. Following the fall, DON stated a nurse is expected to document in "risk management" (incident report) in the EHR which triggers post-fall observation documentation to be done by nurses on the up-coming shifts. DON confirmed PN-A had not done this, nor had PN-A written a progress note. Although DON had initiated the risk management incident report, DON was unable to state whether PN-A had asked R10 any questions about the fall or his condition, or if PN-A had tried to figure out why the incident had happened (root cause) to initiate any new and appropriate intervention. DON said, "(PN-A) said it wasn't a fall, but of course we know it is considered a fall, but she said he looked fine."

During the 10/14/21, 10:42 a.m. interview, DON said PN-A had started work on 8/10/21. DON confirmed the facility did not have a copy of PN-A's nursing license upon hire, and did not have one as of 10/14/21. DON said facility had a check list of skills that a nurse trainer would go through with a newly hired nurse during orientation shifts, but they did not have any type of skills tests. DON stated the nurse providing orientation would see if the newly hired nurse felt comfortable with the skill, and then mark if they were competent or not.

A request was made for a copy of PN-A's nursing skills checklist, but facility was unable to provide this document.

According to a phone interview with PN-A on 10/14/21, 2:03 p.m. she had graduated from college in May of 2021, and had never worked as a nurse before. PN-A stated she had taken her nursing board exams in July, but did not yet have

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a nursing license. PN-A said she was told by the facility there was a waiver, and she was able to start work before she was licensed. She had not confirmed this with the Minnesota Board of Nursing. PN-A said she had received a checklist of items she would be trained on during her first day of orientation, but said this did not include a list of nursing skills, but rather was a list for all employees. PN-A said she had not undergone any testing by the facility to determine her competency level. PN-A said she had received four or five shifts for orientation, but had not been asked if she felt ready to work independently, or if she needed further training. PN-A was unable to provide specifics, but stated there were some shifts where she sent a text to the physician to ask questions because she felt she did not know what her job required at that time. PN-A said she had been instructed to call the DON if she had questions, but said the DON did not always respond to phone calls. PN-A said she had asked questions about wound care and was told to just look at the bandage already on the wound and "try to make it look the same." When R10 suffered his fall on 9/22/21, PN-A stated she was working at that time, and it was the first fall that she had to respond to as a nurse. PN-A was unable to describe what she had learned in nursing school about what to do if a resident had fallen. PN-A said her experience with falls was from when she was a nursing assistant, but said an assessment should be done by the nurse, including a set of vital signs , the nurse should document findings and notify the DON and the physician. PN-A could not recall if she had written a progress note (no progress note was found); she thought she may have given R10 some Tylenol for pain because he complained of pain all over, and could not localize the pain. PN-A

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said she had called the DON and asked what paperwork she had to do, but said the DON told her she did not have to do anything because R10 was "lowered to the floor" and did not fall. PN-A asked if she needed to call the physician, but said the DON said she "would take care of it." PN-A said "I found out the next day things were worse and I felt horrible, and asked what I needed to do." PN-A said she was told by the DON that the over-night nurse had charted everything, and she did not have to do anything else.

According to an interview 10/14/21, 2:44 p.m. RN-A said she often participates in orientation with the newly hired nurses. RN-A said there were not any hand-outs or written orientation information that she was aware of, but said a new nurse should have a check-list. RN-A said the check-list mostly covered medication administration. A binder of steps to take with common emergencies was kept at the nurses' stations, but RN-A said there were no skills tests, or competency checks related to those items.

According to an interview 10/14/21, 2:52 p.m. the Executive Director stated it was extremely important for a facility to have competent staff. Part of competence was ensuring staff had received proper training, and he stated the Human Resource department was to check licensure of staff before they started to work. Executive Director stated PN-A's lack of licensure had not been brought to his attention and she should not have been allowed to work as a nurse until she was properly licensed. Executive Director stated it was the responsibility of the DON to be knowledgeable about nurse licensure and stated an expectation for the DON to look up the rules and regulations if unsure. Additionally,

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F 726	Continued From page 82 he stated the DON was responsible to develop a competency program, but he did not believe this had been accomplished yet. The Executive Director stated a concern that residents may not get the care they require if the facility employed unlicensed staff, or staff who's competence had not yet been determined.	F 726		
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to be free from medication error rate of 5 percent or greater identified during observations of 26 medications with 7 errors (for resident R24) which resulted in an error rate of 26.92 percent. Findings include: On 10/13/21, at 8:10 a.m. R24's medication pass was observed and completed by registered nurse (RN)-A. RN-A was observed to set up the following five medications including: atorvastatin 40 mg 1 tab daily via g-tube, vitamin D3 1000 unit 1 tab daily via g-tube, hydralyzine 25 mg 1 tab every 6 hours via g-tube, levetiracetam 750 mg 1 tab twice a day via g-tube, lisinopril 10 mg 1 tab daily via g-tube. RN-A crushed all five meds together and placed in a plastic cup then set up the following two medications in a separate cup: clearlax 17 grams daily via g-tube and docusate	F 759	R24 orders in electronic charting system updated to read, “may crush medications and give individually via G-tube.” Facility residents with enteral tube medications have the potential to be affected. Licensed staff educated by the Director of Clinical Services starting on 11/12/21 to the Enteral Tube Medication Administration policy and procedures. Director of Nursing/Designee to complete random med pass audits on all shifts including enteral tube med administration weekly for 8 weeks. The results of the audits will be reviewed by the QAPI committee for trends and any needs for adjustment of audit schedules	12/1/21

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F 759	Continued From page 83 50 mg/5 ml 5 ml daily via g-tube. RN-A added 60 cc of water to each cup, flushed R24's g-tube with 30 cc of water, administered first cup of crushed medications, flushed with with 30 cc of water then administered second cup of medications with 120 cc of water and finished with 30 cc water flush. During interview with RN-A on 10/13/21, at 8:10 a.m. RN-A stated there was no order stating the meds had to be given separately therefore all medications were given together except for Potassium, that is given separately. On 10/13/21, at 9:01 a.m. a follow-up interview was conducted with RN-A. RN-A stated combining medications together for g-tube administration is how RN-A has always given R24's medications, except potassium was to be given separate. On 10/13/21, at 12:20 p.m. the director of nursing (DON) was asked if staff were trained on G-Tubes and DON stated there was no education done since this DON was hired a year and a half ago. During a follow-up interview on 10/13/21, at 2:03 p.m. DON verified the expectation for administering medications via G-Tube was each medication was to be given individually with a flush in between each medication. When asked what could happen if medications were given all together DON stated, "Many things, meds may not be compatible." Facility policy titled Medication Administration dated June 2017 did not address how to administer medications via G-Tube. Facility policy titled Enteral Nutritional Therapy (Tube Feeding)	F 759	or content, as well as any further educational needs. The Executive Director is responsible to ensure this action occurs.	

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F 759	Continued From page 84 dated June 2017 also did not address how to administer medications via G-Tube.	F 759		
F 761 SS=D	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 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 inhalers were properly labeled to allow staff to identify a beyond use date and avoid administration of inhalant medications after beyond use date for 3 of 3 residents (R13, R19 and R184) reviewed for safe	F 761	R13, R19, R184 medication labeled appropriately. Facility residents have the potential to be affected.	12/1/21

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F 761	Continued From page 85 medication storage. Additionally, the facility failed to dispose of expired medications in 1 of 1 medication carts and 1 of 11 medication storage rooms. Findings include: On 10/12/21, at 9:36 a.m. the 300 Wing medication cart was observed with Registered Nurse (RN)-A present and the following was found: - R13's open Flovent inhaler found with no date to indicate when it was opened. - R19's open Spiriva inhaler and Albuterol inhaler found with no date to indicate when opened. - R184's open Albuterol inhaler found with no date to indicate when it was opened. - A stock bottle of fish oil was found with an expiration date of 07/2021. During an interview on 10/15/21, at 1:44 p.m. the director of nursing (DON) stated that when nurses open a new inhaler, eye drop or insulin pen they should label the medication with the date open. On 10/15/2021 at 1:34 P.M., facility med storage room was observed with Director of Nursing (DON) present and the following was found: - 8 boxes of stock cerumen ear drops found that expired in 07/2021. - 1 box of Tylenol suppositories prescribed to R8 that expired 08/2021. During an interview on 10/15/21 at 1:44 P.M., the DON stated that when nurses open a new inhaler, eye drop of insulin pen they should label	F 761	Medication storage room and carts were audited for any opened medications without a date opened label present or resident name present on 10/18/21. Any medications found without correct labeling were disposed of. NOC shift nurse to complete weekly checking of the medication carts and storage room with sign off on checkoff sheet. Nursing staff to check items for date, label, etc. throughout med pass. Monthly pharmacy reviews to continue. Licensed staff educated by the director of Clinical Services starting on 11/12/21 to the Medication storage, labeling, and expiration information and tips education, Medication expiration dates education, and the Medication storage policy and procedures. Director of Nursing/Designee to audit NOC shift checkoff sheet weekly for completion for 8 weeks. Licensed staff educated to the Medication storage, labeling, and expiration information and tips education, Medication expiration dates education, Medication Administration policy and procedures and Medication storage policy and procedures. The results of the audits will be reviewed by the QAPI committee for trends and any needs for adjustment of audit schedules	

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F 761	Continued From page 86 the medication with the date open. The DON also verified the boxes of cerumen ear drops were expired and should have been disposed. Facility policy titled Medication Administration, dated June 2017, indicated on page 4 to record date a bottle or container is opened on the label, as well as to return expired or outdated medications promptly to the pharmacy.	F 761	or content, as well as any further educational needs. The Executive Director is responsible to ensure this action occurs.	
F 839 SS=D	Staff Qualifications CFR(s): 483.70(f)(1)(2) §483.70(f) Staff qualifications. §483.70(f)(1) The facility must employ on a full-time, part-time or consultant basis those professionals necessary to carry out the provisions of these requirements. §483.70(f)(2) Professional staff must be licensed, certified, or registered in accordance with applicable State laws. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure 1 of 1 practicing nurse (PN)-A and 1 of 3 licensed practical nurse (LPN)-C reviewed was licensed by the State to practice nursing. Findings included: During an interview on 10/11/21, at 7:01 p.m. LPN-C stated PN-A had passed her boards but did not have license yet and was working as a licensed practical nurse. LPN-C stated, "they also let me work as a licensed practical nurse for a month before she was assigned a license number."	F 839	PN-A removed from schedule until background check completed and valid license obtained. PN-C license obtained. Facility residents have the potential to be affected. Audit of current employees to verify background check, license, and certification documentation complete 10/17/21 Employees will have on file current and	12/1/21

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F 839	Continued From page 87 Practical Nurse (PN)-A's employee personal file was reviewed. The record indicated an original hire date of 8/10/21. The personal file review revealed PN-A did not have a license to practice nursing in the state of Minnesota. During an interview on 10/12/21, at 4:59 p.m. with the business office manager (BOM) PN-A's timecard was reviewed from 8/10/21 to 10/3/21 and revealed PN-A had worked in the facility as a licensed practical nurse without supervision or a license 28 times. The BOM stated I do know during her interview that NP-A asked if she could start before her license came through or not and she was told yes. The BOM stated the director of nursing (DON) thought she could work under a temporary license, and I honestly did not know. The BOM stated NP-A was allowed to work as an LPN and stated she was not asked to provide a copy of a temporary license. The BOM stated I thought it was like a certified nursing assistant that when they pass their boards, they were good to go. The BOM stated the DON thought that NP-A had a temporary license and NP-A thought she was underneath a graduate nurse waiver. The BOM stated she had been checking every Monday to see if her license had been updated yet. During an interview on 10/14/21, at 2:19 p.m. PN-A stated she graduated in May 2021 from nursing school and passed her boards in July 2021. PN-A when she was applying to jobs after she had passed her boards she had reached out to LPN-C, and she stated they were hiring. PN-A stated she explained to LPN-C she had not gotten her official nursing license yet and LPN-C stated don't worry about that there was a waiver.	F 839	validated license information, and credential documentation prior to working with residents. Interdisciplinary team educated by the Director of Clinical Services starting on 11/12/21 on the new hire policy and the state of Minnesota regulations and the need to verify license/certification prior to working with residents. Executive Director/Designee will audit new hires for 8 weeks for complete documentation. Audit tracking tool developed. The results of the audits will be reviewed by the QAPI committee for trends and any needs for adjustment of audit schedules or content, as well as any further educational needs. The Executive Director is responsible to ensure this action occurs.	

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F 839	Continued From page 88	F 839		

PN-A stated upon hire they (DON and BOM) were aware she did not have her license and stated there was a waiver that she could work under as a new graduate nurse. PN-A stated she was told by the DON it took LPN-C it took three times to pass her boards and LPN-C had worked under a waiver. PN-A Stated I was suspended by the executive director on Monday because I do not have a valid license to work as a licensed practical nurse. PN-A stated she felt like she was manipulated and taken advantage off.

Licensed practical nurse (LPN)-C's employee personal file was reviewed. The record indicated a hire date of 2/15/21 as a licensed practical nurse. LPN-A's personnel record indicated a Minnesota LPN license was issued on 3/17/21. However, between 2/15/21 and 3/17/21, LPN-A did not have a license to practice nursing in the state of Minnesota

During an interview on 10/13/21, at 9:12 a.m. with the business office manager (BOM) stated in February of 2021, LPN-C reached out to her and was hired back on 2/15/21 as a licensed practical nurse (LPN) as she had passed her boards. The BOM stated LPN-C's licensure came through on 3/17/21. During a subsequent interview at 11:22 a.m. LPN-C's timecard was reviewed from 2/15/21 to 3/17/21 and revealed LPN-C had worked in the facility as a licensed practical nurse without supervision or a license 23 times.

During an interview on 10/12/21, at 5:17 p.m. the executive director stated he was unaware the facility had an unlicensed nurse working in the building. The executive director stated the expectation was the facility to have a copy of the

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F 839	Continued From page 89 license in the personal file and to check the Minnesota Board of Nursing registry. The executive director stated he would want to be in the loop if the DON and BOM were hiring a staff member under any abnormal circumstances where the staff member was not licensed yet. The executive director stated a copy of background checks should be kept in employee personal files The Pre-Employment Screening for License/Certifications policy dated July 2018 included, "1. Prospective employees must have a Valid license and/or certification along with job application when a license or certification is required as set forth in the current job description ...2. Licensure Designee must check with all applicable state licensing board(s) to confirm that the prospective employee possesses a valid license and/pr certification that is in good standing and applicable to the position."	F 839		
F 947 SS=E	Required In-Service Training for Nurse Aides CFR(s): 483.95(g)(1)-(4) §483.95(g) Required in-service training for nurse aides. In-service training must- §483.95(g)(1) Be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year. §483.95(g)(2) Include dementia management training and resident abuse prevention training. §483.95(g)(3) Address areas of weakness as determined in nurse aides' performance reviews and facility assessment at § 483.70(e) and may address the special needs of residents as	F 947		12/1/21

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F 947	Continued From page 90 determined by the facility staff. §483.95(g)(4) For nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure annual performance reviews were conducted for 5 of 5 nursing assistants (NA-A. NA-B, NA-C, and NA-D) whose personnel records were reviewed. Findings include: NA-B was hired on 5/18/2019. NA-A's employee record lacked documentation of annual performance evaluations. NA-C was hired on 10/4/2019. NA-C's employee record lacked documentation of annual performance evaluations. NA-D was hired on 10/4/2013. NA-D's record lacked documentation of annual performance evaluation. NA-D's last performance evaluation was dated 10/31/16. NA-E was hired on 10/31/2001. NA-E's record lacked documentation of annual performance evaluation. NA-D's last performance evaluation was dated 10/31/16. NA-F was hired on 9/6/2018. NA-F's employee record lacked documentation of annual performance evaluations. During an interview on 10/18/21, at 3:14 p.m. the director of nurses (DON) stated performance	F 947	Performance evaluations completed for current staff. Facility residents have the potential to be affected. Performance evaluations will be completed annually for licensed and certified staff. Interdisciplinary team educated by the Director of Clinical Services starting on 11/12/21 on performance evaluation requirements per policy. Executive Director/Designee will audit performance evaluation completion annually. The results of the audits will be reviewed by the QAPI committee for trends and any needs for adjustment of audit schedules or content, as well as any further educational needs. The Executive Director is responsible to ensure this action occurs.	

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F 947	Continued From page 91 reviews were supposed to be completed by December 2020. The DON stated they were not caught up on performance reviews, "We did not have concerns with any of the five staff members requested from the survey team and we just did not get to them." The DON stated no performance evaluations had been completed for the requested staff since 2017 when Northshore started managing the facility. During an interview on 10/18/21, at 3:20 p.m. the executive director stated before the end of the calendar year, Northshore expected the facility to complete performance evaluations on all to staff to include strengths, weakness, and opportunities for growth. The executive director stated he was under the assumption the facility would have completed the performance evaluation by the end of last year like the facility was supposed to and stated he was not aware they had not been done. A policy and procedure on annual performance evaluations was requested and not provided.	F 947		

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E 000	Initial Comments On 10/11/21, 10/12/21, 10/13/21, 10/14/21, 10/15/21 and 10/18/21, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) was conducted during a standard recertification survey. The facility was NOT in compliance. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulation has been attained.	E 000		
E 007 SS=C	EP Program Patient Population CFR(s): 483.73(a)(3) §403.748(a)(3), §416.54(a)(3), §418.113(a)(3), §441.184(a)(3), §460.84(a)(3), §482.15(a)(3), §483.73(a)(3), §483.475(a)(3), §484.102(a)(3), §485.68(a)(3), §485.625(a)(3), §485.727(a)(3), §485.920(a)(3), §491.12(a)(3), §494.62(a)(3). [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following:] (3) Address [patient/client] population, including, but not limited to, persons at-risk; the type of services the [facility] has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession	E 007		12/1/21

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

Electronically Signed | 11/19/2021

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

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E 007	Continued From page 1 plans.** *[For LTC facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do all of the following: (3) Address resident population, including, but not limited to, persons at-risk; the type of services the LTC facility has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans. *NOTE: ["Persons at risk" does not apply to: ASC, hospice, PACE, HHA, CORF, CMCH, RHC/FQHC, or ESRD facilities.] This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to address their resident population including the persons at risk, in their emergency operations plan. This had the potential to affect all 34 residents residing at the facility. Findings include: The facility's Emergency Operations Plan, undated, failed to include an assessment of their population to include persons at risk. During interview on 10/18/21, at 10:04 a.m. the executive director verified the facility emergency plan did not address the population of persons served.	E 007	Assessment of current resident population conducted on 11/19/2021. Assessment tool placed in emergency evacuation kit at each nurse's station for use by staff in the event of an emergency. Assessment will be updated weekly. Audits will be conducted weekly to ensure compliance. Audit findings will be reviewed at QAPI meeting.	
E 015 SS=C	Subsistence Needs for Staff and Patients CFR(s): 483.73(b)(1)	E 015		12/1/21

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E 015	Continued From page 2 §403.748(b)(1), §418.113(b)(6)(iii), §441.184(b)(1), §460.84(b)(1), §482.15(b)(1), §483.73(b)(1), §483.475(b)(1), §485.625(b)(1) [(b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following: (1) The provision of subsistence needs for staff and patients whether they evacuate or shelter in place, include, but are not limited to the following: (i) Food, water, medical and pharmaceutical supplies (ii) Alternate sources of energy to maintain the following: (A) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (B) Emergency lighting. (C) Fire detection, extinguishing, and alarm systems. (D) Sewage and waste disposal. *[For Inpatient Hospice at §418.113(b)(6)(iii):] Policies and procedures. (6) The following are additional requirements for hospice-operated inpatient care facilities only. The policies and procedures must address the following: (iii) The provision of subsistence needs for	E 015		

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E 015	Continued From page 3 hospice employees and patients, whether they evacuate or shelter in place, include, but are not limited to the following: (A) Food, water, medical, and pharmaceutical supplies. (B) Alternate sources of energy to maintain the following: (1) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (2) Emergency lighting. (3) Fire detection, extinguishing, and alarm systems. (C) Sewage and waste disposal. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to include in their emergency operations plan (EOP) how to obtain pharmaceutical supplies and how to maintain sewage and waste disposal during an emergency. This had the potential to affect 34 residents at the facility. Findings include: Review of the facility's undated EOP reviewed 10/18/21, the facility failed to address how they would obtain pharmaceutical supplies and how they would maintain sewage and waste disposal during an emergency. During interview on 10/18/21, at 10:22 a.m., the executive director verified this information.	E 015	Shelter in place and evacuation procedures updated in emergency preparedness plan to reflect how we would ensure delivery of medication in either situation. Agreement with Kimo's obtained in the event our sewage system fails. In this situation, Kimo's would bring portable bathrooms and we would empty commodes and sewage into the portable bathrooms, keeping a few designated for staff use. Agreement has been added to emergency preparedness plan. Will ensure compliance upon annual review of emergency preparedness plan.	
E 023 SS=C	Policies/Procedures for Medical Documentation CFR(s): 483.73(b)(5) §403.748(b)(5), §416.54(b)(4), §418.113(b)(3),	E 023		12/1/21

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E 023	Continued From page 4 §441.184(b)(5), §460.84(b)(6), §482.15(b)(5), §483.73(b)(5), §483.475(b)(5), §484.102(b)(4), §485.68(b)(3), §485.625(b)(5), §485.727(b)(3), §485.920(b)(4), §486.360(b)(2), §491.12(b)(3), §494.62(b)(4). [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:] [(5) or (3),(4),(6)] A system of medical documentation that preserves patient information, protects confidentiality of patient information, and secures and maintains availability of records. *[For RNHCIs at §403.748(b):] Policies and procedures. (5) A system of care documentation that does the following: (i) Preserves patient information. (ii) Protects confidentiality of patient information. (iii) Secures and maintains the availability of records. *[For OPOs at §486.360(b):] Policies and procedures. (2) A system of medical documentation that preserves potential and actual donor information, protects confidentiality of potential and actual donor information, and secures and maintains the availability of records.	E 023		

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E 023	Continued From page 5 This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to develop a policy and procedure for preservation of medical documents. This had the potential to affect all 34 residents residing in the facility. Findings include: The facility's emergency operations plan reviewed 10/18/21, was reviewed with the executive director. The facility had no system in place that would preserve patient information, protect confidentiality of patient information, and secure and maintain availability of records in the event of an emergency. During an interview on 10/18/21, at 10:32 a.m. the executive director verified there was not a policy or procedure to preserve medical documents.	E 023	Resident demographic pages, including physician and contact information, placed in the center's emergency evacuation kit by 12/1/2021 and will be updated on a weekly basis. Audits will be conducted weekly to ensure compliance. Audit findings will be reviewed at QAPI meeting.	
E 026 SS=C	Roles Under a Waiver Declared by Secretary CFR(s): 483.73(b)(8) §403.748(b)(8), §416.54(b)(6), §418.113(b)(6)(C)(iv), §441.184(b)(8), §460.84(b)(9), §482.15(b)(8), §483.73(b)(8), §483.475(b)(8), §485.625(b)(8), §485.920(b)(7), §494.62(b)(7). [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years	E 026		12/1/21

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E 026	Continued From page 6 [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:] (8) [(6), (6)(C)(iv), (7), or (9)] The role of the [facility] under a waiver declared by the Secretary, in accordance with section 1135 of the Act, in the provision of care and treatment at an alternate care site identified by emergency management officials. *[For RNHCIs at §403.748(b):] Policies and procedures. (8) The role of the RNHCI under a waiver declared by the Secretary, in accordance with section 1135 of Act, in the provision of care at an alternative care site identified by emergency management officials. This REQUIREMENT is not met as evidenced by: Based on document review and interview, the facility failed to develop policies and procedures in its emergency plan describing the facility's role in providing care and treatment at alternate care sites under section 1135 act waiver. This had the potential to affect all 34 residents currently residing in the facility. Findings Include: The facility emergency operations plan reviewed did not contain information of a policy describing the facility's role in providing care and treatment at alternate care sites under an 1135 waiver. During an interview on 10/18/21, at 10:40 a.m. the executive director confirmed the lack of a policy and procedure, which specifically identified the facility's role in providing care and treatment at alternate care sites under an 1135 waiver.	E 026	Information regarding 1135 Waiver placed in emergency preparedness plan on 11/17/2021. Will ensure compliance upon annual review of emergency preparedness plan.	

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	245270	A. BUILDING _____ B. WING _____	C 10/18/2021

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E 030 SS=C	Names and Contact Information CFR(s): 483.73(c)(1) §403.748(c)(1), §416.54(c)(1), §418.113(c)(1), §441.184(c)(1), §460.84(c)(1), §482.15(c)(1), §483.73(c)(1), §483.475(c)(1), §484.102(c)(1), §485.68(c)(1), §485.625(c)(1), §485.727(c)(1), §485.920(c)(1), §486.360(c)(1), §491.12(c)(1), §494.62(c)(1). [(c) The [facility must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities]. The communication plan must include all of the following:] (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians (iv) Other [facilities]. (v) Volunteers. *[For Hospitals at §482.15(c) and CAHs at §485.625(c)] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians (iv) Other [hospitals and CAHs]. (v) Volunteers. *[For RNHCIs at §403.748(c):] The communication plan must include all of the following:	E 030		12/1/21

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E 030	Continued From page 8 (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Next of kin, guardian, or custodian. (iv) Other RNHCIs. (v) Volunteers. *[For ASCs at §416.45(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Volunteers. *[For Hospices at §418.113(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Hospice employees. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Other hospices. *[For HHAs at §484.102(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Volunteers. *[For OPOs at §486.360(c):] The communication plan must include all of the following:	E 030		

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E 030	Continued From page 9 (2) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Volunteers. (iv) Other OPOs. (v) Transplant and donor hospitals in the OPO's Donation Service Area (DSA). This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility's communication plan failed to include the required information including facility staff names and contact numbers and names and contact information for physicians. This had the potential to affect all 34 residents in the facility. Findings include: During interview on 10/18/21, at 10:46 a.m. the executive director acknowledged there was not a list of physicians and their contact numbers or staff names and their contact numbers information in the emergency operations plan.	E 030	Physician information and contact information is included on resident demographic sheets which were placed at the nurses stations in the evacuation kits by 12/1/2021. Audits will be conducted weekly to ensure compliance. Findings will be reviewed at QAPI meeting.	
E 031 SS=C	Emergency Officials Contact Information CFR(s): 483.73(c)(2) §403.748(c)(2), §416.54(c)(2), §418.113(c)(2), §441.184(c)(2), §460.84(c)(2), §482.15(c)(2), §483.73(c)(2), §483.475(c)(2), §484.102(c)(2), §485.68(c)(2), §485.625(c)(2), §485.727(c)(2), §485.920(c)(2), §486.360(c)(2), §491.12(c)(2), §494.62(c)(2). [(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every	E 031		12/1/21

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E 031	Continued From page 10 2 years [annually for LTC facilities]. The communication plan must include all of the following: (2) Contact information for the following: (i) Federal, State, tribal, regional, and local emergency preparedness staff. (ii) Other sources of assistance. *[For LTC Facilities at §483.73(c):] (2) Contact information for the following: (i) Federal, State, tribal, regional, and local emergency preparedness staff. (ii) The State Licensing and Certification Agency. (iii) The Office of the State Long-Term Care Ombudsman. (iv) Other sources of assistance. *[For ICF/IIDs at §483.475(c):] (2) Contact information for the following: (i) Federal, State, tribal, regional, and local emergency preparedness staff. (ii) Other sources of assistance. (iii) The State Licensing and Certification Agency. (iv) The State Protection and Advocacy Agency. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure their Emergency Operations Plan (EOP) included contact information for federal emergency preparedness staff and contact information for the Ombudsman. This had the potential to affect all 34 residents currently residing in the facility. Findings include: The facility's EOP was reviewed with the executive director. The plan-included	E 031	Ombudsman contact information added to emergency preparedness plan on 11/17/2021. Will ensure compliance upon annual review of emergency preparedness plan.	

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E 031	Continued From page 11 components of a communication plan however, lacked documentation of contact information for federal emergency preparedness staff and contact information for the Ombudsman. On 10/18/21, at 10:50 a.m. the executive director verified this information.	E 031		
E 035 SS=C	LTC and ICF/IID Sharing Plan with Patients CFR(s): 483.73(c)(8) §483.73(c)(8); §483.475(c)(8) *[For LTC Facilities at §483.73(c):] [(c) The LTC facility must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually. The communication plan must include all of the following:] *[For ICF/IIDs at §483.475(c):] [(c) The ICF/IID must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years. The communication plan must include all of the following:] (8) A method for sharing information from the emergency plan, that the facility has determined is appropriate, with residents [or clients] and their families or representatives. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the Emergency Operations Plan (EOP) was communicated to residents and/or representatives. This had the potential to	E 035	Emergency preparedness information shared with residents and representatives by 12/1/2021 including information on how to obtain additional details. New residents	12/1/21

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E 035	Continued From page 12 affect all 34 residents who resided at the facility. Findings include: The facility's EOP plan reviewed 10/18/21, lacked documentation of a method for sharing information from the emergency plan the facility had determined appropriate with residents and their families or representatives. During an interview on 10/19/21, at 2:20 p.m. the executive director confirmed the facility had not developed a method for sharing information from the emergency plan with residents and their families.	E 035	and representatives will be provided with emergency preparedness information upon admission via the new admission packet. Training provided to social services director regarding the requirement to include in the admissions packet.	
E 037 SS=C	EP Training Program CFR(s): 483.73(d)(1) §403.748(d)(1), §416.54(d)(1), §418.113(d)(1), §441.184(d)(1), §460.84(d)(1), §482.15(d)(1), §483.73(d)(1), §483.475(d)(1), §484.102(d)(1), §485.68(d)(1), §485.625(d)(1), §485.727(d)(1), §485.920(d)(1), §486.360(d)(1), §491.12(d)(1). *[For RNCHIs at §403.748, ASCs at §416.54, Hospitals at §482.15, ICF/IIDs at §483.475, HHAs at §484.102, "Organizations" under §485.727, OPOs at §486.360, RHC/FQHCs at §491.12:] (1) Training program. The [facility] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of all emergency	E 037		12/1/21

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E 037	Continued From page 13	E 037		

preparedness training.
(iv) Demonstrate staff knowledge of emergency procedures.
(v) If the emergency preparedness policies and procedures are significantly updated, the [facility] must conduct training on the updated policies and procedures.

*[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following:
(i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles.
(ii) Demonstrate staff knowledge of emergency procedures.
(iii) Provide emergency preparedness training at least every 2 years.
(iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others.
(v) Maintain documentation of all emergency preparedness training.
(vi) If the emergency preparedness policies and procedures are significantly updated, the hospice must conduct training on the updated policies and procedures.

*[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following:
(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their

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E 037	Continued From page 14	E 037		

expected roles.
(ii) After initial training, provide emergency preparedness training every 2 years.
(iii) Demonstrate staff knowledge of emergency procedures.
(iv) Maintain documentation of all emergency preparedness training.
(v) If the emergency preparedness policies and procedures are significantly updated, the PRTF must conduct training on the updated policies and procedures.

*[For PACE at §460.84(d):] (1) The PACE organization must do all of the following:
(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, contractors, participants, and volunteers, consistent with their expected roles.
(ii) Provide emergency preparedness training at least every 2 years.
(iii) Demonstrate staff knowledge of emergency procedures, including informing participants of what to do, where to go, and whom to contact in case of an emergency.
(iv) Maintain documentation of all training.
(v) If the emergency preparedness policies and procedures are significantly updated, the PACE must conduct training on the updated policies and procedures.

*[For LTC Facilities at §483.73(d):] (1) Training Program. The LTC facility must do all of the following:
(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their

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expected role.
(ii) Provide emergency preparedness training at least annually.
(iii) Maintain documentation of all emergency preparedness training.
(iv) Demonstrate staff knowledge of emergency procedures.

*[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following:
(i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.
(ii) Provide emergency preparedness training at least every 2 years.
(iii) Maintain documentation of the training.
(iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment.
(v) If the emergency preparedness policies and procedures are significantly updated, the CORF must conduct training on the updated policies and procedures.

*[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following:
(i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and

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E 037	Continued From page 16 cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the CAH must conduct training on the updated policies and procedures. *[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least every 2 years. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to conduct annual training of the Emergency Operations Plan (EOP) plan with staff. This had the potential to affect all 34 residents and staff. Findings include: During an interview on 10/18/21, at 11:09 a.m. the executive director confirmed EOP training was completed upon hire however, lacked	E 037	All staff were provided training on emergency preparedness by 12/1/2021. Annual training will be provided on an ongoing basis. Compliance with emergency preparedness training will be monitored at QAPI meetings.	

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E 037	Continued From page 17 documentation to indicate the facility had annual training based on the emergency plan and risk assessment completed by the facility. The executive director verified the facility was not completing annual training on the EOP.	E 037		
F 000	INITIAL COMMENTS On 10/11/21, 10/12/21, 10/13/21, 10/14/21 10/15/21 and 10/18/21, a standard recertification survey was conducted at your facility. Complaint investigations were 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: H5270031C (MN73537), with a deficiency cited at F661. The following complaints were found to be UNSUBSTANTIATED: H5270032 (MN55823), H5270033 (MN54134), and H5270034 (MN53307), H5270035 (MN53097), H5270036 (MN48867). The IJ began on 8/11/21, when R13 was admitted to the facility and the facility failed to address code status, therefore considering him to be Full Code status, when R13 wished not to be resuscitated if his heart were to stop. R10 had returned from the hospital on 9/30/21, and had both Full Code and DNR (Do Not Resuscitate) directions in the medical record. R32 had directions for Full Code on a POLST (provider orders for life sustaining treatment) dated 4/20/21, a physician order dated 9/21/21 indicating DNR, a care plan dated 9/7/21	F 000		

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F 000	Continued From page 18 indicating the code status was on hold. The administrator and director of nursing (DON) were notified of the IJ on 10/12/21, at 2:35 p.m. The IJ was removed on 10/13/21, at 4:30 p.m. but noncompliance remained at the lower scope and severity of an E- pattern scope and severity level, which indicated no actual harm with potential for more than minimal harm that is not immediate jeopardy. The above findings constituted substandard quality of care and an extended survey was conducted 10/18/21. 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 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and	F 561		12/1/21

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F 561	Continued From page 19 waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on interview, and document review, the facility failed to ensure assessed and identified preferences for frequency of bathing was honored for 1 of 1 resident (R86) reviewed for choices. Finding include: During an interview on 10/11/21, at 1:56 p.m. R86 stated he got one shower a week, "I would like to have two and they know this." R86 stated, "They even interviewed me and asked me how many I would like, and I told them two and I get one a week." R86's baseline care plan indicated R86 was alert and orientated and was admitted to the facility on 9/24/21.	F 561	R86 interviewed and care plan updated to reflect bathing preferences. Facility residents have the potential to be affected. Residents interviewed for bathing preferences; care plans updated to reflect those preferences. Residents will be interviewed on admission and as requested for bathing preferences which will be reflected in the care plan, and bath schedule. Interdisciplinary team and nursing staff were educated by Director of Clinical Services starting on11/12/21on the	

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F 561	Continued From page 20 R86's bathing preference form dated 9/27/21, indicated resident's preference for a morning shower and indicated twice a week would be acceptable. During an interview on 10/13/21, at 12:45 p.m. nursing assistant (NA)-A stated R86 had a bath on Mondays, and he was just scheduled for once a week. NA-A showed surveyor the bath schedule that indicated room (R86's room number) was on the bath schedule for Monday only. During an interview on 10/13/21, at 12:51 p.m. licensed practical nurse (LPN)-B stated she was not sure what the process was to determine how many times a week a resident wanted a bath and stated she would find out and get back to surveyor. LPN-B returned to surveyor and stated upon admission the admitting nurse asked the resident how often they would like a bath, what type of bath and they were to put it on the bath schedule. During a subsequent interview at 1:04 p.m. LPN-B verified she was the nurse who had completed R86's bathing preference form and stated she did not know where she placed the form after she completed it upon admission. LPN-B stated she was unaware the form was to be placed in the box on the director of nursing's (DON) door for the DON to update the bath schedule. During an interview on 10/13/21, at 12:56 p.m. the DON stated the bath schedules were updated by LPN-A or herself. The DON stated the bathing preference sheet was to be placed in the mailbox on their door, then they update the bath sheet, and the form is filed in the resident chart. This was missed for R86.	F 561	Resident Rights Policy which includes bathing preferences, and showers, baths, and nail care education. Task was added to the revised Admission/Re-admission checklist. Director of Nursing/Designee will audit care plans once weekly x 8 weeks to ensure bathing preferences are honored and care plans are up to date. The results of the audits will be reviewed by the QAPI committee for trends and any needs for adjustment of audit schedules or content, as well as any further educational needs. The Executive Director is responsible to ensure this action occurs.	

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F 561	Continued From page 21 A policy was requesting on resident bathing preferences and was not provided.	F 561		
F 565 SS=E	Resident/Family Group and Response CFR(s): 483.10(f)(5)(i)-(iv)(6)(7) §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other	F 565		12/1/21

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F 565	Continued From page 22 residents in the facility. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure concerns raised at the resident council meetings were documented and presented back to the council, for 5 of 5 resident (R26, R21, R4, R23, and R186) who were present during the resident council meeting with survey team. Findings include: The resident council meeting minutes were reviewed for the months of 7/23/21, 8/27/21 and 9/30/21. The meeting minutes revealed the following concerns were shared. The meeting minutes from the resident council meeting held 7/23/21, included concerns with quality of food and food being cold, the attitude of the nursing assistants, the need for better communication between staff and residents would like to be introduced to new staff. Residents also voiced housekeeping concerns and missing clothing concerns. The meeting minutes from the resident council meeting held on 8/27/21, included concerns with housekeeping resident room and bathroom dirty, need better ramps for going inside and outside front lobby doors, the social work office is small and is hard for residents to get wheelchairs in her office to talk to her, if need be, making sure resident meal tickets are accurate with preferences, short staffed on weekends and shower days seem to be the worst. Staff talking outside of resident rooms about stuff they do not need to hear, sometimes snacks and ice water	F 565	Resident Council meeting held on 10/28/21 R26, R21, R4, R23 in attendance. R186 discharged. Grievances concerns documented appropriately and followed up on with resolution. Resolutions will be shared with individuals involved with specific concerns and will be shared with resident council group at next meeting in November. Facility residents have the potential to be affected. Activity Director, Executive Director, and other invited Interdisciplinary team members will document grievances from the Resident Council meetings and ensure follow up is complete per policy. Current staff educated by Executive Director starting on 11/12/21 to the Grievance policy and procedure and the Resident Council policy and procedure. Executive Director/Designee will audit the Grievance binder weekly x 8 weeks to ensure all grievances were addressed and complete. The results of the audits will be reviewed by the QAPI committee for trends and any needs for adjustment of audit schedules or content, as well as any further educational needs. The Executive Director is responsible to ensure this action occurs.	

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F 565	Continued From page 23	F 565		

are not being passed, lack of communication between staff all staff should be on the same page and if you do not know find out.

The meeting minutes from the resident council meeting held 9/30/21, included concerns dusting of large furniture in common areas needs to be completed, request for all windowsills to be cleaned. Would like all activities to last an hour.

On 10/13/21, at 10:00 a.m. a resident council meeting was held with R26, R21, R4, R23 and R186 and one surveyor. When asked the following questions: Does the facility consider the views of the resident or family groups and act promptly upon grievances and recommendations? Does the Grievance Official respond to the resident or family group's concerns? If the facility does not respond to concerns, does the Grievance Official provide a rationale for the response? The residents responded no. The resident's shared they have had concerns with the food being cold and stated they had shared these concerns in resident council meetings in the past. R186 stated 99% of the time her food was cold and stated she eats in her room. The residents stated the facility did not follow-up on concerns shared during the resident council meetings.

During an interview on 10/13/21, at 1:28 p.m. licensed social worker (LSW)-A stated, "To be honest I was not aware the facility needed to process resident council grievances the same as any other grievance needed to be done, but obviously in the future that will change." LSW-A stated there was only one response to the resident council concerns that was in writing for the last three months of resident council meeting

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F 565	Continued From page 24 minute concerns. LSW-A stated, "Its like the residents have the same concerns that do not get resolved." During an interview on 10/14/21, at 11:05 a.m. the executive director stated he expected concern shared in the resident council meeting to be documented in the meeting minutes, the social worker to share the concern with the department responsible and that it was that staff members job to follow up to address the concern and follow up with the resident. The executive director stated he would expect the follow-up and the resolution with the residents to be documented. A policy and procedure for resident council grievances was requested and not provided.	F 565		
F 576 SS=C	Right to Forms of Communication w/ Privacy CFR(s): 483.10(g)(6)-(9) §483.10(g)(6) The resident has the right to have reasonable access to the use of a telephone, including TTY and TDD services, and a place in the facility where calls can be made without being overheard. This includes the right to retain and use a cellular phone at the resident's own expense. §483.10(g)(7) The facility must protect and facilitate that resident's right to communicate with individuals and entities within and external to the facility, including reasonable access to: (i) A telephone, including TTY and TDD services; (ii) The internet, to the extent available to the facility; and (iii) Stationery, postage, writing implements and the ability to send mail.	F 576		12/1/21

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F 576	Continued From page 25 §483.10(g)(8) The resident has the right to send and receive mail, and to receive letters, packages and other materials delivered to the facility for the resident through a means other than a postal service, including the right to: (i) Privacy of such communications consistent with this section; and (ii) Access to stationery, postage, and writing implements at the resident's own expense. §483.10(g)(9) The resident has the right to have reasonable access to and privacy in their use of electronic communications such as email and video communications and for internet research. (i) If the access is available to the facility (ii) At the resident's expense, if any additional expense is incurred by the facility to provide such access to the resident. (iii) Such use must comply with State and Federal law. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to ensure mail was delivered to residents on Saturdays. This had the potential to affect all residents in the facility who received personal mail, including but not limited to 5 of 5 residents (R26, R21, R4, R23, and R186) at the resident council meeting, who verbally confirmed not receiving mail on Saturdays. This has the potential to affect all 34 residents living in the facility. Findings include: On 10/13/21, at 10:00 a.m. a group of residents met to discuss the resident council. When asked whether residents received their mail on Saturdays, all five residents voiced they did not	F 576	Facility residents have the potential to be affected. Weekend manager task list update to include delivery of mail on Saturdays if a manager is not available, nursing staff to deliver mail. Interdisciplinary team and nursing staff educated by the Director of Clinical Services starting on 11/12/21 on the Residents Rights policy and procedures which includes the right to send and receive mail and the Mail policy and procedures. Executive Director/Designee will be	

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F 576	Continued From page 26 receive their mail on Saturdays. The residents shared the staff do not deliver mail on Saturdays. The residents shared they only received mail when the activity director (AC) was working. During an interview on 10/14/21, at 4:24 p.m. activity director (AD) stated she was the staff member that delivered the mail. The AD stated on Saturday, the manager on duty was supposed to deliver the mail. The AD stated she had come in to work on a Monday and the mail had not been delivered and stated this has been frustrating. The AD was not sure if the mail was delivered during the week if she was not at work. During an interview on 10/14/21, at 4:29 p.m. the executive director stated the facility had a manager on duty on Saturdays and it was their responsibility to pass the mail. A policy on resident mail was requested and not provided. The Combined Federal and State Bill of Rights revised 6/18/19 included, "The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service."	F 576	responsible to ensure manager on duty schedule is complete monthly for Saturdays with nursing staff back-up as needed. Executive Director/Designee will audit the Manager on duty task list for completion and check off of the mail pass task weekly for 8 weeks. The results of the audits will be reviewed by the QAPI committee for trends and any needs for adjustment of audit schedules or content, as well as any further educational needs. The Executive Director is responsible to ensure this action occurs.	
F 578 SS=J	Request/Refuse/Dscntnue Trmnt;FormIte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse	F 578		12/1/21

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F 578	Continued From page 27 to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by:	F 578		

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F 578	Continued From page 28 Based on interview and document review, the facility failed to ensure a system was in place to clearly identify resident wishes for code status, cardiopulmonary resuscitation (CPR), for 6 of 34 residents (R13, R10, R32, R184, R26 and R86) reviewed for advanced directives. This failure resulted in an immediate jeopardy (IJ) for R13, R10, and R32, when their medical records failed to identify the residents wishes accurately. In addition to the residents in immediate jeopardy, the facility failed to ensure R184, R26, and R86's code status wishes were addressed with the resident or ordered by the physician. The IJ began on 8/11/21, when R13 was admitted to the facility and the facility failed to address code status, therefore considering him to be Full Code status, when R13 wished not to be resuscitated if his heart were to stop. R10 had returned from the hospital on 9/30/21, and had both Full Code and DNR (Do Not Resuscitate) directions in the medical record. R32 had directions for Full Code on a POLST (provider orders for life sustaining treatment) dated 4/20/21, a physician order dated 9/21/21 indicating DNR, a care plan dated 9/7/21 indicating the code status was on hold. The administrator and director of nursing (DON) were notified of the IJ on 10/12/21, at 2:35 p.m. The IJ was removed on 10/13/21, at 4:30 p.m. but noncompliance remained at the lower scope and severity of an E- pattern scope and severity level, which indicated no actual harm with potential for more than minimal harm that is not immediate jeopardy. Findings include:	F 578	Residents R13, R10, and R32 Advance Directives reviewed and updated, to reflect accurate information. Physician updated. R184, R26, and R86 Advance Directives addressed with the resident, Physician updated, and care plan updated. Facility residents have the potential to be affected. Resident orders in electronic charting system, care plans and hard charts audited and updated with accurate, complete, signed, and dated CPR/code status and POLST for each resident (10/11/2021 and 10/12/2021). Any errors or conflicting information detected on the forms were corrected and sent to Physician for review and signature on 10/12/2021. If not already completed prior to admission and provided to facility, residents will be asked to complete an Advance Directive. Residents will be given the opportunity to complete the POLST (Physician Orders for Life-Sustaining Treatment). The admitting nurse will be responsible to enter this information into the resident's chart, resident's orders in PCC, and care plan. The admitting nurse will verify upon admission that Advanced Directive wishes are current prior to processing. Clear identification will be available for staff regarding CPR/code status and POLST in PCC (resident orders), in residents' hard chart, and in resident care plan.	

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F 578	Continued From page 29 R13's admission MDS dated 8/11/21, included cognitively intact with diagnoses of lung disease and heart failure. R13's physician's orders in the EHR on 10/11/21 failed to include any order for advanced directives or code status. The code status banner in the EHR did not indicate a wish for CPR or DNR. R13's paper medical chart contained a POLST which was signed by the facility's medical director (MD)-A on 8/5/21, but the form was blank and not filled out. R13's wishes were not expressed on the physician signed form. When interviewed on 10/11/21, at 2:35 p.m. R13 stated, nobody at the facility has asked about code status, but R13 would want to be considered DNR. R10's quarterly Minimum Data Set (MDS) dated 7/30/21, included moderate cognitive impairment with diagnoses including Alzheimer's disease and heart failure. R10 had a discharge, return anticipated MDS which indicated he had an unplanned discharge to an acute care hospital on 9/23/21. An entry tracking MDS indicated he had returned to the facility from the hospital on 9/30/21. R10's care plan dated 5/24/21, with a date initiated of 2/3/18, identified, "[R10] has an advanced directive. Full Code, Long term artificial nutrition, IV/IM [intravenous/intramuscular] antibiotics." The goal was listed as, "Resident wishes will be honored." Staff were directed, "Full Code [CPR] Long term artificial nutrition, IV/IM antibiotics. Follow facility protocol for identification of code status. Review code status at least	F 578	Interdisciplinary team and licensed staff educated by the Director of Clinical Services starting on 11/12/21 on Living Will/Advance Directives/Life-sustaining treatment orders policy and procedure, including CPR/code status and POLST Policy and procedure, and default code status of “full code” if POLST documentation is undecided. Director of Nursing/Designee will audit admission checklist for completion of admission tasks during next days clinical meeting. If advance directive/CPR/POLST documentation is absent, incomplete, or contains conflicting instructions. Director of Nursing/designee will follow up to determine status of documentation and/or resident’s wishes. If resident has yet to make decisions as to advanced care planning, the default status of “full code” will be entered/verified and follow up will be completed with resident until decisions are made. Advance Directives will be reviewed with resident/representative during care plan meetings, with changes in resident condition, and as requested by resident/representative. Executive Director/Designee will complete random audits of Advance Directive, POLST documentation three x weekly for 12 weeks. The results of the audits will be reviewed by the QAPI committee for trends and any needs for adjustment of audit schedules or content, as well as any further educational needs. The Executive Director is responsible to ensure this action occurs.	

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F 578	Continued From page 30	F 578		

quarterly and as directed by resident's/responsible party's wishes."

R10's physician orders in the electronic health record (EHR) did not include any order for code status when reviewed on 10/11/21. The banner in the EHR also did not identify if R10's wishes were for full code (cardiopulmonary resuscitation) or for DNR (do not resuscitate).

When interviewed on 10/11/21, at 4:44 p.m. licensed practical nurse (LPN)-B stated in the event of cardiac arrest, they nurse locates the residents desired code status by going to the paper medical record and locating a POLST (Provider Orders for Life-Sustaining Treatment). LPN-B retrieved R10's paper medical record and located a POLST in the front of the chart. This POLST was dated 1/31/18, and identified R10 wished to have cardiopulmonary resuscitation (CPR) and full medical treatment, additional preferences were checked off as long-term artificial nutrition by tube and use of IV/IM antibiotic treatment. The POLST indicated a discussion was held with R10 and his health care agent and was signed by the health care agent - family member (FM)-D. The provider had signed this form on 1/31/18. A second POLST was also located, this one was signed by the social worker (SW)-B and R10 on 7/21/19. However, there was a note scribbled next to cardiopulmonary resuscitation (CPR) and the note included, "Discussed with PT [patient] with daughter 12/1/202 [unknown which year]. The box for "Attempt Resuscitation" had an X in it, which was crossed off, and the box for "Do Not Attempt resuscitation/DNR (allow natural death)" also had an X in it and was circled. Under additional preferences, both the box for Use IV/IM antibiotic

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treatment and Oral antibiotics only (no IV/IM) both had an X in them. LPN-B stated the POLST's were conflicting and staff would not know what to do in the event of cardiac arrest, "A mistake is going to happen, we are going to do CPR when we are not supposed to." LPN-B stated if she noted any conflicting orders, she would report it to the director of nursing (DON). On 10/12/21, at 2:35 p.m. R10's medical record was reviewed and remained unchanged with the conflicting POLST's and no physician order addressing code status was located.

R32's annual MDS dated 9/10/21, severe cognitive impairment with diagnoses including heart failure and lung disease.

R32's order summary dated 10/12/21, included an order for DNR/DNI [do not intubate] dated 9/7/21.

On 10/12/21, R32's paper medical record contained a POLST dated 4/20/21, which indicated R32 wished to have CPR performed.

R32's care plan dated 9/7/21, included, "Code Status: Changed again from Full CODE to DNR/DNI per MD and POA [power of attorney] as of 9/7/2021." However, listed under interventions directed staff, "ON HOLD: DNR/DNI, Comfort Cares, No artificial nutrition, IV/IM ATB [antibiotics]." It was unclear if the full code or DNR/DNI status was on hold.

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R184's admission MDS dated 10/7/21, included moderate cognitive impairment with diagnoses including heart and lung disease.

When reviewed on 10/11/21, R184's EMR and paper medical record failed to include any advanced directives or POLST.

When interviewed on 10/11/21, at 5:42 p.m. R184 stated, if was found with no pulse and was not breathing they would like CPR performed.

When interviewed on 10/11/21, at 7:22 p.m. R184's family member (FM)-E stated R184 would like to have CPR performed. The facility had not addressed this with either R184 or FM-E.

R26's admission MDS dated 9/1/21, included cognitively intact with diagnosis including heart failure.

R26's Physician Orders in the EHR on 10/11/21, included an order for, "Full Code," which was dated 9/17/21. However, there was no apparent written or verbal order from the physician.

R26's paper medical record contained a POLST dated 9/21/21. The POLST was blank/not filled out, however MD-A and LPN-B had signed the POLST and dated it with 9/21/21. Even though the POLST was signed by the physician, R26's wishes were not on the form.

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When interviewed on 10/11/21, at 7:01 p.m. licensed practical nurse (LPN)-C she stated she was going around trying to find the orders for all of the POLST's and getting information for the residents. LPN-C stated she had to fill out some of them (the POLST's) herself as it was so important to have those. LPN-C stated most of the time when the POLST's were in a resident's chart they were not filled out. LPN-C stated she did her best to update them but could not get to everybody. LPN-C stated she'd previously shared her concerns with the DON, executive director, and the social worker. LPN-C stated it caused her anxiety because staff would not know what to do in an emergency. LPN-C stated if no code status was found in a medical record, the staff would be expected to perform CPR if they were found to have no pulse and no respirations.

When interviewed on 10/11/21, at 4:19 p.m. LPN-A stated, it was not the facility's policy to put the resident's code status into the electronic record in point click care (PCC). LPN-A said she became aware that LPN-C had entered, "verbal orders" for code status in a number of residents' charts but was unsure when this had happened. LPN-A also stated there was a, "system issue" for code status of residents. LPN-C verified R26's current POLST was blank and had been signed by the physician and nurse. LPN-C stated the facility staff would need to initiate CPR if needed, "as you can't ask an unresponsive resident their code status."

When interviewed on 10/10/21, at 3:21 p.m. LPN-B stated, she was the admission nurse that completed the POLST upon admission with R26 but did not recall what R26 has said. LPN-B verified the POLST did not indicate R26's code

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status as the form was blank. LPN-B stated she would look in the hard (paper) chart for the POLST and if the POLST was blank, she would have needed to look in the computer and verified there was a verbal order that indicated full code. LPN-B stated she would have started CPR as the EHR had indicated R26 was full code.

When interviewed on 10/11/21, at 4:12 p.m. LPN-D stated she would look at the POLST in the front of the resident's medical record for a resident's code status. LPN-D stated, if the POLST was blank, "you should initiate CPR until you know their CPR status." LPN-D stated the charge nurse completed the POLST upon admission.

When interviewed on 10/12/21, at 1:37 p.m. the DON stated, "In the state of Minnesota, we would do CPR if we do not have a signed POLST." The DON stated the POLST was reviewed with the resident or representative upon admission and, "We need to make sure we are checking what they want for code status." The DON stated the nurse that prepares the POLST document with the resident wishes is supposed to sign it on the back, and then route it to the physician for signature. The physician should not sign a blank POLST form prior the resident wishes added to the form.

R86's baseline care plan indicated R86 was alert and orientated and was admitted to the facility on 9/24/21.

R86's POLST in the paper medical record dated 9/27/21, indicated R86 wished to have an Attempt Resuscitation (CPR) order in the case of cardiac

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arrest with selective treatment. This form was signed by LPN-B and R86 on 9/27/21. There was no signature from a physician.

When interviewed on 10/12/21, at 8:53 a.m. DON stated the admitting nurse meets with the resident to discuss the POLST, educate the resident and determine what their wishes were. The DON stated once that was completed, "the physician has a book we put the POLST in for it to be signed." The DON stated the physician comes to the facility on Tuesdays and Thursday and will sign items placed in a book. The DON verified R86 was admitted on 9/24/21, and did not have the POLST signed as of yet.

When interviewed on 10/13/21, at 1:15 p.m. the facility medical director (MD-A) and R10's physician, stated in the case of newly admitted residents, the facility should first review to see if the resident had come to the facility with a pre-existing POLST. If not, the facility should review any medical orders, or orders from a recent hospital stay for an indication of what has previously been ordered. MD-A stated an expectation for the facility to discuss any pre-existing POLST or pre-existing medical orders with the new resident to ensure their current wishes, and contact the provider of any new orders needed following admission. MD-A stated, she had been receiving a POLST for signature from a nurse or social worker, but thought it was usually the admitting nurse who would send it for review. MD-A stated she was in her office three days per week so any form coming to the office might take 24-48 hours to come to her attention, but said more recently, the POLST forms were not being sent to the office, but were being placed in a "doctor's rounds" book

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at the facility and would not be available for her review until the next date she made rounds. MD-A confirmed that a physician may not sign a blank POLST and allow the facility to fill it in after it was signed. MD-A confirmed that she had done so and stated, "that is my error. That is on me."

The facility policy titled, Living Will/Advance Directives/Life-Sustaining Treatment Orders dated 6/1/2017, identified residents would be offered an option of completing a Living Will or Advance Directive if they have not already done so, upon admission. A POLST is a set of medical orders that are developed and documented following a resident's (or the resident's designated decision-maker) conversation with his/her physician. The POLST form provides for communication to all health care professionals as tot he resident's wishes.

The immediate jeopardy that began on 8/11/21 was removed on 10/13/21, when it could be determined that the facility had implemented an appropriate removal plan including correcting/clarifying the orders for R10, R13, R26, R32, R86, R184 and all other residents currently residing in the building. Additionally, the facility reviewed it's policy and identified that going forward, code status orders would be reviewed upon admission, but if a resident was not willing or able to make a decision upon admission, their code status would default to perform CPR in the case of cardiac arrest, but resident wishes would be reviewed again within 48-72 hours and then weekly until a decision had been made. The facility reviewed all current resident's codes status wishes with residents or responsible parties and obtained a physician's order which was placed in the resident charts, and ensured

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F 578	Continued From page 37 any POLST form was accurate, complete and signed. As well as any conflicting information was clarified and corrected. Facility staff were educated in the policy and procedures for code status and POLST, and a plan was in place to educate any staff prior to working their next shift if not available during initial training. An audit system was designed and the medical director was instructed and updated.	F 578		
F 607 SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure a criminal background check was obtained and verified prior to employment for 1 of 1 practical nurse (PN)-A reviewed for employee licensure. Findings include: Review of licensed practical nurse (PN)-A's employee file lacked evidence a criminal background study had been obtained and verified upon hire at the facility as PN-A had been working	F 607	PN-A removed from schedule until background check completed and valid license obtained. Facility residents have the potential to be affected. Audit of current employees to verify background check, license, and certification documentation complete 10/17/21	12/1/21

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F 607	Continued From page 38 in the facility as an unlicensed practical nurse. During an interview on 10/11/21, at 7:23 p.m. the director of nursing (DON) stated PN-A was a brand-new nurse and working under a temporary license. The DON stated PN-A's license was held up by her criminal background check. The DON stated PN-A had made her aware of the concern with her criminal background check. During an interview on 10/12/21, at 4:41 p.m. the business office manager (BOM) stated there was an issue with the finger printing for PN-A's criminal background check and verified PN-A had been working as an unlicensed practical nurse without a completed criminal background check since her first date of orientation on 8/16/21. During an interview on 10/12/21, at 5:17 p.m. the executive director stated he was unaware the facility had an unlicensed nurse working in the building. The executive director stated the expectation was the facility to have a copy of the license in the personal file and to check the Minnesota Board of Nursing registry. The executive director stated he would want to be in the loop if the DON and BOM were hiring a staff member under any abnormal circumstances where the staff member was not licensed yet. The executive director stated a copy of background checks should be kept in employee personal files. The Background Checks policy and procedure dated August 2017 included, "Upon hire and as required, the B.O.M. [business office manager] (or designee) will ensure that background checks will be completed to include ...Criminal History: includes review of criminal convictions and probation consistent with the State background	F 607	Employees will have on file complete background check information, current and validated license information, and credential documentation prior to working with residents. Interdisciplinary team educated by Director of Clinical Services starting on 10/18/21 on the Background Check policy and procedure, Abuse prevention policy and procedure and state of Minnesota regulations. Executive Director/Designee will audit new hires for 8 weeks for complete documentation. Audit tracking tool developed. The results of the audits will be reviewed by the QAPI committee for trends and any needs for adjustment of audit schedules or content, as well as any further educational needs. The Executive Director is responsible to ensure this action occurs.	

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F 607	Continued From page 39 check requirements." The Abuse Prevention Program dated March 2018 included: 1) Screening: Abuse Policy Requirement: It is the policy of this facility to screen employees, medical directors, contractors, volunteers and students (in nurse aide programs and affiliated academic institutions, including nursing, therapy, social and activity programs) prior to working with our residents. Screening components include verification of references, licenses, certifications and background checks. Procedures: Employee screening - Before new employees are permitted to work with residents, references will be verified as well as certifications, licenses, credentials, and criminal background checks. The facility will not employ or otherwise engage individuals who have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a Court of law. The facility will not employ or otherwise engage any nursing assistant with a finding entered into the State registry concerning abuse, neglect, exploitation, misappropriation of resident property, or mistreatment of residents. The facility will also not employ or otherwise engage a licensed professional who has a disciplinary action in effect against his/her professional license as a result of a finding of abuse, neglect, exploitation of resident property, or mistreatment of a resident. A criminal background check will be conducted on all prospective employees as per the policy. A significant finding will result in denied employment consistent with the policy, the permanent and 5-year bars to employment per State and Federal regulations.	F 607		
F 622 SS=D	Transfer and Discharge Requirements CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii)	F 622		12/1/21

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§483.15(c) Transfer and discharge-
§483.15(c)(1) Facility requirements-
(i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless-
(A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility;
(B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility;
(C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident;
(D) The health of individuals in the facility would otherwise be endangered;
(E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or
(F) The facility ceases to operate.
(ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health

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or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose.

§483.15(c)(2) Documentation.
When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider.
(i) Documentation in the resident's medical record must include:
(A) The basis for the transfer per paragraph (c)(1)(i) of this section.
(B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s).
(ii) The documentation required by paragraph (c)(2)(i) of this section must be made by-
(A) The resident's physician when transfer or discharge is necessary under paragraph (c)(1)(A) or (B) of this section; and
(B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section.
(iii) Information provided to the receiving provider must include a minimum of the following:
(A) Contact information of the practitioner responsible for the care of the resident.
(B) Resident representative information including contact information
(C) Advance Directive information
(D) All special instructions or precautions for

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F 622	Continued From page 42 ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure medical information, including skin conditions, medications and contact information were provided to a home health agency, for 1 of 1 residents (R36) reviewed for discharge who was to receive home health services. Findings include: R36's admission record identified an admission date of 4/7/21 with diagnoses of multiple sclerosis, mild cognitive impairment and muscle contractures. R36's admission Minimum Data Set (MDS) dated 4/16/21, indicated R36 was an assist of one with bed mobility, transfers, locomotion on/off unit, dressing, toileting and personal hygiene and had no skin issues. R36's discharge MDS dated 6/2/21 indicated R36 was an assist of one with bed mobility, transfers, locomotion on/off unit, dressing, toileting and personal hygiene. The MDS also indicated R36 had a stage 3 pressure ulcer in unknown location. On 10/14/21 a review of R36's record was performed and the last progress note entered in R36's medical record was dated 6/1/21 at 3:24	F 622	R36 discharged Facility discharged residents have the potential to be affected. Transfer/Discharge checklist and folder implemented for nursing staff when a transfer/discharge is initiated. Interdisciplinary team and licensed staff educated by the Director of Clinical Services starting on 11/12/21 on Discharge-Transfer of Resident policy and procedure including discharge documentation, required discharge information provided to resident or representative, documentation and communication education, discharge care information and the Change of Condition of the Resident policy and procedure. Executive Director/Designee will complete audits of discharged resident documentation weekly as they occur for 8 weeks. The results of the audits will be reviewed by the QAPI committee for trends and any needs for adjustment of audit schedules or content, as well as any further	

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F 622	Continued From page 43 A.M. and was titled Daily Skilled Note. The medical record revealed no evidence that R36 was discharged, where R36 was discharged to, and what information was sent with resident or communicated to receiving agency. During an interview on 10/14/21, at 9:36 A.M. the director of nursing (DON) stated the expectation was for the social worker to document in a progress note the discharge summary, recap of stay and any conversations with home care agency. During an interview on 10/14/21, at 9:52 A.M. the social worker (SW) stated it was the SW's job to make sure home care is set up, including transportation and depending on cognition, a list of resources if they have other needs. SW stated discharge paperwork is printed off from the medical record and would have admission info, diagnoses, med list, prescriptions for controlled substances and if there is rehab or wound care that information is also included. Furthermore, SW stated, "I have not been documenting as well the last few months, but we have been really busy and I am working 10-12 hour days so some things fall through the cracks, I'll be honest." Facility policy titled Discharge - Transfer of Resident dated June 2017 indicated to complete a discharge summary and post discharge plan of care form which should include the following: A list of medications with instructions in simple terms. Do not use medical terms or abbreviations. Include instructions for post discharge care. Review with the resident and/or representative. Have resident and/or representative or person responsible for care sign discharge summary and post discharge care	F 622	educational needs. The Executive Director is responsible to ensure this action occurs.	

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F 622	Continued From page 44 form. This includes release of medications. Give copy of form to the resident and/or representative or person(s) responsible for care. Place signed original of form in the medical record.	F 622		
F 636 SS=D	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information	F 636		12/1/21

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F 636	Continued From page 45 regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts. §483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.) (iii)Not less than once every 12 months. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to complete, encode an admission Minimum Data Set (MDS) assessment for 2 of 2 residents (R84 and R86) reviewed who were new admissions. Findings include: R84's admission record printed 10/14/21 identified an admission date to facility of 9/21/21.	F 636	R84 and R86 admission MDS complete and submitted. Facility residents have the potential to be affected. MDS schedule reviewed for current resident to ensure MDS timely submission. MDS schedule will be reviewed at each	

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F 636	Continued From page 46 R84's admission MDS indicated, "in progress." Review of R84's electronic health record (EHR) lacked evidence of a completion, or transmission, of an admission MDS. R86's admission record printed 10/13/21 identified an admission date to facility of 9/24/21. Review of R86's electronic health record (EHR) lacked evidence of a completion, or transmission, of an admission MDS. During an interview on 10/14/21, at 9:36 a.m. licensed practical nurse (LPN)-A stated, admissions MDS's were to be completed within 14 days of admission to the facility. LPN-A verified R84's and R86's admission MDS were still in progress and had not been completed. LPN-A stated she was the only one that completed MDS assessments in the building and stated she was behind. LPN-A stated she had shared her concern with the executive director, stated she was to be going downstairs to work 4 hours a day on MDS assessments and that was to start last week and that did not happen. LPN-A stated she had a lot of work to do, and she did not get any help. LPN-A stated she was working 12 hours a day and stated she wound not do it anymore and now she was behind. A policy was requested on MDS completion and was not provided. The Centers for Medicare and Medicare Services (CMS) Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual dated 10/2019, identified the RAI MDS and CAA's primary purpose was to identify resident care	F 636	morning meeting. MDS nurse educated by Regional Reimbursement Director on 10/18/21 to The Centers for Medicare and Medicaid Services (CMS) Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 user's manual completion dates requirements. Executive Director/Designee to audit MDS completion and submission at morning meetings for 8 weeks. Regional Reimbursement Director to audit closing and submission of MDS assessments off-site weekly-on-going. The results of the audits will be reviewed by the QAPI committee for trends and any needs for adjustment of audit schedules or content, as well as any further educational needs. The Executive Director is responsible to ensure this action occurs.	

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F 636	Continued From page 47 problems which would be addressed in an individualized care plan. Further, data collected from MDS assessments was also used for the Skilled Nursing Facility Prospective Payment System (SNF PPS) Medicare reimbursement system, many State Medicaid reimbursement systems, and for monitoring the quality of care provided to nursing home residents. The manual identified comprehensive "assessment completion is defined as completion of the CAA process in addition to the MDS items, meaning that the RN [registered nurse] assessment coordinator has signed and dated both the MDS (item Z0500) and CAA(s) (item V0200B) completion attestations." In addition, the manual instructed the MDS, and CAA(s) admission (comprehensive) completion date(s) (items Z0500 and V0200B2) were to be no later than the "14th calendar day of the resident's admission (admission date + [plus] 13 calendar days)."	F 636		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and	F 656		12/1/21

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F 656	Continued From page 48 (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to develop a care plan for anticoagulation for 1 of 1 resident (R26) reviewed for anticoagulation management. Findings include: R26's Admission Record printed 10/14/21, indicated R26 was admitted to the facility on 8/26/21 with diagnoses that included personal history of pulmonary embolism (blood clot).	F 656	R26 anticoagulant care plan completed. Facility residents prescribed anticoagulant medication have the potential to be affected. Residents with anticoagulant orders audited for complete comprehensive care plan. Care plan schedule will be reviewed at each morning meeting.	

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F 656	Continued From page 49 R26's admission Minimum Data Set (MDS) dated 9/1/21, indicated R26 required anticoagulant medications. R26's care plan printed 10/14/21 did not identity a plan of care for R26's risk for bleeding, goals, and interventions for anticoagulation management R26's physician orders included: Coumadin (anticoagulant medication) 4 milligram (mg) by mouth at bedtime for Chronic Atrial Fibrillation related to chronic kidney disease stage 5 until 10/15/21. (Order start date 10/11/2021). During an interview on 10/14/21, at 12:11 p.m. licensed practical nurse (LPN)-A stated coumadin was a high-risk medication and if a resident was on coumadin they should have a care plan for being at risk for bleeding. LPN-A stated R26's comprehensive care plan was not finished yet and stated it should be. LPN-A stated she was behind on completing care plans for new admissions. LPN-A stated R26's comprehensive care plan should have been complete on 9/15/21. During an interview on 10/18/21, at 8:43 a.m. the director of nursing (DON) stated the baseline care plan was done for the first 72 hours and the comprehensive care plan should be completed within 72 hours of admission. The DON stated she would expect a care plan for coumadin as it was a risk medication and residents need to be monitoring for bleeding. The DON stated she was not aware LPN-A was behind in completing care plans. The Comprehensive care Planning Policy dated 8/23/21 included, A comprehensive care plan for each resident is developed within seven (7) days	F 656	Coumadin orders, PT/INR checks calendar implemented. Interdisciplinary team and licensed staff educated by Director of Clinical Services starting on 11/12/21 on the Comprehensive Care Planning policy and procedure, including baseline care plan requirements, and comprehensive care plan requirements. Licensed staff educated on the Warfarin policy and procedure. Director of Nursing/Designee to audit coumadin calendar daily weekly for 8 weeks. Director of Nursing/Designee to audit admissions for complete care plan if receiving anticoagulant medications. The results of the audits will be reviewed by the QAPI committee for trends and any needs for adjustment of audit schedules or content, as well as any further educational needs. The Executive Director is responsible to ensure this action occurs.	

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F 656	Continued From page 50 of completion of the resident comprehensive assessments (MDS).	F 656		
F 661 SS=D	Discharge Summary CFR(s): 483.21(c)(2)(i)-(iv) §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). (iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services. This REQUIREMENT is not met as evidenced by: Based on interviews and record review the facility failed to complete a comprehensive discharge summary including a recapitulation of	F 661	R36 discharged Facility discharged residents have the	12/1/21

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F 661	Continued From page 51 stay for 1 of 1 residents (R36) reviewed for discharge. Findings include: R36's admission record identified an admission date of 4/7/21 with diagnoses of multiple sclerosis, mild cognitive impairment and muscle contractures. R36's admission Minimum Data Set (MDS) dated 4/16/21, indicated R36 was an assist of one with bed mobility, transfers, locomotion on/off unit, dressing, toileting and personal hygiene and had no skin issues. R36's discharge MDS dated 6/2/21 indicated R36 was an assist of one with bed mobility, transfers, locomotion on/off unit, dressing, toileting and personal hygiene. The MDS also indicated R36 had a stage 3 pressure ulcer in unknown location. On 10/14/21 a review of R36's record was performed and the last progress note entered in R36's medical record was dated 6/1/21 at 3:24 A.M. and was titled Daily Skilled Note. The medical record revealed no evidence that a discharge summary or recapitulation of stay was completed. During an interview on 10/14/21 at 9:36 A.M., DON stated the expectation was for the social worker to document in a progress note the discharge summary, recap of stay and any conversations with home care agency. During an interview on 10/14/21 at 9:52 A.M., facility social worker (SW) stated discharge summary notes and recapitulation of stay should	F 661	potential to be affected. Transfer/Discharge checklist and folder implemented for nursing staff when a transfer/discharge is initiated. Interdisciplinary team and licensed staff educated by Director of Clinical Services starting on 11/12/21 on Discharge-Transfer of Resident policy, the Discharge Planning policy, the Change of Condition of the Resident policy and procedure including discharge documentation, required discharge information, discharge summary, and recapitulation of stay. Director of Nursing/Designee will complete audits of discharged resident documentation weekly as they occur for 12 weeks. The results of the audits will be reviewed by the QAPI committee for trends and any needs for adjustment of audit schedules or content, as well as any further educational needs. The Executive Director is responsible to ensure this action occurs.	

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F 661	Continued From page 52 be documented in the medical record in a progress note. SW then stated that the discharge summary note in the medical record should be completed by the staff member that saw the resident out the door. SW then verified that there was no discharge note or recapitulation of stay for R36. Furthermore, SW stated, "I have not been documenting as well the last few months, but we have been really busy and I am working 10-12 hour days so some things fall through the cracks, I'll be honest." Facility policy titled Discharge - Transfer of Resident dated June 2017 indicated to complete a discharge summary and post discharge plan of care form which should include the following: A list of medications with instructions in simple terms. Do not use medical terms or abbreviations. Include instructions for post discharge care. Review with the resident and/or representative. Have resident and/or representative or person responsible for care sign discharge summary and post discharge care form. This includes release of medications. Give copy of form to the resident and/or representative or person(s) responsible for care. Place signed original of form in the medical record.	F 661		
F 686 SS=G	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition	F 686		12/1/21

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F 686	Continued From page 53 demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to notify the medical provider and obtain wound care orders when 1 of 1 residents (R10) reviewed for pressure ulcers, had developed a new coccyx pressure ulcer, and failed to transcribe and follow orders from a provider for a newly developed heel ulcer. This failure resulted in actual harm when R10's coccyx pressure ulcer became larger and the heel ulcer deteriorated from a stage 2 to a stage 3 ulcer. Findings include: Pressure Ulcer stages defined by the Minimum Data Set (MDS) per Center Medicare/Medicaid Services: Stage I pressure ulcer (An observable, pressure-related alteration of intact skin, whose indicators as compared to adjacent or opposite area on the body may include changes in one or more of the following parameters: skin temperature (warmth or coolness); tissue consistency (firm or boggy); sensation (pain, itching); and/or a defined area of persistent redness in lightly pigmented skin, whereas in darker skin tones, the ulcer may appear with persistent red, blue, or purple hues.) Stage II pressure ulcers (Partial thickness loss of dermis presenting as a shallow open ulcer with a	F 686	R10 wounds measured and assessed, MD updated, new treatment orders obtained and care plan updated. Facility residents have the potential to be affected. Skin assessments completed for current residents on 10/13/21 and 10/14/21. Skin checks will be completed weekly with bath/shower. Wound rounds will be completed every 7 days per policy, wound binder developed to assist with wound tracking. Licensed staff educated by Director of Clinical Services starting on 11/12/21 on Skin Management policy and Pressure and Non-pressure Injury policy and procedures including identification of a new wound requirements, assessment requirements, notification requirements, and monitoring requirements. Licensed staff educated on Physicians orders policy and procedure. Director of Nursing/Designee to audit resident consultation notes for new orders after appointments, hospital stays, and MD rounds 3 times weekly for 12 weeks.	

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F 686	Continued From page 54 red-pink wound bed, without slough. May also present as an intact or open/ ruptured blister.) Stage III pressure ulcers (Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining or tunneling.) R10's quarterly Minimum Data Set (MDS) dated 7/30/21, included moderate cognitive impairment with diagnoses including, diabetes, Alzheimer's disease and peripheral vascular disease. R10's diagnoses list included a recent nondisplaced comminuted (where the bone breaks in 3 or more places) fracture of the right fibula and tibia (calf and shin bones). R10's MDS indicated he required extensive assistance with most activities of daily living (ADL's) and rejected cares 1-3 days during the 7 day assessment period. R10 was at risk for pressure ulcers, but did not have any current pressure ulcers. R10's care plan dated 9/1/21, included, "[R10] has skin breakdown related to immobility, incontinence and decreased sensation." R10's goal was, "Resident will develop clean and intact skin." Staff were instructed, "Apply protective or barrier lotion after incontinence, .Assist resident to turn and reposition every 2-3 hours. May refuse at times. Staff are to educate [R10] and reapproach. Change incontinence product ASAP after voiding or a bowel movement. Will refuse at times. Staff are to educate and reapproach. Increase out of bed activity as tolerated. Inspect skin integrity every day. Keep bed linen, clean, dry, and free of wrinkles. Keep skin clean and dry. Maintain adequate nutrition and hydration. Provide measure to decrease pressure/irritation	F 686	Director of Nursing/Designee to audit weekly wound rounds for measurements, assessments, notifications, and treatment orders for 12 weeks. The results of the audits will be reviewed by the QAPI committee for trends and any needs for adjustment of audit schedules or content, as well as any further educational needs. The Executive Director is responsible to ensure this action occurs.	

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to skin: 1)pressure reduction mattress. 2)pressure reduction chair cushion." The care plan lacked identification or staff direction for actual pressure ulcers.

R10's progress note dated 10/5/21, identified R10 had been to the, "cast room," and was to continue with no weight bearing on the right side and to elevate leg for edema control. The note also identified R10 had some loose stools soiling the cast and a call was placed to advise if needs to return to cast room for new cast.

According to a "wound tracker document" in R10's EHR dated 10/6/21, R10 had an open pressure ulcer on his coccyx (lower part of spine/tailbone). No previous documentation in the medical record was found. The wound measurements were written as 2.5 cm by 1 cm with 0.1 cm depth, identified as a stage II. The document indicated R10's pressure ulcer as having both, "slough and granulation tissue" (Slough is necrotic tissue that does not occur in superficial wounds and is part of the inflammatory process generally seen in chronic wounds. Granulation tissue is a sign of tissue regeneration not generally seen in superficial wounds). The form indicated R10's family was notified of the wound, but did not indicate the physician was notified.

R10's Cast Visit provider note dated 10/7/21, R10 had been to the Department of Orthopedic Surgery and was seen by a certified nurse practitioner (CNP)-A in order to remove a soiled cast on his right leg. CNP-A wrote, "the skin about the lower extremity has one very small superficial skin tear anterior and a developing heel ulcer. The heel ulcer is stable and improving since the

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last visit." The document included the following directions for care: "today patient was placed into a stockinette [dressing similar to a thin sock to provide skin protection] and knee immobilizer, a Mepilex heel dressing with a multi-Podus boot [a product that lifts the heel to prevent pressure]. I recommend that they remove the knee immobilizer and stockinette and check his skin twice daily. They are also to remove the multi-Podus boot twice daily to check his skin. The facility can change the Mepilex heel dressing once weekly. He is to have no pressure on his heel."

R10's physician Order Summary Sheet from the electronic health record (EHR) on 10/11/21, did not include any direction or treatment for a pressure ulcer on heel, or pressure ulcer on buttocks. R10's treatment administration record (TAR) and medication administration records (MAR) from 10/6/21 to 10/11/21, failed to identify any treatment for R10's pressure ulcers on heel or on buttocks.

R10's TAR had an order for, "Weekly skin review," and directed staff if new skin area is identified to follow protocol and notify physician. This was initialed as being completed on 10/4/21 and 10/11/21.

According to a "wound tracker document" in R10's EHR dated 10/12/21, the coccyx wound was measured at being 2.2 cm by 2.5 cm with a depth of 0.2 cm, still rated as a, "stage II" pressure ulcer, but condition listed as, "worsening." The document did not provide any indication of the cares being provided, but did include, R10 should lay down after meals. The document did not indicate the medical provider

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was notified of R10's condition.

During an observation of morning cares 10/13/21, 7:14 a.m. a nursing assistant (NA)-C and an unidentified NA came into R10's room to provide morning cares. He was laying on his back in his bed. R10 had a scab on his left shin, and had a large plastic leg immobilizer on his right leg, held in place with straps, and a stocking type dressing covered his leg so the skin could not be visualized at that time. There was nothing in place to prevent pressure to R10's right leg except for the splint itself. NAs both stated the immobilizer was not to be removed as he had a fractured leg. NAs assisted R10 to turn towards his right, affected side, so they could wash his buttocks. A square foam dressing, approximately 3 inches by 3 inches and 1/4 inch thick was observed on R10's coccyx, but was not adhered to the skin along the edges and was quite loose along the bottom edge. During cares, R10 began to have a bowel movement which oozed up under the loose edge of the dressing and the unidentified NA removed the dressing. R10's entire left buttock was observed to be slightly pink and mottled. A shallow ulcer about the size of a quarter was observed after removal of the foam dressing. The wound was situated between the left ischium and the coccyx. The top layers of skin were missing and the wound bed was a bright red color. The dressing had a small amount of bloody drainage soaked into the foam. After the NAs finished washing R10's buttocks, they returned him to his previous position on his back. The unidentified NA threw away the soiled dressing, and NA-C said they would need to report to the nurse that R10 needed a new dressing on his wound. Neither NA knew how long he had had the wound on his buttocks. Neither one knew of any other

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F 686	Continued From page 58 wounds except for the small scab on R10's left shin. When interviewed on 10/13/21, at 8:26 a.m. licensed practical nurse (LPN)-B stated R10 had had the long splint on his leg for approximately a week or more, and said they were not to remove the splint even though it was merely held in place by Velcro straps. LPN-B stated R10 was at risk for skin breakdown due to the application of the splint and it was important to monitor his condition, but said they were only able to check the skin that was not covered by the straps or splint. LPN-B stated she was aware that R10 had a wound on his buttocks and had seen it several days before. LPN-B said she was unable to find a physician's order for the care of the wound, but stated they had been applying a "Mepilex" dressing to R10's open wound near his coccyx (Mepilex is a trade name and can mean a variety of dressing types, the most common are a foam dressing meant to be held in place with some other type of dressing, or a self-adhesive, occlusive foam dressing). LPN-B stated that when a new wound is identified, or a wound is getting worse, the nurse should report it to the director of nursing (DON) and call the medical provider to get an order for care. If an NA notices a new wound or a wound that requires a new dressing, the NA is to report to the nurse on duty. LPN-B stated the removal of R10's dressing that morning, and need for wound care had not been reported to her and she would have been the nurse it should have been reported to. When interviewed on 10/13/21, at 8:51 a.m. a registered nurse consultant (NC) confirmed that R10's physician orders did not include any order for the care of the wound on his buttocks. NC	F 686		

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stated the expected process for nurses to follow in the event of a newly identified pressure ulcer were to notify the medical provider for wound care orders, and add new interventions to the resident's care plan. The resident's name should be added to the facility "wound list" and initial measurements should be taken, followed by weekly measurements to monitor the efficacy or the treatment order. NC confirmed that recommendations for care of a right heel ulcer provided by the orthopedic services cast room on 10/7/21, including removal of the splint for observation and skin care, for care of a right heel pressure ulcer and for no pressure to the right heel had not been transcribed from the paper note into R10's physician's orders and thus these recommendations for care had not been communicated to nursing staff through the EHR, and could not be confirmed to have been provided.

According to an interview 10/13/21, 9:17 a.m. DON stated immediately prior to interview DON and NC had gone to R10's room, removed his "boot" and the dressing applied on 10/7/21. DON stated she had not known about the right heel pressure ulcer prior to 10/13/21 and had not read the recommendations from CNP-A before that day. DON confirmed CNP-A's documentation indicated the wound had been "just developing" and was "healing" on 10/7/21, but confirmed the condition of the wound had deteriorated. DON said, "It's a stage III by now" (pressure ulcers are graded from stage I, superficial redness that does not go away, to stage IV, a deep tissue injury involving tendons, ligament and bone. A stage III wound extends through all layers of the skin into the subcutaneous tissue, but not to tendons or bone). DON stated an expectation for nurses to

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review any papers accompanying a resident from any medical appointment upon their return to the facility. DON was unable to confirm that CNP-A's recommendations for care were actual orders, but said the nurse on duty should have contacted their medical director (MD)-A who is also R10's physician to verify orders following the appointment. DON stated the nurse should have then entered the orders into the EHR and should also have reported to the nurse manager and the DON, but said this had not occurred. DON stated she had replaced the soiled Mepilex on R10's heel, but had not removed the brace or replaced the stockinette due to "pain", saying, "I am going to be in touch with (MD)-A about how to proceed." During the 10/13/21, 9:17 a.m. interview, DON described expectations of nursing staff when a new pressure ulcer or wound were identified. DON said the nurse in charge at the time the wound was found was responsible to take measurements of the wound and document this information and a description of the wound in a progress note. DON said the facility did not have any standing orders for wound care so the nurse on duty would need to notify the medical provider in order to get treatment orders for the wound. DON said the nurse should also notify the DON who was responsible to monitor and assess the wound weekly, and document in their "pressure injury tracker." DON stated she had become aware of R10's wound on his bottom and had applied a Mepilex dressing; however, DON confirmed she had not notified the physician and did not have an order for treatment.

When interviewed on 10/13/21, at 1:15 p.m. R10's physician and the facility's medical director MD-A stated she was aware that R10 had a pressure ulcer on his right heel and stated the

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F 686	Continued From page 61 documentation from CNP-A during the visit to the Orthopedic Surgery Cast Room should have been considered as medical provider orders, and should have been transcribed and followed as orders. MD-A stated there was no problems with the recommendations written by CNP-A and no reason for the facility to contact the facility medical director to review or confirm those orders. MD-A stated she had not seen R10's heel wound, but said, according to CNP-A's description on 10/7/21 and the DON's description on 10/13/21, the condition of the pressure ulcer had worsened since he was seen by CNP-A. MD-A stated an expectation for the facility to notify the medical provider if a resident's pressure wounds were not improving, were worsening or if a new pressure ulcer developed. MD-A confirmed she had not been notified of R10's change in condition until that morning but had previously received a copy of his 10/7/21 cast room visit notes from the Orthopedic Services. Facility did not provide a policy related to notification of wounds to provider, or transcribing and following physician orders.	F 686		
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:	F 689		12/1/21

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F 689	Continued From page 62 Based on observations, interviews and record review, facility failed to conduct a thorough investigation and analysis to determine the causative factors of a resident's fall that resulted in a significant injury, or update the resident's care-plan with appropriate interventions to reduce the likelihood of similar incidents for 1 of 2 residents (R10) reviewed for falls. Findings include: According to the electronic health record (EHR) Admission Record/diagnoses sheet, R10 had the following diagnoses, among other co-morbidities, Alzheimer's disease, generalized muscle weakness, difficulty walking, not elsewhere classified, and history of falling. R10's quarterly Minimum Data Set (MDS) dated 7/30/2021, R10 required extensive assistance of one person to walk and transfer. The MDS indicated R10 was unsteady and required assistance for balance and turning. Furthermore, R10 required the assistance of two persons to use the toilet. His cognitive status was marked as moderately impaired and R10 was assessed as sometimes exhibiting behaviors of rejecting care. R10 had no falls since the prior assessment. According to R10's EHR care plan, R10 had a focus problem area dated 4/4/2018 that indicated R10 had a self-care deficit related to difficulty in walking. An intervention dated 12/10/2019 indicated: allow [R10] to direct cares. He may choose to transfer, move, etc. with minimal help. Be patient and assist as he directs, but an intervention dated 4/20/20 indicated: transfers-assist of two with gait belt and a walker. At times he will not transfer due to behaviors. Staff are to	F 689	R10 wounds measured and assessed, MD updated, new treatment orders obtained and care plan updated. Facility residents have the potential to be affected. Skin assessments completed for current residents on 10/13/21 and 10/14/21. Skin checks will be completed weekly with bath/shower. Wound rounds will be completed every 7 days per policy, wound binder developed to assist with wound tracking. Licensed staff educated by Director of Clinical Services starting on 11/12/21 on Skin Management policy and Pressure and Non-pressure Injury policy and procedures including identification of a new wound requirements, assessment requirements, notification requirements, and monitoring requirements. Licensed staff educated on Physicians orders policy and procedure. Director of Nursing/Designee to audit resident consultation notes for new orders after appointments, hospital stays, and MD rounds 3 times weekly for 12 weeks. Director of Nursing/Designee to audit weekly wound rounds for measurements, assessments, notifications, and treatment orders for 12 weeks. The results of the audits will be reviewed by the QAPI committee for trends and any	

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F 689	Continued From page 63 leave him in a safe environment and reapproach after a short while. An additional focus problem dated 2/06/2018 indicated the following: [R10] has the potential for injury-fall risk related to: unsteady gait, impaired safety awareness, use of psychotropic medications, impaired mobility as evidenced by his inability to transfer/ambulate without assistance. Corresponding interventions for this focus problem indicated staff should: ensure resident is wearing appropriate footwear shoes, gripper socks, or slippers) (date initiated 2/6/2018 and revised 10/25/20); grip strips in front of recliner, side of bed, in bathroom in front of toilet (1/30/20); maintain room free of clutter and ensure adequate lighting (2/03/20);review information on fast falls and attempt to determine cause of falls or risk factors as indicated (2/6/18, revised 2/3/20). According to an interview 10/11/21, 1:19 p.m. R10 stated he had recently been hospitalized with a "broken hip" following a fall, but he was not able to relate any other information regarding the fall or the injury. According to a phone interview 10/14/21,1:52 p.m. a certified nursing assistant NA-D stated she had been assisting R10 to the bathroom by herself on 9/22/21 using a mechanical "sit to stand" lift rather than the two assist as indicated in his careplan. When R10's cares were complete in the bathroom, NA-D said he did not want to get off the toilet, but otherwise seemed his usual self. NA-D reported she moved R10 from the bathroom to his bed, using the lift. When NA-D got R10 as far as the bed, NA-D realized the lift would not fit under the bed and NA-D was only able to seat R10 on the very edge of the bed. NA-D stated both she and R10 were "scared" and	F 689	needs for adjustment of audit schedules or content, as well as any further educational needs. The Executive Director is responsible to ensure this action occurs.	

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she called for help. A practical nurse (PN-A) was working nearby and came to assist. NA-D stated she asked PN-A to help move R10 to his recliner. Then they put a transfer belt on R10 and asked him to walk to the bed. They started towards the bed, and R10 said, "I'm going to sit right now" and he went down onto PN-D's knees and NA-D's foot. NA-D was unable to say if R10 appeared to have twisted his leg at that time. She went to get a Hoyer lift that did not require him to stand, and they lifted him into bed using that equipment. NA-D recalled that R10 stated he had pain in his right leg, but she thought it was caused by the use of the Hoyer lift. NA-D said she reported this pain to PN-A, and later to the registered nurse (RN-B) working the overnight shift. NA-D reported that later she noticed "his leg looked extended, like he couldn't straighten it, kind of to the right and I told [PN-A] there was something really wrong with it. She was going off duty so she reported to the night nurse who followed up."

According to a phone interview with PN-A on 10/14/21, 2:03 p.m. she had graduated from college in May of 2021, and had never worked as a nurse before. PN-A stated she had taken her nursing board exams in July, but did not yet have a nursing license. When R10 suffered his fall on 9/22/21, PN-A stated she was working at that time, and it was the first fall that she had to respond to as a nurse. PN-A was unable to describe what she had learned in nursing school about what to do if a resident had fallen. PN-A said her experience with falls was from when she was a nursing assistant, but said an assessment should be done by the nurse, including a set of vital signs , the nurse should document findings and notify the DON and the physician. PN-A could not recall if she had written a progress note (no

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progress note was found). PN-A said she had called the DON and asked what paperwork she had to do, but said the DON told her she did not have to do anything because R10 was "lowered to the floor" and did not fall. PN-A asked if she needed to call the physician, but said the DON said she "would take care of it." PN-A said "I found out the next day things were worse and I felt horrible, and asked what I needed to do." PN-A said she was told by the DON that the over-night nurse had charted everything, and she did not have to do anything else.

According to a progress note in R10's EHR dated 9/23/21, 6:54 a.m. "Report from evening nurse that resident was lowered to the floor while trying to get into bed. CNA notified nurse that resident was in significant pain around 23:15 [11:15 p.m.] Assessed resident at approx 23:30 [11:30 p.m.]. Observed right leg turned outward. Swelling and bruising noted approx 1 inch below right knee ..."(progress note continued to describe R10's condition, pain level, notification to physician and update to director of nursing/DON at 5:00 a.m. R10 agreed to a transfer to hospital at 7:00 a.m.) Progress note did not include information about R10 prior to the fall, what happened during the transfer to bed or any immediate interventions to prevent further falls.

According to a Risk Management Report (incident report) for 9/22/21 the description of the incident stated R10 was being transferred from his chair to the bed using a walker and gait belt when he was suddenly weak and leaned back on a nurse and sat on her knees. The immediate action taken was listed as lowering R10 to the floor and assisting to bed via Hoyer lift without mention of additional fall prevention interventions

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specific to the incident initiated. The report indicated no injuries were observed and he did not go to the hospital. No pain level, level of consciousness were reported. Mental status was not documented. The form included 33 check list items of predisposing environmental factors, including equipment issues, but nothing was marked. The form provided a checklist of 48 predisposing physiological factors to choose from including a recent change in condition, illness, weakness, infection, various medications, but only gait imbalance was marked. The form included 47 checklist items of predisposing situation factors including footwear, use of assistive devices, whether assistance was being provided and also the opportunity to choose "other" and describe. No predisposing situation factors were checked including any information related to whether or not care plan interventions were present and followed, or why a mechanical sit to stand lift was used when not indicated on R10's care plan.

According to a progress note dated 10/12/2021, 11:52 a.m. the interdisciplinary team (IDT) found: the root cause to be that R10 had an undiagnosed respiratory infection which "may" have made him weak. The response to this was to choose an intervention of a Hoyer lift and two assist for transfers. The progress note indicated R10's care plan was updated; however, a review of his care plan did not reveal a change to include the use of a Hoyer lift. Care plan did not address a response to the "undiagnosed respiratory infection."

A review of R10's progress notes in the EHR did not indicate any notes related to respiratory symptoms for several days prior to fall; however,

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nurses had provide R10 cough syrup on several occasions without notation on his condition.

A request was made for the hospital discharge summary for R10 following his admission on 9/23/21. Facility only provided R10's hospital labs, radiology reports and diagnoses list, but no physician progress notes. R10's principle diagnosis for hospital admission was "fracture fibula shaft comminuted nondisplaced closed initial right, and fracture tibia shaft comminuted nondisplaced closed initial right." A diagnosis of sepsis was given three days after admission. Lab studies indicated a urinary tract infection with a specimen collected 9/26/21. A viral panel detected antibodies to respiratory syncytial virus on 9/27/21. Unknown if either infection was present prior to hospitalization.

According to an interview 10/14/21, 10:42 a.m. DON explained the procedure for a nurse to follow when a resident falls. DON said first the nurse was to assess the resident for injury, review a possible cause of the incident, and based on those findings, either use a Hoyer lift with additional help, to place the resident into bed, or call for emergency assistance up to and including transfer to the hospital. Following the fall, DON stated a nurse is expected to document in "risk management" (incident report) in the EHR which triggers post-fall observation documentation to be done by nurses on the up-coming shifts. DON confirmed PN-A had not done this, nor had PN-A written a progress note. DON confirmed she was the one to initiate the report, but had not been present during the incident. Although DON was the person to initiate the risk management incident report, DON was unable to state whether PN-A had asked R10 any

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questions about the fall or his condition, or if PN-A had tried to figure out why the incident had happened (root cause) to initiate any new and appropriate intervention. DON said, "(PN-A) said it wasn't a fall, but of course we know it is considered a fall, but she said he looked fine." DON indicated the persons completing the risk management report were to get witness statements from any staff who were present to best determine the cause of the fall, and were to completely fill out the report so that the IDT could best determine appropriate interventions to prevent further incidents, but DON confirmed the risk management report did not include any assessment or evaluation of the R10's condition prior to the fall; did not contain information related to environmental factors or problems with equipment and witness statements did not include the names or titles of the staff, and provided only a very brief account of the actual fall and no other information or evaluation. DON confirmed the report did not contain evidence of any immediate interventions to provide for safety or further injury at the time of the fall.

Facility provided a document titled Fall Prevention and Management Guidelines dated as effective February of 2017 and revised 3/10/2021. The policy stated they would maintain a fall prevention and management program for resident determined to be at risk for falls in order to better manage any risk factor and prevent and/or manage as much as is possible the resident from falling and/or sustaining injuries related to falling. The policy statement included a definition "a fall refers to unintentionally coming to rest on the ground, floor or other lower level but not as a result of an overwhelming external force."
The policy indicated that following a fall, a post

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F 689	Continued From page 69 fall evaluation should be completed including a physical assessment with vital signs, resident and witness statement regarding the fall, environmental assessment, contributing factors to the fall, medication changes, mental status changes and any new diagnoses. An update to the physician and responsible party was indicated as an expectation. The policy also indicated "upon initial review, investigation and assessment, nurse to update the care plan as to (1) any new intervention put in place to try to prevent additional falls, and (2) removal of any interventions determined to be no longer appropriate. The policy also indicated the IDT should review the fall the following morning to determine the potential root cause of the fall, and review updates to the plan of care, and add additional revisions as needed.	F 689		
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, facility failed to adequately and comprehensively monitor the pre-and post-treatment stability of 1 of 1 resident (R11) reviewed for dialysis; also, the facility failed to evaluate R11's fluid intake or daily weights on a regular basis to ensure stability while receiving hemodialysis treatments.	F 698	R11 PCC orders updated to include parameters for weight changes per Physician order and fluid intakes for each 24 hours. Current weight and daily fluid intake reviewed with Physician. Facility residents on Dialysis have the potential to be affected.	12/1/21

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F 698	Continued From page 70 Findings include: According to R11's electronic health record (EHR) Admission Record/diagnosis sheet, R11 has the following diagnoses among other co-morbidities: hypertensive chronic kidney disease with stage 5 chronic kidney disease or end stage renal disease, dependence on renal dialysis and acute on chronic diastolic (congestive) heart failure, and hypertensive heart failure. According to a minimum data set (MDS) assessment dated 8/6/21, R11 was assessed to have a 13/15 BIMS (brief interview for mental status) showing she was cognitively intact. According to R11's physician orders in the EHR, on 11/09/2020 the following was entered: Dialysis at [site] every day shift every Mon, Wed, Fri related to dependence on renal dialysis. An order 11/07/2020 directed nurses to monitor the dialysis catheter site every evening for "redness, drainage or warmth and notify MD if any of these symptoms present." An order stating "staff are to complete dialysis UDA and send with [R11] to dialysis every evening shift every Mon, Wed, Fri for dialysis monitoring" was entered 5/14/21. An order for vital signs to be completed on R11's bath day, once weekly on Sundays had been entered on 11/08/20. Weight prior to breakfast every day shift was entered on 11/08/20; weight order did not include any directions for staff on reporting vacillations in weigh findings. On 11/07/20 an order for Fluid restriction 1.5 to 2 liters per 24 hours was entered in the EHR. Recommended breakdown: 360cc/meal, 340cc AM/PM shifts, 240cc at night. Order failed to instruct on when to tally daily intake, or how to determine if R11 should receive 1.5 liters or 2	F 698	Morning meeting form updated to include review of residents on dialysis including weight, fluid intake, and dialysis UDA. Licensed staff educated by the Director of Clinical Services starting on 11/12/21 on the Hemodialysis Communication policy and procedure including the User Defined Assessment communication tool and procedures and required monitoring for dialysis residents. Director of Nursing/Designee to complete audit 3 x weekly for 8 weeks of residents on dialysis for completion of weights, User Defined Assessment, and fluid monitoring. The results of the audits will be reviewed by the QAPI committee for trends and any needs for adjustment of audit schedules or content, as well as any further educational needs. The Executive Director is responsible to ensure this action occurs	

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liters daily, or how to decide if R11 had exceeded the fluid restriction given the ordered range. On 8/23/21 the order was updated to read "fluid restriction 1.5 liters per 24 hours. Recommended breakdown 240cc/meal; 300 cc AM/PM shifts; 180cc nights." The order still failed to instruct on a daily total, assessment or report to be made.

A review of R11 treatment administration record (TAR) for August, September and October 2021 showed that nurses were documenting they had completed the Dialysis UDA tool; however, a review of the assessment portion of the EHR failed to show this form had been completed. R11's fluid intake was documented, but not totaled. No corresponding assessment or note related to R11's intake was found indicating if she was within her designated fluid intake, or had exceeded or had not met her allotted fluid amount. A review of R11's daily weights in August showed a generally stable weight with slow vacillations, except 8/29/21 when R11's weight was 5.8 pounds higher than the day prior without reweigh noted or other documentation. On 9/1/21 weight remained elevated, 9/2/21 weight was not done, and 9/3/21 weight had dropped only one pound from the 9/1/21 weight; 9/4/21 weight was not documented. On9/5/21 the weight order was moved from the TAR to the medication administration record (MAR) and no weight was documented 9/5/21. The first weight documented on the MAR was 195.8 pounds and the following day was 201 pounds, a difference of 5.2 pounds, with no evidence of reweigh, further assessment or report. On 9/12/21 R11's weight was 198. 6, the next day 203.6, up 5lbs, and no weight documented on 9/14/21. According to R11's October 2021 MAR, R11's weight on 10/10/21 was 194.4 lbs and on 10/11/21 it was 202lbs, or a

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7.6 lb increase without reweigh or other assessment. On 10/12/21 weight was 196.8 and on 10/13/21 it was 202, an increase of 5.2 lbs.

A review of R11's EHR assessment list was done and only one Dialysis Communication UDA was found to have been completed (date 9/15/21) between August and October of 2021. The document did not include pre-treatment information except for a set of vital signs from 9/13/21, two days prior, and the same set of vital signs upon return. No other information was documented including a nurse signature.

According to an interview 10/11/21, 3:43 p.m. R11 stated she went to dialysis three times weekly. She said the facility usually weighed her before she left for dialysis and they were to check her port site to make sure there were no problems. R11 also said staff were supposed to be monitoring how much fluid she had to drink, and showed me she had soda cans in her room, but felt the staff were writing down how much she had to drink. She was unable to state her current fluid restriction.

According to an interview 10/13/21, 12:10 p.m. a licensed practical nurse stated a nurse should assess a dialysis patient's vital signs, including temperature and oxygen saturation level before sending them to a dialysis treatment, but stated that information was not sent with R11 to dialysis. LPN-B stated the facility nurse would send a copy of R11's "face sheet", medication list and a "consult sheet," but that dialysis was the ones who would send information on R11's condition to them. LPN-B was unable to confirm that information on weight changes or fluid intake were sent to dialysis, and said information on

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what to do with signs of fluid overload, such as weight changes should be listed in a resident's physician orders. LPN-B said usually they were to notify a physician if a resident had a change of 3 to 5 pounds in a day. LPN-B stated she believed a dialysis patient's port (where dialysis would access the venous system) site should be assessed every shift for signs of redness, swelling or leaking.

During an interview 10/13/21, 12:27 p.m. the director of nursing (DON) stated an expectation for nurses to monitor a dialysis patient's port site to make sure the dressing was intact and there were no signs of infection. DON was unable to state how often this should be done. DON also stated an expectation for staff to be monitoring a dialysis patient's weight and stated a change in three pounds in one day should be reported to the physician by the nurse working with that resident on that day. DON stated an expectation for nurses to document R11's fluid intake, including the amount consumed from what the kitchen provided. The DON said they were able to calculate what the facility offered R11, but R11 often went out of the building with family and because she was "her own person" could consume what she wanted and they would not know how much she had had when she was out of the building; however, DON, confirmed that R11 was their responsibility even when out of the building and they could have asked her about her intake upon return. The documentation of the 24 hour fluid total was the responsibility of the overnight nurse and any excess fluid intake should be documented in a progress note according to the DON. The DON confirmed that any dialysis patient is considered at high risk for fluid imbalance and the risks include such things

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as pulmonary complications, but DON was unable to state any additional complications. The DON explained the facility had a document in the EHR called the Dialysis UDA that was to be completed prior to R11 leaving for dialysis and upon her return. The Dialysis UDA contains all the expected assessments for monitoring a dialysis patients stability prior to and after hemodialysis. DON stated after completing in the morning before treatment, the form could be printed out and sent with R11 when she went for her dialysis treatment. DON confirmed that the Dialysis UDA had rarely been completed in R11's EHR, although the order for completion had been signed by nurses as having been done. DON also confirmed that the order instructed nurses to complete in the evening and then to send to dialysis with R11 even though she was actually returning to the facility from dialysis in the evening. DON stated the facility had not provided any nursing staff education specific to dialysis, and had not discussed the care of a dialysis patient within at least the last year.

According to an interview 10/13/21, 1:15 p.m. with R11's physician and facility medical director (MD-A), complications of hemodialysis include fluid overload which could result in heart failure or conversely, problems with dehydration and also electrolyte imbalance. MD-A stated facility should monitor R11's daily weights and intake of fluids to ensure stability. Failure to monitor or report changes could result in a failure to identify complications. MD-A also said R11 should have her blood pressure monitored on a regular basis, at least daily. MD-A said she was unsure how often the facility was checking R11's blood-pressure but confirmed that once a week would not be adequate for a dialysis patient.

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F 698	Continued From page 75 A request was made for a policy related to the care of a dialysis patient. Facility provided a document titled Hemodialysis dated 4/13/21. The policy statement is as follows: The center has designed and implemented a process which strives to ensure the comfort, safety, and appropriate management of a hemodialysis resident regardless if the procedure is performed at the dialysis center or at the center. The center [facility] will utilize the "Dialysis Communication UDA" for continuity of care between the facility and dialysis unit. Clinical responsibilities of the facility included: assure daily assessment and documentation of fistula or graft site (policy fails to include description of monitoring of a port); document post-dialysis (dry weight) obtained by the dialysis cneter in the Dialysis Communication UDA after each dialysis treatment; monitor fluid status of resident and maintain fluid restriction as ordered by Provider/dialysis center. If resident chooses to not follow ordered fluid restrictions, educate resident/responsible part on the risk of their choice, document this education and response to education and notify the provider and dialysis center. Complete the Risk vs Benefit UDA in the electronic medical record. Further responsibilities listed include: manage fluid restrictions as ordered by provider/dialysis center; manage special dietary regime and dietary restrictions as ordered. In addition, the policy listed the following: assess and manage post-dialysis complications which may include, but are not limited to, the following: bleeding, fatigue, signs/symptoms of infection, hypotension (low blood-pressure), chest pain, unsteady gait, electrolyte imbalance, seizures, leg cramps, fluid imbalance and headache. The policy instructs in	F 698		

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F 698	Continued From page 76 the use of the Dialysis Center Communication UDA for continuity of care. A request was made for a policy related to monitoring residents for fluid imbalance, but facility did not provide such a document.	F 698		
F 726 SS=F	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c) §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident	F 726		12/1/21

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F 726	Continued From page 77 assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure a newly graduated, unlicensed practical nurse (PN-A) received adequate training and demonstrated competency skills related to identifying and responding to changes in condition, and documenting resident assessment and nursing response for continuity of care specifically related to falls and injury. A resident (R10) suffered a fall resulting in a fractured fibula/tibia without a knowledgeable or timely response post-fall by (PN-A). This lack of competency training and assessment had the potential to affect all 34 residents in the facility. Findings include: According to education documents provided by the facility, PN-A received general employee orientation on 8/10/2021. Eighteen general topics with multiple sub-topics were covered in an 8 hour period. A competency test for hand hygiene was completed and a post-test for all staff related to understanding falls and infection control were completed. A test related to compliance was completed, but no evidence of competency test-outs for any specific nursing skills completed on that date or any other date were provided. Facility reported PN-A completed a half hour computer training module on general documentation 9/9/2021. Facility provided PN-A's college transcript showing that PN-A had completed 14 didactic and 10 clinical credit hours, totaling only 24 credit hours specific to nursing process, disease knowledge, patient care and documentation. Facility was unable to provide evidence of a nursing license for PN-A.	F 726	Facility residents have the potential to be affected. Current staff to have competency checkoff complete per policy annually. Director of Nursing/Designee to complete a competency checklist for licensed and certified staff per policy on hire and annually. Interdisciplinary team educated by the Director of Clinical Services starting on 11/12/21 to the MN Board of Nursing license requirements, the Employee orientation policy and procedure and the annual competency check off policy and procedure. Executive Director/Designee to audit new hire documentation weekly as new staff are hired and annually for complete reviews. The results of the audits will be reviewed by the QAPI committee for trends and any needs for adjustment of audit schedules or content, as well as any further educational needs. The Executive Director is responsible to ensure this action occurs.	

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According to documentation in R10's electronic health record (EHR), a progress note dated 9/23/21, 6:54 a.m. indicated the registered nurse (RN-B) writing the note, had received report from the evening nurse [PN-A] that R10 was "lowered to the floor while trying to get into bed" [9/22/21]. RN-B wrote that R10's lower right leg was rotated outward, was swollen and bruised, and R10 was complaining of significant pain. The progress note indicated RN-B assessed and responded to R10's condition and sent him to the hospital in the morning, notifying family and physician. No previous note was found in R10's EHR describing R10's condition or cares provided prior to or after the incident on 9/22/21 during the time PN-A was responsible for R10's care. No vital signs for R10 were found documented by PN-A following the incident on 9/22/21.

According to a document, an incident report related to the 9/22/21 fall, it had been completed by the director of nursing (DON) who was not present at the time of the fall, and PN-A, the nurse responsible for R10 at the time of the fall did not document in the report. No predisposing environmental factors were documented, no predisposing situation factors were documented and of predisposing physiological factors, only gait imbalance was marked.

According to an interview 10/14/21, 10:42 a.m. DON explained the procedure for a nurse to follow when a resident falls. DON said first the nurse was to assess the resident for injury, review a possible cause of the incident, and based on those findings, either use a Hoyer lift with additional help, to place the resident into bed, or call for emergency assistance up to and

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including transfer to the hospital. Following the fall, DON stated a nurse is expected to document in "risk management" (incident report) in the EHR which triggers post-fall observation documentation to be done by nurses on the up-coming shifts. DON confirmed PN-A had not done this, nor had PN-A written a progress note. Although DON had initiated the risk management incident report, DON was unable to state whether PN-A had asked R10 any questions about the fall or his condition, or if PN-A had tried to figure out why the incident had happened (root cause) to initiate any new and appropriate intervention. DON said, "(PN-A) said it wasn't a fall, but of course we know it is considered a fall, but she said he looked fine."

During the 10/14/21, 10:42 a.m. interview, DON said PN-A had started work on 8/10/21. DON confirmed the facility did not have a copy of PN-A's nursing license upon hire, and did not have one as of 10/14/21. DON said facility had a check list of skills that a nurse trainer would go through with a newly hired nurse during orientation shifts, but they did not have any type of skills tests. DON stated the nurse providing orientation would see if the newly hired nurse felt comfortable with the skill, and then mark if they were competent or not.

A request was made for a copy of PN-A's nursing skills checklist, but facility was unable to provide this document.

According to a phone interview with PN-A on 10/14/21, 2:03 p.m. she had graduated from college in May of 2021, and had never worked as a nurse before. PN-A stated she had taken her nursing board exams in July, but did not yet have

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a nursing license. PN-A said she was told by the facility there was a waiver, and she was able to start work before she was licensed. She had not confirmed this with the Minnesota Board of Nursing. PN-A said she had received a checklist of items she would be trained on during her first day of orientation, but said this did not include a list of nursing skills, but rather was a list for all employees. PN-A said she had not undergone any testing by the facility to determine her competency level. PN-A said she had received four or five shifts for orientation, but had not been asked if she felt ready to work independently, or if she needed further training. PN-A was unable to provide specifics, but stated there were some shifts where she sent a text to the physician to ask questions because she felt she did not know what her job required at that time. PN-A said she had been instructed to call the DON if she had questions, but said the DON did not always respond to phone calls. PN-A said she had asked questions about wound care and was told to just look at the bandage already on the wound and "try to make it look the same." When R10 suffered his fall on 9/22/21, PN-A stated she was working at that time, and it was the first fall that she had to respond to as a nurse. PN-A was unable to describe what she had learned in nursing school about what to do if a resident had fallen. PN-A said her experience with falls was from when she was a nursing assistant, but said an assessment should be done by the nurse, including a set of vital signs , the nurse should document findings and notify the DON and the physician. PN-A could not recall if she had written a progress note (no progress note was found); she thought she may have given R10 some Tylenol for pain because he complained of pain all over, and could not localize the pain. PN-A

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said she had called the DON and asked what paperwork she had to do, but said the DON told her she did not have to do anything because R10 was "lowered to the floor" and did not fall. PN-A asked if she needed to call the physician, but said the DON said she "would take care of it." PN-A said "I found out the next day things were worse and I felt horrible, and asked what I needed to do." PN-A said she was told by the DON that the over-night nurse had charted everything, and she did not have to do anything else.

According to an interview 10/14/21, 2:44 p.m. RN-A said she often participates in orientation with the newly hired nurses. RN-A said there were not any hand-outs or written orientation information that she was aware of, but said a new nurse should have a check-list. RN-A said the check-list mostly covered medication administration. A binder of steps to take with common emergencies was kept at the nurses' stations, but RN-A said there were no skills tests, or competency checks related to those items.

According to an interview 10/14/21, 2:52 p.m. the Executive Director stated it was extremely important for a facility to have competent staff. Part of competence was ensuring staff had received proper training, and he stated the Human Resource department was to check licensure of staff before they started to work. Executive Director stated PN-A's lack of licensure had not been brought to his attention and she should not have been allowed to work as a nurse until she was properly licensed. Executive Director stated it was the responsibility of the DON to be knowledgeable about nurse licensure and stated an expectation for the DON to look up the rules and regulations if unsure. Additionally,

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F 726	Continued From page 82 he stated the DON was responsible to develop a competency program, but he did not believe this had been accomplished yet. The Executive Director stated a concern that residents may not get the care they require if the facility employed unlicensed staff, or staff who's competence had not yet been determined.	F 726		
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to be free from medication error rate of 5 percent or greater identified during observations of 26 medications with 7 errors (for resident R24) which resulted in an error rate of 26.92 percent. Findings include: On 10/13/21, at 8:10 a.m. R24's medication pass was observed and completed by registered nurse (RN)-A. RN-A was observed to set up the following five medications including: atorvastatin 40 mg 1 tab daily via g-tube, vitamin D3 1000 unit 1 tab daily via g-tube, hydralyzine 25 mg 1 tab every 6 hours via g-tube, levetiracetam 750 mg 1 tab twice a day via g-tube, lisinopril 10 mg 1 tab daily via g-tube. RN-A crushed all five meds together and placed in a plastic cup then set up the following two medications in a separate cup: clearlax 17 grams daily via g-tube and docusate	F 759	R24 orders in electronic charting system updated to read, “may crush medications and give individually via G-tube.” Facility residents with enteral tube medications have the potential to be affected. Licensed staff educated by the Director of Clinical Services starting on 11/12/21 to the Enteral Tube Medication Administration policy and procedures. Director of Nursing/Designee to complete random med pass audits on all shifts including enteral tube med administration weekly for 8 weeks. The results of the audits will be reviewed by the QAPI committee for trends and any needs for adjustment of audit schedules	12/1/21

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F 759	Continued From page 83 50 mg/5 ml 5 ml daily via g-tube. RN-A added 60 cc of water to each cup, flushed R24's g-tube with 30 cc of water, administered first cup of crushed medications, flushed with with 30 cc of water then administered second cup of medications with 120 cc of water and finished with 30 cc water flush. During interview with RN-A on 10/13/21, at 8:10 a.m. RN-A stated there was no order stating the meds had to be given separately therefore all medications were given together except for Potassium, that is given separately. On 10/13/21, at 9:01 a.m. a follow-up interview was conducted with RN-A. RN-A stated combining medications together for g-tube administration is how RN-A has always given R24's medications, except potassium was to be given separate. On 10/13/21, at 12:20 p.m. the director of nursing (DON) was asked if staff were trained on G-Tubes and DON stated there was no education done since this DON was hired a year and a half ago. During a follow-up interview on 10/13/21, at 2:03 p.m. DON verified the expectation for administering medications via G-Tube was each medication was to be given individually with a flush in between each medication. When asked what could happen if medications were given all together DON stated, "Many things, meds may not be compatible." Facility policy titled Medication Administration dated June 2017 did not address how to administer medications via G-Tube. Facility policy titled Enteral Nutritional Therapy (Tube Feeding)	F 759	or content, as well as any further educational needs. The Executive Director is responsible to ensure this action occurs.	

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F 759	Continued From page 84 dated June 2017 also did not address how to administer medications via G-Tube.	F 759		
F 761 SS=D	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 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 inhalers were properly labeled to allow staff to identify a beyond use date and avoid administration of inhalant medications after beyond use date for 3 of 3 residents (R13, R19 and R184) reviewed for safe	F 761	R13, R19, R184 medication labeled appropriately. Facility residents have the potential to be affected.	12/1/21

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F 761	Continued From page 85 medication storage. Additionally, the facility failed to dispose of expired medications in 1 of 1 medication carts and 1 of 11 medication storage rooms. Findings include: On 10/12/21, at 9:36 a.m. the 300 Wing medication cart was observed with Registered Nurse (RN)-A present and the following was found: - R13's open Flovent inhaler found with no date to indicate when it was opened. - R19's open Spiriva inhaler and Albuterol inhaler found with no date to indicate when opened. - R184's open Albuterol inhaler found with no date to indicate when it was opened. - A stock bottle of fish oil was found with an expiration date of 07/2021. During an interview on 10/15/21, at 1:44 p.m. the director of nursing (DON) stated that when nurses open a new inhaler, eye drop or insulin pen they should label the medication with the date open. On 10/15/2021 at 1:34 P.M., facility med storage room was observed with Director of Nursing (DON) present and the following was found: - 8 boxes of stock cerumen ear drops found that expired in 07/2021. - 1 box of Tylenol suppositories prescribed to R8 that expired 08/2021. During an interview on 10/15/21 at 1:44 P.M., the DON stated that when nurses open a new inhaler, eye drop of insulin pen they should label	F 761	Medication storage room and carts were audited for any opened medications without a date opened label present or resident name present on 10/18/21. Any medications found without correct labeling were disposed of. NOC shift nurse to complete weekly checking of the medication carts and storage room with sign off on checkoff sheet. Nursing staff to check items for date, label, etc. throughout med pass. Monthly pharmacy reviews to continue. Licensed staff educated by the director of Clinical Services starting on 11/12/21 to the Medication storage, labeling, and expiration information and tips education, Medication expiration dates education, and the Medication storage policy and procedures. Director of Nursing/Designee to audit NOC shift checkoff sheet weekly for completion for 8 weeks. Licensed staff educated to the Medication storage, labeling, and expiration information and tips education, Medication expiration dates education, Medication Administration policy and procedures and Medication storage policy and procedures. The results of the audits will be reviewed by the QAPI committee for trends and any needs for adjustment of audit schedules	

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F 761	Continued From page 86 the medication with the date open. The DON also verified the boxes of cerumen ear drops were expired and should have been disposed. Facility policy titled Medication Administration, dated June 2017, indicated on page 4 to record date a bottle or container is opened on the label, as well as to return expired or outdated medications promptly to the pharmacy.	F 761	or content, as well as any further educational needs. The Executive Director is responsible to ensure this action occurs.	
F 839 SS=D	Staff Qualifications CFR(s): 483.70(f)(1)(2) §483.70(f) Staff qualifications. §483.70(f)(1) The facility must employ on a full-time, part-time or consultant basis those professionals necessary to carry out the provisions of these requirements. §483.70(f)(2) Professional staff must be licensed, certified, or registered in accordance with applicable State laws. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure 1 of 1 practicing nurse (PN)-A and 1 of 3 licensed practical nurse (LPN)-C reviewed was licensed by the State to practice nursing. Findings included: During an interview on 10/11/21, at 7:01 p.m. LPN-C stated PN-A had passed her boards but did not have license yet and was working as a licensed practical nurse. LPN-C stated, "they also let me work as a licensed practical nurse for a month before she was assigned a license number."	F 839	PN-A removed from schedule until background check completed and valid license obtained. PN-C license obtained. Facility residents have the potential to be affected. Audit of current employees to verify background check, license, and certification documentation complete 10/17/21 Employees will have on file current and	12/1/21

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F 839	Continued From page 87 Practical Nurse (PN)-A's employee personal file was reviewed. The record indicated an original hire date of 8/10/21. The personal file review revealed PN-A did not have a license to practice nursing in the state of Minnesota. During an interview on 10/12/21, at 4:59 p.m. with the business office manager (BOM) PN-A's timecard was reviewed from 8/10/21 to 10/3/21 and revealed PN-A had worked in the facility as a licensed practical nurse without supervision or a license 28 times. The BOM stated I do know during her interview that NP-A asked if she could start before her license came through or not and she was told yes. The BOM stated the director of nursing (DON) thought she could work under a temporary license, and I honestly did not know. The BOM stated NP-A was allowed to work as an LPN and stated she was not asked to provide a copy of a temporary license. The BOM stated I thought it was like a certified nursing assistant that when they pass their boards, they were good to go. The BOM stated the DON thought that NP-A had a temporary license and NP-A thought she was underneath a graduate nurse waiver. The BOM stated she had been checking every Monday to see if her license had been updated yet. During an interview on 10/14/21, at 2:19 p.m. PN-A stated she graduated in May 2021 from nursing school and passed her boards in July 2021. PN-A when she was applying to jobs after she had passed her boards she had reached out to LPN-C, and she stated they were hiring. PN-A stated she explained to LPN-C she had not gotten her official nursing license yet and LPN-C stated don't worry about that there was a waiver.	F 839	validated license information, and credential documentation prior to working with residents. Interdisciplinary team educated by the Director of Clinical Services starting on 11/12/21 on the new hire policy and the state of Minnesota regulations and the need to verify license/certification prior to working with residents. Executive Director/Designee will audit new hires for 8 weeks for complete documentation. Audit tracking tool developed. The results of the audits will be reviewed by the QAPI committee for trends and any needs for adjustment of audit schedules or content, as well as any further educational needs. The Executive Director is responsible to ensure this action occurs.	

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PN-A stated upon hire they (DON and BOM) were aware she did not have her license and stated there was a waiver that she could work under as a new graduate nurse. PN-A stated she was told by the DON it took LPN-C it took three times to pass her boards and LPN-C had worked under a waiver. PN-A Stated I was suspended by the executive director on Monday because I do not have a valid license to work as a licensed practical nurse. PN-A stated she felt like she was manipulated and taken advantage off.

Licensed practical nurse (LPN)-C's employee personal file was reviewed. The record indicated a hire date of 2/15/21 as a licensed practical nurse. LPN-A's personnel record indicated a Minnesota LPN license was issued on 3/17/21. However, between 2/15/21 and 3/17/21, LPN-A did not have a license to practice nursing in the state of Minnesota

During an interview on 10/13/21, at 9:12 a.m. with the business office manager (BOM) stated in February of 2021, LPN-C reached out to her and was hired back on 2/15/21 as a licensed practical nurse (LPN) as she had passed her boards. The BOM stated LPN-C's licensure came through on 3/17/21. During a subsequent interview at 11:22 a.m. LPN-C's timecard was reviewed from 2/15/21 to 3/17/21 and revealed LPN-C had worked in the facility as a licensed practical nurse without supervision or a license 23 times.

During an interview on 10/12/21, at 5:17 p.m. the executive director stated he was unaware the facility had an unlicensed nurse working in the building. The executive director stated the expectation was the facility to have a copy of the

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F 839	Continued From page 89 license in the personal file and to check the Minnesota Board of Nursing registry. The executive director stated he would want to be in the loop if the DON and BOM were hiring a staff member under any abnormal circumstances where the staff member was not licensed yet. The executive director stated a copy of background checks should be kept in employee personal files The Pre-Employment Screening for License/Certifications policy dated July 2018 included, "1. Prospective employees must have a Valid license and/or certification along with job application when a license or certification is required as set forth in the current job description ...2. Licensure Designee must check with all applicable state licensing board(s) to confirm that the prospective employee possesses a valid license and/pr certification that is in good standing and applicable to the position."	F 839		
F 947 SS=E	Required In-Service Training for Nurse Aides CFR(s): 483.95(g)(1)-(4) §483.95(g) Required in-service training for nurse aides. In-service training must- §483.95(g)(1) Be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year. §483.95(g)(2) Include dementia management training and resident abuse prevention training. §483.95(g)(3) Address areas of weakness as determined in nurse aides' performance reviews and facility assessment at § 483.70(e) and may address the special needs of residents as	F 947		12/1/21

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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 947	Continued From page 90 determined by the facility staff. §483.95(g)(4) For nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure annual performance reviews were conducted for 5 of 5 nursing assistants (NA-A. NA-B, NA-C, and NA-D) whose personnel records were reviewed. Findings include: NA-B was hired on 5/18/2019. NA-A's employee record lacked documentation of annual performance evaluations. NA-C was hired on 10/4/2019. NA-C's employee record lacked documentation of annual performance evaluations. NA-D was hired on 10/4/2013. NA-D's record lacked documentation of annual performance evaluation. NA-D's last performance evaluation was dated 10/31/16. NA-E was hired on 10/31/2001. NA-E's record lacked documentation of annual performance evaluation. NA-D's last performance evaluation was dated 10/31/16. NA-F was hired on 9/6/2018. NA-F's employee record lacked documentation of annual performance evaluations. During an interview on 10/18/21, at 3:14 p.m. the director of nurses (DON) stated performance	F 947	Performance evaluations completed for current staff. Facility residents have the potential to be affected. Performance evaluations will be completed annually for licensed and certified staff. Interdisciplinary team educated by the Director of Clinical Services starting on 11/12/21 on performance evaluation requirements per policy. Executive Director/Designee will audit performance evaluation completion annually. The results of the audits will be reviewed by the QAPI committee for trends and any needs for adjustment of audit schedules or content, as well as any further educational needs. The Executive Director is responsible to ensure this action occurs.	

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	245270	A. BUILDING _____ B. WING _____	C 10/18/2021

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WHITEWATER HEALTH SERVICES	**525 BLUFF AVENUE ST CHARLES, MN 55972**

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F 947	Continued From page 91 reviews were supposed to be completed by December 2020. The DON stated they were not caught up on performance reviews, "We did not have concerns with any of the five staff members requested from the survey team and we just did not get to them." The DON stated no performance evaluations had been completed for the requested staff since 2017 when Northshore started managing the facility. During an interview on 10/18/21, at 3:20 p.m. the executive director stated before the end of the calendar year, Northshore expected the facility to complete performance evaluations on all to staff to include strengths, weakness, and opportunities for growth. The executive director stated he was under the assumption the facility would have completed the performance evaluation by the end of last year like the facility was supposed to and stated he was not aware they had not been done. A policy and procedure on annual performance evaluations was requested and not provided.	F 947		

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	245270	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**10/12/2021**

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WHITEWATER HEALTH SERVICES	**525 BLUFF AVENUE** **ST CHARLES, MN 55972**

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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 10/12/2021. At the time of this survey, WHITEWATER HEALTH SERVICES 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		11/19/2021

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

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K 000	Continued From page 1 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. WHITEWATER HEALTH SERVICES is a 1 story building with partial basements. The building was constructed at 2 different times. The original building was constructed in 1967 and is a 1 structure with partial basement and was determined to be Type II (111) construction. In 1969 a 1 story addition with partial basement was constructed and determined to be of Type II (111) construction.	K 000		

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K 000	Continued From page 2 Because the original building and additions are compatible construction types allowed for existing buildings of this height, the facility was surveyed as one building as allowed in the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies. The facility is fully protected throughout by an automatic sprinkler system and has a fire alarm system with smoke detection in corridors and spaces open to the corridors which is monitored for automatic fire department notification. The facility has a capacity of 45 beds and had a census of 35 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidence by:	K 000		
K 271 SS=F	Discharge from Exits CFR(s): NFPA 101 Discharge from Exits Exit discharge is arranged in accordance with 7.7, provides a level walking surface meeting the provisions of 7.1.7 with respect to changes in elevation and shall be maintained free of obstructions. Additionally, the exit discharge shall be a hard packed all-weather travel surface. 18.2.7, 19.2.7 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the exit discharge in accordance with the NFPA 101 (2012 edition), Life Safety Code, sections 19.2.7, 7.1.6.2, 7.1.7, 7.7. These deficient findings could have a widespread impact on the residents within the	K 271	Maintenance Director filled the horizontal separation between concrete slabs outside of the North Dining Room Exit Door with caulk. Maintenance Director also placed a small ramp over the separation so there would not be a vertical	12/1/21

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K 271	Continued From page 3 facility. Findings include: 1. On 10/12/2021 at 09:15 AM, it was revealed by observation that the egress to grade outside of North Dining Room Exit Door had a horizontal separation between concrete slabs greater than one inch presenting a fall and trip hazard. 2. On 10/12/2021 at 09:20 AM, it was revealed by observation that the egress to grade outside of West Dining Room Exit Door had a vertical displacement greater than one-half inch presenting a fall and trip hazard. An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K 271	displacement. Maintenance Director placed a small ramp outside the West Dining Room Exit door to reduce the vertical displacement to less than one-half inch. All other exits were looked at and we were not able to identify any additional trip/fall hazards. To prevent this from becoming a problem in the future, Audits of all exit doors and their horizontal/vertical displacements will be completed monthly as a part of our preventative maintenance program. Maintenance Director and Executive Director will be responsible for monitoring the completion of these audits. The results of the audits will be reviewed by the QAPI committee for trends and any needs for adjustment of audit schedules or content, as well as any further educational needs. The Executive Director is responsible to ensure this action occurs.	
K 324 SS=D	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or	K 324		12/1/21

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K 324	Continued From page 4 * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This REQUIREMENT is not met as evidenced by: Based on document review and staff interview, the facility failed to inspect the Ansul type fire extinguishing equipment in accordance with NFPA 101 (2012 edition), Life Safety Code, sections 19.3.2.5, 19.3.2.5.3(1), and 9.2.3, and the NFPA 96 (2011 edition), Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations sections 11.2.1. This deficient finding could have an isolated impact on the residents within the facility. Findings Include: On 10/12/2021 at 12:15 PM, it was revealed during a review of available documentation that the Ansul-type fire suppression system had not been inspected in over a year. The most recent record presented for review was dated 09/03/2020. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 324	Vendor completed an Ansul R102-3 Wet Chemical Semi Annual Inspection on 7/1/2021. This is scheduled as a semi-annual inspection and will continue to be done on a semi-annual basis. Having this scheduled with vendor for every 6 months will prevent recurrence of this issue. Maintenance Director and Executive Director will ensure each time this inspection is done that the next semi-annual inspection is scheduled. Our next inspection is scheduled for 1/11/21. The results of the audits will be reviewed by the QAPI committee for trends and any needs for adjustment of audit schedules or content, as well as any further educational needs. The Executive Director is responsible to ensure this action occurs.	

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K 353	Continued From page 5	K 353		
K 353 SS=E	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the sprinkler system in accordance with NFPA 101 (2012 edition), Life Safety Code, section 9.7.5, and NFPA 25 (2011 edition) Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, sections 5.1, 5.2, 5.2.1.1.1, 5.2.1.1.2, 5.2.1.1.4, 5.2.1.2, 5.2.2.2. NFPA 13 (2010 edition), Standard for the Installation of Sprinkler Systems, sections 8.5.6, 8.5.6.1. These deficient findings could have a patterned impact on the residents within the facility. Findings include:	K 353	Maintenance Director reached out to vendor to set up an inspection and replacement of the oxidated sprinkler heads. Replacement of these oxidated sprinkler heads is scheduled for 11/23/21. Maintenance director or designee to complete a monthly audit of sprinkler heads building wide, to ensure no oxidation is present. Maintenance Director and Executive Director went through storage rooms #3 and #4 in the employee lounge to remove the items that were located within 18 inches of the sprinkler heads. A monthly audit will be completed by Maintenance Director to ensure all	12/1/21

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K 353	Continued From page 6 1. On 10/12/2021 at 09:30 AM, it was revealed by observation that sprinkler heads located in the Kitchen exhibited signs of oxidation. 2. On 10/12/2021 at 09:35 AM, it was revealed by observation that items were placed closer than eighteen inches to the sprinkler heads in the Basement Staff Lounge Area - storage closets # 3 and #4. An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K 353	storage areas do not have storage or items within 18 inches of sprinkler heads. Maintenance Director and Executive Director will be responsible to monitor these audits are complete. The results of the audits will be reviewed by the QAPI committee for trends and any needs for adjustment of audit schedules or content, as well as any further educational needs. The Executive Director is responsible to ensure this action occurs.	
K 521 SS=F	HVAC CFR(s): NFPA 101 HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to maintain the heating, ventilation, and air conditioning in compliance with NFPA 101 (2012 edition), Life Safety Code, sections 19.5.2.1 and 9.2.1, and NFPA 80 (2010 edition), Standard for Fire Doors and Other Opening Protectives, sections 19.4.1.1, 19.4.9, 19.4.10, and 19.4.11, and NFPA 105 (2010 edition), Standard for Smoke Door Assemblies and Other Opening Protectives,	K 521	Vendor completed inspection of fire dampers on 9/28/2020. To ensure this is done at least every 4 years, we will set up a follow-up appointment at the time of each inspection and continue to do this with each visit. Maintenance Director and Executive Director will be responsible for making this follow-up appointment with each visit. Maintenance Director or designee will audit last inspected date	12/1/21

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K 521	Continued From page 7 sections 6.5.2, 6.5.11, 6.5.12 and 6.6. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 10/12/2021 between 12:05 PM, it was revealed during documentation review that the smoke dampers were past due to the required 4-year inspection frequency. Dampers were last tested in 2011. An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K 521	annually to ensure we have an inspection scheduled within the 4-year timeframe. The results of the audits will be reviewed by the QAPI committee for trends and any needs for adjustment of audit schedules or content, as well as any further educational needs. The Executive Director is responsible to ensure this action occurs.	
K 541 SS=F	Rubbish Chutes, Incinerators, and Laundry Chu CFR(s): NFPA 101 Rubbish Chutes, Incinerators, and Laundry Chutes 2012 EXISTING (1) Any existing linen and trash chute, including pneumatic rubbish and linen systems, that opens directly onto any corridor shall be sealed by fire resistive construction to prevent further use or shall be provided with a fire door assembly having a fire protection rating of 1-hour. All new chutes shall comply with 9.5. (2) Any rubbish chute or linen chute, including pneumatic rubbish and linen systems, shall be provided with automatic extinguishing protection in accordance with 9.7. (3) Any trash chute shall discharge into a trash collection room used for no other purpose and protected in accordance with 8.4. (Existing laundry chutes permitted to discharge into same room are protected by automatic sprinklers in accordance with 19.3.5.9 or 19.3.5.7.)	K 541		12/1/21

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K 541	Continued From page 8 (4) Existing fuel-fed incinerators shall be sealed by fire resistive construction to prevent further use. 19.5.4, 9.5, 8.4, NFPA 82 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to test and maintain laundry chute in accordance with the NFPA 101 (2012 edition), Life Safety Code, sections 19.5.4.3, 8.7, 8.7.1.3, 7.2.1.8. This deficient condition could have a widespread impact on the residents within the facility. Findings include: On 10/12/2021 at 09:40 AM, it was revealed by observation that the laundry cute located in the Utility Room was found ajar and did not self-close and latch upon testing. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 541	Maintenance Director inspected and repaired the laundry chute door in the east utility room, ensuring that it self-closes and latches. A weekly audit of the functionality of this door and other chute doors will be completed by the maintenance director on a monthly basis for the next 12 months. Maintenance Director and Executive Director will be responsible for ensuring these audits are being completed. The results of the audits will be reviewed by the QAPI committee for trends and any needs for adjustment of audit schedules or content, as well as any further educational needs. The Executive Director is responsible to ensure this action occurs.	
K 920 SS=F	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for	K 920		12/1/21

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K 920	Continued From page 9 PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to implement the usage of power strips in accordance with NFPA 99 (2012 edition), Health Care Facilities Code, section 10.2.3.6, 10.2.4 and NFPA 70, (2011 edition), National Electrical Code, sections 400-8, 590.3(D). These deficient findings could have a widespread impact on the residents within the facility. Findings include: 1. On 10/12/2021 at 09:45 AM, it was revealed by observation in the Main Nurses Station - Medications Storage Room that a refrigerator was connected to a power strip 2. On 10/12/2021 at 09:50 AM, it was revealed by observation in Room 214 that an extension cord was connected to a power strip 3. On 10/12/2021 at 09:55 AM, it was revealed by observation in the West Nurses Station that a refrigerator was connected to a power strip	K 920	Maintenance Director disconnected the refrigerator at the “Main Nurses Station” from the power strip and plugged it in to the wall. Maintenance Director removed the extension cord from the power strip in office 214 and ensured only allowable items were plugged into the power strip. Maintenance Director removed the power cord for the refrigerator at the West Nurses Station from the power strip and ensured it was plugged straight into the wall. Maintenance Director disconnected the sump-pump from the power strip. To prevent recurrence, a monthly audit will be completed of all offices, nurse stations, and utility areas to ensure power strips/extension cords are only being used where safe/appropriate. Maintenance Director and Executive Director will be responsible for ensuring these audits are completed for 12 months. The results of the audits will be reviewed by the QAPI committee for trends and any needs for adjustment of audit schedules or content,	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245270	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**10/12/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITEWATER HEALTH SERVICES	**525 BLUFF AVENUE** **ST CHARLES, MN 55972**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 920	Continued From page 10 4. On 10/12/2021 at 10:15 AM, it was revealed by observation in the Basement Mechanical Room that a sump-pump was connected to a power strip An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K 920	as well as any further educational needs. The Executive Director is responsible to ensure this action occurs.	
K 926 SS=F	Gas Equipment - Qualifications and Training CFR(s): NFPA 101 Gas Equipment - Qualifications and Training of Personnel Personnel concerned with the application, maintenance and handling of medical gases and cylinders are trained on the risk. Facilities provide continuing education, including safety guidelines and usage requirements. Equipment is serviced only by personnel trained in the maintenance and operation of equipment. 11.5.2.1 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to confirm that a medical gas training program is in use per NFPA 99 (2012 edition), Health Care Facilities Code, section 11.5.2. This deficient finding widespread impact on the residents within the facility. Findings include: On 10/12/2021 at 12:30 PM, it was revealed by a review of available documentation that no evidence was presented for review to confirm that a medical gas training program currently exists or is used by the facility.	K 926	The Director of Nursing will complete medical gas training with nursing staff on 11/17/2021. To ensure staff receive this training, it will be completed at orientation upon hire. It will also be completed annually for each nursing staff member. The Director of Nursing and Executive Director will be responsible for ensuring education is done upon hire and on an annual basis. The results of the audits will be reviewed by the QAPI committee for trends and any needs for adjustment of audit schedules or content, as well as any further educational needs. The Executive Director is responsible to ensure this	12/1/21

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	245270	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**10/12/2021**

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K 926	Continued From page 11 An interview with the Director of Nursing verified this deficient finding at the time of discovery.	K 926	action occurs.	