DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
March 5, 2024

Administrator
The Villas At New Brighton
825 First Avenue Northwest
New Brighton, MN 55112

RE: CCN: 245164
Cycle Start Date: January 11, 2024

Dear Administrator:

On February 21, 2024, the Minnesota Departments of Health and Public Safety, completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

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

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

March 5, 2024

Administrator
The Villas At New Brighton
825 First Avenue Northwest
New Brighton, MN 55112

Re: Reinspection Results
Event ID: P99U12

Dear Administrator:

On February 21, 2024 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on January 11, 2024. At this time these correction orders were found corrected.

Please feel free to call me with any 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

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
January 19, 2024

Administrator
The Villas At New Brighton
825 First Avenue Northwest
New Brighton, MN 55112

RE: CCN: 245164
Cycle Start Date: January 11, 2024

Dear Administrator:

On January 11, 2024, 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 a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Renee McClellan, Unit Supervisor
Metro A District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: renee.mcclellan@state.mn.us
Office: 651-201-4391 Mobile: 651-328-9282

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

If substantial compliance has been achieved, certification of your facility in the Medicare and/or

Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

If substantial compliance with the regulations is not verified by April 11, 2024 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by July 11, 2024 (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:

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

Feel free to contact me if you have questions.

Sincerely,

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245164	A. BUILDING _____ B. WING _____	C 01/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VILLAS AT NEW BRIGHTON	825 FIRST AVENUE NORTHWEST NEW BRIGHTON, MN 55112

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments On 1/8/24 - 1/11/24, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73 was conducted during a standard recertification survey. The facility was in compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On 1/8/24 - 1/11/24, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was not in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed with no deficiencies cited: H51648550C (MN94824), H51648551C (MN94822), H51648552C (MN99387), and H51648642C (MN99389). The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F 000		
F 554	Resident Self-Admin Meds-Clinically Approp	F 554		2/15/24

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

Electronically Signed | 01/28/2024

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

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F 554 SS=D	Continued From page 1 CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to assess residents for the ability to self administer medications (SAM) for 2 of 2 residents (R42, R79) with medications noted at bedside. R42's admission MDS dated 12/21/23, identified intact cognition and diagnoses of type two diabetes with kidney complications, depression, and cataracts, glaucoma, or macular degeneration. R42 required partial to moderate assistance with eating. R42's care plan dated 12/18/23, lacked a focus area for SAM. R42's order summary and assessments dated 1/8/24, lacked direction related to SAM. During an observation and interview on 1/8/24 at 3:45 p.m., R42 was in bed. There was a half-full 8 ounce bottle of Pepto-Bismol on his bedside table, without a pharmacy label. R42 stated he could take the Pepto-Bismol any time he wanted to, and usually took "a swig" a few times per day for nausea. During an observation on 1/8/24 at 4:07 p.m., nursing assistant (NA)-D and NA-E entered R42's room to assist with cares. At 4:15 p.m. NA-D and NA-E exited the room. R42's Pepto-Bismol	F 554	1. Immediate Corrective Action: R 42 and R 79 had SAMS assessment completed which determined they were safe to self-administer. Orders were received from MD to self-administer medication, and care plan was updated. 2. How did we identify others: A full house audit completed to identify those who self-administer medications. 3. Corrective Action as it applies to others: SAMS assessment completed, orders received from MD to self-administer medications and care plan updated for those identified and shown to be safe to self-administer. 4. Recurrence will be prevented by (process changes and educations): Reviewed Self administration of medications policy and no changes needed. Began education with all staff on SAMS policy beginning 1/30. All staff educated to notify nurse if they see medications in a resident room. Licensed nurses educated regarding not leaving medications in resident room without orders. Licensed nurses educated to process to complete when resident wishes to self-administer medications.	

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F 554	Continued From page 2 remained on the bedside table. During an interview on 1/8/24 at 6:57 p.m., NA-E stated if medications were found in a resident's room the NA's should let the nurse know, so they can find out what the medication is or make sure the resident can take it. NA-E stated she saw the bottle of Pepto-Bismol in R42's room, but since she didn't know him she had not checked with the nurse whether or not it was okay. NA-E stated in hindsight R42 probably should not have had medications stored in his room. During an interview on 1/8/24 at 6:58 p.m., licensed practical nurse (LPN)-C observed the Pepto-Bismol in R42's room. LPN-C reviewed R42's medical record and stated a SAM assessment had not been completed first and should have been. During an interview on 1/9/24 at 2:49 p.m., registered nurse (RN)-E stated medications should not be stored in resident rooms or left with residents without a completed SAM assessment first. R79's admission Minimum Data Set (MDS) dated 11/12/23, indicated R79 had intact cognition and diagnoses of type two diabetes, atherosclerotic heart disease (plaque build up in the arteries in the heart) and cardiomyopathy (difficulty pumping blood to the rest of the body). It further indicated he was dependent on staff for activities of daily living (ADL) and mobility.	F 554	Clinical leaders were educated to care planning self-administration and process for reviewing self-administration per ARD schedule. 5. Audits and who they will be monitored by: Audits to be completed for 9 residents weekly x4 weeks to ensure SAMS policy is followed. The result of these audits will be shared with facility QAPI committee for input on need to increase, decrease, or discontinue audits. DON/designee to complete audits.	

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F 554	Continued From page 3 R79's physician's orders lacked an order to SAM. R79's medical record lacked an assessment to SAM. During observation on 1/8/24 at 12:25 p.m., R79 was laying in bed and there was a medication cup with four unidentified pills on the night stand next to him. During observation and interview on 1/8/24 at 12:52 p.m., registered nurse (RN)-C verified R79 had medications on the nightstand in his room and stated he did not have a doctor's order to be able to keep medications at the bedside and had not been assessed to administer his own medications. During an interview on 01/09/24 at 9:28 a.m., RN-A stated in order for a resident to be able to self administer their own medications they need a doctor's order and an assessment. RN-A further stated if the resident didn't have an order and hadn't been assessed the nurse should not leave their medications at bedside. During an interview on 1/9/24 at 9:30 a.m., RN-B stated in order for a resident to be able to self administer their own medications they need a doctor's order and an assessment. RN-A further stated if the resident didn't have an order and hadn't been assessed the nurse should not leave their medications at bedside. During an interview on 1/10/24 at 7:57 a.m., RN-D stated residents need to have a doctor's order to be able to administer their own medications and if they don't have an order, the nurse was expected to stay in the room until the	F 554		

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F 554	Continued From page 4 resident had taken their medications. During interview on 01/10/24 at 9:19 a.m., the director of nursing (DON) stated a SAM assessment should be done by nursing within a few days of admission and then quarterly thereafter. The DON further stated medications should not be left in the resident's rooms unless they've been assessed for the ability to safely do so. If the resident wanted to SAM, nursing would be responsible for assessing them and then notifying the provider to get a doctor's order. The facility's policy on self administration of medication dated 5/22, identified in order to maintain the resident's high level of independence, residents who desire to SAM are permitted to do so if the facility's interdisciplinary team has determined that the practice would be safe for the resident and other residents of the facility, and there is a prescribers' order to self administer.	F 554		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the	F 584		2/15/24

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F 584	Continued From page 5 physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a clean and comfortable environment as well as failed to ensure a tube feeding pole and tracheostomy supplies cart was cleaned and in sanitary condition for 1 of 1 residents (R54) reviewed for homelike environment. Findings include: R54's annual Minimum Data Set (MDS) dated	F 584	1. Immediate Corrective Action: R54 room was cleaned to include tube feeding pole, floor, and tracheostomy supply cart. 2. How did we identify others: A full house audit completed to identify areas needing cleaning. 3. Corrective Action as it applies to others: Areas identified needing cleaning were cleaned.	

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F 584	Continued From page 6 12/25/23, indicated R54 was in a persistent vegetative state, had impairment on both sides of his upper and lower extremities, and was dependent on staff for all activities of daily living (ADLs). Additionally, MDS indicated R54 received 51% or more of his total calories and average fluid intake through tube feeding. R54's diagnoses included brain damage from lack of oxygen, aphasia (language disorder affecting the ability to communicate), gastrostomy (a surgically inserted tube through his abdomen into the stomach for nutrition), and tracheostomy (a surgically inserted hole into his windpipe that provided an alternative airway for breathing). R54's treatment administration record (TAR) included the following: - Clean tube feeding pole every night shift, dated 6/9/23. R54's care plan dated 12/31/21, indicated he was non-verbal and unable to make his needs known. Furthermore, R54's care plan indicated his goal was to have his needs anticipated by staff. During observation on 1/8/24 at 12:50 p.m., R54 was sitting up in his wheelchair. R54's tube feeding pole had dried tan-to-light brown colored substances covering two of the four legs of the pole. The tube feeding pump was running and at his side with a bottle hanging above the pump with tan-colored liquid formula in it. Under the head of the bed was a round, dried substance of tan-to-light brown in color that was approximately 4-inches x 7 inches. The call light cord had dried substance throughout the length of the cord of tan-to-light brown color. The tracheostomy supplies cart in the room had dried substances on the side that faced the tube feeding pole that	F 584	4. Recurrence will be prevented by (process changes and educations): Reviewed cleaning policy and no changes needed. Began training of housekeeping staff on 1/30 of cleaning expectations. Nursing, recreation, administration, and social services education began on 1/30 to notify housekeeping staff of cleaning concerns. 5. Audits and who they will be monitored by: Audits of one resident room on each unit will be completed 5 days per week x 4 weeks. The result of these audits will be shared with facility QAPI committee for input on need to increase, decrease, or discontinue audits. Housekeeping Supervisor/designee to complete audits.	

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F 584	Continued From page 7	F 584		

were tan-to-brown in color and were splattered and round and dripped down the side of the cart. There were round, dried substances of similar brown colors to the top of the supplies cart. There were dried, dark tan substances underneath the hand sanitizer dispenser that spanned from the dispenser to the floor. Additionally, on the bathroom door, there were approximately 75 light-pink, dried, splattered substances all about a 1/4 inch in diameter. On the wall next to the bathroom, there were about 24 areas of light-pink dried substances that varied from approximately 4 inches in length up to 2 feet.

Observation on 1/9/24 at 8:47 a.m., revealed the room condition remained unchanged.

Observation on 1/9/24 at 2:54 p.m., revealed the room condition remained unchanged.

On 1/101/24 between 7:07 a.m. and 7:30 a.m., respiratory therapist (RT)-C is observed providing tracheostomy cares for R54. He used the top of the supply cart to set-up his sterile field for a portion of the cares. The tan-to-light brown dried substances were present on the tube feed pole, floor, and supply cart. RT-C stated the dried substances on the pole and supplies cart were dried tube feed. RT-C stated whoever sees the spills would try to clean it up, but housekeeping should be doing that task. RT-C stated ideally whoever spilled the tube feed would clean it up right away due to how difficult it was to clean once dried.

During interview on 1/10/24 at 9:35 a.m., housekeeper (H)-A stated if there was a dirty spot in a room or someone reported one, it would be cleaned immediately. H-A entered R54's room

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F 584	Continued From page 8	F 584		

and stated the areas on the wall, floor, and bathroom door required a deep clean and to do that, H-A would wait for the resident to leave the room and use a cleanser and disinfectant. H-A stated these things are checked daily, but sometimes there is a fear to move the equipment, but stated a nurse could be asked to move it. The tube feed pole and supplies cart no longer had dried tan-to-light brown dried substances on them. H-A acknowledged the dried substances under the hand sanitizer dispenser and stated those were common under the dispensers from the sanitizer dripping down.

During observation on 1/10/24 at 9:57 a.m., the 4-inch x 7-inch dried substance under the head of the bed remained and the dried substances on the wall behind the head of the bed were present. The dried substances under the hand sanitizer dispenser were present.

During interview on 1/11/24 at 8:38 a.m., H-B stated housekeeping staff are trained to move equipment, such as tube feeding poles and beds, for room cleaning and if they are not comfortable doing so, they were instructed to contact someone who could assist them in moving the equipment.

During interview on 1/11/24 at 11:35 a.m., the interim director of nursing (DON) stated the expectation for room cleanliness was housekeeping would clean a spill or dirty room once they saw it or were made aware of it, and if a housekeeper was not comfortable moving equipment, they would be expected to ask a nurse or nurse manager to move it.

Facility policy titled Homelike Environment dated

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F 584	Continued From page 9 2/2021, stated the facility staff and management maximizes, the extent possible, the characteristics of the facility that reflect a personalized, homelike setting, including a clean, sanitary and orderly environment.	F 584		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record	F 657	1. Immediate Corrective Action: R 23	2/15/24

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F 657	Continued From page 10 review the facility failed to revise the comprehensive care plan for 1 of 5 residents (R23), reviewed for activities of daily living (ADL). In addition, the facility failed to ensure residents/resident representatives were allowed to participate in care planning for 2 of 5 (R23, R67) reviewed for ADLs. Findings include: R23's admission Minimum Data Set (MDS) dated 11/28/23, identified R23 had moderate cognitive impairment and had diagnoses which included: schizophrenia, chronic obstructive pulmonary disease (COPD) and respiratory failure. R23's MDS also identified R23 required supervision or touching assistance for upper and lower body dressing and set up assistance for personal hygiene. R23's Care Area Assessment (CAA) dated 12/6/23, identified R23 had some cognition issues, planned to return to her apartment where R23 lived alone. R23's CAA also identified R23 received physical therapy (PT) and occupational therapy (OT) per doctor of medicine (MD) order and was at risk for further decline in ADLs, isolation, complications of immobility and incontinent. R23's functional abilities, self-care, and mobility, would be addressed in care plan to minimize risks. R23's care plan dated 11/29/23, identified R23 was admitted to the facility 11/22/23, and had alteration in psychosocial well-being related to schizophrenia diagnosis. R23's care plan also identified R23 had self-care deficit, with goal that R23 would be dressed, groomed, and bathed per preference. R23's interventions included OT per	F 657	care planned ADL section was reviewed and revised to show the person-centered cares needed for that resident. R23 and R67 had a care conference set up and completed. 2. How did we identify others: Full house audit of the ADL section of all care plans. Full house audit of all residents last ARD to ensure care conference was completed. 3. Corrective Action as it applies to others: ADL sections of care plans were revised where found needed more focus on the resident□s person-centered care. Residents found to miss documentation of care conference from last ARD will be approached to set up a care conference to have scheduled within the next 3 weeks. 4. Recurrence will be prevented by: Social services have been educated to care conference scheduling and process for scheduling. IDT was educated to the care conference form. Clinical leaders were educated regarding care planning ADLs. 5. Audits and who they will be monitored by: 5 residents will be audited weekly to ensure ADLs in care plan are specific to resident needs. 5 residents will be audited weekly to ensure care conferences are set up per ARD and are documented. The result of these audits will be shared with facility QAPI committee for input on need to increase, decrease, or discontinue	

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F 657	Continued From page 11 MD order and follow OT instructions. Review of R23's electronic health record (EHR) lacked documentation of OT instructions to staff for R23's self-care deficit interventions. R23's EHR identified R23's admission MDS was completed on 11/28/23, but lacked documentation a care conference occurred which included R23 or R23's representative. On 1/9/24 at 8:41 a.m., an attempt of phone interview was made to R23's family member, but no answer. During interview on 1/10/24 at 9:41 a.m., licensed social worker (LSW)-B confirmed R23's EHR lacked documentation a care conference was completed. LSW-B stated the facility's usual process to complete care conferences based on the MDS schedule and to ask the residents if they wish to attend the conference. LSW-B stated care conferences were then documented in the residents' progress notes. During interview on 1/10/24 at 10:13 a.m., interim director of nursing (DON) confirmed R23's EHR lacked OT instructions, and R23's care plan lacked specific interventions related to self-care deficit. DON stated the facility recently made adjustments to assist the unit coordinator on the transitional care unit (TCU) due to amount of new admissions. DON stated they were in the process of reviewing care plans to assure accurate. DON confirmed R23's EHR lacked documentation of a care conference, and DON indicated care conferences were scheduled based on residents MDS assessment reference dates (ARD) at which time the residents' care plans were	F 657	audits. DON/designee to complete audits.	

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F 657	Continued From page 12 reviewed and adjusted as needed. DON then indicated it was expected to be documented in the residents' EHR. R67's quarterly Minimum Data Set (MDS) dated 10/6/23, indicated R67 was cognitively intact and had diagnoses of stroke with left-sided muscle weakness, anxiety, depression, history of substance use, and psychosis (mental disorder in which a person is disconnected from reality). R67's electronic health record (EHR) lacked documentation that a care conference was completed within the time frame of R67's quarterly MDS assessment for 10/6/23. During interview on 1/09/24 at 8:12 a.m., R67 indicated a desire to be more involved in the care planning process and wanted more information about what it would take to be discharged home. R67 stated she had not been invited to care conferences. During interview on 1/10/24 at 7:46 a.m., LSW-B reviewed R67's progress notes for record of a care conference for the MDS dated 10/6/23 and verified there had not been a formal meeting since September, but stated staff speak with R67's family and loved ones often. LSW-B stated the normal process for care conferences was to mail a notification to the resident's representative and leave a letter with the resident stating care conference details. During interview on 1/11/24 at 11:35 a.m., the interim director of nursing (DON) stated care conferences were scheduled based on the	F 657		

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F 657	Continued From page 13 assessment reference date (ARD), as needed for any significant change, or as a resident or family requested. The DON stated care conferences were important because of the communication between the facility's interdisciplinary team and the resident and their family. Additionally, the DON expected consistency in care planning and the care conference schedule if a resident moved from the facility's rehabilitation unit to their long-term care unit. The DON stated having frequent contact with a resident's family would not be the same as having a care conference. The DON reviewed R67's EHR for record of a care conference for the ARD of 10/6/23 and verified the EHR lacked documentation. The DON stated the expectation would be to document any attempts to schedule a care conference and reasons why it did not occur. The facility policy titled Care Planning dated 1/6/22, identified each resident would have a person-centered care plan developed by the interdisciplinary team (IDT) for the purpose of meeting the resident's individual medical, physical, psychosocial, and functional needs. The IDT, in conjunction with the resident and the resident representative, will develop and implement a comprehensive individualized care plan no later than the 21st day of admission of the resident. The care plan would be modified and updated as the condition and care needs of the resident changes. The policy lacked identification of residents and their representatives, if applicable, were routinely invited to participate in care planning.	F 657		
F 676 SS=D	Activities Daily Living (ADLs)/Mntn Abilities CFR(s): 483.24(a)(1)(b)(1)-(5)(i)-(iii)	F 676		2/15/24

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F 676	Continued From page 14 §483.24(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that: §483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section ... §483.24(b) Activities of daily living. The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living: §483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care, §483.24(b)(2) Mobility-transfer and ambulation, including walking, §483.24(b)(3) Elimination-toileting, §483.24(b)(4) Dining-eating, including meals and snacks, §483.24(b)(5) Communication, including (i) Speech, (ii) Language, (iii) Other functional communication systems. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document	F 676	1. Immediate Corrective Action: R23	

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F 676	Continued From page 15 review the facility failed to provide the services to maintain dressing and personal hygiene needs for 1 of 5 residents (R23) observed for activities of daily living (ADL's). Findings include: R23's admission Minimum Data Set (MDS) dated 11/28/23, identified R23 had moderate cognitive impairment and had diagnoses which included: schizophrenia, chronic obstructive pulmonary disease (COPD) and respiratory failure. R23's MDS also identified R23 required supervision or touching assistance for upper and lower body dressing and set up assistance for personal hygiene. R23's Care Area Assessment (CAA) dated 12/6/23, identified R23 had some cognition issues, planned to return to her apartment where R23 lived alone. R23's CAA also identified R23 received physical therapy (PT) and occupational therapy (OT) per doctor of medicine (MD) order and was at risk for further decline in ADLs, isolation, complications of immobility and incontinent. R23's functional abilities, self-care and mobility, would be addressed in care plan to minimize risks. R23's care plan dated 11/29/23, identified R23 was admitted to the facility 11/22/23, and had alteration in psychosocial well-being related to schizophrenia diagnosis. R23's care plan also identified R23 had self-care deficit, with goal that R23 would be dressed, groomed and bathed per preference. R23's interventions included OT per MD order and follow OT instructions. R23's care plan and electronic health record	F 676	was offered to have hair combed and face shaved and assistance with dressing. The care plan and care guide was updated with residents amount of assistance needed with these tasks and her preferences. 2. How did we identify others: Full house audit completed regarding hair care, shaving and dressing. 3. Corrective Action as it applies to others: Residents identified were assisted with dressing and had hair combed and shaving per preferences. Care plans and care guides were revised where needed to include amount of assistance needed and preferences regarding hair care and shaving and dressing. 4. Recurrence will be prevented by: Reviewed ADL policy and no changes needed. Education began with all nursing staff regarding assisting with hair care, shaving and dressing per care plan on 1/30. 5. Audits and who they will be monitored by: Audits to be completed for 9 residents weekly x4 weeks to ensure hair care, shaving and dressing is being completed per plan of care. The result of these audits will be shared with facility QAPI committee for input on need to increase, decrease or discontinue audits. DON/designee to complete audits.	

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F 676	Continued From page 16 (EHR) lacked OT instructions or reference to R23's preference related to facial hair. Review of R23's progress notes reviewed from 11/22/23 to 1/10/24, identified the following: -11/26/23 at 11:33 a.m. no mood indicators or behaviors observed. R23 required assist of one extensive for dressing, toileting, and shower. R23 compliant with cares. R23's progress notes lacked documentation of refusals of cares. During observation on 1/8/24 at 3:11 p.m., R23 was sitting on the edge of her bed. R23 had a large amount of white/gray facial hairs on her chin ¼ to ½ inch long. R23's hair was pulled back into a pony tail, with a large amount of hair on her right side hanging loose and sticking up in the air, with wisps of hair loose all around. R23 was dressed in a hospital gown, with a second gown on her back worn as a robe, and slipper socks. R23 indicated she did not have any clothes. R23 stated she needed assistance to get rid of facial hair, which she used to tweeze herself. R23 stated no one had offered to assist her to remove her facial hair and she did not like it. R23 also confirmed her hair was messy, as she touched the right side of her head. During observation on 1/9/24 at 9:52 a.m., R23's door was open, and R23 was lying on her right side in bed, facing the door, eyes closed. R23 continued to wear the hospital gown and was covered to her shoulders with bedding. During observation on 1/9/24 at 12:44 p.m., R23 was sitting on the edge of her bed, wearing the hospital gowns, and slipper socks. R23's hair	F 676		

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F 676	Continued From page 17	F 676		

remained uncombed with a large amount of hair on her right side hanging loose and sticking up in the air, with wisps of hair loose all around. R23's chin continued to have a large amount of white/gray facial hairs on her chin ¼ to ½ inch long. A staff member was in R23's room assisting her to open a bottle of pop, then left R23's room. R23 indicated her hair was uncombed, and no one had assisted her today with morning cares. R23 also indicated no one had offered to assist her to remove her facial hair then pointed to the cupboard by sink and stated I think there is a razor up there. R23 rubbed her hand across her chin and stated, "I do want them gone".

During interview on 1/9/24 at 1:02 p.m., nursing assistant (NA)-A indicated she had taken care of R23 that morning. NA-A stated she had given R23 her breakfast, and had asked her if she wanted to wipe her face, and R23 refused. NA-A stated she had not offered to assist R23 to comb her hair. NA-A confirmed R23 had facial hair on her chin, but was new to the facility and was not sure of their process for removing facial hair. NA-A stated her usual process would be to offer to assist the resident to remove the facial hair. NA-A indicated she had offered to dress R23, but R23 did not want to at that time. NA-A indicated she had not re-approached R23 to dress or assist her with personal hygiene again.

During interview on 1/9/24 at 2:05 p.m., licensed practical nurse (LPN)-A confirmed R23 had a large amount of facial hair on her chin. LPN-A asked R23 if she could remove her facial hair, and R23 responded yes, just be careful. LPN-A confirmed R23's hair was messy, but indicated R23 refused at times. LPN-A stated no one had

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informed her that R23 had refused cares that morning. LPN-A indicated she expected staff to inform her if a resident refused cares then she would attempt to complete the cares herself. LPN-A indicated she would assist R23 to remove her facial hair.

During interview on 1/9/24 at 2:40 p.m., NA-B stated her usual process to assist residents with morning cares included assisting them with washing, dressing, oral cares and combing their hair. NA-B stated facial hair was removed during resident's showers, or as needed. NA-B stated she had asked R23 two weeks ago if she could assist her with shaving, but R23 refused, so she reported it to the nurse. NA-B indicated she had not worked with R23 since then, except briefly today.

During interview on 1/9/24 at 3:01 p.m., unit coordinator LPN-B stated R23 was mostly independent with her ADLs. LPN-B stated she had shaven R23 about a month ago, but was not aware she now had facial hair present. LPN-B stated she would expect staff to offer to assist residents with ADLs, even if independent, if needed. LPN-B stated if a resident refused, she expected that to be reported. LPN-B indicated R23 required a lot of encouragement, and refused at times.

During interview on 1/10/24 at 7:07 a.m., NA-C indicated R23 could brush her own hair, but required set up and reminding. NA-C stated if R23's hair was messy, she would assist her to brush it. NA-C stated if a resident was not taking care of themselves, she would assist them as needed. NA-C indicated she did not notice R23 had facial hair on her chin, and stated she had

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F 676	Continued From page 19 never shaven R23. During interview on 1/10/24 at 10:30 a.m. interim director of nursing (DON) indicated she would expect staff to assist residents with ADLs as needed, and every resident required different amounts of assistance. DON indicated if a resident's hair was messy, she would expect staff to ask if they could assist them to comb it and if facial hair present to ask if wanted it removed. DON indicated if a resident refused assistance, she would expect staff to report it, re-approach, and document. DON stated offering to assist with ADLs was important for resident dignity. The facility policy titled Activities Of Daily Living (ADLs)/Maintain Abilities Policy dated 3/31/23, identified the facility would provide the necessary care and services to ensure that a resident's abilities in ADLs did not diminish unless circumstances of the individual's clinical condition demonstrated that such diminution was unavoidable. The policy further identified they would provide care and services for the following ADLs, which included hygiene, bathing, dressing, grooming, and oral care.	F 676		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide fingernail care to a dependent resident for 1 of 1 resident (R54)	F 677	1. Immediate Corrective Action: R 54 had fingernails trimmed	2/15/24

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F 677	Continued From page 20 reviewed for dependent activities of daily living (ADL) care. Findings include: R54's annual Minimum Data Set (MDS) dated 12/25/23, indicated R54 was in a persistent vegetative state and was dependent on staff for hygiene and grooming. R54's diagnoses included brain damage from lack of oxygen, contractures (fixed, tightening of muscles, tendons, and/or ligaments that prevent movement), and aphasia (language disorder affecting the ability to communicate). R54's Care Area Assessment (CAA) dated 12/25/23, triggered for alteration in skin integrity related to brain damage, immobility, and contractures. R54's Braden Scale Assessment dated 12/22/23, indicated R54 was at a high risk for developing pressure injuries in part, due to his very limited response to pain and his inability to communicate discomfort. R54's physician orders included the application of splints and stockinettes to both arms twice daily for contracture of muscle, and to remove twice daily for two hours for hygiene and skin care dated 11/20/23. R54's treatment administration record (TAR) dated 12/2023 and 1/2024, indicated R54 had completed weekly skin assessments every Wednesday evening shift. R54's care plan, dated 1/1/22, indicated R54 required total staff assistance with personal	F 677	2. How did we identify others: Full house audit completed to view residents finger nails to identify those with long finger nails 3. Corrective Action as it applies to others: Nails were trimmed per preference. Care plans and care guides were revised where needed to include residents preferences regarding nail care 4. Recurrence will be prevented by (process changes and education): Reviewed ADL policy and no changes needed. Education began with all nursing staff in regards to nail care on 1/30 5. Audits and who they will be monitored by: Audits to be completed for 9 residents weekly x4 weeks to ensure nail care is being completed per plan of care. The result of these audits will be shared with facility QAPI committee for input on need to increase, decrease or discontinue audits. DON/designee to complete audits.	

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F 677	Continued From page 21	F 677		

hygiene care, including nails. Furthermore, R54's care plan indicated a risk for alteration in skin integrity related to contractures.

R54's weekly skin inspections dated 12/13/23 through 12/29/23, indicated fingernails were trimmed every inspection except on 12/29/23 when R54 refused.

During observation on 1/08/24 at 1:02 p.m., R54 was sitting up in his wheelchair with both arm splints on. He had long fingernails, approximately 0.25 inch to 0.5 inch in length, with one fingernail on the right hand that appeared to be approximately 1 inch long.

During observation on 1/10/24 at 10:04 a.m., R54's fingernails remained untrimmed and long. NA-B and NA-F entered room to provide hygiene cares. NAs washed his face and underarms before R54 began coughing. NAs covered R54 and raised the head of the bed for comfort. Cares were paused while respiratory therapy was at the bedside. NA-F stated nail care is normally done on bath day, but for R54, "he's a diabetic", so the nurses do their nail care.

During observation on 1/10/24 at 12:22 p.m., R54 is sitting up in his wheelchair and his fingernails appear trimmed.

During interview on 1/10/24 at 10:22 a.m., NA-G stated nail cares are done on bath days or during cares as needed. For diabetic residents, the nurses will perform nail care. NA-G stated the care plan or care sheets indicate which residents are diabetic. NA-G further stated pertinent information is relayed through change of shift report as well as on the computer charting.

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F 677	Continued From page 22 During interview on 1/10/24 at 12:24 p.m., RN-D verified that R54 is not diabetic, and the NAs have care sheets that list which residents are diabetic. Additionally, RN-D stated staff have daily report where they are kept updated on residents' conditions. During interview on 1/11/2024 at 11:35 a.m., the interim director of nursing (DON) stated floor nurses supervised cares on the floor and managers performed spot-checks on things they saw to ensure staff were implementing care-planned interventions. The DON stated nail care was expected to be done on bath days and that information is on a weekly skin check form where nurses complete the task for diabetic residents and NAs complete nail care for non-diabetic residents. If staff are not able to complete nail care for a resident, NAs are expected to notify the charge nurse. The DON stated the nurse should either do the task themselves or chart on the refusal. The DON identified skin concerns for R54 related to long fingernails as "worry about his nails digging into his hands." Facility policy titled Activities of Daily Living (ADLs)/Maintain Abilities Policy dated 3/31/23, indicated a resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.	F 677		
F 697 SS=D	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is	F 697		2/15/24

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F 697	Continued From page 23 provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure pain management was provided in accordance with professional standards of practice for 1 of 1 resident (R21) reviewed for pain during wound care. Finding include: The undated, National Pressure Injury Advisory Panel (NPIAP) Pressure Injury Stages document defines a stage 2 pressure injury (pressure ulcer) as partial-thickness skin loss with exposed dermis (middle layer of skin). Fat was not visible and deeper tissues were not visible. Granulation tissue (new tissue and blood vessels that form on a healing wound), slough and eschar (dead tissue) were not present. A stage 4 pressure injury was defined as full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer. Slough and/or eschar may be visible. Epibole (rolled edges), undermining (when the tissue under the wound edges becomes eroded, resulting in a pocket beneath the skin at the wound ' s edge) and/or tunneling often occur. Depth varies by anatomical location. R21's admission Minimum Data Set (MDS) dated 12/13/23, identified intact cognition and diagnoses of respiratory failure, heart failure (HF), peripheral vascular disease (PVD/blood circulation disorder), and encounter for palliative	F 697	1. Immediate Corrective Action: R 21 is no longer a resident of the facility. 2. How did we identify others: All residents with wounds have potential to be affected, audit completed to identify all residents with wounds. 3. Corrective Action as it applies to others: All residents with wounds will be asked if they would like medication for pain prior to wound treatment and will be asked about their pain during wound treatments. 4. Recurrence will be prevented by: Pain policy has been reviewed and no changes needed. Began education with all licensed nurses 1/30 in regard to pain policy, offering pain medication prior to starting wound treatment and assessing pain during wound treatments. 5. Audits and who they will be monitored by: Audits to be completed for 9 residents with wounds weekly x4 weeks to ensure they were offered pain medication prior to wound treatment and that pain was assessed during treatment. The result of these audits will be shared with facility QAPI committee for input on need to increase, decrease, or discontinue audits. DON/designee to complete audits.	

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F 697	Continued From page 24 care. R21 required substantial/maximal assistance with bathing, lower body dressing and rolling left to right; partial/moderate assistance with upper body dressing and hygiene; and was totally depending on staff assistance for moving from sitting to lying position or lying to sitting on the bed. R21 had two stage 2 pressure ulcers and one stage 4 pressure ulcer present upon admission. R21 received scheduled and PRN (as needed) pain medications. R21 experienced pain frequently over the five day lookback period and reported the pain interfered with sleep, therapy, day to day activities and the worst pain level rating was 8 out of 10 (with 10 being the most intense pain imaginable). R21 also had a condition or chronic disease that may result in a life expectancy of less than six months. R21's Health Care Directive dated 10/8/20, identified he wanted appropriate pain medication to be used to assure comfort. R21's pain Care Area Assessment (CAA) dated 12/13/23, identified per pain interview R21 reported he had pain frequently, and received scheduled and PRN pain medications. Pain affected sleep, activities of daily living and was rated by R21 as 8 out of 10. R21 was at risk for uncontrolled pain, social isolation, and decline, and the CAA indicated to proceed to care plan with goal to have pain managed. R21's care plan dated 12/18/23 identified he had an alteration in comfort due to diagnosis of cervicalgia. R21's goal was to have adequate relief from pain as evidence by verbalization and freedom from non-verbal indicators of pain. Goals were to provide pain medication as ordered by the doctor and to provide non-medicinal	F 697		

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F 697	Continued From page 25 interventions such as positioning, rest, and massage. Pressure injuries were not identified as a contributing cause to pain. R21's care plan dated 12/18/23, identified he was at risk for alteration in skin integrity due to limited mobility, PVD, and HF. R21 was admitted with wounds. Interventions included treatment as ordered, assist to turn and reposition every two to three hours and PRN, pressure redistribution mattress to bed and wheelchair. R21 was followed by the wound care team. Measures for pain management of the wound were not identified. R21's physician orders identified the following start dates and wound care orders: - 12/21/23, wound care to coccyx area every day shift, cleanse wound with sound cleanser, pat dry and pack wound with calcium alginate and cover with a foam dressing - 12/19/23, wound care to left knee and upper spine wounds, every day shift and PRN, cover with foam dressing, cleanse and replace foams. R21's physician orders identified the following start dates and pain medications: - 1/4/24, buprenorphine sublingual (sl) tablet 8 milligrams (mg), give 1 tablet sl three times a day for pain - 1/4/24, hydromorphone oral liquid 1 mg/milliliter (ml), give 1 ml by mouth every 6 hours as needed for pain - 12/14/23, lidocaine external patch 4%, apply to affected area topically one time a day related to encounter for palliative care and remove per schedule - 12/13/23, baclofen oral tablet 10 mg, give 1 tablet by mouth as needed for muscle spasms	F 697		

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F 697	Continued From page 26 twice daily - 12/13/23, pregabalin oral capsule 150 mg, give 1 capsule by mouth two times a day related to cervicalgia - 12/13/23, acetaminophen oral tablet 500 mg, give 1,000 mg by mouth at bedtime for pain and give 1,000 mg by mouth every 24 hours as needed for pain in the morning R21's wound round notes with the advanced practice registered nurse (APRN) wound team identified the following: - 12/19/23, vital signs section pain rating 10/10, and procedural pain was 5/10 - 12/26/23, vital signs pain rating was 1/10 and procedure pain was 5/10. During both visits removal of excess slough from the coccyx wound with sharp debridement was performed with curette (scraping tool), scalpel, and/or scissors - 1/2/24, vital signs pain rating was 7/10 and procedure pain was not rated. No debridement was performed on 1/2/24. R21's nurse practitioner (NP) note dated 1/2/24, identified pressure ulcers were ongoing. R21 had called 911 to go to the hospital for surgery on the pressure ulcers, but the hospital declined to take him. R21 stated the area was painful. R21 was seen by wound care team today and refused to have bedside debridement. No orders for pain management were identified. R21's pain doctor note dated 1/4/24, identified R21 reported pain daily, on and off, mild to moderate at the coccyx area. Pain medications were adjusted but there was no mention of orders to pre-medicate before wound care. During an interview on 1/10/24 at 8:40 a.m.,	F 697		

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F 697	Continued From page 27 licensed practical nurse (LPN)-E stated she had not been in to assess R21's pain nor administer R21's morning medications yet. During an observation and interview on 1/10/24 at 8:45 a.m. through 9:10 a.m., the APRN and wound care management team, which included LPN-D entered R21's room for wound rounds. R21 was assisted to roll onto his right side. The APRN removed the dressings from R21's left leg stump, the mid-spine and coccyx pressure injury areas. R21's coccyx wound had visible muscle tissue in the open area and the wound had undermining around the edges. The removed dressing had a moderate mount of yellow and bloody drainage. Wounds were not measured on-site. The APRN began to perform sharp debridement of the coccyx wound removing slough. The APRN then packed the undermining area around the wound with calcium alginate strips. R21 moaned, grimaced, clenched his hands and began to yell ow, OW, OW during the debridement and packing which lasted approximately one minute. R21 was not assessed for pain prior to the wound care, nor during wound care. Surveyor asked LPN-D to ask R21's pain level. APRN asked R21 instead and and R21 stated pain was 10/10. The APRN stated he thought R21 got pain meds around the clock. LPN-D stated R21 was off hospice by personal choice now but continued to have scheduled and PRN pain medications. LPN-D reviewed R21's medication administration record (MAR) with surveyor and agreed no pain medications were given prior to wound care. According to the MAR, R21's last pain medications were given at 8:00 PM the previous night, 1/9/24. LPN-D stated R21 should have had his pain medications just prior to wound care and had not.	F 697		

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F 697	Continued From page 28 During a follow up interview on 1/10/24 at 9:15 a.m., LPN-E stated sometimes wound care providers came on Wednesday and sometimes on Tuesday. LPN-E stated if the providers wanted pain meds administered before wound care it would be explicitly ordered. LPN-E stated she would have given R21 his scheduled morning pain medications and/or PRN pain medications, because he has frequent pain, and if she knew the wound care providers were coming. During a follow up interview on 1/10/24 at 12:14 p.m., R21 stated he always had pain during wound care, especially in the coccyx area. R21 stated having pain medication beforehand helps reduce pain, however, the wound dressing were still painful. R21 stated an acceptable pain level would be around 3 or 4, and he could sleep at that level. R21 stated he wished he had pain medications before the sharp debridement and dressing change. R21 stated his pain was coming back now and rated it at a 9/10. R21 stated the nurse gave him hydromorphone a couple hours ago (after the dressing change) and he was waiting to talk to the doctor. During an interview on 1/10/24 at 12:39 p.m., registered nurse (RN)-D stated she had completed R21's wound care before. RN-D stated R21 usually tolerated the sound care well, with pain medication beforehand. RN-D stated R21 usually would whimper or whine during the dressing change on the coccyx, because it was so deep and required packing. RN-D stated residents should be assessed for pain prior to wound care and during. Pain	F 697		

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F 697	Continued From page 29 During an interview on 1/11/24 at 9:55 a.m. the interim director of nursing (DON) stated residents should be assessed prior to wound care for pain so medications could be provided if needed. The facility's undated policy titled Pain Management Protocol, identified nursing staff would identify any situations or interventions where an increase in the resident's pain may be anticipated; for example, wound care or repositioning. With input from the resident and/or resident representative, the provider and staff will establish goals of pain treatment; for example, freedom from pain with minimal medication side effects, less frequent headaches, or improved functioning, mood, and sleep. The facility's policy titled Skin Assessment and Wound Management dated 7/2018, lacked pain management as a component of pressure ulcer or pressure injury prevention and management.	F 697		
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on interview, and document review, the facility failed to ensure post-dialysis access site monitoring was completed and documented for 1 of 1 resident (R41) reviewed for dialysis. Findings include:	F 698	1. Immediate Corrective Action: R41 fistula was assessed with no concerns observed. Orders were entered regarding monitoring site including checking bruit and thrill. Care plan was revised regarding assessment and care related to access	2/15/24

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F 698	Continued From page 30 R41's quarterly Minimum Data Set (MDS) dated 10/25/23, indicated R41 was cognitively intact impairment and had diagnoses of end stage kidney failure, heart disease, and required dialysis (treatment to filter blood when kidneys are no longer able). R41's Care Area Assessment (CAA) dated 10/25/23, lacked documentation of R41's fistula (dialysis intravenous access site) and required monitoring of thrill and bruit (an auditory method of checking fistula patency). R41's provider orders dated 6/9/23, instructed staff to monitor vital signs before and after dialysis treatments on Mondays, Wednesdays, and Fridays. No further orders located in treatment administration record (TAR) to assess dialysis access site. R41's nursing progress notes from 12/9/23 through 1/8/24, reviewed and lacked documentation of assessment of fistula access site. During interview on 1/9/24 at 1:19 p.m., R41 stated she had dialysis on Mondays, Wednesdays, and Fridays, and had a left upper arm fistula. R41 stated facility staff checked her blood pressure and weight before and after dialysis but did not assess the fistula by listening to it for a bruit. During observation and interview on 1/10/24 at 2:29 p.m., R41 returned from dialysis and licensed practical nurse (LPN)-E entered the room, donned gloves, and told R41 she needed to check her blood pressure. LPN-E visually	F 698	site. 2. How did we identify others: full house audit completed to identify others that receive dialysis services. 3. Corrective Action as it applies to others: Orders were entered for all residents that receive dialysis services including monitoring access site and monitoring bruit and thrill for those with fistulas. Care plans were revised for all residents that receive dialysis to include assessment and care related to access sites. 4. Recurrence will be prevented by: Hemodialysis policy was reviewed, and no changes needed. Began education with licensed nurses 1/30 in regards to monitoring dialysis access sites including checking bruit and thrill. 5. Audits and who they will be monitored by: Audits will be completed weekly x 4 weeks for all residents that receive dialysis to ensure cares related to fistulas/ports are being completed. The result of these audits will be shared with facility QAPI committee for input on need to increase, decrease, or discontinue audits. DON/designee to complete audits.	

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F 698	Continued From page 31 assessed a dressing over R41's left upper arm without touching the dressing. LPN-E stated the assessment was monitoring for drainage, any change in color or abnormalities, and any sound. LPN-E did not use a stethoscope to listen over the fistula and stated to check for the swooshing sound, one would need a stethoscope. LPN-E removed gloves, performed hand hygiene, and exited the room. LPN-E reported being unsure of what type of dialysis R41 was receiving but acknowledged the care plan would be where to find that information. To document post-dialysis assessments, LPN-E pulled up R41's TAR and stated that was where all documentation goes for the post dialysis assessment. The order LPN-E viewed indicated for staff to assess blood pressure and heart rate, but no orders to assess fistula. LPN-E stated for any abnormalities, a progress note would be documented, and the provider notified. LPN-E stated the importance of assessing a fistula was to make sure the site was not bleeding. During interview on 1/11/24 at 8:47 a.m., registered nurse (RN)-C stated after a resident returned from dialysis, a fistula should be assessed for a thrill and bruit to ensure patency and the dressing covering it should be assessed for any drainage or bleeding. RN-C stated the importance of this was to monitor for signs of infection. RN-C stated documentation depended on the nurse because some nurses only check a yes or no on the TAR, while some nurses documented their findings in a progress note. During interview on 1/11/24 at 9:35 a.m., LPN-D stated after a resident returned from dialysis, staff assessed vital signs, weight, and the fistula for a thrill, bruit, and dressing for any drainage or	F 698		

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F 698	Continued From page 32 bleeding. LPN-D stated documentation of fistula assessments are in R41's TAR and required "either a yes or no". LPN-D reviewed with the surveyor R41's TAR order dated 1/11/24, instructed staff to monitor fistula in addition to blood pressure and heart rate. During interview on 1/11/24 at 11:35 a.m., the interim director of nursing (DON) stated nurses are expected to assess a resident's fistula for a thrill and bruit and any signs of bleeding at the site. The DON stated this was important to monitor for signs of infection, bleeding, and a functioning fistula. The DON stated orders are in the TAR and nurses document by clicking yes or no if the task has been completed. The DON further stated abnormal assessment findings are expected to be documented in progress notes. The DON stated for R41, there were no orders prior to 1/11/24, which indicated nurses should assess R41's fistula. Facility policy titled Hemodialysis dated 11/22/19, indicated ongoing assessment and evaluation of the resident's condition and monitoring for complications should occur before and after dialysis treatments (i.e. infection and patency of fistula or graft). Furthermore, the policy identified assessing for patency by feel for a thrill and to listen with a stethoscope for a bruit. Additionally, the policy stated documentation should include post dialysis assessment and observation of the access site (fistula, graft, or external catheter), evaluation for signs and symptoms of infection, and fluid intake amounts for each shift with a 24 hour total, if a fluid restriction is in place.	F 698		
F 745 SS=D	Provision of Medically Related Social Service CFR(s): 483.40(d)	F 745		2/15/24

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F 745	Continued From page 33 §483.40(d) The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to provide medically related social services for 1 of 1 resident (R23) who lacked sufficient clothing. Findings Include: R23's admission Minimum Data Set (MDS) dated 11/28/23, identified R23 had moderate cognitive impairment and had diagnoses which included: schizophrenia, chronic obstructive pulmonary disease (COPD) and respiratory failure. R23's MDS also identified R23 required supervision or touching assistance for upper and lower body dressing and set up assistance for personal hygiene. R23's Care Area Assessment (CAA) dated 12/6/23, identified R23 had some cognition issues, planned to return to her apartment where R23 lived alone, and was at risk for isolation, depression, and further cognitive decline. R23's care plan dated 11/29/23, identified R23 was admitted to the facility 11/22/23, and had alteration in psychosocial well-being related to schizophrenia diagnosis. R23's interventions included monitor and respond to unmet needs, contact family with any concerns. R23's care plan also identified R23 was a vulnerable adult while R23 resided in the facility.	F 745	1. Immediate Corrective Action: R23 was provided clothing on 1/9/24. 2. How did we identify others: Full house audit completed to identify others needing clothing. 3. Corrective Action as it applies to others: Clothing provided for all residents who did not have clothing. Care plans were reviewed or revised based on preferences. 4. Recurrence will be prevented by: Education completed for social services staff on the need to ensure residents have clothing. Education began with nursing staff 1/30 regarding informing social services if a resident does not have clothing. A new process was put in place for new admissions to ask about clothing available and if they need donated clothing or assistance notifying family they would like items brought to the facility. 5. Audits and who they will be monitored by: Audits will be completed for 3 new admission/recent admission residents x 5 weeks. The result of these audits will be shared with facility QAPI committee for	

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F 745	Continued From page 34 Review of R23's progress notes dated 11/22/23 to 1/10/23, identified the following: -11/22/23 at 11:54 p.m., late entry: R23 admitted from hospital, alert, and orientated times three, with some short-term memory issues. -11/28/23 at 5:35 p.m., R23 sent to hospital due to shortness of breath (SOB). -11/28/23 at 11:58 p.m., R23 arrived at facility at 6p.m. from hospital. -12/11/23 at 10:25 p.m., R23 called 911 due to difficulty breathing, was sent to hospital for evaluation. -1/9/24, at 1:56 p.m. R23 requested some clothing to go to the church activity at 1:30 p.m. Writer brought up two pairs of pants and three shirts for R23 to have. R23's medical record lacked documentation related to R23's need for clothing, prior to 1/9/24. During observation on 1/8/24 at 3:11 p.m., R23 was in sitting on the edge of her bed, wearing a hospital gown, slipper socks and wore a second gown over her back as a robe. R23 indicated someone had taken her clothing. R23 indicated the last time she was dressed in street clothing was before she was at the facility. During observation on 1/9/24 at 9:52 a.m., R23's door was open, R23 was lying in bed on her right side facing the doorway, eyes closed, wearing a hospital gown. During interview on 1/9/24 at 12:44 p.m., R23 was sitting on the edge of her bed, had her call light on and had asked a staff member to open her can of pop, staff opened the pop, then left the room. R23 was wearing a hospital gown, with a second gown over her back, with slipper socks on	F 745	input on need to increase, decrease, or discontinue audits. Social Services Director/Designee to complete audits.	

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F 745	Continued From page 35	F 745		

her feet. R23 stated she did not have her clothing, they were missing, and someone needed to contact the hospital to get them for her. R23 allowed surveyor to look in her wardrobe closet, which was completely empty. The only item of clothing in R23's room was a black coat hanging over a chair.

During interview on 1/9/24 at 1:02 p.m., nursing assistant (NA)-A indicated she had taken care of R23 that morning. NA-A indicated she had offered to get R23 dressed, but R23 just wanted pop at that time. NA-A stated she did not reapproach R23 to ask again to get her dressed. NA-A indicated she was new at the facility.

During observation on 1/9/24 at 1:37 p.m., R23 was sitting on the edge of her bed, receiving a nebulizer treatment. R23 was wearing a shirt and pants. A few items of clothing were sitting on a chair in her room, pants, and shirts.

During interview on 1/9/24 at 2:05 p.m., LPN-A indicated she thought R23 wore a gown because she was very specific of her needs. When asked about her clothing, LPN-A stated she did not come with much and they brought her some clothing today.

During interview on 1/9/24 at 2:52 p.m., licensed social worker (LSW)-A stated R23 came from the hospital in a gown and was told the hospital had R23's clothes. LSW-A indicated R23 usually wore a hospital gown, but R23 did not leave her room. LSW-A indicated she was not aware R23 did not have any clothing and would expect the nursing staff to inform her. LSW-A stated she was made aware today R23 did not have clothing, because R23 wanted to go to an activity, so LSW-A got her

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F 745	Continued From page 36 some clothing. During interview on 1/9/24 at 3:01 p.m., unit coordinator LPN-B confirmed R23 always wore a hospital gown with another over her shoulders. LPN-B indicated was unsure if LSW-A had been made aware R23 did not have clothing. LPN-B stated if a resident did not have clothing, the staff knew where they could get clothing for residents. During interview on 1/10/24 at 7:07 a.m., NA-C confirmed R23 did not come to the facility with clothing, so R23 wore hospital gowns. NA-C indicated she had informed the nurse, and others were aware such as therapy and activity staff. NA-C stated she had offered donated clothing to R23 in the past, which she had refused at that time. During interview on 1/10/24 at 9:41 a.m., LSW-B indicated LSW-A admitted R23, as he worked on another unit, and was unaware R23 did not have any clothing. LSW-B indicated if a resident needed clothing, there was donated clothing available for residents to wear. LSW-B stated it was important for a resident to have clothing for dignity and self-worth. At 9:45 a.m. LSW-B stated administrator had notified him that R23 did not have clothing since her first hospitalization (11/28/23), and LSW-A got her some clothing yesterday. During interview on 1/10/24 at 10:30 a.m., interim director of nursing (DON) indicated she was not aware until yesterday R23 did not have clothing. DON confirmed she would expect social services to get involved, as it was part of their responsibility. DON indicated it was important for residents to have clothing for their dignity.	F 745		

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F 745	Continued From page 37 A policy was requested but not provided. The facility form titled Job Description: Social Services Director, revised 11/18/21, identified essential responsibilities and duties which included to act as liaison between residents/families and facility staff for concerns, questions and in particular, personal needs.	F 745		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §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:	F 880		2/15/24

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F 880	Continued From page 38 (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct 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:	F 880		

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F 880	Continued From page 39 Based on observation, interview and document review, the facility failed to implement appropriate personal protective equipment per Centers for Disease Control and Prevention (CDC) to prevent and/or minimize spread of COVID-19 for 2 of 2 residents (R5, R15) observed for COVID-19 transmission based precaution (TBP). This deficient practice had the potential to affect all 82 residents who were currently residing in the facility. Findings Include: CDC guidance, Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic, updated 5/8/23, identified health care personal (HCP) who enter the room of a patient with suspected or confirmed SARS-CoV-2 infection should adhere to standard precautions and use a NIOSH approved particulate respirator with N95 filters or higher, gown, gloves, and eye protection (i.e., goggles or a face shield that covers the front and sides of the face). R5's quarterly Minimum Data Set dated 11/12/23, identified R5 had moderate cognitive impairment with diagnoses which included: dementia, depression and hypertension (high blood pressure). R5's progress notes reviewed 12/1/23, to 1/10/24, identified the following: -1/8/24, at 3:21 p.m. R5 COVID-19 testing, a rapid nose swab was performed as a result of contact tracing exposure, and the results were positive. R5 moved to room 176.	F 880	1. Immediate Corrective Action: R5 and R15 have appropriate PPE and signage to alert staff to precautions needed. 2 & 3. How did we identify others and corrective action as it applies to others: All residents on precautions were reviewed to ensure proper signage and PPE available. All residents are being monitored for covid 19 and all residents are being swabbed for covid per outbreak testing unless currently positive or have had covid in the past 30 days. 4. Recurrence will be prevented by: Donning and doffing PPE competencies began 1/10/24 with all staff that enter rooms of residents on covid precautions. 5. Audits and who they will be monitored by: Audits will be completed for 9 residents on precautions weekly x4 weeks to ensure PPE was donned and doffed appropriately. The result of these audits will be shared with facility QAPI committee for input on need to increase, decrease, or discontinue audits. DON/designee to complete audits.	

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F 880	Continued From page 40 During observation on 1/9/24 at 8:05 a.m., R5's door was closed with the following signs posted: -Use Personal Protective Equipment (PPE) When Caring for Patients with Confirmed or Suspected COVID-19, identified preferred PPE use: face shield or goggles, N95 or higher respirator, non-sterile gloves, and isolation gown. -Stop Droplet Precautions Stop; everyone must; clean their hands, make sure eyes, nose and mouth were fully covered before room entry. -Stop Contact Precautions Stop: everyone must; clean their hands, put gloves and gowns on before room entry. R5 also had a plastic drawer container on the right side of R5's door with PPE supplies and sanitizing wipes and hand sanitizer on top with a garbage can next to the container. Nursing assistant (NA)-A was standing outside R5's room, applied a gown, gloves, wore a blue surgical mask, knocked then entered R5's room. NA-A failed to apply eye protection or a N95 mask prior to entering R5's room. At 8:12 a.m., NA-A left R5's room wearing a blue surgical mask, went down hallway carrying a clear garbage bag, to the soiled utility room. During observation on 1/9/24 at 12:50 p.m., R5's door was open 4-5 inches. NA-A exited R5's room wearing a blue surgical mask. During interview on 1/9/24 at 12:55 p.m., NA-A stated she had entered R5's room to care for R5's roommate, who was also positive for COVID-19. NA-A wore two surgical masks, which she indicated she had worn into R5's room, and confirmed she did not wear a N95 mask or eye protection when she entered R5's room. NA-A indicated she was aware she should have worn a N95 mask and eye protection when she entered	F 880		

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F 880	Continued From page 41 R5's room, for her protection and everyone else's. During observation on 1/9/24 at 1:42 p.m. licensed practical nurse (LPN)-A placed a glass or water and medications in a cup next to a face shield on a bedside stand located on the left side of R5's door. LPN-A sanitized her hands, applied a gown, removed a blue surgical mask, then applied a N95 mask she took from the PPE cart located on the right side of R5's door and applied gloves. LPN-A took the water glass and med cup from the table, while the face shield remained on the bedside stand, LPN-A knocked then entered R5's room. LPN-A failed to apply eye protection before entering R5's room. During interview on 1/9/24 at 2:27 p.m. LPN-A confirmed R5 had COVID-19, and had entered R5's room to give her medications. LPN-A confirmed she had not worn eye protection, and stated she forgot because she wore eye glasses. LPN-A indicated she was aware she should have worn eye protection before entering R5's room. During interview on 1/10/24 at 10:42 a.m. interim director of nursing (DON) stated she expected staff to wear PPE based on CDC guidance for COVID-19, which included gowns, gloves, N95 mask and eye protection. DON indicated it was important to wear appropriate PPE when a resident was on TBP for COVID-19 to not spread the infection. R15's significant change Minimum Data Set (MDS) dated 10/23/23, indicated moderate cognitive impairment with diagnoses that included respiratory failure and a disturbance in brain	F 880		

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F 880	Continued From page 42 function. R15's treatment administration record (TAR), dated 1/8/24, indicated monitoring for positive coronavirus-19 (COVID-19). During observation on 1/8/24 at 6:23 p.m., R15's door was closed with the following signs posted: - Use Personal Protective Equipment (PPE) When Caring for Patients with Confirmed or Suspected COVID-19, identified preferred PPE use: face shield or goggles, N95 or higher respirator, non-sterile gloves, and isolation gown. - Stop Droplet Precautions Stop; everyone must; clean their hands, make sure eyes, nose and mouth were fully covered before room entry. - Stop Contact Precautions Stop: everyone must; clean their hands, put gloves and gowns on before room entry. R15 had a plastic drawer container on the left side of the door with PPE supplies and sanitizing wipes and hand sanitizer on top with a garbage can next to the container. An unidentified nursing assistant (NA) performed hand hygiene, donned gown, gloves, and a N95 mask before entering R15's room with his meal tray. The NA did not wear eye protection before entering the room. During observation on 1/10/24 at 8:25 a.m., NA-B brought a meal tray to R15's room, donned gloves and a face shield. NA-B was reminded by a passing respiratory therapist to wear a N95 mask instead of a surgical mask. NA-B removed face shield and surgical mask, applied N95 mask and donned gown and gloves, and entered R15's room. NA-B did not put eye protection back on before entering the room. At 8:32 a.m., NA-B exited the room and performed hand hygiene. NA-B acknowledged forgetting to put eye	F 880		

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F 880	Continued From page 43 protection back on before entering R15's room. NA-B stated staff were expected to wear eye protection, like a face shield, when entering R15's room because he had COVID-19 and staff should protect other residents from getting it. During interview on 1/10/24 at 10:42 a.m., interim director of nursing (DON) stated expected staff to wear PPE based on CDC guidance for COVID-19, which included gowns, gloves, N95 mask and eye protection. DON indicated it was important to wear appropriate PPE when a resident was on TBP for COVID-19 to not spread the infection. The facility policy titled Infection Prevention And Control: Transmission-Based Precautions (TBP) dated 7/31/23, identified TBP were used for residents who were known to be or were suspected of being infected or colonized with an infectious agent(s). The policy further identified the facility would comply with standard approaches as it related to TBP per the giudance of the CDC. The policy included droplet precautions required the use of facemask upon entry into a residents room with respiratory droplet precautions. The facility policy titled COVID Policy updated 9/26/23, identified HCP who entered the room of a patient with suspected or confirmed SARS-CoV-2 infection should be placed in contact and droplet precautions and utilize a NIOSH-approved particulate respirator with N95 filters or higher, gown, gloves, and eye protection.	F 880		
F 883 SS=D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2)	F 883		2/15/24

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F 883	Continued From page 44 §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has	F 883		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245164	A. BUILDING _____ B. WING _____	C 01/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VILLAS AT NEW BRIGHTON	825 FIRST AVENUE NORTHWEST NEW BRIGHTON, MN 55112

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F 883	Continued From page 45 already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to have a method or system to ensure the facility offered or provided updated pneumococcal vaccine to residents per Centers for Disease Control (CDC) vaccination recommendations for 1 of 5 residents (R49) reviewed for immunizations. This had the ability to affect all 82 residents. Findings include: Review of the current CDC pneumococcal vaccine guidelines located at https://www.cdc.gov/vaccines/vpd/pneumo/hcp/pneumo-vaccine-timing.html, identified for: 1) Adults 19-64 years old with specified immunocompromising conditions, staff were to offer and/or provide: a) the pneumococcal conjugate vaccines (PCV)-20 at least 1 year after prior PCV-13, b) the pneumococcal polysaccharide vaccine (PPSV)-23 (dose 1) at least 8 weeks after prior PCV-13 and PPSV-23 (dose 2) at least 5 years	F 883	1. Immediate Corrective Action: R49 was offered pneumococcal vaccine. 2. How did we identify others: full house audit was completed to identify others eligible for pneumococcal vaccine. 3. Corrective action as it applies to others: those found to be eligible for pneumococcal vaccine were offered the vaccine. 4. Recurrence will be prevented by: education completed with clinical leaders and admission coordinator regarding CDC guidance for pneumococcal vaccines. Education completed with clinical nurse leaders regarding their role in regard to gathering consents, entering vaccine orders entered and administering vaccines. 5. Audits and who they will be monitored by: Audits will be complete weekly for 5 residents to ensure they are offered pneumococcal vaccines per CDC guidelines. The result of these audits will	

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F 883	Continued From page 46 after first dose of PPSV-23. Staff were to review the pneumococcal vaccine recommendations again when the resident turned 65 years old. 2) Adults 65 years of age or older, staff were to offer and/or provide based off previous vaccination status as shown below: a) If NO history of vaccination, offer and/or provide: aa) the PCV-20 OR bb) PCV-15 followed by PPSV-23 at least 1 year later. b) For PPSV-23 vaccine ONLY (at any age): aa) PCV-20 at least 1 year after prior PPSV-23 OR bb) PCV-15 at least 1 year after prior PPSV-23 c) For PCV-13 vaccine ONLY (at any age): aa) PCV-20 at least 1 year after prior PCV13 OR bb) PPSV-23 at least 1 year after prior PCV13 d) For PCV-13 vaccine (at any age) AND PPSV-23 BEFORE 65 years: aa) PCV-20 at least 5 years after last pneumococcal vaccine dose OR bb) PPSV-23 at least 5 years after last pneumococcal vaccine dose e) Received PCV-13 at Any Age AND PPSV-23 AFTER Age 65 Years: aa) Use shared clinical decision-making to decide whether to administer PCV20. If so, the dose of PCV-20 should be administered at least 5 years after the last pneumococcal vaccine. R49's quarterly Minimum Data Set dated 11/4/23, indicated he was cognitively intact and was up to date on pneumococcal vaccinations.	F 883	be shared with facility QAPI committee for input on need to increase, decrease, or discontinue audits. DON/designee to complete audits.	

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F 883	Continued From page 47 Review of sampled residents for vaccinations identified: Review of R49's electronic health record (EHR) revealed he was 75 years old and admitted to the facility in July of 2023. R49 had the PPSV-23 on 8/18/2017. R49 should have been offered and/or provided the PCV-20 at least 5 years after the last pneumococcal vaccine given. R49's EHR lacked consent or declination to receive the PCV-20 vaccination or documentation of discussion on whether to get the PCV-20 at least 5 years after his last dose on 8/8/2017 as recommended by the CDC. During interview on 1/1/24 at 12:30 p.m., the interim director of nursing (DON) stated the admission nurse used the CDC's PneumoRecs VaxAdvisor application upon admission to determine if the resident was or was not eligible for the pneumonia vaccines and then would obtain consent so the vaccines could be ordered and administered. The DON stated R49 did not have a discussion on file whether to get the PCV-20 at least 5 years after the last dose of his PPSV-23 on 8/8/2017 as recommended by the CDC.	F 883		

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	245164	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**01/09/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 01/09/2024. At the time of this survey, The Villas At New Brighton was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, the Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. IF OPTING TO USE AN EPOC, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES	K 000		

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

Electronically Signed | 01/28/2024

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

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K 000	Continued From page 1 (K-TAGS) TO: HEALTH CARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 445 CEDAR STREET, SUITE 145 ST. PAUL, MN 55101-5145, or Or by email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. This 1 story building, built in 1963, was determined to be of Type II (222) construction. It has a partial basement, and is fully fire sprinkled throughout. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that are monitored for automatic fire department notification.	K 000		

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K 000	Continued From page 2 The facility has a capacity of 99 beds and had a census of 78 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 321 SS=D	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322)	K 321		1/9/24

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K 321	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain hazardous storage rooms per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.2.1.3 and 7.2.1.8.1. These deficient finding could have an isolated impact on the residents within the facility. Findings include: On 01/09/2024 between 09:00am and 12:00pm, it was revealed by observation that TCU storage room did not have a working self-closing device. An interview with the Director of Maintenance and Regional Maintenance Director verified these deficient findings at the time of discovery.	K 321	1. Corrective Action taken: The TCU self-closing device was replaced by Maintenance on 1/9/24. 2. Measures taken to prevent reoccurrence: Maintenance was educated on the importance of functioning self-closing devices. Education began for all staff on 1/30 to notify maintenance of non-functioning self-closing devices. 3. Monitor: Audits of doors with self-closing devices will be conducted monthly x 4 months to ensure all self-closing devices are working. The result of these audits will be shared with facility QAPI committee for input on need to increase, decrease, or discontinue audits. 4. Responsible for corrective action and monitoring: Maintenance Director/designee will conduct audits.	
K 353 SS=D	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____	K 353		2/15/24

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K 353	Continued From page 4 c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain spacing between storage and the sprinkler system per NFPA 101 (2012 edition), Life Safety Code, Section 9.7.5, NFPA 25 (2011 edition), Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, Section 5.2.1.2, and NFPA 13 (2010 edition), Standard for the Installation of Sprinkler Systems, Sections 8.6.5.3.2 and 8.15.9. These deficient findings could an isolated impact on the residents within the facility. Findings include: On 01/09/2024, between 09:00am and 12:00pm, it was revealed by observation that storage materials had been placed on a storage rack, bringing the storage materials within the required 18 inch clearance area under the sprinkler heads. These obstructions were found in the central supply room. An interview with the Director of Maintenance and Regional Maintenance Director verified these deficient findings at the time of discovery.	K 353	1. Corrective Action taken: The items placed within the 18- inch clearance under sprinkler heads in the central supply room were moved by Maintenance on 1/9/24. 2. Measures taken to prevent reoccurrence: Maintenance was educated on the importance of maintaining the 18-inch clearance around sprinkler heads. A paint line was added to identify 18- inch lines in storage rooms by Maintenance. Education began for all staff on 1/30 on the purpose of the lines in storage rooms and maintaining the 18-inch clearance. 3. Monitor: Audits storage rooms will be conducted monthly x 4 months to ensure the 18-inch requirement is maintained. The result of these audits will be shared with facility QAPI committee for input on need to increase, decrease, or discontinue audits. 4. Responsible for corrective action and monitoring: Maintenance Director/designee will conduct audits.	

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
January 19, 2024

Administrator
The Villas At New Brighton
825 First Avenue Northwest
New Brighton, MN 55112

Re: State Nursing Home Licensing Orders
Event ID: P99U11

Dear Administrator:

The above facility was surveyed on January 8, 2024 through January 11, 2024 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

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

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

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

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

Renee McClellan, Unit Supervisor
Metro A District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: renee.mcclellan@state.mn.us
Office: 651-201-4391 Mobile: 651-328-9282

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

Please feel free to call me with any questions.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00114	A. BUILDING: _____ B. WING _____	C 01/11/2024

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 1/8/24 - 1/11/24, a licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you have reviewed these orders and	2 000		

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2 000	Continued From page 1 identify the date when they will be completed. The following complaints were reviewed during the survey: H51648550C (MN94824), H51648551C (MN94822), H51648552C (MN99387), and H51648642C (MN99389) and NO licensing orders were issued. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled " ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin <https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html> The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is	2 000		

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THE VILLAS AT NEW BRIGHTON	825 FIRST AVENUE NORTHWEST NEW BRIGHTON, MN 55112

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2 000	Continued From page 2 enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 915	MN Rule 4658.0525 Subp. 6 A Rehab - ADLs Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that: A. a resident is given the appropriate treatments and services to maintain or improve abilities in activities of daily living unless deterioration is a normal or characteristic part of the resident's condition. For purposes of this part, activities of daily living includes the resident's ability to: (1) bathe, dress, and groom; (2) transfer and ambulate; (3) use the toilet; (4) eat; and (5) use speech, language, or other functional communication systems; and This MN Requirement is not met as evidenced by: Based on observation, interview and document	2 915	Corrected	2/15/24

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2 915	Continued From page 3 review the facility failed to provide the services to maintain dressing and personal hygiene needs for 1 of 5 residents (R23) observed for activities of daily living (ADL's). Findings include: R23's admission Minimum Data Set (MDS) dated 11/28/23, identified R23 had moderate cognitive impairment and had diagnoses which included: schizophrenia, chronic obstructive pulmonary disease (COPD) and respiratory failure. R23's MDS also identified R23 required supervision or touching assistance for upper and lower body dressing and set up assistance for personal hygiene. R23's Care Area Assessment (CAA) dated 12/6/23, identified R23 had some cognition issues, planned to return to her apartment where R23 lived alone. R23's CAA also identified R23 received physical therapy (PT) and occupational therapy (OT) per doctor of medicine (MD) order and was at risk for further decline in ADLs, isolation, complications of immobility and incontinent. R23's functional abilities, self-care and mobility, would be addressed in care plan to minimize risks. R23's care plan dated 11/29/23, identified R23 was admitted to the facility 11/22/23, and had alteration in psychosocial well-being related to schizophrenia diagnosis. R23's care plan also identified R23 had self-care deficit, with goal that R23 would be dressed, groomed and bathed per preference. R23's interventions included OT per MD order and follow OT instructions. R23's care plan and electronic health record (EHR) lacked OT instructions or reference to	2 915		

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2 915	Continued From page 4 R23's preference related to facial hair. Review of R23's progress notes reviewed from 11/22/23 to 1/10/24, identified the following: -11/26/23 at 11:33 a.m. no mood indicators or behaviors observed. R23 required assist of one extensive for dressing, toileting, and shower. R23 compliant with cares. R23's progress notes lacked documentation of refusals of cares. During observation on 1/8/24 at 3:11 p.m., R23 was sitting on the edge of her bed. R23 had a large amount of white/gray facial hairs on her chin ¼ to ½ inch long. R23's hair was pulled back into a pony tail, with a large amount of hair on her right side hanging loose and sticking up in the air, with wisps of hair loose all around. R23 was dressed in a hospital gown, with a second gown on her back worn as a robe, and slipper socks. R23 indicated she did not have any clothes. R23 stated she needed assistance to get rid of facial hair, which she used to tweeze herself. R23 stated no one had offered to assist her to remove her facial hair and she did not like it. R23 also confirmed her hair was messy, as she touched the right side of her head. During observation on 1/9/24 at 9:52 a.m., R23's door was open, and R23 was lying on her right side in bed, facing the door, eyes closed. R23 continued to wear the hospital gown and was covered to her shoulders with bedding. During observation on 1/9/24 at 12:44 p.m., R23 was sitting on the edge of her bed, wearing the hospital gowns, and slipper socks. R23's hair remained uncombed with a large amount of hair on her right side hanging loose and sticking up in	2 915		

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2 915	Continued From page 5 the air, with wisps of hair loose all around. R23's chin continued to have a large amount of white/gray facial hairs on her chin ¼ to ½ inch long. A staff member was in R23's room assisting her to open a bottle of pop, then left R23's room. R23 indicated her hair was uncombed, and no one had assisted her today with morning cares. R23 also indicated no one had offered to assist her to remove her facial hair then pointed to the cupboard by sink and stated I think there is a razor up there. R23 rubbed her hand across her chin and stated, "I do want them gone". During interview on 1/9/24 at 1:02 p.m., nursing assistant (NA)-A indicated she had taken care of R23 that morning. NA-A stated she had given R23 her breakfast, and had asked her if she wanted to wipe her face, and R23 refused. NA-A stated she had not offered to assist R23 to comb her hair. NA-A confirmed R23 had facial hair on her chin, but was new to the facility and was not sure of their process for removing facial hair. NA-A stated her usual process would be to offer to assist the resident to remove the facial hair. NA-A indicated she had offered to dress R23, but R23 did not want to at that time. NA-A indicated she had not re-approached R23 to dress or assist her with personal hygiene again. During interview on 1/9/24 at 2:05 p.m., licensed practical nurse (LPN)-A confirmed R23 had a large amount of facial hair on her chin. LPN-A asked R23 if she could remove her facial hair, and R23 responded yes, just be careful. LPN-A confirmed R23's hair was messy, but indicated R23 refused at times. LPN-A stated no one had informed her that R23 had refused cares that morning. LPN-A indicated she expected staff to inform her if a resident refused cares then she	2 915		

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2 915	Continued From page 6 would attempt to complete the cares herself. LPN-A indicated she would assist R23 to remove her facial hair. During interview on 1/9/24 at 2:40 p.m., NA-B stated her usual process to assist residents with morning cares included assisting them with washing, dressing, oral cares and combing their hair. NA-B stated facial hair was removed during resident's showers, or as needed. NA-B stated she had asked R23 two weeks ago if she could assist her with shaving, but R23 refused, so she reported it to the nurse. NA-B indicated she had not worked with R23 since then, except briefly today. During interview on 1/9/24 at 3:01 p.m., unit coordinator LPN-B stated R23 was mostly independent with her ADLs. LPN-B stated she had shaven R23 about a month ago, but was not aware she now had facial hair present. LPN-B stated she would expect staff to offer to assist residents with ADLs, even if independent, if needed. LPN-B stated if a resident refused, she expected that to be reported. LPN-B indicated R23 required a lot of encouragement, and refused at times. During interview on 1/10/24 at 7:07 a.m., NA-C indicated R23 could brush her own hair, but required set up and reminding. NA-C stated if R23's hair was messy, she would assist her to brush it. NA-C stated if a resident was not taking care of themselves, she would assist them as needed. NA-C indicated she did not notice R23 had facial hair on her chin, and stated she had never shaven R23. During interview on 1/10/24 at 10:30 a.m. interim director of nursing (DON) indicated she would	2 915		

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2 915	Continued From page 7 expect staff to assist residents with ADLs as needed, and every resident required different amounts of assistance. DON indicated if a resident's hair was messy, she would expect staff to ask if they could assist them to comb it and if facial hair present to ask if wanted it removed. DON indicated if a resident refused assistance, she would expect staff to report it, re-approach, and document. DON stated offering to assist with ADLs was important for resident dignity. The facility policy titled Activities Of Daily Living (ADLs)/Maintain Abilities Policy dated 3/31/23, identified the facility would provide the necessary care and services to ensure that a resident's abilities in ADLs did not diminish unless circumstances of the individual's clinical condition demonstrated that such diminution was unavoidable. The policy further identified they would provide care and services for the following ADLs, which included hygiene, bathing, dressing, grooming, and oral care. SUGGESTED METHOD OF CORRECTION: The director of nursing and/or designee could educate responsible staff to provide care to residents requiring assistance from facility staff, based on residents' comprehensively assessed needs. The DON or designee could conduct audits of resident cares to ensure their personal hygiene needs are met consistently.The results of those audits should be taken to QAPI to determine compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 915		

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2 920	Continued From page 8	2 920		
2 920	MN Rule 4658.0525 Subp. 6 B Rehab - ADLs Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that: B. a resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide fingernail care to a dependent resident for 1 of 1 resident (R54) reviewed for dependent activities of daily living (ADL) care. Findings include: R54's annual Minimum Data Set (MDS) dated 12/25/23, indicated R54 was in a persistent vegetative state and was dependent on staff for hygiene and grooming. R54's diagnoses included brain damage from lack of oxygen, contractures (fixed, tightening of muscles, tendons, and/or ligaments that prevent movement), and aphasia (language disorder affecting the ability to communicate). R54's Care Area Assessment (CAA) dated 12/25/23, triggered for alteration in skin integrity related to brain damage, immobility, and contractures. R54's Braden Scale Assessment dated 12/22/23, indicated R54 was at a high risk for developing pressure injuries in part, due to his very limited response to pain and his inability to communicate	2 920	Corrected	2/15/24

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2 920	Continued From page 9 discomfort. R54's physician orders included the application of splints and stockinettes to both arms twice daily for contracture of muscle, and to remove twice daily for two hours for hygiene and skin care dated 11/20/23. R54's treatment administration record (TAR) dated 12/2023 and 1/2024, indicated R54 had completed weekly skin assessments every Wednesday evening shift. R54's care plan, dated 1/1/22, indicated R54 required total staff assistance with personal hygiene care, including nails. Furthermore, R54's care plan indicated a risk for alteration in skin integrity related to contractures. R54's weekly skin inspections dated 12/13/23 through 12/29/23, indicated fingernails were trimmed every inspection except on 12/29/23 when R54 refused. During observation on 1/08/24 at 1:02 p.m., R54 was sitting up in his wheelchair with both arm splints on. He had long fingernails, approximately 0.25 inch to 0.5 inch in length, with one fingernail on the right hand that appeared to be approximately 1 inch long. During observation on 1/10/24 at 10:04 a.m., R54's fingernails remained untrimmed and long. NA-B and NA-F entered room to provide hygiene cares. NAs washed his face and underarms before R54 began coughing. NAs covered R54 and raised the head of the bed for comfort. Cares were paused while respiratory therapy was at the bedside. NA-F stated nail care is normally done on bath day, but for R54, "he's a diabetic", so the	2 920		

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2 920	Continued From page 10 nurses do their nail care. During observation on 1/10/24 at 12:22 p.m., R54 is sitting up in his wheelchair and his fingernails appear trimmed. During interview on 1/10/24 at 10:22 a.m., NA-G stated nail cares are done on bath days or during cares as needed. For diabetic residents, the nurses will perform nail care. NA-G stated the care plan or care sheets indicate which residents are diabetic. NA-G further stated pertinent information is relayed through change of shift report as well as on the computer charting. During interview on 1/10/24 at 12:24 p.m., RN-D verified that R54 is not diabetic, and the NAs have care sheets that list which residents are diabetic. Additionally, RN-D stated staff have daily report where they are kept updated on residents' conditions. During interview on 1/11/2024 at 11:35 a.m., the interim director of nursing (DON) stated floor nurses supervised cares on the floor and managers performed spot-checks on things they saw to ensure staff were implementing care-planned interventions. The DON stated nail care was expected to be done on bath days and that information is on a weekly skin check form where nurses complete the task for diabetic residents and NAs complete nail care for non-diabetic residents. If staff are not able to complete nail care for a resident, NAs are expected to notify the charge nurse. The DON stated the nurse should either do the task themselves or chart on the refusal. The DON identified skin concerns for R54 related to long fingernails as "worry about his nails digging into his hands."	2 920		

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2 920	Continued From page 11 Facility policy titled Activities of Daily Living (ADLs)/Maintain Abilities Policy dated 3/31/23, indicated a resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. SUGGESTED METHOD OF CORRECTION: The director of nursing and/or designee could educate responsible staff to provide care to residents' dependant on facility staff, based on residents' comprehensively assessed needs. The DON or designee could conduct audits of dependent resident cares to ensure their personal hygiene needs are met consistently, The results of those audits should be taken to QAPI to determine compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 920		
21390	MN Rule 4658.0800 Subp. 4 A-I Infection Control Subp. 4. Policies and procedures. The infection control program must include policies and procedures which provide for the following: A. surveillance based on systematic data collection to identify nosocomial infections in residents; B. a system for detection, investigation, and control of outbreaks of infectious diseases; C. isolation and precautions systems to reduce risk of transmission of infectious agents; D. in-service education in infection prevention and control; E. a resident health program including an	21390		2/15/24

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21390	Continued From page 12 immunization program, a tuberculosis program as defined in part 4658.0810, and policies and procedures of resident care practices to assist in the prevention and treatment of infections; F. the development and implementation of employee health policies and infection control practices, including a tuberculosis program as defined in part 4658.0815; G. a system for reviewing antibiotic use; H. a system for review and evaluation of products which affect infection control, such as disinfectants, antiseptics, gloves, and incontinence products; and I. methods for maintaining awareness of current standards of practice in infection control. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to implement appropriate personal protective equipment per Centers for Disease Control and Prevention (CDC) to prevent and/or minimize spread of COVID-19 for 2 of 2 residents (R5, R15) observed for COVID-19 transmission based precaution (TBP). This deficient practice had the potential to affect all 82 residents who were currently residing in the facility. Findings Include: CDC guidance, Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic, updated 5/8/23, identified health care personal (HCP) who enter the room of a patient with suspected or confirmed SARS-CoV-2 infection should adhere to standard precautions and use a NIOSH approved	21390	Corrected	

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21390	Continued From page 13 particulate respirator with N95 filters or higher, gown, gloves, and eye protection (i.e., goggles or a face shield that covers the front and sides of the face). R5's quarterly Minimum Data Set dated 11/12/23, identified R5 had moderate cognitive impairment with diagnoses which included: dementia, depression and hypertension (high blood pressure). R5's progress notes reviewed 12/1/23, to 1/10/24, identified the following: -1/8/24, at 3:21 p.m. R5 COVID-19 testing, a rapid nose swab was performed as a result of contact tracing exposure, and the results were positive. R5 moved to room 176. During observation on 1/9/24 at 8:05 a.m., R5's door was closed with the following signs posted: -Use Personal Protective Equipment (PPE) When Caring for Patients with Confirmed or Suspected COVID-19, identified preferred PPE use: face shield or goggles, N95 or higher respirator, non-sterile gloves, and isolation gown. -Stop Droplet Precautions Stop; everyone must; clean their hands, make sure eyes, nose and mouth were fully covered before room entry. -Stop Contact Precautions Stop: everyone must; clean their hands, put gloves and gowns on before room entry. R5 also had a plastic drawer container on the right side of R5's door with PPE supplies and sanitizing wipes and hand sanitizer on top with a garbage can next to the container. Nursing assistant (NA)-A was standing outside R5's room, applied a gown, gloves, wore a blue surgical mask, knocked then entered R5's room. NA-A failed to apply eye protection or a N95 mask prior to entering R5's room. At 8:12 a.m., NA-A left	21390		

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21390	Continued From page 14 R5's room wearing a blue surgical mask, went down hallway carrying a clear garbage bag, to the soiled utility room. During observation on 1/9/24 at 12:50 p.m., R5's door was open 4-5 inches. NA-A exited R5's room wearing a blue surgical mask. During interview on 1/9/24 at 12:55 p.m., NA-A stated she had entered R5's room to care for R5's roommate, who was also positive for COVID-19. NA-A wore two surgical masks, which she indicated she had worn into R5's room, and confirmed she did not wear a N95 mask or eye protection when she entered R5's room. NA-A indicated she was aware she should have worn a N95 mask and eye protection when she entered R5's room, for her protection and everyone else's. During observation on 1/9/24 at 1:42 p.m. licensed practical nurse (LPN)-A placed a glass or water and medications in a cup next to a face shield on a bedside stand located on the left side of R5's door. LPN-A sanitized her hands, applied a gown, removed a blue surgical mask, then applied a N95 mask she took from the PPE cart located on the right side of R5's door and applied gloves. LPN-A took the water glass and med cup from the table, while the face shield remained on the bedside stand, LPN-A knocked then entered R5's room. LPN-A failed to apply eye protection before entering R5's room. During interview on 1/9/24 at 2:27 p.m. LPN-A confirmed R5 had COVID-19, and had entered R5's room to give her medications. LPN-A confirmed she had not worn eye protection, and stated she forgot because she wore eye glasses. LPN-A indicated she was aware she should have worn eye protection before entering R5's room.	21390		

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21390	Continued From page 15 During interview on 1/10/24 at 10:42 a.m. interim director of nursing (DON) stated she expected staff to wear PPE based on CDC guidance for COVID-19, which included gowns, gloves, N95 mask and eye protection. DON indicated it was important to wear appropriate PPE when a resident was on TBP for COVID-19 to not spread the infection. R15's significant change Minimum Data Set (MDS) dated 10/23/23, indicated moderate cognitive impairment with diagnoses that included respiratory failure and a disturbance in brain function. R15's treatment administration record (TAR), dated 1/8/24, indicated monitoring for positive coronavirus-19 (COVID-19). During observation on 1/8/24 at 6:23 p.m., R15's door was closed with the following signs posted: - Use Personal Protective Equipment (PPE) When Caring for Patients with Confirmed or Suspected COVID-19, identified preferred PPE use: face shield or goggles, N95 or higher respirator, non-sterile gloves, and isolation gown. - Stop Droplet Precautions Stop; everyone must; clean their hands, make sure eyes, nose and mouth were fully covered before room entry. - Stop Contact Precautions Stop: everyone must; clean their hands, put gloves and gowns on before room entry. R15 had a plastic drawer container on the left side of the door with PPE supplies and sanitizing wipes and hand sanitizer on top with a garbage can next to the container. An unidentified nursing assistant (NA) performed hand hygiene, donned gown, gloves, and a N95 mask before entering R15's room with his meal tray. The NA did not	21390		

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	00114	A. BUILDING: _____ B. WING _____	C 01/11/2024

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21390	Continued From page 16 wear eye protection before entering the room. During observation on 1/10/24 at 8:25 a.m., NA-B brought a meal tray to R15's room, donned gloves and a face shield. NA-B was reminded by a passing respiratory therapist to wear a N95 mask instead of a surgical mask. NA-B removed face shield and surgical mask, applied N95 mask and donned gown and gloves, and entered R15's room. NA-B did not put eye protection back on before entering the room. At 8:32 a.m., NA-B exited the room and performed hand hygiene. NA-B acknowledged forgetting to put eye protection back on before entering R15's room. NA-B stated staff were expected to wear eye protection, like a face shield, when entering R15's room because he had COVID-19 and staff should protect other residents from getting it. During interview on 1/10/24 at 10:42 a.m., interim director of nursing (DON) stated expected staff to wear PPE based on CDC guidance for COVID-19, which included gowns, gloves, N95 mask and eye protection. DON indicated it was important to wear appropriate PPE when a resident was on TBP for COVID-19 to not spread the infection. The facility policy titled Infection Prevention And Control: Transmission-Based Precautions (TBP) dated 7/31/23, identified TBP were used for residents who were known to be or were suspected of being infected or colonized with an infectious agent(s). The policy further identified the facility would comply with standard approaches as it related to TBP per the giudance of the CDC. The policy included droplet precautions required the use of facemask upon entry into a residents room with respiratory droplet precautions.	21390		

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21390	Continued From page 17 The facility policy titled COVID Policy updated 9/26/23, identified HCP who entered the room of a patient with suspected or confirmed SARS-CoV-2 infection should be placed in contact and droplet precautions and utilize a NIOSH-approved particulate respirator with N95 filters or higher, gown, gloves, and eye protection. SUGGESTED METHOD OF CORRECTION: The DON (Director of Nursing) or designee should review/revise facility policies to ensure appropriate use of PPE are implemented to mitigate potential COVID-19 transmission. The DON or designee could educate all staff on existing or revised policies and perform ongoing continuous audits to ensure compliance. The results of those audits should be taken to QAPI to determine compliance. Time Period for Correction: Twenty-one (21) days.	21390		
21426	MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of	21426		2/15/24

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21426	Continued From page 18 Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure a tuberculosis skin test (TST), or chest X-rays were conducted, and the results documented for 2 of 6 new employees (cooks (C's)-A and B) reviewed for tuberculosis (TB) screening as directed by the Centers for Disease Control and Prevention (CDC). Further, the facility failed to ensure the completion of the TB symptom screen was completed and the results documented for 4 of 6 new employees (C-A, C-B, nursing assistants (NA'S)-H and I) for TB screening as directed by the CDC. Findings include: C-A's hire date was 8/14/23, and a Baseline TB Screening Tool for Healthcare Workers and Tuberculin skin test (TST) was requested on 1/10/24 but not received. C-B's hire date was 11/14/23, and a and a Baseline TB Screening Tool for Healthcare Workers and TST was requested on 1/10/24 but not received. NA-H's hire date was 11/27/23, and a copy of an IGRA lab report dated 3/10/22, was received and	21426	Corrected	

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21426	Continued From page 19 verified to be negative. A TB symptom screen was requested on 1/11/24, but not received. NA-I's hire date was 11/29/23, and a chest X-ray result dated 11/28/23, was received and verified to be negative. A TB symptom screen was requested on 1/11/24, but not received. When interviewed on 1/11/24 at 7:42 a.m., interim director of nursing (DON) reported they did not have the mantoux results for C-A and C-B. When interviewed on 1/11/24 at 9:54 a.m., the interim DON stated lab results were all they had for NA-H as they were previously a corporate float pool staff and, "that is what was sent to us." The DON also stated they did not have a TB screen for NA-I. A policy titled Facility Tuberculosis (TB) Risk Assessment Instructions and Worksheet for Health Care Settings Licensed by MDH* dated 6/2023, indicated a baseline TB screening was required at the time of hire for all health care personnel in Minnesota that included assessing for current symptoms of active TB disease, assessing TB history, and testing for the presence of infection with Mycobacterium tuberculosis by administering either a two-step tuberculin skin test (TST) or single TB blood test. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON), or designee, could monitor to assure tuberculin testing procedures were developed and implemented to ensure staff was free of tuberculosis prior to working with residents. The DON, or designee, could conduct audits to ensure TB testing was conducted.	21426		

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21426	Continued From page 20 TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21426		
21565	MN Rule 4658.1325 Subp. 4 Administration of Medications Self Admin Subp. 4. Self-administration. A resident may self-administer medications if the comprehensive resident assessment and comprehensive plan of care as required in parts 4658.0400 and 4658.0405 indicate this practice is safe and there is a written order from the attending physician. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to assess residents for the ability to self administer medications (SAM) for 2 of 2 residents (R42, R79) with medications noted at bedside. R42's admission MDS dated 12/21/23, identified intact cognition and diagnoses of type two diabetes with kidney complications, depression, and cataracts, glaucoma, or macular degeneration. R42 required partial to moderate assistance with eating. R42's care plan dated 12/18/23, lacked a focus area for SAM. R42's order summary and assessments dated 1/8/24, lacked direction related to SAM. During an observation and interview on 1/8/24 at 3:45 p.m., R42 was in bed. There was a half-full 8 ounce bottle of Pepto-Bismol on his bedside table, without a pharmacy label. R42 stated he could take the Pepto-Bismol any time he wanted	21565	Corrected	2/15/24

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21565	Continued From page 21 to, and usually took "a swig" a few times per day for nausea. During an observation on 1/8/24 at 4:07 p.m., nursing assistant (NA)-D and NA-E entered R42's room to assist with cares. At 4:15 p.m. NA-D and NA-E exited the room. R42's Pepto-Bismol remained on the bedside table. During an interview on 1/8/24 at 6:57 p.m., NA-E stated if medications were found in a resident's room the NA's should let the nurse know, so they can find out what the medication is or make sure the resident can take it. NA-E stated she saw the bottle of Pepto-Bismol in R42's room, but since she didn't know him she had not checked with the nurse whether or not it was okay. NA-E stated in hindsight R42 probably should not have had medications stored in his room. During an interview on 1/8/24 at 6:58 p.m., licensed practical nurse (LPN)-C observed the Pepto-Bismol in R42's room. LPN-C reviewed R42's medical record and stated a SAM assessment had not been completed first and should have been. During an interview on 1/9/24 at 2:49 p.m., registered nurse (RN)-E stated medications should not be stored in resident rooms or left with residents without a completed SAM assessment first. R79's admission Minimum Data Set (MDS) dated 11/12/23, indicated R79 had intact cognition and diagnoses of type two diabetes, atherosclerotic heart disease (plaque build up in the arteries in the heart) and cardiomyopathy (difficulty pumping blood to the rest of the body). It further indicated	21565		

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21565	Continued From page 22 he was dependent on staff for activities of daily living (ADL) and mobility. R79's physician's orders lacked an order to SAM. R79's medical record lacked an assessment to SAM. During observation on 1/8/24 at 12:25 p.m., R79 was laying in bed and there was a medication cup with four unidentified pills on the night stand next to him. During observation and interview on 1/8/24 at 12:52 p.m., registered nurse (RN)-C verified R79 had medications on the nightstand in his room and stated he did not have a doctor's order to be able to keep medications at the bedside and had not been assessed to administer his own medications. During an interview on 01/09/24 at 9:28 a.m., RN-A stated in order for a resident to be able to self administer their own medications they need a doctor's order and an assessment. RN-A further stated if the resident didn't have an order and hadn't been assessed the nurse should not leave their medications at bedside. During an interview on 1/9/24 at 9:30 a.m., RN-B stated in order for a resident to be able to self administer their own medications they need a doctor's order and an assessment. RN-A further stated if the resident didn't have an order and hadn't been assessed the nurse should not leave their medications at bedside. During an interview on 1/10/24 at 7:57 a.m., RN-D stated residents need to have a doctor's order to be able to administer their own	21565		

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21565	Continued From page 23 medications and if they don't have an order, the nurse was expected to stay in the room until the resident had taken their medications. During interview on 01/10/24 at 9:19 a.m., the director of nursing (DON) stated a SAM assessment should be done by nursing within a few days of admission and then quarterly thereafter. The DON further stated medications should not be left in the resident's rooms unless they've been assessed for the ability to safely do so. If the resident wanted to SAM, nursing would be responsible for assessing them and then notifying the provider to get a doctor's order. The facility's policy on self administration of medication dated 5/22, identified in order to maintain the resident's high level of independence, residents who desire to SAM are permitted to do so if the facility's interdisciplinary team has determined that the practice would be safe for the resident and other residents of the facility, and there is a prescribers' order to self administer. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review applicable policies and procedures to ensure residents' are assessed timely with self administration of medications; then provide staff education. The DON or designee could educate all staff on existing or revised policies and perform ongoing continuous audits to ensure compliance. The results of those audits should be taken to QAPI to determine compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21565		

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21695	Continued From page 24	21695		
21695	MN Rule 4658.1415 Subp. 4 Plant Housekeeping, Operation, & Maintenance Subp. 4. Housekeeping. A nursing home must provide housekeeping and maintenance services necessary to maintain a clean, orderly, and comfortable interior, including walls, floors, ceilings, registers, fixtures, equipment, lighting, and furnishings. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a clean and comfortable environment as well as failed to ensure a tube feeding pole and tracheostomy supplies cart was cleaned and in sanitary condition for 1 of 1 residents (R54) reviewed for homelike environment. Findings include: R54's annual Minimum Data Set (MDS) dated 12/25/23, indicated R54 was in a persistent vegetative state, had impairment on both sides of his upper and lower extremities, and was dependent on staff for all activities of daily living (ADLs). Additionally, MDS indicated R54 received 51% or more of his total calories and average fluid intake through tube feeding. R54's diagnoses included brain damage from lack of oxygen, aphasia (language disorder affecting the ability to communicate), gastrostomy (a surgically inserted tube through his abdomen into the stomach for nutrition), and tracheostomy (a surgically inserted hole into his windpipe that provided an alternative airway for breathing).	21695	Corrected	2/15/24

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21695	Continued From page 25 R54's treatment administration record (TAR) included the following: - Clean tube feeding pole every night shift, dated 6/9/23. R54's care plan dated 12/31/21, indicated he was non-verbal and unable to make his needs known. Furthermore, R54's care plan indicated his goal was to have his needs anticipated by staff. During observation on 1/8/24 at 12:50 p.m., R54 was sitting up in his wheelchair. R54's tube feeding pole had dried tan-to-light brown colored substances covering two of the four legs of the pole. The tube feeding pump was running and at his side with a bottle hanging above the pump with tan-colored liquid formula in it. Under the head of the bed was a round, dried substance of tan-to-light brown in color that was approximately 4-inches x 7 inches. The call light cord had dried substance throughout the length of the cord of tan-to-light brown color. The tracheostomy supplies cart in the room had dried substances on the side that faced the tube feeding pole that were tan-to-brown in color and were splattered and round and dripped down the side of the cart. There were round, dried substances of similar brown colors to the top of the supplies cart. There were dried, dark tan substances underneath the hand sanitizer dispenser that spanned from the dispenser to the floor. Additionally, on the bathroom door, there were approximately 75 light-pink, dried, splattered substances all about a 1/4 inch in diameter. On the wall next to the bathroom, there were about 24 areas of light-pink dried substances that varied from approximately 4 inches in length up to 2 feet. Observation on 1/9/24 at 8:47 a.m., revealed the room condition remained unchanged.	21695		

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21695	Continued From page 26 Observation on 1/9/24 at 2:54 p.m., revealed the room condition remained unchanged. On 1/101/24 between 7:07 a.m. and 7:30 a.m., respiratory therapist (RT)-C is observed providing tracheostomy cares for R54. He used the top of the supply cart to set-up his sterile field for a portion of the cares. The tan-to-light brown dried substances were present on the tube feed pole, floor, and supply cart. RT-C stated the dried substances on the pole and supplies cart were dried tube feed. RT-C stated whoever sees the spills would try to clean it up, but housekeeping should be doing that task. RT-C stated ideally whoever spilled the tube feed would clean it up right away due to how difficult it was to clean once dried. During interview on 1/10/24 at 9:35 a.m., housekeeper (H)-A stated if there was a dirty spot in a room or someone reported one, it would be cleaned immediately. H-A entered R54's room and stated the areas on the wall, floor, and bathroom door required a deep clean and to do that, H-A would wait for the resident to leave the room and use a cleanser and disinfectant. H-A stated these things are checked daily, but sometimes there is a fear to move the equipment, but stated a nurse could be asked to move it. The tube feed pole and supplies cart no longer had dried tan-to-light brown dried substances on them. H-A acknowledged the dried substances under the hand sanitizer dispenser and stated those were common under the dispensers from the sanitizer dripping down. During observation on 1/10/24 at 9:57 a.m., the 4-inch x 7-inch dried substance under the head of the bed remained and the dried substances on	21695		

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21695	Continued From page 27 the wall behind the head of the bed were present. The dried substances under the hand sanitizer dispenser were present. During interview on 1/11/24 at 8:38 a.m., H-B stated housekeeping staff are trained to move equipment, such as tube feeding poles and beds, for room cleaning and if they are not comfortable doing so, they were instructed to contact someone who could assist them in moving the equipment. During interview on 1/11/24 at 11:35 a.m., the interim director of nursing (DON) stated the expectation for room cleanliness was housekeeping would clean a spill or dirty room once they saw it or were made aware of it, and if a housekeeper was not comfortable moving equipment, they would be expected to ask a nurse or nurse manager to move it. Facility policy titled Homelike Environment dated 2/2021, stated the facility staff and management maximizes, the extent possible, the characteristics of the facility that reflect a personalized, homelike setting, including a clean, sanitary and orderly environment. SUGGESTED METHOD OF CORRECTION: The administrator or designee, could educate staff regarding the importance of a safe, clean, functional and homelike environment. The administrator or designee, could coordinate with maintenance, housekeeping and nursing staff to conduct periodic audits of areas residents frequent to ensure a safe, clean, functional and homelike environment is maintained to the extent possible. The results of those audits should be taken to QAPI to determine compliance.	21695		

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21695	Continued From page 28 TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21695		