Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
May 9, 2023

Administrator
Sleepy Eye Care Center
1105 3rd Avenue Southwest
Sleepy Eye, MN 56085

RE: CCN: 245225
Cycle Start Date: April 20, 2023

Dear Administrator:

On April 20, 2023, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Elizabeth Silkey, Unit Supervisor
Mankato District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
12 Civic Center Plaza, Suite #2105
Mankato, Minnesota 56001
Email: elizabeth.silkey@state.mn.us
Office: (507) 344-2742 Mobile: (651) 368-3593

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

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

If substantial compliance with the regulations is not verified by July 20, 2023 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by October 20, 2023 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

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

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

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

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

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

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

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

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER #	MULTIPLE CONSTRUCTION	DATE SURVEY COMPLETE:
	245225	A. BUILDING: _____ B. WING _____	**4/20/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SLEEPY EYE CARE CENTER	**1105 3RD AVENUE SOUTHWEST SLEEPY EYE, MN**

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 623	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address

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

The above isolated deficiencies pose no actual harm to the residents

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 245225	MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	DATE SURVEY COMPLETE: 4/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SLEEPY EYE CARE CENTER	**1105 3RD AVENUE SOUTHWEST SLEEPY EYE, MN**

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 623	Continued From Page 1

and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.

§483.15(c)(6) Changes to the notice.
If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.

§483.15(c)(8) Notice in advance of facility closure
In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l).
This REQUIREMENT is not met as evidenced by:
Based on interview and document review, the facility failed to ensure a written notification and reason for transfer to a hospital was provided to the resident or resident representative for 2 of 2 residents (R9 and R42) reviewed for transfer/discharge.

Findings include:

R9's significant change Minimums Data Set (MDS) assessment dated 4/3/23, included intact cognition.

A progress note dated 3/17/23, at 1:39 a.m. registered nurse (RN)-C indicated R9 was transferred via ambulance to the hospital. The medical record lacked evidence a written notice of transfer had been offered or provided to the resident and/or the resident representative. The resident returned to the facility on 3/27/23.

During interview on 3/30/23, at 8:51 a.m. R9 indicated he does not remember if he got anything in writing regarding his transfer to the hospital, but didn't think so.

During interview on 4/19/23, at 1:29 p.m. licensed practical nurse (LPN)-A indicated the facility completes a bed hold form and transfer checklist but nothing is given in writing to the resident or family member.

During interview on 4/19/23, at 2:07 p.m. registered nurse (RN)-A indicated necessary paper work is sent including face sheet, diagnosis list, medication administration record, advanced directive, along with a checklist but nothing is given in writing except a bed hold to the resident or family. Most times, staff will call the family member and get a verbal permission.

During interview on 4/19/23, at 3:27 p.m. social services (SS)-A, indicated nothing is given in writing to the resident or family regarding transfer, but they do have a "Room/Transfer/Discharge Form" but is only used for moving rooms for residents and not for transfer or discharge. SS-A added aware that corporate is currently working on updating the form.

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ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 623	Continued From Page 2 During interview on 4/19/23, at 6:12 p.m., the director of nursing (DON) indicated the facility does not have a transfer form. The DON confirmed there was no documentation present or transfer form was completed and given to the resident or family. Facility policy and procedure was requested and a Room Transfer/Discharge Form, undated, was received. This included: -Residents and/or families must be notified in advance of room changes, and discharges/transfer from the facility... R42 R42's Admission Record printed 4/20/23, indicated diagnoses including dementia and depression. Progress note dated 4/11/23, at 10:38 a.m. by registered nurse (RN)-A indicated R42 was transferred to inpatient psych, family member (FM)-A picked up resident at 10:26 a.m. R42's medical record lacked evidence a written notice for transfer was provided in writing to R42 and/or R42's representative On 4/20/23, at 12:00 p.m. the assistant director of nursing (ADON) indicated she could not find R42's discharge transfer was completed and expected the facility completed and provide the discharge transfer form to the resident or resident's family. On 4/20/23, at 12:04 p.m. an interview with social services (SS)-A confirmed a written notice was not provided to R42 or resident representative, and further verified it was not the facility's practice to provide a written notice of transfer to residents and/or resident representatives. SS stated going forward the facility would utilize the form when residents were transferred. Facility policy titled Transfer and Discharge Planning, dated 10/24/22, indicated: Complete the Discharge Summary Data Collection form in point click care for planned discharges.
F 625	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any;

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ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
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(iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and
(iv) The information specified in paragraph (e)(1) of this section.

§483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section.
This REQUIREMENT is not met as evidenced by:
Based on interview and document review, the facility failed to ensure 1 of 2 residents (R9) or legal representatives reviewed for hospitalizations had been informed of bed hold rights at the time of transfer/discharge to hospital.

Findings include:

R9's face sheet printed 4/20/23, indicated diagnosis including aneurysm (bulging) of artery of lower extremity.

R9's significant change Minimum Data Set (MDS) assessment dated 4/3/23, indicated R9 had intact cognition, is understood and understands and exhibited no behaviors

A progress note dated 3/17/23, at 1:39 a.m. registered nurse (RN)-C indicated R9 was complaining of right leg pain and upon evaluation leg was pale in color. Ambulance was called and resident was transferred to the emergency department. R9 returned to the facility on 3/27/23.

Review of medical record did not include documentation regarding bed hold written notification given to the resident or family member. A progress note dated 3/17/23, at 12:36 p.m. indicated a family member (FM) was called to update regarding R9's condition who indicated the hospital has been keeping him updated. No mention of a bed hold was present.

During interview on 3/30/23, at 8:51 a.m. R9 indicated he does not remember if he got anything in writing regarding a bed hold, but didn't think so.

During interview on 4/19/23, at 1:29 p.m. licensed practical nurse (LPN)-A indicated the facility completes a bed hold form and transfer checklist and sends medical records with the resident upon transfer. Family and providers are notified.

Upon request of R9's bed hold form on 4/19/23, at 1:26 p.m. a blank bed hold form was received.

During interview on 4/19/23, at 1:31 p.m. registered nurse (RN)-B indicated she is not aware of the transfer procedure and would call her assistant director of nursing or director of nursing for further guidance.

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ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 625	Continued From Page 4

During interview on 4/19/23, at 2:44 p.m. RN-A indicated a bed hold agreement is completed when residents are transferred to the hospital. RN-A indicated if resident can not sign the bed hold, we contact the family for verbal agreement.

The DON indicated this was an emergency situation so the priority was to get the resident to the hospital. When questioned about follow up process, the DON indicated they do have a written procedure for bed hold follow up but it wasn't followed. The DON confirmed the family at a minimum should have been contacted to get verbal consent for a bed hold.

Facility policy titled Bed Holds, undated included:
-All resident leaving the facility for hospitalization should be placed on an 18 day bed hold.
-Upon admission, all residents and/or responsible patients are to be given a "Notice of Bed Hold" Policy, which contains this information. Upon transfer to the hospital, this notice should be reissued to the resident and/or responsible party.

Facility procedure titled Transfer to/Return from Hospital Tracking, undated included:
- When a resident is transferred to the hospital and will be on bed hold, write their name, medical record number, and the date transferred to the hospital in the corresponding boxes on the "Transfer to/Return from Hospital Tracking Sheet".
-Complete the transfer to the hospital audit within 48-82 hours after the transfer and mark the date completed in the transaction audit done box.
-If the resident is discharged to the hospital (goes off of bed hold), mark the date discharged in the return or discharge date box and draw a line through the remaining boxes.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245225	A. BUILDING _____ B. WING _____	C 04/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SLEEPY EYE CARE CENTER	1105 3RD AVENUE SOUTHWEST SLEEPY EYE, MN 56085

(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 4/17/23-4/20/23, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On 4/17/23-4/20/23, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. In addition to the recertification survey, the following complaints were reviewed. The following complaints were reviewed with no deficiency cited. H5225042C (MN00080648), H52251102C (MN00085722), H52251103C (MN00091533) 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	F 000		

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

Electronically Signed | 05/17/2023

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 000	Continued From page 1 onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.	F 550		5/29/23

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F 550	Continued From page 2 §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide a dignified atmosphere for 1 of 1 resident (R9) observed to have an uncovered catheter bag which was visible to others. Findings include: R9's Face Sheet, printed 4/20/23, indicated R9 had a diagnosis of benign prostatic hyperplasia (enlarged prostrate)with lower urinary tract symptoms. R9's significant change Minimum Data Set (MDS) assessment dated 4/3/23, indicated R9 was cognitively intact, requires extensive assistant of 2 persons and has an indwelling catheter. During observation on 4/18/23, at 8:20 a.m. nursing assistant (NA)-C assisted R9 using EZ stand to his wheelchair and placed the Foley catheter bag under the wheelchair, next to the catheter bag cover. R9 wheeled himself through the hallway past main entrance of the facility and into the dining room where 9 other residents were having breakfast. Catheter bag was visible under wheelchair draining clear yellow urine. During observation and interview on 4/18/23, at 9:07 a.m., R9 left the dining room and wheeled	F 550	R9's catheter bag was immediately placed inside its catheter cover, which was already provided. All other residents with catheters were audited to assure the catheter bags were placed inside the catheter covers provided. Policy was reviewed and remains current. Re-education was immediately provided to the employee involved. Re-education will be provided to all nursing staff regarding proper placement of catheter bag inside catheter cover to provide a dignified atmosphere for all residents. Audits of catheter placement according to procedure will be completed 3x/wk for 2 wks, 2x/wk for 2 wks, 1x/wk for 2 wks, monthly with results reported to QAPI and will continue until QAPI Team approves resolution. DON or designee is responsible for compliance	

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F 550	Continued From page 3 himself back to his room past the main entrance area and through the hallway. Catheter bag remained uncovered with cover hanging next to the catheter bag. R9 indicated he is thankful he has the Foley catheter and when questioned about the urinary bag uncovered stated "I guess it doesn't bother me too much, but added he isn't sure how other people feel about looking at it. During observation on 4/18/23, at 1:02 p.m., physical therapist (PT)-A assisted R9 from the bed using the EZ stand and placed R9 in his wheelchair. Catheter bag was hung under R9's wheelchair and was not covered. R9 was wheeled down the hallway to the therapy room. During interview on 4/19/23, at 3:50 p.m. assistant director of nursing (ADON) indicated catheter bags should always be covered and "buried" under the chair if resident is out of their room. During interview on 4/20/23, at 8:11 a.m. the director of nursing confirmed all catheter bags should be covered stating "it is a dignity issue." The DON indicated if residents have a room mate it should be covered in their room also. The DON stated its like toileting, you close the door. A policy and procedure related to ensuring catheter bags are covered was requested and not provided.	F 550		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan,	F 658		5/29/23

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	245225	A. BUILDING _____ B. WING _____	C 04/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SLEEPY EYE CARE CENTER	1105 3RD AVENUE SOUTHWEST SLEEPY EYE, MN 56085

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F 658	Continued From page 4 must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to meet professional standards of care when the NA (nursing assistant) applied prescribed medication cream for 1 of 1 resident (R9). Findings include: R9's Face Sheet, printed 4/20/23, included diagnoses of aneurysm (bulging) of artery of lower extremity and osteoarthritis of left knee. R9's significant change Minimum Data Set (MDS) assessment dated 4/3/23, indicated R9 was cognitively intact, understands and is understood and required extensive assistance from staff with transfers, dressing, toilet use, and personal hygiene. R9's physician order dated 3/8/23, indicated R9 had an order for topical analgesic rub/cream at bedside and may use per self as needed. A care plan dated 1/31/23, indicated R9 could self administer medications that included Aspercreme, Icy Hot, Biofreeze and other topical analgesic rubs at bedside and is appropriate to administer to self per assessment. A self-administration of medication assessment was completed on 1/31/23, and R9 was deemed safe to self-administer topical analgesic rubs. During observation on 4/18/23, at 8:09 a.m. nursing assistant (NA)-C, upon request from R9,	F 658	R9 - Immediate education was provided to CNA and TMA on Scope of Practice for medicated creams and ointments and self administration of medication All residents that have prescribed creams and ointments may be affected Procedure has been reviewed and is current. Reeducation of nursing staff on scope of practice was completed on 4/21/23 and again at skills fair 5/16 and 5/17. Audits of medicated creams and ointment procedure will be completed 3x/wk for 2 wks, 2x/wk for 2 wks, 1x/wk for 2 wks, monthly until QAPI Team approves resolution. DON or designee is responsible for compliance	

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F 658	Continued From page 5 unwrapped right lower leg from vascular boot and applied "Pain Relief" rub cream to R9's lower leg and foot. Trained medication assistant (TMA)-A was present in the room and unwrapped ace wrap from left lower leg. NA-C applied cream to left foot and TMA-A rewrapped left lower leg. NA-C then placed vascular boot back on right lower leg. NA-C was not able to state what the pain relief medication contained just that he gets it from the Veterans Administration. Review of "Pain Relieving Rub" ingredients included methyl salicylate (aspirin)15.% (a nonsteroidal anti-inflammatory drug). During interview on 4/18/23, at 1:03 p.m. NA-C indicated nursing assistants are able to apply R9's pain relief rub because it is an over the counter lotion. NA-C indicated R9 is capable of doing it himself but he likes staff to do it for him. NA-C indicated she has not had any training on application of pain relief creams but has on barrier creams and lotions. During interview on 4/18/23, at 1:05 p.m. registered nurse (RN)-B indicated NA's are able to apply over the counter creams. RN-B added she will usually do Aspercreme, but NA's can do moisture barriers. RN-B indicated she had not observed NA's apply pain relief cream but indicated R9 is capable of putting it on himself. During interview on 4/19/23, at 2:44 p.m. RN-A indicated since there is an order for R9 to have his pain relief cream at the beside, the NA's are able to apply the cream. RN-A added the medication comes directly to him from the Veterans Administration and is a generic Aspercreme.	F 658		

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F 658	Continued From page 6 During interview on 4/19/23, at 4:22 p.m. Pharmacist (P)-D indicated nursing assistants should not be applying pain relief creams unless they have specific training related to the cream. P-D indicated they don't know the effects of the medications, and what side effects to monitor for. During interview 4/20/23, at 9:15 a.m. the director of nursing (DON) indicated NA's should not be applying aspirin based creams unless they have additional training, which has not been completed. Trained medication aides (TMA's) are allowed to apply the creams otherwise it is a licensed nurse role. The DON added aspirin based creams are considered a medication regardless if it is over the counter or not. Requested policy and procedure for medication administration and none was received.	F 658		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility to ensure provider order was present for use of ace wraps for 1 of 1 resident (R9) reviewed for skin.	F 684	R9 - Immediate education was provided to Nurses on the need of doctor's orders to apply Ace Wraps. Facility reviewed all residents and	6/7/23

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F 684	Continued From page 7 Findings include: R9's face sheet printed 4/20/23, indicated a recent hospitalization from 3/16/23 until 3/27/23 with diagnosis including aneurysm of artery of lower extremity and bifascicular block(conduction abnormality of the heart). R9's significant change Minimum Data Set dated 4/3/23 indicated R9 had intact cognition, had recent surgery and required extensive assist of 2 for personal hygiene, toileting and transfers. R9's care plan dated 3/28/23, indicated R9 has an alternation in activities of daily living. Interventions included weight bearing as tolerated to right lower extremity, no lifting greater than 10 pounds, pulling or pushing for 4-6 weeks post operative and right foot ankle foot orthoses (provide support and proper joint alignment of foot and ankle). No mention of an ace wrap was present on the plan of care. Review of provider orders 4/7/23, indicated to elevate legs and feet as resident allows every shift but no order for ace wrap was present to left lower extremity. During interview and observation on 4/18/23, at 8:09 a.m. R9 was lying in bed with both feet elevated. R9's left ankle and foot had an ace wrap present. Trained medication aide (TMA)-A removed the ace wrap and nursing assistant (NA)-A applied pain cream per R9's request. R9's skin on lower leg had multiple creases present. Skin was warm to the touch per TMA-A. TMA-A then reapplied ace wrap to R9's left lower leg. R9 indicated he just woke up and slept with	F 684	identified 3 total residents with Ace Wraps and confirmed all have physician orders for application Procedure has been reviewed and is current. Reeducation to nursing staff regarding necessity of doctor's orders for treatment administration was completed on 4/21/23 and again at skills fair 5/16 and 5/17. Audits of Ace Wrap orders will be completed 3x/wk for 2 wks, 2x/wk for 2 wks, 1x/wk for 2 wks, monthly until QAPI Team approves resolution. DON or designee is responsible for compliance	

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F 684	Continued From page 8 the ace wrap on his foot. Upon review of R9's treatment administration record (TAR) and medication administration record on 4/18/23, at 8:36 a.m. identified no instructions were present for application or removal of ace wraps. During interview on 4/19/23, at 2:00 p.m., licensed practical nurse (LPN)-A indicated there was no order for the ace wrap in the electronic medical record. LPN-A indicated we generally take ace wraps off on nights but usually have instructions on the order with when to put it on and take it of. During interview on 4/19/23, at 2:07 p.m., registered nurse (RN)-A was not able to locate an order for ace wrap on left lower leg for R9. RN-A indicated generally we would remove them at night. RN-A added resident likely returned from the hospital with the ace wrap in place. During interview on 4/19/23, at 2:10 p.m. R9 indicated no one removed the ace wrap last night. During interview on 4/20/23, at 9:15 a.m., the director of nursing indicated ace wraps should be put on in the morning and taken off at bedtime. An order is required for use of ace wraps. The DON added she would hope the nursing staff would catch the order was missing. A policy and procedure was requested for ace wrap use and none was received.	F 684		
F 685 SS=D	Treatment/Devices to Maintain Hearing/Vision CFR(s): 483.25(a)(1)(2)	F 685		6/7/23

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F 685	Continued From page 9 §483.25(a) Vision and hearing To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility must, if necessary, assist the resident- §483.25(a)(1) In making appointments, and §483.25(a)(2) By arranging for transportation to and from the office of a practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing assistive devices. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure an eye doctor appointment was scheduled for 1 of 2 residents (R8), reviewed for treatment to maintain hearing and vision. Findings include: R8's significant change Minimum Data Set (MDS) assessment dated 3/23/23, identified R8 had intact cognition and was able to communicate needs and wishes without difficulty. R8's medical diagnoses included diabetes mellitus type 2, and hypertension (high blood pressure). R8's care plan revised 9/3/20, indicated R8 has adequate vision. R8 has eye glasses but was not wearing them for assessment and was able to read 14 point print on the assessment chart. R8 said she could see 12 point print, but it was blurry. The care plan directed staff to to assist R8 as needed if she wishes to wear/use her eye glasses.	F 685	Nursing has immediately followed up with R8s provider to reschedule eye appointment. A HUC binder has been created to ensure accuracy for the completion of each appointment and will coordinate with Resident Appointment book, including transportation per orders. All residents were reviewed for up coming appointments and validated that appropriate follow up appointments were written in the Resident Appointment book and the HUC's binder. Completed appointments are highlighted and signed off showing completion of the appointment including transportation and any follow up charting. Education to nursing staff regarding the new organizational book for appointments and appropriate follow up was completed on 4/21/23 and again at skills fair on 5/17. Audits of appointment binder by comparing to new orders will be	

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F 685	Continued From page 10 During interview and observation on 4/17/23 at 10:44 a.m., R8 was in her room sitting in front of her television with no glasses on. R8 indicated she needs an eye appointment for glasses and went once but hasn't gone back as no one has made her an appointment. R8 indicated she did not currently have any eye glasses. An "After Visit Summary" dated 5/19/22, indicated R8 was seen by ophthalmology for type 2 diabetes mellitus, intermediate stage age related macular degeneration (results in blurred or no vision in the center of the visual field) of both eyes, cataract (clouding of the lens) of both eyes, glaucoma (damage to the optic nerve causing loss of vision) suspected, bilateral and myopia with stigmatism (optical defect where vision is blurred) and presbyopia (loss of near focusing ability), bilateral. Discharge instructions included return in about 3 months around 8/19/22 for HVF (Humphrey Visual Field, a test that measures the entire area of peripheral vision while the eye is focused on a central point). During interview on 4/18/23, at 8:54 a.m. R8 indicated she can't see very far anymore. R8 indicated she has to sit in front of the television to see it and can not read things further than 10 feet. R8 added she sometimes get headaches from trying to read things afar. R8 indicated she requested an eye doctor appointment at the last care conference meeting in March but she hasn't been informed if an appointment has been scheduled. A progress note dated 3/22/23, indicated a care conference was held and R8 expressed interest in an eye exam. Health unit coordinator will set up appointment.	F 685	completed 3x/wk for 2 wks, 2x/wk for 2 wks, 1x/wk for 2 wks, monthly until QAPI Team proves resolution. DON or designee is responsible for compliance	

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F 685	Continued From page 11 During interview on 4/18/23 at 9:10 a.m. registered nurse (RN)-A checked in appointment book and indicated nothing is currently scheduled for R8. During interview on 4/18/23, at 9:15 a.m. health unit coordinator (HUC) indicated she believes R8 was seen by ophthalmology a couple months ago. The HUC confirmed nothing currently scheduled for R8 to see an eye doctor. The HUC then indicated she does remember being told to schedule an eye doctor appointment after her last care conference, but it slipped her mind and the appointment was not made. During interview on 4/18/23, at 9:30 a.m. director of nursing (DON) indicated R8 should have had a follow up appointment with the ophthalmologist scheduled last August but it was missed. The DON added it is our job not to miss things. During interview on 4/20/23, at 8:11 a.m. the DON confirmed eye doctor and ophthalmology appointments were not scheduled per follow-up and request, but should have been. A facility policy regarding resident assessment for vision and coordination of appointments was requested, but none was provided.	F 685		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical	F 688		6/7/23

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F 688	Continued From page 12 condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to provide exercises to maintain strength and mobility for 1 of 4 residents (R18) reviewed for range of motion (ROM). Findings include: R18's face sheet printed 4/19/23, indicated admitted 2/5/21, diagnoses of hemiplegia affecting left nondominant side (loss of strength and weakness on half of the body) and cerebral infarction (stroke). R18's significant change in status Minimum Data Set (MDS) assessment dated 3/18/23, identified severe cognitive impairment, one person physical assist with bed mobility, transfer, walk in room, dressing, toilet use, personal hygiene; upper impairment on one side; utilized wheelchair; and restorative nursing range of motion was not performed. R18's care plan dated 3/22/23, indicated alteration in ability to complete activities of daily	F 688	R18 - PT/OT re-eval and setup ROM Care Plan for this resident All residents with ROM or exercise programs have been evaluated, care plan updated, and placed in restorative book for CNA instruction. Process change includes PT/OT to give charge nurse / unit health coordinator or designee the ROM exercise plan to be entered as an order, put into Care Plan, TAR and CNA tasks in POC as well as in the restorative binder The HUC and charge nurses have been trained on the proper order of entering PT/OT ROM exercise plan and expectation of communicating this plan to the floor staff. Audits of residents with PT/OT ROM plan will be completed 3x/wk for 2 wks, 2x/wk for 2 wks, 1x/wk for 2 wks, monthly until QAPI Team proves resolution. DON or designee is responsible for compliance	

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F 688	Continued From page 13 living related to decline in mobility, post non traumatic intercranial hemorrhage, diabetes and depression. PT/OT (physical therapy/occupational therapy) as ordered, assist of 1 for pivot transfers with belt, FWW(front wheeled walker)/grab bars wheel to toilet no ambulating at this time and interventions indicated: complete attached exercises 3x (times) week, ambulate to/from bathroom with FWW and gait belt, verbal cues for resident to push up with hands and turn completely before sitting down in the chair, wheelchair as needed if too fatigued or unsafe to walk, and refer to therapy updates/notes/documentation for current status or changes R18's OT discharge summary dated 3/30/23, indicated R18 was discharged from OT on 3/30/23, with recommendations staff continue green t-band (resistance band used for strength) 4-5/week. R18's therapy referral to nursing dated 3/30/23, indicated OT therapy completed instructions to nursing exercises continue with green t-ban exercises 4-5x/week. R18's Kardex dated 4/20/23, indicated PT: continue with green t-band exercises 4-5x week complete exercise 3x. R18's task history indicated on 3/30/23, task for aide cares was entered and indicated PT: continue with green t-band exercises 4-5x week complete exercise 3x. R18's point of care audit report printed 4/20/23, identified R18 continue with green t-band exercise 4-5x/week the and the report identified	F 688		

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F 688	Continued From page 14 exercises were documented completed 4/17/23, 4/12/,23, 4/10/23, 47/7/23, 4/5/23, and 4/3/23; and not applicable on 4/19/23. However, interview and observation confirmed the exercise were not completed as documented. On 4/18/23, at 10:36 a.m. R18 was observed seated in recliner, left foot elevated on the bed, and ROM (range of motion) exercise instructions and pictures were posted on R18's closet door. R18 indicated exercises with a green band were not completed routinely with staff. On 4/19/23, at 5:58 p.m. during an interview nursing assistant (NA)-D indicated R18 had ROM orders and NA staff were expected to complete the ROM as ordered. NA-D further indicated staff did not always have time to complete R18's ROM. NA-D verified not applicable was documented for R18's ROM exercises today (4/19/23) due to unawareness of the specific exercises R18 had ordered. On 4/19/23, at 6:12 p.m. NA-E indicated ROM exercises were not ordered for R18. NA-E confirmed he documented the exercises on 4/17/23, 4/12/,23, 4/10/23, and verified the exercises were not completed as documented. NA-E indicated unaware of a green band or exercise instructions posted in R18's room. R18's room was observed with NA-E and confirmed the exercise instructions were posted on the closet door and were expected completed when documented completed.. On 4/19/23, at 6:19 p.m. licensed practical nurse (LPN)-D indicated was aware R18 had orders for exercises and was not aware of the specifics of the order. LPN-D stated was not aware of a green	F 688		

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F 688	Continued From page 15 band in R18's room. LPN-D stated nursing was responsible to ensure the NA's completed the ROM exercises . On 4/19/23, at 7:47 p.m. the director of nursing (DON), assistant director of nursing (ADON), and administrator indicated staff were expected to complete resident's ROM exercises as ordered and nursing assistants should follow up with nurse, DON, or charge nurse if concerns and expected supplies in the residents room. On 4/20/23, at 8:12 a.m. LPN-C indicated a binder was located on each of the three resident's hallway and available for staff; and included resident's ROM exercise orders from OT/PT. LPN-C stated staff were expected to review the binder for instructions for resident's OT/PT orders and included resident specific ROM orders. LPN-C stated when residents were discharged from OT/PT a communication paper order was placed in the binder, and the HUC (health unit coordinator) or charge nurse placed the order as a task in the EMR (electronic medical record) for NA's or nursing. LPN-C stated pictures and instructions of exercises were placed on the resident' s closet doors by OT and PT. LPN-C indicated unaware R18 had ROM exercises order with a green band, and confirmed the binder did not include an order from OT. R18's room was observed with LPN-C and the green band was located in R18's bedside drawer. LPN-C indicated was not aware or familiar with the policy or procedure for nursing restorative care or ROM. LPN-C indicated R18's ROM was not on the nursing treatment order, and was on the NA's task list. On 4/20/23, at 8:28 a.m. NA-C and NA-F	F 688		

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F 688	Continued From page 16 indicated R18's computer orders or hallway binder did not indicate ROM exercises, and further stated they were not aware of the green band R18 was to use for ROM exercises. Observed NA-F access the EMR and indicated R18 ROM was not a task NA's were responsible to complete. NA-F confirmed R18's ROM instructions were located R18's closet door, but had not seen a communication note from therapy. On 4/20/23, at 9:18 a.m. occupational therapy assistant (OTA)-G indicated R18 was discharged from OT on 3/30/23 and copies of order were placed in the hallway binder, with the charge nurse to enter the order in the EMR, and with the DON. OTA-G indicated staff were expected to assist R18 with the green t-band exercises 4-5 times per week and document completion. Facility policy titled Contracture Prevention and Management, dated 2017, indicated - Prevent or reduce contractures/deformity/atrophy - Increase and/or maintain individually determined normal range of motion. - Prevent progression of further joint mobility limitation and loss of function.	F 688		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.	F 689		6/7/23

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F 689	Continued From page 17 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to conduct a comprehensive reassessment after a resident sustained an injury to identify root cause and ensure new interventions were implemented to prevent further injuries for 1 of 1 resident (R37) reviewed for accidents. Findings include: R37's significant change in status Minimum Data Set (MDS) assessment dated 3/12/23, indicated moderate cognitive impairment, required one person physical assist with bed mobility, transfers, eating, dressing, toileting, and personal hygiene, unsteady, only able to stabilize with staff assistance when moved from seated to standing position; upper and lower extremity impairment on one side, utilized a wheelchair and walker, and diagnoses indicated arthritis, other fracture, lesion of ulnar nerve right upper limb (an abnormal change in structure of the right upper limb). R37's care plan dated, 3/20/23 indicated trigger for ADL's (activities of daily living); interventions included no weight bearing restrictions, independent for eating with set up and clean up, try L (left) angled silverware and feed self with R (right) hand, ext.(extensive) assist for all transfers with use of EZ stand (mechanical device), assistance to transfer on/off toilet, totally dependent for bathing/shower, extensive staff assist with personal hygiene and grooming, need limited assist with oral cares, require extensive assistance of staff to dress/undress; nutrition potential for alteration; interventions indicated use divided plate and left curved utensils for eating r/t	F 689	R37 Resident had a comprehensive assessment completed. Care Plan reviewed and updated. Other residents who have had an incident were reviewed to ensure RCA and new interventions were put into place. The nurse responsible for the risk management has been educated on the proper documentation and root cause analysis procedure and implementation of a new intervention to prevent further injuries. Risk management is reviewed routinely during weekday IDT meeting and PRN. Policy reviewed and is current Licensed Nursing staff re-educated on the importance and process of filling out Risk Management/RCA and adding a new intervention. Audits of Risk management/RCA care plan updates according to procedure will be completed 3x/wk for 2 wks, 2x/wk for 2 wks, 1x/wk for 2 wks, monthly until QAPI Team proves resolution. DON or designee is responsible for compliance	

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F 689	Continued From page 18 (related to) distal radial fracture; bladder and bowel monitoring: able to use the call light to call for assistance to the bathroom, walks with 4 wheel walker, transfer belt and 1, client is requesting that EZ stand up lift be used, it is too hard for her to transfer and pivot to the commode at bedside. R37's care plan revised 3/20/23, failed to indicate revised transfer, mobility, and assistance following R37's right distal radial fracture(wrist break) to prevent prevent reoccurrence and future avoid accidents during transfers with R37. R37's progress notes indicated: -3/6/23, at 7:48 p.m. R37 bumped her right arm, c/o (complaints of) pain of 8, able to flex and extend elbow, move wrist up and down, twist arm over palm up and down, can wiggle fingers, fell asleep and resting quietly. -3/6/26, at 10:23 p.m. R37 has been using arm and now sleeping. -3/7/23, at 4:41 a.m. R37 was assisted to the BR (bathroom) during the noc. (night) and c/o pain on rt. (right) forearm but no swelling or redness noted. -3/7/23, at 9:11 a.m. R37's family was called due to rt arm pain after bumping it on the doorframe in room last pm 3/6/23, Xray was suggested and FM-I in agreement, arrangements being made for R37 transported for Xray. -3/7/23, at 1:37 p.m. R37 returned to facility with Xray showing a distal radial fracture, wear a splint 24 hours a day, elevate her arm, and ice it as	F 689		

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F 689	Continued From page 19 needed, Tylenol is to be given for pain as needed, Xray to be done 1-2 weeks to recheck. -3/8/23, at 3:57 a.m. right hand, continue splint, with wrap, elevated, no complaints of pain, CMS present, resident rested tonight -3/9/23, at 5:10 a.m. ice pack to left wrist, elevated during night. -4/17/23, at 1:08 p.m. Dr. appointment resident was seen for right arm fracture, continue with right arm splint and f/u (follow-up) in 2 weeks. Document titled Physician orders dated 3/7/23, located in R37's medical record and RN-B indicated R37 bumped her right elbow on a door frame while being transferred from bathroom last p.m. 3/6/23, she had c/o pain in rt. forearm since then, ROM in elbow flex and extend without pain, moves wrist up and down, no co/o pain with pressure, no bruising, slight swelling noted inner wrist. Xray report dated 3/7/23, indicated R37 had acute, impacted, nondisplaced, transverse fracture of the distal radius (broken wrist). Office visit report dated 3/7/23, indicated R37 presented with FM-I for concerns of right wrist pain, that started yesterday (3/6/23) after she had hit her arm while being transferred from the bathroom, she had slight deformity in the distal right wrist area, this is the area of pain, and mild swelling in this area, and the plan indicated distal radial fracture: R37 was placed in a volar splint(device applied to immobilize the wrist and hand), recommended follow up in 1-2 weeks for repeat assessment and x-ray, continue Tylenol	F 689		

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F 689	Continued From page 20 for pain, elevate and ice as need for comfort. Office visit report dated 4/17/23, indicated R37 had distal radial fracture: x-ray today reviewed, there was continue distal radial fracture of the right wrist, splint for 2 more weeks. Physical therapy progress report indicated: -3/22/23, referred to PT services due to right distal radius fracture, R37 bumped her arm during a transfer on the door frame. EZ stand no issues until recently bumped arm on doorframe during transfer with subsequent distal radius fracture, EZ stand with right radial fracture still tolerates transfer well, will assess for room safety, including considering padding to door frames to decrease risk of further injury. -4/11/23, R37 able to respond to vc's (voice commands) for RUE (right upper extremity) placement to prevent further injury/pain during E/Z stand transfers. -4/17/23, instructed R37 in upright posture during EZ stand transfers recliner, toilet., holds only with left upper extremity, discussed with nursing staff how transfers have been going and they report ok but need to remind pt to stand tall and keep legs still as pt sometimes pushes with legs pushing his backward as they raise EZ stand. R37's medical record lacked any evidence of a comprehensive assessment to identify root cause analysis or implementation of any new interventions to prevent future injuries/accidents. On 4/17/23, at 12:47 p.m. R37 was seated in a wheelchair and splinted right arm extended from	F 689		

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F 689	Continued From page 21 hand to the elbow. R37 stated approximately one month ago while transferred by one staff with an EZ stand lift from her bathroom toilet to the bed, her right arm caught the bathroom door frame. R37 further indicated she voiced to the staff her arm was broken. R37 indicated a day or two later, FM-I transported her to the doctor and was determined her right arm was broke. R37 indicated no surgery was needed and required the "bandage" at all times. R37 stated difficulty with eating and brushing her teeth due to her inability to use her right hand. On 4/18/23, at 8:34 a.m. licensed practical nurse (LPN)-B indicated uncertain how R37 broke her wrist, and stated new orders included splint on 24/7, wiggle fingers, and R37 continued to transfer with EZ stand with one person, and was unaware of any new interventions to prevent injury. On 04/18/23, at 8:49 a.m. director of nursing (DON) indicated on 3/7/23, she became aware of R37's arm pain, and immediately had the resident assessed with a provider and the Xray indicated a pathological fracture (spontaneous break in a bone). When asked if the fracture occurred on 3/6/23, when R37 bumped her arm on the doorframe, DON indicated the injury was from age and how R37 positioned herself on her right side in her wheelchair and in bed. The DON indicated she would provider further information from the Xray report. On 4/19/23, at 12:52 p.m. registered nurse (RN)-B indicated on 3/6/23, during evening shift report LPN-B reported R37 had bumped her elbow on the bathroom doorframe. RN-B indicated R37 was immediately assessed and	F 689		

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F 689	Continued From page 22 R37 indicated her right arm was bumped on the doorframe, reported pain, no redness, swelling, or bruising was observed. RN-B stated the information LPN-B reported included R37's elbow was bumped, but not the forearm. RN-B indicated R37's reported pain at the forearm area. RN-B indicated the end of her shift was 3/6/23, at 11:00 p.m. and R37 had no changes with assessment throughout the shift. RN-B stated on 3/7/23, started her shift and around 7:00 a.m. observed R37's right arm swollen, and notified FM-I and suggested an x-ray to rule out injury, and further notified the provider. RN-B indicated R37 sustained a right radial fracture, and assumed was caused when R37 bumped her arm on the doorframe the previous evening. RN-B further indicated an incident report was not filled out at the time or after learning of the fracture, and indicated had worked at the facility for a month and had not received education on the procedure for incident reports. RN-B indicated was not aware of any interventions implemented to prevent further injuries with R37. On 4/19/23, at 1:08 p.m. during an interview RN-A indicated risk management implementation was expected when an injury occurred with a transfer and stated any type of skin concern, fall, or accident required a risk management and required the nurse complete a form in the EMR (electronic medical record). RN-A indicated the risk management provided the steps and procedures for the expectations of a nurse when an injury occurs, and a risk management would include an incident report embedded in the form. On 4/19/23, at 1:53 p.m. NA-C via telephone interview stated on 3/6/23, immediately after supper assisted R37 to the toilet and transferred	F 689		

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F 689	Continued From page 23 with an EZ-stand out of the bathroom, NA-C indicated the support strap cushion of the EZ-stand was bulky and caused R37's arms to go outside of the strap and enabled R37 to keep her arms next to her body while transferred, and caused R37 arm to bump the bathroom doorframe. NA-C indicated R37 immediately grabbed her elbow, and the incident was immediately reported to LPN-B. NA-C indicated R37 stated arm was painful, and was holding her arm at the elbow. NA-C stated she observed R37's elbow and found no open areas, no blood and no swelling, NA-C indicated on the morning of 3/7/23, reported the incident to the DON and observed the DON record the information. NA-C indicated she then proceed to find a different sling to use with R37 and placed a sling with less cushion to prevent R37's elbows from extending outward. On 4/19/23, at 1:34 p.m. during a follow up interview the DON confirmed the Xray indicated the fracture was not pathological, when asked how the injury occurred the DON indicated a risk management form through the EMR was expected to assist the facility with the root cause of the injury. The DON indicated the implementation of risk management form was expected with an injury or an accident to ensure a cause was investigated. The DON stated the risk management procedure mimicked a fall incident report, and provided the nurse the steps to ensure a comprehensive assessment was completed, and included a causal analysis and updated care plan with interventions to prevent reoccurrence. The DON verified no new interventions were implemented after R37's diagnosis of right radial fracture on 3/7/23. The DON indicated on the spot education was	F 689		

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F 689	Continued From page 24 completed with NA-C on 3/6/23, in regards with safe transfers. On 4/20/23, at 8:38 a.m. LPN-C indicated R37 sustained an injury during a transfer, when her arm bumped the doorframe. LPN-C indicated unaware of any formal interventions implemented to prevent reoccurrence. LPN-C indicated R37 used the EZ-stand with the small sling after the incident, and stated the care plan did not reflect R37's sling size. LPN-C indicated the care plan was expected to indicate transfer specifics for residents to assist staff. On 4/20/23, at 8:58 a.m. physical therapist (PT)-G indicated R37 sustained an injury when her arm bumped the doorframe during a transfer. PT-G indicated therapy looked at options for padding at the doorway, and have not been able to find anything to stay in door way, and assisted with R37's positioning in EZ-stand and alignment. PT-G indicated education with nursing about slowing down with transfer or use the commode to eliminate the reoccurrence of injury, however R37 preferred to use the bathroom to toilet. Policy titled Mechanical Lifts dated 3/18, indicated: 7. All adverse events involving a mechanical lift will have a root cause analysis completed and reported on at the QA&A/QAPI meeting. Incident Report Guide dated 12/11, indicated Injury-no fall -complete incident report P&P -Place on 24 hour report. - Complete appropriate assessments. -Witnessed-obtain witness statements. -If significant injury.-(fracture, laceration, large	F 689		

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F 689	Continued From page 25 hematoma etc.) Investigation must occur per protocol. -Immediate notification NHA, DON, Social services notification per facility protocol. If her physical injuries sustained which could not be explained. Report filed with state agencies per protocol. ,	F 689		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal	F 690		5/29/23

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F 690	Continued From page 26 incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure appropriate treatment and services for a Foley catheter for 1 of 1 resident (R9) reviewed for catheter cares. Findings include: R9's face sheet, printed 4/20/23, included diagnosis of benign prostatic hyperplasia (swelling) with lower urinary tract symptoms). R9's significant change Minimum Data Set (MDS) assessment dated 4/3/23, indicated R9 had intact cognition, required extensive assistance with activities of daily living. The MDS indicated R9 had a Foley catheter. R9's care plan dated 3/28/23, identified R9 had a indwelling Foley catheter with interventions including keep catheter tubing free of kinks, keep drainage bag below bladder level, maintain a closed catheter drainage system, and monitor patency of catheter. During an observation on 4/18/23, at 7:45 a.m. R9 was lying in bed asleep. Catheter bag was lying on the floor next to the bed. During interview on 4/18/23, at 8:18 a.m. nursing assistant (NA)-C, indicated she wasn't aware the catheter bag was lying on the floor and added	F 690	R9's catheter bag was immediately removed from the floor and hangs on proper location on bed, recliner or wheelchair placed below kidney level . All other residents with catheters were audited to assure the catheter bags were not on the floor. Policy was reviewed and remains current. Re-education was immediately provided to the employee involved. Re-education will be provided to all nursing staff regarding proper placement of catheter bag when resident is in bed, WC, or recliner to provide a dignified atmosphere for all residents, infection control and resident safety. Audits of catheter placement according to procedure will be completed 3x/wk for 2 wks, 2x/wk for 2 wks, 1x/wk for 2 wks, monthly until QAPI Team proves resolution. DON or designee is responsible for compliance	

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F 690	Continued From page 27 night shift must have done that. NA-C indicated she always hooks the catheter bag to the bed and had not noticed it was on the floor this morning. During observation on 4/19/23, at 1:34 p.m. R9 was asleep in his chair next to his bed. The catheter bag was lying on the floor next to the chair. During interview on 4/19/23, at 2:00 p.m. licensed practical nurse (LPN)-A indicated catheter bags should not be on the floor and entered R9's room and hooked the catheter bag under the chair off the floor. During interview on 4/19/23, at 3:50 p.m. assistant director of nursing (ADON), indicated catheter bags should not be laying on the floor due to increase risk of infection. The ADON indicated staff should know better. During interview on 4/20/23, at 8:11 a.m. the director of nursing confirmed catheter bags should not be laying on the floor. If no hook is present on the catheter bag, then it should be put in a wash basin so it isn't on the floor. The DON added that is the standard of nursing practice. Facility policy and procedure titled Indwelling urinary catheter (Foley) Care and Management from Lippincott Procedures, dated 11/28/22 included: - Keep the drainage bag below the level of the patient's bladder to prevent backflow of urine into the bladder, which increases the risk of catheter associate urinary tract infection (CAUTI). However, don't place the drainage bag on the floor to reduce the risk of contamination and subsequent CAUTI.	F 690		

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F 849 SS=D	Hospice Services CFR(s): 483.70(o)(1)-(4) §483.70(o) Hospice services. §483.70(o)(1) A long-term care (LTC) facility may do either of the following: (i) Arrange for the provision of hospice services through an agreement with one or more Medicare-certified hospices. (ii) Not arrange for the provision of hospice services at the facility through an agreement with a Medicare-certified hospice and assist the resident in transferring to a facility that will arrange for the provision of hospice services when a resident requests a transfer. §483.70(o)(2) If hospice care is furnished in an LTC facility through an agreement as specified in paragraph (o)(1)(i) of this section with a hospice, the LTC facility must meet the following requirements: (i) Ensure that the hospice services meet professional standards and principles that apply to individuals providing services in the facility, and to the timeliness of the services. (ii) Have a written agreement with the hospice that is signed by an authorized representative of the hospice and an authorized representative of the LTC facility before hospice care is furnished to any resident. The written agreement must set out at least the following: (A) The services the hospice will provide. (B) The hospice's responsibilities for determining the appropriate hospice plan of care as specified in §418.112 (d) of this chapter. (C) The services the LTC facility will continue to provide based on each resident's plan of care. (D) A communication process, including how the communication will be documented between the LTC facility and the hospice provider, to ensure	F 849		6/7/23

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F 849	Continued From page 29 that the needs of the resident are addressed and met 24 hours per day. (E) A provision that the LTC facility immediately notifies the hospice about the following: (1) A significant change in the resident's physical, mental, social, or emotional status. (2) Clinical complications that suggest a need to alter the plan of care. (3) A need to transfer the resident from the facility for any condition. (4) The resident's death. (F) A provision stating that the hospice assumes responsibility for determining the appropriate course of hospice care, including the determination to change the level of services provided. (G) An agreement that it is the LTC facility's responsibility to furnish 24-hour room and board care, meet the resident's personal care and nursing needs in coordination with the hospice representative, and ensure that the level of care provided is appropriately based on the individual resident's needs. (H) A delineation of the hospice's responsibilities, including but not limited to, providing medical direction and management of the patient; nursing; counseling (including spiritual, dietary, and bereavement); social work; providing medical supplies, durable medical equipment, and drugs necessary for the palliation of pain and symptoms associated with the terminal illness and related conditions; and all other hospice services that are necessary for the care of the resident's terminal illness and related conditions. (I) A provision that when the LTC facility personnel are responsible for the administration of prescribed therapies, including those therapies determined appropriate by the hospice and	F 849		

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F 849	Continued From page 30 delineated in the hospice plan of care, the LTC facility personnel may administer the therapies where permitted by State law and as specified by the LTC facility. (J) A provision stating that the LTC facility must report all alleged violations involving mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property by hospice personnel, to the hospice administrator immediately when the LTC facility becomes aware of the alleged violation. (K) A delineation of the responsibilities of the hospice and the LTC facility to provide bereavement services to LTC facility staff. §483.70(o)(3) Each LTC facility arranging for the provision of hospice care under a written agreement must designate a member of the facility's interdisciplinary team who is responsible for working with hospice representatives to coordinate care to the resident provided by the LTC facility staff and hospice staff. The interdisciplinary team member must have a clinical background, function within their State scope of practice act, and have the ability to assess the resident or have access to someone that has the skills and capabilities to assess the resident. The designated interdisciplinary team member is responsible for the following: (i) Collaborating with hospice representatives and coordinating LTC facility staff participation in the hospice care planning process for those residents receiving these services. (ii) Communicating with hospice representatives and other healthcare providers participating in the provision of care for the terminal illness, related	F 849		

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F 849	Continued From page 31 conditions, and other conditions, to ensure quality of care for the patient and family. (iii) Ensuring that the LTC facility communicates with the hospice medical director, the patient's attending physician, and other practitioners participating in the provision of care to the patient as needed to coordinate the hospice care with the medical care provided by other physicians. (iv) Obtaining the following information from the hospice: (A) The most recent hospice plan of care specific to each patient. (B) Hospice election form. (C) Physician certification and recertification of the terminal illness specific to each patient. (D) Names and contact information for hospice personnel involved in hospice care of each patient. (E) Instructions on how to access the hospice's 24-hour on-call system. (F) Hospice medication information specific to each patient. (G) Hospice physician and attending physician (if any) orders specific to each patient. (v) Ensuring that the LTC facility staff provides orientation in the policies and procedures of the facility, including patient rights, appropriate forms, and record keeping requirements, to hospice staff furnishing care to LTC residents. §483.70(o)(4) Each LTC facility providing hospice care under a written agreement must ensure that each resident's written plan of care includes both the most recent hospice plan of care and a description of the services furnished by the LTC facility to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, as required at §483.24.	F 849		

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F 849	Continued From page 32 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to coordinate services between the facility and the hospice agency to ensure coordination of care for 1 of 1 resident (R25) reviewed for hospice care. Findings include: R25's face sheet printed on 4/20/23, included diagnosis of cerebral infraction (stroke). R25's admission Minimum Data Set (MDS) assessment dated 3/6/23, indicated R25 was cognitively intact and required limited assistance of one staff for most activities of daily living (ADL's). R25's physician order dated 4/6/23, indicated a referral to hospice. R25's care plan with revised date of 4/11/23, indicated R25 was at end stage of life and utilizing hospice services. Intervention included to coordinate care with hospice. Further, the care plan indicated R25 had a terminal diagnosis of acute CVA (cerebral vascular accident) with less than six month terminal diagnosis. Interventions included: "hospice patient -- see hospice care plan." During an interview and observation on 4/17/23, at 1:17 p.m., R25 was sitting in a chair in her room, well groomed and alert. When asked if she was receiving hospice services, R25 replied, I think I have that kind of insurance; I don't know if it pays well though. Further questioning revealed R25 did not realize she had been receiving care	F 849	R25 - Immediately informed hospice nursing of need for coordination of Care Documentation Only one resident is currently on Hospice services. As other residents may require these services the hospice nurse and facility nurse will establish the mutual coordination of care and communication and document in the hospice binder and scan into resident chart. Policy reviewed and remains current. Change of process to include Hospice nursing will add progress notes for coordinating care and notes will be scanned into electronic medical record. Education to hospice nursing and facility nursing provided. Education to facility nursing about coordinating hospice care has been provided Audits of Hospice care plans and progress notes will be completed 3x/wk for 2 wks, 2x/wk for 2 wks, 1x/wk for 2 wks, monthly until QAPI Team proves resolution. DON or designee is responsible for compliance	

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F 849	Continued From page 33 from a hospice agency. During interview and record review on 4/19/23, at 1:03 p.m., while in the nurses station looking through the hospice binder for R25 and not seeing a hospice plan of care, the health unit coordinator (HUC) stated they had not received a hospice care plan yet for R25 who had been enrolled in hospice 12 days ago. When asked where to find hospice nurses notes, the HUC provided a hard copy of R25's hospice nurses notes dated 4/17/23, and stated she would be scanning it into the EMR (electronic medical record). The HUC stated that was the only hospice nurses note that had to be scanned for R25. During an interview on 4/19/23, at 4:24 p.m., the director of nursing (DON) was asked for R25's hospice plan of care. The DON provided a copy of R25's POLST (physician orders for life-sustaining treatment), hospice acknowledgement of services and medicare notice, plus other non-clinical documents, but not the hospice plan of care. When informed these documents did not include the hospice plan of care, the DON stated that was all she could find. During an interview on 4/20/23, at 10:09 a.m., when asked where to find R25's hospice plan of care and hospice nurses notes, licensed practical nurse (LPN)-C looked at progress notes in the EMR. Not finding any hospice nurses notes, LPN-C stated she did not know where hospice agency documented their notes. Regarding the hospice care plan, LPN-C stated that would be in the hospice binder at the "charge desk" (nurses station).	F 849		

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F 849	Continued From page 34 During an interview on 4/20/23, at 10:19 a.m., the DON was informed there was no hospice care plan or hospice nurses notes for R25, except for one nurses note dated 4/17/23. The DON admitted the facility did not have either and would need to contact the hospice agency to get them. The DON acknowledged hospice nurses notes and hospice plan of care were important for communication between the hospice agency and the facility and for continuation of care for R25. During an interview on 4/20/23, at 1:03 p.m., the assistant director of nurses (ADON) stated R25's hospice nurses notes were emailed to her by the hospice agency. When she received one, she printed it and gave it to the HUC. The notes were first reviewed by the charge nurse, then given to the HUC to be scanned into the EMR. The ADON looked through her emails and did not locate additional hospice nurses notes for R25. During an interview and observation on 4/20/23, at 1:08 p.m., the HUC again confirmed the only hospice nurses notes waiting to be scanned was a hospice nurse visit from 4/17/23. During a telephone interview on 4/20/23, at 1:26 p.m., hospice agency receptionist (HAR) stated R25 had been seen by a nurse on 4/7, 4/8, 4/11, and 4/17/23. HAR did not know how hospice nurses notes were provided to this facility, adding it varied by facility. Facility policy titled Hospice Policy and Procedure, with revised dated of 8/2013, indicated when a resident was enrolled in hospice, the nursing home would establish a coordinated plan of care. The facility would work with the hospice team in integrating the hospice	F 849		

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F 849	Continued From page 35 practice for medical records, including documentation of visits. The facility care plan would include the most recent hospice care plan.	F 849		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be	F 880		6/7/23

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F 880	Continued From page 36 reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure facility-wide infection prevention and control program (IPCP) policies and procedures were reviewed at least annually. In addition, staff failed to properly transport soiled linen. This had the potential to	F 880	No residents were directly affected for improper linen transporting of soiled linens. All residents could be at risk for infection control concerns. Policy Reviewed and remains current.	

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F 880	Continued From page 37 impact all 49 residents residing in the facility. Findings include: Infection Prevention and Control Program Upon entrance on 4/17/23, infection prevention and control program standards, policies and procedures were requested in writing and was informed these policies and procedures were in the survey-readiness binder. The survey readiness binder had multiple individual policies, including surveillance program, antibiotic stewardship, Covid-19 immunization policy, and influenza vaccine program. However, there was no policy addressing the facility-wide infection prevention and control program. Furthermore, the policies provided had not been updated annually, with most dated 2019, or 2021. During an interview on 4/18/23, at 10:30 a.m., the director of nursing (DON) was asked for the policy addressing the facility-wide infection prevention and control program. The DON stated the infection prevention and control program policies and procedures were all online and provided a six-page index titled Infection Prevention and Control Manual, dated 2020. During an interview on 4/20/23, at 11:31 a.m., the facility corporate nurse consult was asked to provide evidence that the corporate infection prevention and control polices and procedures were updated annually. On 4/20/2023, at 2:02 p.m. via email, the corporate nurse consult provided a document with "Pathway Health" letterhead and titled "Preface - Infection Prevention and Control	F 880	All infection control policies will be reviewed annually for current compliance. Changes to the policies may be updated within the annual timeline. Evidence of this review will be maintained within the QAPI program Immediate education was provided to the employee involved for linen transport. Re-education will be provided to all nursing staff. Audits of linen transport will be completed 3x/wk for 2 wks, 2x/wk for 2 wks, 1x/wk for 2 wks, monthly until QAPI Team proves resolution. DON or designee is responsible for compliance	

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F 880	Continued From page 38 Manual 2020." The document indicated in part: In health care, the only constant is change. Staying on top of the most recent Infection Prevention and Control material is a never-ending job. The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections." In addition, page three of the document indicated: "This manual was written based on the most recent federal regulatory requirements (OSHA [Occupational Safety and Health Administration], CMS [Centers for Medicare & Medicaid Services]), and the most recent Best Practice Guidelines written by various organizations, such as the Center for Disease Control (CDC), and the National Institute for Occupational Safety and Health (NIOSH). When implementing this manual, make certain that your organization meets state and local regulatory requirements. Check with state specific infection control requirements and with regional Department of Public Health entities. Be sure to update policies and procedures as it relates to any new/updated guidance from CDC, OSHA, CMS and State/Local resources. This manual is intended to be a resource for quality assurance purposes only." The document did not indicate it would be or was updated annually. The facility assessment dated 12/8/22, indicated the facility utilized the Pathway Health Services, Infection Prevention and Control manual as the main infection prevention and control resource. Laundry On 4/18/23, at 7:12 a.m. nursing assistant (NA)-B	F 880		

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F 880	Continued From page 39 was observed to exit R42's room and used ungloved hands and carried unbagged soiled linen against her clothing. NA-B carried unbagged dirty linens through the memory care resident hallway, and a white cloth dropped on the hallway floor. NA-B picked the dirty wash cloth with a bare hand. NA-B when interviewed stated dirty laundry was expected bagged prior to the exit of a resident's room and transported bagged in the hallways. The memory unit dirty linen utility room was observed with NA-B and compartments for the linen were observed with unbagged linen. NA-B indicated the linen was expected bagged prior to placing in the compartments and confirmed she did not follow the procedure for transportation of dirty linen. On 4/20/23, at 9:37 a.m. during an interview assistant director of nursing (ADON) indicated awareness staff carrying soiled laundry unbagged in the facility and stated staff were expected to bag laundry prior to the removal from a resident's room. ADON indicated she had provided staff on various occasions education on the transportation of soiled laundry expectations. Facility policy titled Infection Prevention and Control Manual Environmental Services/Housekeeping Laundry Handling Lines to Prevent and Control Infection, dated 2020, indicated: Purpose: All potentially contaminated lined to be handled with appropriate measures to prevent cross transmission. 4. Soiled laundry/linen should be bagged or contained where collected. 5. Carry soiled linen away from/body/uniform to	F 880		

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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 880	Continued From page 40 prevent self-contamination. 6. Do not place soiled linen on furniture, floor, or other surfaces.	F 880		
F 919 SS=D	Resident Call System CFR(s): 483.90(g)(1)(2) §483.90(g) Resident Call System The facility must be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area from- §483.90(g)(1) Each resident's bedside; and §483.90(g)(2) Toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure resident bathroom call light cords were within reach from the bathroom floor for 3 of 3 residents (R25, R11, R14), reviewed for call lights. Findings include: R25 R25's admission Minimum Data Set (MDS) assessment dated 3/6/23, included diagnosis of cerebral infarction (stroke). R25 was cognitively intact and required limited assistance of one staff for walking and toileting. During an observation on 4/17/23, at 12:53 p.m., observed the end of the call light cord in R25's bathroom (which was shared by three other female residents), approximately 18 inches off the floor.	F 919	The call light cords listed have been replaced with a cord that is within 6 inches from the ground. All other resident cords have been audited and replaced as necessary. All resident call light cords are monitored by the preventative maintenance program as stated by the Maintenance director. The length of the call cord has been added to this monthly audit. The call cords will be audited monthly or as needed per the preventative maintenance program by the Director of Environmental Services or designee. Results shall be reported to the facility QAPI meeting for review and further action. Maintenance Supervisor or designee are responsible for compliance.	5/29/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245225	A. BUILDING _____ B. WING _____	C 04/20/2023

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SLEEPY EYE CARE CENTER	1105 3RD AVENUE SOUTHWEST SLEEPY EYE, MN 56085

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F 919	Continued From page 41 During an observation on 4/17/23, at 12:59 p.m., a staff member was observed assisting R25 to the bathroom and then left the room. R25 was observed on the toilet by herself. R11 R11's quarterly MDS assessment dated 3/24/23, included diagnosis of epilepsy (a disorder causing seizures). R11 was cognitively intact and required supervision of one staff for set-up help when walking and toileting. During an observation on 4/17/23, at 10:30 a.m., observed the end of the call light cord in R11's bathroom appropriately two feet from the floor. During an interview and observation on 4/19/23, at 12:44 p.m., R11 was walking in her room by herself, with the aide of a cane. R11 stated she used the bathroom independently. R14 R14's significant change MDS assessment dated 3/21/23, included diagnoses of acute and chronic respiratory failure and morbid (severe) obesity. R14 was cognitively intact and required extensive assistance of one staff for walking and toileting. During an observation on 4/17/23, at 2:29 p.m., observed the end of the call light cord in R14's bathroom approximately 18 inches from the floor. During an observation on 4/18/23, at 8:14 a.m., observed a staff member ambulate R14 to the bathroom and leave the room. During an interview and observation on 4/18/23, at 12:39 p.m., the administrator stated he was not aware call light cords in resident bathrooms	F 919		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245225	A. BUILDING _____ B. WING _____	C 04/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SLEEPY EYE CARE CENTER	1105 3RD AVENUE SOUTHWEST SLEEPY EYE, MN 56085

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F 919	Continued From page 42 needed to extend to the floor to be accessible to a resident lying on the floor. Together went to R25, R11 and R14's bathrooms to observe the length of the call cord lengths. The administrator agreed residents would not be able to reach them if lying on the floor, and stated he would ask maintenance to address it. During an interview and observation on 4/18/23, at 12:50 p.m. in R11's room, the maintenance director measured the call cord at 23 inches from the floor. The other two bathrooms were occupied. During an interview on 4/18/23, at 1:36 p.m., the maintenance director reported the end of the call light cord in R14's room was 19 inches from the floor, and in R25's room was 14 inches from the floor. The maintenance director stated he had already changed the call light cords and would add it to routine maintenance audits to ensure sustained compliance. Facility policy regarding resident call lights was requested and a one page document titled Logbook Documentation, dated 3/24/23, was received. The document listed instructions how to conduct a nurse call system test. Instructions included: check call cords in bathrooms and shower rooms. Ensure call cord length is no more than six inches from the floor. Repair as necessary.	F 919		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245225	A. BUILDING **01 - SLEEPY EYE CARE CENTER** B. WING _____	**04/19/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SLEEPY EYE CARE CENTER	**1105 3RD AVENUE SOUTHWEST SLEEPY EYE, MN 56085**

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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 04/19/2023. At the time of this survey, Sleepy Eye Care Center was found 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, the Health Care Facilities Code. Sleepy Eye Care Center was constructed in 1972 and was determined to be of Type II(000) construction. In 1985, addition was constructed and was determined to be of Type II(000) construction. There are 3 smoke compartments with smoke detectors in the corridors and spaces open to the corridors with automatic fire department notification. There is a complete fire sprinkler sytem in all areas of the building. The facility has a capacity of 61 beds and had a census of 46 at time of the survey. The requirements at 42 CFR, Subpart 483.70(a), are MET.	K 000		

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

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.

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
June 28, 2023

Administrator
Sleepy Eye Care Center
1105 3rd Avenue Southwest
Sleepy Eye, MN 56085

RE: CCN: 245225
Cycle Start Date: April 20, 2023

Dear Administrator:

On June 23, 2023, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

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