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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: PBC5

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00848

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245363**

2.STATE VENDOR OR MEDICAID NO.
(L2) **908540800**

3. NAME AND ADDRESS OF FACILITY
(L3) **AICOTA HEALTH CARE CENTER**
(L4) **850 SECOND STREET NORTHWEST**
(L5) **AITKIN, MN** (L6) **56431**

4. TYPE OF ACTION: **7** (L8)

1. Initial	**2. Recertification**
3. Termination	**4. CHOW**
5. Validation	**6. Complaint**
7. On-Site Visit	**9. Other**
8. Full Survey After Complaint	

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **10/07/2021** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **75** (L18)

13.Total Certified Beds **75** (L17)

10.THE FACILITY IS CERTIFIED AS:

X A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	75			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Susan Frericks, Unit Supervisor 11/05/2021 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Joanne Simon, Enforcement Specialist 11/05/2021 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
11/17/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
11/03/2021
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
November 5, 2021

CMS Certification Number (CCN): 245363

Administrator
Aicota Health Care Center
850 Second Street Northwest
Aitkin, MN 56431

Dear Administrator:

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

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

Effective October 5, 2021 the above facility is certified for:

75 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 75 skilled nursing facility beds.

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

Please contact me if you have any questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
November 5, 2021

Administrator
Aicota Health Care Center
850 Second Street Northwest
Aitkin, MN 56431

RE: CCN: 245363
Cycle Start Date: August 30, 2021

Dear Administrator:

On September 21, 2021, we notified you a remedy was imposed. On October 7, 2021 the Minnesota Department(s) of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of October 5, 2021.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective October 6, 2021 did not go into effect. (42 CFR 488.417 (b))

However, as we notified you in our letter of September 21, 2021, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from August 30, 2021. This does not apply to or affect any previously imposed NATCEP loss.

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

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: PBC5

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(L3) **AICOTA HEALTH CARE CENTER**
(L4) **850 SECOND STREET NORTHWEST**
(L5) **AITKIN, MN** (L6) **56431**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **08/30/2021** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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From (a) :
To (b) :

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___1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	75			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Sativa Bushey HFE - NE II 10/25/2021 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Joanne Simon, Enforcement Specialist 10/29/2021 (L20)

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

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

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2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION
11/17/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Electronically Submitted
September 21, 2021

Administrator
Aicota Health Care Center
850 Second Street Northwest
Aitkin, MN 56431

RE: CCN: 245363
Cycle Start Date: August 30, 2021

Dear Administrator:

On August 30, 2021, survey was completed at your facility by the Minnesota Department of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

REMOVAL OF IMMEDIATE JEOPARDY

On August 27, 2021, the situation of immediate jeopardy to potential health and safety cited at F 684 was removed. However, continued non-compliance remains at the lower scope and severity of D.

REMEDIES

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

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective October 6, 2021.

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

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective October 6, 2021, (42 CFR 488.417 (b)), (42 CFR 488.417 (b)). They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective October 6, 2021, (42 CFR 488.417 (b)).

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

NURSE AIDE TRAINING PROHIBITION

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

Therefore, your agency is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective August 30, 2021. This prohibition is not subject to appeal. Under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

SUBSTANDARD QUALITY OF CARE

Your facility's deficiencies with with one or more of the following: §483.10, Residents Rights, §483.12, Freedom from Abuse, Neglect, and Exploitation, §483.15, Quality of Life and §483.25, Quality of Care, 483.40 Behavioral Health Services, §483.45 Pharmacy Services, §483.70 Administration, or §483.80 Infection control has been determined to constitute substandard quality of care as defined at §488.301. Sections 1819(g)(5)(C) and 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) require that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. <u>If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.</u>

Please note that, in accordance with 42 CFR 488.325(g), your failure to provide this information timely will result in termination of participation in the Medicare and/or Medicaid program(s) or imposition of alternative remedies.

Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, Aicota Health Care Center is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective August 30, 2021. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

ELECTRONIC PLAN OF CORRECTION (ePOC)

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

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

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

DEPARTMENT CONTACT

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

Susan Frericks, Unit Supervisor
Metro D District Office

Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
PO Box 64990
St. Paul MN 55164-0900
Email: susan.frericks@state.mn.us
Mobile: (218) 368-4467

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by March 1, 2022 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

APPEAL RIGHTS DENIAL OF PAYMENT

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

Tamika.Brown@cms.hhs.gov

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

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

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

APPEAL RIGHTS NURSE AIDE TRAINING PROHIBITION

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

A written request for a hearing must be filed no later than 60 days from the date of receipt of this

letter. Such a request may be made to the Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration) at the following address:

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

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

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

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

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

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

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245363	A. BUILDING _____ B. WING _____	C 08/30/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AICOTA HEALTH CARE CENTER	**850 SECOND STREET NORTHWEST AITKIN, MN 56431**

(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 8/23/21, through 8/30/21, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) was conducted during a standard recertification survey. The facility was 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 8/23/21, through 8/30/21, a standard abbreviated survey was completed at your facility by surveyors from the Minnesota Department of Health (MDH). The facility was not found not to be in compliance with requirements of 42 CFR Part 483, Subpart B, the requirements for Long Term Care Facilities. The survey resulted in an immediate jeopardy (IJ) to resident health and safety on 8/26/21, when it was identified the facility failed to ensure residents R40 and R46 had diabetic management and adequate monitoring, assesesment and physician notification according to current standards of practice and facility standing orders. The administrator and DON were notified of the IJ for R40 and R46 on 8/26/21, at 6:03 p.m. The IJ was removed on 8/27/21, at 2:40 p.m. The above findings constituted substandard quality of care, and an extended survey was conducted from 8/26/21, to 8/30/21. At the time of the abbreviated survey, onsite	F 000		

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

Electronically Signed | 09/28/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245363	A. BUILDING _____ B. WING _____	C 08/30/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AICOTA HEALTH CARE CENTER	**850 SECOND STREET NORTHWEST AITKIN, MN 56431**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	Continued From page 1 investigation(s) were completed and the following complaints were found to be: substantiated H5363014C/MN75515 and H5363017C/MN69130 with no deficiencies and Unsubstantiated H536015C/MN75043, H5363016C/MN70017, H5363018C/MN63945 and MN63666, and H5363019C/MN65290. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each	F 550		10/5/21

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	245363	A. BUILDING _____ B. WING _____	C 08/30/2021

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F 550	Continued From page 2 resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure dignity was maintained following a fall in a public area for 1 of 2 residents (R6) reviewed for dignity. Findings include:	F 550	R6 will receive dignified care and treatment regarding privacy and falls in public spaces. Social Services has discussed the cited concern with R6, and the resident indicated he was satisfied with the way things went. He further states I am glad you took care of me as fast as	

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F 550	Continued From page 3 R6's Admission Record printed 8/27/21, indicated R6's diagnoses included dementia, lymphoma, diabetes, anxiety and depressed mood, dizziness, and abnormalities of heart beat. R6's comprehensive significant change Minimum Data Set (MDS) assessment dated 6/8/21, indicated R6 had a moderate cognitive impairment, required extensive assistance with transfers, ambulation and locomotion, and had 2 falls since the previous MDS assessment, dated 3/29/21. R6's care plan initiated 7/15/20, indicated R6 was at high risk for falls. R6's care plan further indicated R6 was willing to take part in organized activity programs. R6's care planned interventions regarding dizziness and falls during activities dated 8/24/21, included when possible place R6 at a table where he had a place to rest his head if he started to feel dizzy. R6's care plan indicated R6 had depression and anxiety with increased isolation, impulsivity and decreased sense of well-being, and directed staff to encourage involvement in activities or spending time outside of his room. R6's fall report dated 8/23/21, at 6:35 p.m. indicated R6 had fallen from his wheelchair in the activity room. R6 had stated he was dizzy and after falling, complained of pain in his left hip. R6 was transported to the hospital via ambulance. R6's event note dated 8/23/21, indicated R6 was transported to the hospital at 7:00 p.m. R6's "On The Scene Fall Huddle" report dated 8/23/21, indicated R6 had fallen in the multipurpose room at 6:30 p.m. while listening to	F 550	you did. He states he was not bothered by people being around during event. All residents have the potential to be treated in an undignified manner, especially those who have history of falls in public areas. All staff were re-educated on resident dignity. Included in this education was process for falls when occurring in public location. Staff were reminded to report any potential concerns related to resident dignity to their supervisor or any other member of management staff. Dignity policy and procedure was reviewed and revised to include providing privacy during incidents occurring in common areas. All falls occurring in public spaces will be audited X1 month to assure that dignity policy and procedure was followed. Audits will then continue with 1 fall per week X 2 months. Audit results will be brought to QAPI for review and further recommendations for ongoing monitoring.	

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F 550	Continued From page 4	F 550		

music with a group of other residents and staff. A drawing of the incident indicated at least eight other residents were in the room, most of which were behind him; the piano and a staff member were on the left front side of them, with another staff member to the left side of R6.

On 8/23/21, at 6:39 p.m. R6 was observed to be lying on the floor in the multipurpose room and was about to be lifted off the floor using a mechanical lift and the assist of three staff. R6 was observed to be lying on his back, on the lift sling. The multipurpose room was filled with several residents attending an activity. Staff approached R6 and placed some pillows under his head.
-at 6:41 p.m. R6 was lowered to the floor and unhooked from the mechanical lift.
-at 6:42 p.m. staff stood around R6 while he laid on the floor and the music restarted and the activity program continued.
-at 6:45 p.m. R6 continued to lay on the floor and the mechanical lift was removed from over him. Staff explained to another concerned resident that R6 was going to be sent in (to the hospital) to be checked out.
-at 6:46 p.m. staff were getting a blanket to place on R6, as he continued to lay on the floor while waiting for the ambulance to arrive.
-at 6:48 p.m. other residents were slowly exiting the multipurpose room to give R6 more privacy
-at 6:50 p.m. another resident was outside the open door to the multipurpose room watching R6 closely and was worried about him.
-at 6:53 p.m. R6 continued to lay on the floor with staff watching him and monitoring him. The other residents remained in the room.
-at 6:54 p.m. the ambulance had arrived and a male facility staff reported R6 had complained of

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F 550	Continued From page 5 feeling dizzy and had fallen out of his chair. -at 6:55 p.m. staff brought a mechanical lift into the multipurpose room and shut the door. -at 6:58 p.m. the multipurpose room door opened and R6 was brought out on the gurney. -at 7:00 p.m. R6 left for the hospital via the ambulance. On 8/24/21, at 9:28 a.m. R22 stated she was surprised when the staff did not remove all of them (residents) from the multipurpose room when R6 had fallen the previous night. On 8/26/21, at 9:53 a.m. RN-B stated, when R6 fell during the activity in the multipurpose room, the activity should have been stopped immediately and residents should have been removed at that point. RN-B verified there would be a potential for a dignity concern. On 8/27/21, at 1:28 p.m. the director of nursing (DON) verified leaving R6 laying in the room with other residents having an activity could be a dignity concern. The facility policy and procedure for Quality of Life-Resident Dignity dated 1/21, indicated residents would be treated with respect and dignity at all times, and directed staff to maintain and protect resident privacy, including during assistance with treatment procedures.	F 550		
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate.	F 554		10/5/21

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F 554	Continued From page 6 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the faciltiy failed to ensure a resident was not left with medications to self-admininster without a physician's order for self-administration of medications (SAM) for 1 of 2 residents (R12) reviewed for SAM. Findings include: R12's Admission Record printed 8/27/21, indicated R12's diagnoses included Alzheimer's disease, dementia with behavioral disturbance, and chronic pain. R12's comprehensive annual Minimum Data Set (MDS) dated 6/10/21, indicated R12 had a severe cognitive impairment, had no adverse behaviors during the assessment period, and required extensive assist with eating. R12's Order Summary Report dated 8/27/21, indicated R12's physician orders included: -Tylenol LIquid 1000 milligrams (mg) by mouth three times a day for pain and every 6 hours as needed for pain. Okay to administer in resident's Carnation Instant Breakfast. R12's Order Summary Report lacked an order for SAM. R12's SAM-Self Administer of Medications assessment dated 6/1/21, indicated R12 did not have the mental and physical ability to self-administer medications, and approval for SAM was not granted due to R12's impaired cognitive function, poor dexterity, and resident and/or family request that faciltiy nursing staff administer all medications and treatments.	F 554	R12 is not able to self-administer medications. Staff were educated that R12 is not able to self-administer medications and should be supervised by nurse/TMA while consuming Tylenol. All residents that are not able to self-administer medications have the potential to be affected by this deficient practice. All resident□s will be re-assessed to ensure appropriateness of ability to self-administer medications.Self-administration of medication policy was revised, the statement If resident is unable to self-administer, an order to not leave unattended will be placed in their chart/eTAR will be removed, and replaced with if able to self-administer, this will be specified in special instructions. Residents who are able to self-administer medications after set-up will be allowed to administer medications independently after set-up by nurse and licensed staff will document administration in eMAR. Audits of medication administration to 5 resident□s per day X 1 week, then 3 resident a day X 3 days per week X 3 weeks, then 5 resident□s weekly X 2 months. Audit results will be brought to QAPI for review and further recommendation.	

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F 554	Continued From page 7 On 8/23/21, at 4:56 p.m. registered nurse (RN)-A, prepared 31.25 milliliters (ml) of acetaminophen 160 mg/5 ml (1000 mg) to administer to R12. RN-A poured the acetaminophen into a mug of Carnation Instant Breakfast drink, carried it to the dining room, set it down on the table in front of R12, and said, "There you go." RN-A immediately left the dining room. R12 was left sitting alone at the dining room table by herself with the mug in front of her. Staff in the dining room were passing meal trays and sitting down at other tables to assist residents with eating. On 8/23/21, at 5:09 p.m. RN-A verified R12 did not have orders for self-administer medications and was assessed to not self-administer medications. RN-A verified R12 should not have been left with the Tylenol liquid. On 8/27/21, at 1:28 p.m. director of nursing (DON) stated she would expect that medications would not be left with a resident who was assessed to be inappropriate for self-administration of medications. The DON stated she understood there would be a risk to other residents who were near by and could access the drink, also. The facility policy and procedure for Self-Administration of Medication Evaluation dated 7/19, directed all residents to be assessed for SAM and if the resident wwas unable to self-administer, an order would be placed in their chart to "not leave unattended."	F 554		
F 577 SS=B	Right to Survey Results/Advocate Agency Info CFR(s): 483.10(g)(10)(11)	F 577		10/5/21

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F 577	Continued From page 8 §483.10(g)(10) The resident has the right to- (i) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility; and (ii) Receive information from agencies acting as client advocates, and be afforded the opportunity to contact these agencies. §483.10(g)(11) The facility must-- (i) Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility. (ii) Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request; and (iii) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public. (iv) The facility shall not make available identifying information about complainants or residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure State survey results were accessible at wheelchair height for residents. This had the potential to affect all 39 residents who use wheelchairs for locomotion who reside in the facility. Findings include: On 8/25/21, at 1:31 p.m. a meeting with resident council members was held, and residents were asked if the State inspection results were	F 577	Survey results were lowered to be accessible to residents in wheelchair. Deficiency had the potential to affect all 39 resident□s who use a wheelchair for mobility. Signage placed that large print is available upon request. Social Service Director and management staff were educated regarding requirement of accessibility of survey reports, certifications, and complaint investigations. Policy written to outline requirements of survey result accessibility.	

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F 577	Continued From page 9 available to read without having to ask for them. R14 replied that the State inspection results were available, but were not accessible for people who were in wheelchairs. R14 stated the results were too high for people in wheelchairs to reach, and stated they did not have large print State survey results, either. On 8/25/21, at 2:28 p.m. the State Survey results were located in the hallway near the social services office in a metal file holder on the wall, in a binder that was approximately 5 feet from the floor, and above another metal file holder. The State survey results were not at an accessible height for residents in a wheelchair. On 8/26/21, at 9:09 a.m. the social services director (SSD) stated the binder about vulnerable adult concerns, in the metal file holder below the state surveys were a priority that must be at wheelchair height. SSD verified the state survey results were not accessible from wheelchair height and stated the residents could ask for them. On 8/27/21, at 1:28 p.m. the director of nursing (DON) stated she had not realized the State survey results had been placed in a higher file holder that was inaccessible from wheelchair height. The DON verified the State survey results should be accessible for residents in wheelchairs. A policy and procedure was requested, but was not provided.	F 577	Audits regarding accessibility of survey results will be completed weekly X 1 month, then monthly X 2 months. Audit results will be brought to QAPI for review and further recommendation.	
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes.	F 580		10/5/21

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F 580	Continued From page 10 (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15)	F 580		

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F 580	Continued From page 11 Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to update the provider when blood glucose (sugar) levels fell below 50 milligrams (mg) per deciliter (mg/dl) and did not recover in a timely manner for 2 of 2 residents (R40 and R46) reviewed for diabetic management. Findings include: R40's Admission Record printed 8/27/21, indicated R40's diagnoses included diabetes mellitus (DM) type 2 with hyperglycemia, chronic atrial fibrillation, cardiomyopathy (a disease of the heart muscle that makes it harder for your heart to pump blood to the rest of the body), and dementia. R40's quarterly Minimum Data Set (MDS) dated 8/3/21, identified R40 had intact cognition, exhibited no behaviors or rejection of care, and received insulin injections. R40's care plan revised 8/5/21, indicated R40 had the potential for adverse side effects from insulin use and directed staff to observe for any signs and symptoms of hyperglycemia (elevated blood sugars) or hypoglycemia (low blood sugars) of slurred speech, loss of consciousness, confusion, increased lethargy, sweating, increased thirst and	F 580	The provider was updated on R40 and R46 low blood sugars. All residents with diabetes mellitus have the potential to be affected by this deficient practice. All residents with insulin dependent diabetes were reviewed and no additional hypoglycemic events were found to not have been communicated to the provider. Policy and procedure on notification of changes was reviewed and revised. Licensed staff were educated on changes in policy and procedure, and requirement of notification. Audits to determine if provider is notified of changes per policy will be completed daily X1 week, then 3 days weekly X3 weeks, and weekly X 2 months. Audit results will be brought to QAPI for review and further recommendations.	

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F 580	Continued From page 12	F 580		

urination.

The facility standing orders dated 6/2020, indicated if a resident was unable to consume liquids safely and blood sugar was less than 70 milligrams (mg) per deciliter (dl) mg/dl, give four ounces juice or 15 grams glucose gel. If blood sugar was less than 50 mg/dl give 8 oz. juice or 30 gm glucose gel and update physician/nurse practitioner (NP). If resident was unwilling or unable to consume liquids give Glucagon 1 mg intramuscular (IM) injection from emergency kit (E-Kit) (contains medications that are used to control sudden symptoms) and call physician/NP. Repeat accu-checks in 15 minutes following treatment of low blood sugar. If no change in blood sugar or blood sugar had decreased, call physician/NP.

R40's Physician Orders dated 5/25/21, indicated R40 had orders for blood glucose (BG) checks four times a day (q.i.d.) before meals and at bedtime.

R40's Physician Orders dated 8/13/21, indicated R40 had an order for Glucagon (a hormone that can treat severe low blood sugar) 1 mg intramuscularly (IM) to be kept in the medication cart as needed for follow up on S/O hyperglycemia protocol and to administer for low blood glucose, and not able to swallow.

R40's Physician Orders dated 8/24/21, indicated R40 had orders for Humalog (a rapid acting insulin) 8 units in the morning, and 5 units with supper.

R40's physician progress note dated 8/20/21, indicted R40 had significant hypoglycemic

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episodes which typically occurred around 4:00 p.m. R40's physician note further indicated R40 had hypoglycemia unawareness (a condition in which a person with diabetes does not experience the usual early warning symptoms of hypoglycemia)

R40's blood glucose readings less than 50 mg/dl were as follows:
6/2/21, at 8:00 p.m.: 40 mg/dl
6/11/21, at 4:24 p.m.: 41 mg/dl
7/27/21, at 4:04 p.m.: 36 mg/dl
8/4/21, at 4:29 p.m.: 41 mg/dl
8/16/21, 4:38 p.m.: 49 mg/dl

R40's progress note dated 6/2/21, indicated R40 had a BG of 40 mg/dl at bedtime (8:54 p.m.), was confused and unable to fully communicate. R40's progress note lacked documentation R40's physician or NP were notified of R40's BG below 50 mg/dl as directed in the facility's standing orders.

R40's progress notes dated 6/11/21, lacked documentation R40's physician or NP were notified on 6/11/21, of R40's low BG of 41.

R40's progress note dated 7/27/21, indicated R40's BG was 36 at 4:02 a.m. R40's extremities were shaking and flailing, an R40 was diaphoretic. R40's progress lacked documentation R40's physician or NP were notified of R40's BG below 50.

R40's medical record lacked documentation in the progress notes that R40's physician or NP were notified on 8/4/21, of R40's low BG of 41.

R40's progress note dated 8/16/21, indicated R40

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had a BG of 49, at 4:38 p.m. and showed no signs or symptoms of hypoglycemia. R40's progress note lacked documentation R40's physician or NP were notified of R40's BG below 50.

On 8/25/21, at 12:58 p.m. registered nurse (RN)-E stated she would follow the facility standing orders for a blood sugar that was below 50 mg/dl unless other parameters were ordered by the physician.

On 08/26/21, at 4:27 p.m. the director of nursing (DON) stated if the BG was low and if the resident was alert and able to consume food, she would expect staff to use food instead of a rescue medication. The DON further stated If the resident had eaten, the BG would go up, and the resident's BG would not be rechecked, which the DON stated was using nursing judgement. The DON stated standing orders were implemented when a rescue intervention was used such as glucagon and orange juice, the resident's BG was 50 mg/dl or lower, and the residents BG did not increase then the physician was notified.

On 8/27/21, at 2:50 p.m. a telephone interview was conducted with the NP. The NP stated R40 had hypoglycemia awareness and was unable to recognize when her BG levels were low, so monitoring R40's BG closely was important. The NP stated she would expect staff to follow the facility standing orders and to be notified with any BG levels below 50 or when the resident was not responding to the interventions. The NP stated she relied on staff's documentation in the resident's chart to see the history of the resident's BG levels and how the resident responded to intervention. .

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R46's Admission Record printed 8/26/21, indicated R46's diagnoses included diabetes mellitus (DM) type 2, atherosclerotic heart disease, hypertension (a condition in which the force of blood against the artery walls is too high), neurogenic bladder (lack of bladder control), hyperlipidemia, anxiety, depression and Post traumatic stress disorder.

R46's quarterly Minimum Data Set (MDS) dated 8/11/21, identified R46 had a mild cognitive impairment and required extensive assistance for transfers, bed mobility, dressing, toileting and personal hygiene.

R46's care plan dated 8/23/21, indicated R46 was to have blood sugar checks as ordered, and directed staff to observe and report any signs and symptoms of hyperglycemia (elevated blood sugars) or hypoglycemia (low blood sugars).

R46's Physician Orders dated 6/2/21, indicated R46 had an order to check Blood Glucose (BG) four times daily, before mealtimes and at bedtime by nursing staff.

R46's Physician Orders dated 6/21/21, indicated that R46 had an order to begin BG check on 6/22/21, at 2:00 a.m. The order further stated do not give a snack unless the BG was less than 90 and resident was symptomatic.

R46's Physician Orders dated 7/7/21, included orders for Humalog (fast acting insulin) 8 units three times a day with meals, continue sliding scale (the progressive increase in the pre-meal or nighttime insulin dose, based on pre-defined BG ranges), metformin (helps control blood sugar

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levels), Trulicity (medication that helps the body release its own insulin) and Lantus (long-acting insulin). Staff were directed to continue metformin, Trulicity, and Lantus as ordered. In addition, the provider requested an update in one week.

R46's Facility Standing Orders dated 6/7/18, directed staff to notify the nurse practitioner (NP)-C or physician if two BG results were less than 70 or greater than 400 in a 24-hour period and/or condition changed. If no condition change, notify the next business day.

R46 had 12 BG readings under 70. R46s blood sugars were as follows:

6/9/21, at 1:58 a.m. 67
7/4/21, at 7:12 p.m. 61
7/4/21, at 9:28 p.m. 56 Although this was R46's second BG under 70 within 24 hours, R46's medical record lacked documentation of notification of the physician or nurse practitioner of R46's low blood sugars.
7/5/21, at 3:45 a.m. 69 Although this was R46's third BG under 70 within 24 hours, R46's medical record lacked documentation of notification of the physician or nurse practitioner of R46's low blood sugars and documentation of an assessment and interventions implemented regarding R46's medical status or symptoms of hypoglycemia.
7/5/21, at 8:11 p.m. 68 Although this was R46's third BG under 70 within 24 hours, R46's medical record lacked documentation of notification of the physician or nurse practitioner of R46's low blood sugars and documentation of an assessment and interventions implemented regarding R46's medical status or symptoms of hypoglycemia.
7/12/21, at 9:03 p.m. 68

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7/13/21, at 5:38 a.m. 68 Although this was R46's second BG under 70 within 24 hours, R46's medical record lacked documentation of notification of the physician or nurse practitioner of R46's low blood sugars and documentation of an assessment and interventions implemented regarding R46's medical status or symptoms of hypoglycemia.
7/15/21, at 2:25 a.m. 66
7/24/21, at 7:31 p.m. 60
8/12/21, at 1:52 a.m. 66
8/21/21, at 8:08 p.m. 69
8/25/21, at 8:19 p.m. 69

R46's progress note dated 7/4/21, at 9:28 p.m. indicated that R46 refused a snack, BG dropped to 56. R46 then agreed to a glass of regular Coke and two graham crackers after all other options were refused.

R46's progress note dated 7/12/21, at 9:20 p.m. stated R46 consumed sweet and sour pork over rice with mixed vegetables and a glass of Diet Coke.

R46's progress note dated 7/24/21, at 7:33 p.m. stated double check insulin three times a day for diabetes, Humalog checked by registered nurse (RN).

R46's progress note dated 8/12/21, at 2:36 a.m. indicated staff was to obtain a 2:00 a.m. BG. Reading at 2:00 a.m. was 66. RN-D asked resident if he would like a snack. R-46 Resident declined stated he felt fine.

R46's progress note dated 8/21/21, at 10:16 p.m. indicated that R46's BG ran low this whole shift, stated he didn't eat lunch because it was salad.

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R46 ate 100% of supper: salisbury steak, mashed potatoes, drank all his fluids.

R46's progress note dated 8/25/21, at 10:47 p.m. stated that R46 had consumed a pork cutlet and wild rice with mixed vegetables and a sandwich for supper with a glass of milk and had eaten 100%.

The facility standing orders dated 6/2020, indicated if a resident was unable to consume liquids safely and blood sugar was less than 70 milligrams (mg) per deciliter (dl) mg/dl, give four ounces juice or 15 grams glucose gel. If blood sugar was less than 50 mg/dl give 8 oz. juice or 30 gm glucose gel and update physician/nurse practitioner (NP). If resident was unwilling or unable to consume liquids give Glucagon 1 mg IM injection from emergency kit (E-Kit) (contains medications that are used to control sudden symptoms) and call physician/NP. Repeat accu-checks in 15 minutes following treatment of low blood sugar. If no change in blood sugar or blood sugar had decreased, call physician/NP.

On 08/26/21, at 10:33 a.m. licensed practical nurse (LPN)-A stated if the BG was under 100, she would look to see what R46 had eaten, if R46 had not eaten LPN-A would call the provider and still give the Lantus, LPN-A would consult with an RN on duty or RN-B if a good meal was eaten, to see what was recommended.

On 08/26/21, at 11:10 a.m. RN-B stated that depending on what the BG reading was, she would offer a snack, hold the insulin, call the provider and document in the progress note or Treatment Administration Record (TAR). RN-B stated she would have expected staff to follow the

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standing orders.

On 8/26/21, at 12:12 p.m. the registered nurse (RN)-B stated she would expect nursing to document low blood sugars and notify the physician according to the physician orders, parameters and standing orders. RN-B further stated the nurse should conduct an assessment, and document if the resident was experiencing any symptoms with blood sugars outside the parameter. The RN-B verified there was no documentation or indication if the physician or NP-C was notified or if interventions and monitoring were implemented regarding R46's low blood sugars.

On 08/26/21, at 4:27 p.m. the director of nursing (DON) stated if the BG was low and if the resident was alert and able to consume food, she would expect staff to use food instead of a rescue medication. If the resident had eaten, "you know" the BG was going to go up after eating, and we would not recheck the BG after eating. The DON also stated standing orders were looked at as a rescue such as glucagon and orange juice. The DON stated that was her interpretation; "If a rescue medication was used, then the BG would be rechecked after 15 minutes." The DON acknowledged the instructions on the standing order should have been clearer.

On 8/27/21, at 2:41 p.m. in a telephone interview with the NP-C she indicated that R46 was on multiple diabetic medications due to his erratic BG levels. Trulicity was added and R46 responded well initially, and the Lantus dose was decreased. Trulicity had since been increased to the maximum dose of 4.5 milligrams (mg) weekly. The NP would expect staff to follow the facility

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F 580	Continued From page 20 standing orders for diabetics. The NP would expect treatment and monitoring every 15 minutes if symptomatic or at least until BG is above 70. If R46 was not responding to interventions the NP would expect to be notified. Blood Glucose Monitoring Policy recognizing symptoms of altered BG dated 1/15/21, indicated hypoglycemia is a condition resulting when the blood glucose levels drop below the specified limits less than 72 miligrams per decilitre (mg/dl). With confirmed hypoglycemia, implement Aicota's Standing Orders (SO). SO for hypoglycemia is glucose 15 gel 40%, or hypoglycemia Glugagon 1 mg, located in the emergency kit, then update MD/NP.	F 580		
F 583 SS=E	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident,	F 583		10/5/21

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F 583	Continued From page 21 including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to maintain confidentiality for all 41 residents who eat in the dining room whose Personal Health Information (PHI) was observed posted in the dining area on a six by eight-inch laminated dining card on all tables visible to all who entered the dining room during mealtimes. Findings include: On 8/23/21, at 5:00 p.m. during an evening meal, laminated dining cards were on all tables for assigned seating. The dining cards contained the following information: resident name, admit date, birth date, religion, room number, diet order including special diets, textures, allergies, adaptive equipment needed, alerts, standing orders, dislikes, and preferences. The information was visible to all who entered the room. On 8/25/21, at 12:30 p.m. the laminated meal cards were on all tables in the dining room.	F 583	All resident□s who eat in the dining room had the potential to be affected by this deficient practice. During survey meal cards were modified to remove some private information. Meal cards will no longer be placed at tables where they can be seen by other resident□s/visitors. Meal cards will be used only for staff visualization while getting the resident□s plate of food and liquids, it will then be placed in an area to assure privacy of information contained on meal card. Policy and procedure regarding Quality of Life-Dignity was reviewed and revised, it will continue to state that staff will protect confidential clinical information, and that resident□s clinical status or care needs will not be openly posted unless specifically requested by resident/resident representative. Privacy policy was created along with Dignity policy to further define privacy practices in line with current standard of practice. Meal service process	

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F 583	Continued From page 22 On 8/26/21, at 1:07 p.m. the dietary manager (DM) was interviewed. DM stated the facility had been using the laminated dining cards for three to four years with no resident complaints. DM further stated the cards were generated from the electronic medical record system (EMR) and there was no way to change or modify the information. The DM did not agree it was a violation of resident privacy. The facility Dining policy dated 11/1/17, indicates family and visitors are welcome to dine with their loved ones. The facility policy titled Quality of Life - Resident Dignity dated 1/21/21, directed staff to treat all residents with dignity and respect. The policy further directed staff to protect confidential clinical information. Examples given were signs indicating the resident's clinical status or care needs would not be openly posted unless specifically requested by the resident or family member. Discreet posting of important clinical information for safety reasons was permissible, an example given was to tape the information inside the resident's closet door. A privacy policy was requested but not received.	F 583	will be modified to assist in not placing meal cards at resident tables. All staff were educated on new process of meal service and use of meal cards. They will also be educated on changes to Dignity policy as well as the new privacy policy. Dining room audits and use of meal cards will be completed 1 meal per day X 1 week, 3 meals per week X 3 weeks and then weekly X 2 months. Audit results will be brought to QAPI for review and further recommendations.	
F 585 SS=D	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with	F 585		10/5/21

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respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay.

§483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph.

§483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident.

§483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include:
(i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman

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program or protection and advocacy system;
(ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations;
(iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated;
(iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law;
(v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued;
(vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement

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F 585	Continued From page 25 Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure grievances related to missing item of clothing were resolved for 1 of 1 resident (R24) reviewed for missing property. Findings include: R24's Admission Record printed 8/27/21, indicated R24's diagnoses included emphysema, left lower leg open wound, and depression. R24's quarterly Minimum Data Set (MDS) dated 6/21/21, indicated R24 was cognitively intact, and required assistance with bed mobility, transferring, dressing, toileting, and personal hygiene. R24's Clothing Inventory sheet dated 7/5/21, listed a pair of moose pajama pants. The facility's Grievance/Concern Log dated 4/1/21, through 8/4/21, did not include R24's missing purple moose printed pajama pants. On 8/23/21, at 7:05 p.m. R24 stated she had reported to staff she was missing a blue shirt and a pair of purple pants with moose print which she wore on admission, and had not seen since. R24 stated she had not filled out any forms and has not been updated about her missing items of	F 585	R24□s missing pants were documented on a grievance form and grievance was satisfied. All resident□s have the potential to be affected by this deficient practice. All resident□s have been interviewed to determine if any clothing items are missing. All concerns from interviews have been addressed. Grievance policy is up to date and reflects current standard of practice. All staff were educated on grievance process including how, when and why to fill out a grievance. Social service director and management staff have been educated regarding grievance process as well. Grievance forms continue to be located outside of Social Service office and are accessible to all resident□s and staff. Audits will be conducted by interviewing resident□s to determine if they have any grievances and if so, has the grievance been satisfied. This will be completed on 5 resident□s X 1 week, 3 residents per week X3 weeks and 1 resident weekly for 2 months. Results will be brought to QAPI for review and recommendation.	

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F 585	Continued From page 26	F 585		

clothing.

On 8/25/21, at 12:39 p.m. housekeeping (HK)-A stated she was aware R24 was missing a pair of moose printed pants, and was unaware if R24's pants were found. HK-A stated when laundry staff marked residents clothing it was logged on a Clothing Inventory form that was kept in a three-ring binder book in the laundry room. HK-A reviewed R24's Clothing Inventory sheet and verified moose pajama paints were listed. HK-A verified there was no Missing Laundry Item form completed for R24 in the clothing inventory book, or listed on the dry erase board where missing clothing items were written.

On 8/25/21, at 12:45 p.m. HK-B stated if a someone reported a missing item of clothing a Missing Laundry Item form would be completed, and if unable to find the missing item, would report to environmental director (ED)-A. HK-B stated R24's blue shirt was found a while ago and returned to R24 and R24's pants were not found. HK-B stated she could not find a Missing Laundry Item form for R24's purple pants and verified R24's Clothing inventory sheet dated 7/5/21, listed a pair of moose pajama pants. HK-A further stated according to R24's Clothing Inventory sheet, laundry staff had R24's pants at one time to be labeled.

On 8/25/21, at 1:27 p.m. ED-A stated he heard R24 was missing a pair of plaid pants which were found in the unmarked missing laundry, which were not R24's pants. ED-A stated if a someone reported a missing item of clothing, ED-A would expect staff to report it to social service director (SSD)-A to initiate an investigation, and further stated that process did not happen in R24's case.

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F 585	Continued From page 27 On 8/26/21, at 9:59 a.m. SSD-A stated she was not informed until yesterday R24 was missing clothing, so she was unable to follow the process on investigating and follow up with R24. SSD-A further stated she expected staff to complete a grievance form which would bring the concern to her attention. On 8/27/21, at 10:36 a.m. registered nurse (RN)-C stated staff had not reported R24 was missing a pair of purple moose printed pants. RN-C stated if R24 reported to staff she was missing clothing, staff should have completed a grievance form and notified SSD-A so it could be looking into further. On 8/30/21, at 1:56 p.m. the director of nursing (DON) stated the staff should have reported the missing items of clothing to start the investigation and grievance process. The facility policy Missing Resident Clothing Items dated 5/7/21, directed any missing clothing item would be brought to the attention of the Social Services Department via grievance form per staff, resident, or representative, receiving complaint of the missing item. The policy further directed if the item was not found, it would be added to the list for laundry staff to continue to look for as unlabeled items were returned to the laundry department.	F 585		
F 604 SS=D	Right to be Free from Physical Restraints CFR(s): 483.10(e)(1), 483.12(a)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including:	F 604		10/5/21

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F 604	Continued From page 28 §483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(2) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure 1 of 3 residents (R36) was free from the use of physical restraints. Findings include: R36's quarterly Minimum Data Set (MDS) dated 7/21/21, indicated severe cognitive impairment with inattention and disorganized thinking. R36	F 604	Assessment for R36 lap buddy was completed. All residents with limited mobility or cognitive impairment have the potential to be affected by this deficient practice. All resident□s utilizing devices that have the potential to be restraints have been assessed for devices to determine if device meets the criteria for restraint. New restraint assessment was built into EMR	

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F 604	Continued From page 29 was an extensive assist with bed mobility, transfers, and toileting. R36's diagnoses included Alzheimer's disease, non-Alzheimer's dementia, and wandering. R36's MDS did not identify the use of any restraints. R36's Falls Care Area Assessment (CAA) dated 1/20/21, identified a potential for falls related to impaired cognition, impaired balance and mobility. Anti-rollback brakes were on R36's wheelchair, R36 was to have a low bed, fall mat on floor, and bed alarm while in bed. R36's care plan indicated a history of a fall with a fracture to the right wrist dated 2/1/19. An intervention dated 1/20/20, was a lap buddy (a cushion which goes over the resident's thighs and is strapped to the wheelchair) on wheelchair to decrease self-transfers. R36's Kardex (information a nursing assistant (NA) to care for resident) dated 8/26/21, identified lap buddy on wheelchair to decrease self-transfers. An assessment for restraints was requested, but not received. On 8/23/21, at 2:30 p.m. R36 waas observed with a lap buddy on her wheelchair and strapped to the arms of the wheelchair. On 8/23/21, at 5:36 p.m. R36 was in the common area and the lap buddy was attached to her wheelchair. On 8/24/21, at 9:25 a.m. R36 was pulling at the straps of the lap buddy and attempting to push it away from her.	F 604	system for use when assessing assistive devices. Restraint Free policy and procedure was reviewed and revised to include use of restraint assessment with all assistive devices that could potentially restrict ability or limit mobility. Nursing staff educated on definition of restraint, items that could potentially be determined to be a restraint, new restraint assessment, as well as requirements if using restraint in the facility. Educated on policy and procedure changes. Audits will be completed to identify if an assessment was completed with assistive device. This will be completed on 3 residents□ daily X1 week, then 1 resident daily X3 weeks, and 1 resident weekly X 2 months. Audit results will be brought to QAPI for review and further recommendation.	

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F 604	Continued From page 30 On 8/24/21, at 11:03 a.m. R36 was sitting in the common area with lap buddy in place. On 8/25/21, at 7:31 a.m. R36 was sitting by the dining room and the lap buddy was in place. On 8/25/21, at 12:29 p.m. R36 was by the nurse's station in her wheelchair with the lap buddy in place over her legs and the straps attaching the lap buddy were within reach. During interview on 8/26/21, at 9:09 a.m. nursing assistant (NA)-A stated the family was requesting to have the lap buddy in place so she does not fall. The lap buddy was used to stop the resident from attempting to exit her wheelchair and had prevented a few falls. R36 was not able to remove the lab buddy when asked because she could not understand what was being asked. During interview on 8/26/21, at 9:53 a.m. registered nurse (RN)-C, the unit coordinator, stated the lap buddy was a reminder for R36 to remain in her wheelchair. R36 would periodically pull at the straps of the lap buddy and it would come off, but R36 was not able to do it when asked. There was no restraint assessment done because progress notes indicated R36 was able to remove it on her own when pulling at the straps. RN-C stated there should have been an assessment done on the lap buddy because it can be used as a restraint and was used to keep her in the wheelchair. The facility's Restraint Free Policy dated 1/29/21, identified a physical restraint at any manual method or physical or mechanical device, material or equipment attached or adjacent to the	F 604		

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F 604	Continued From page 31 resident's body that he/she cannot remove easily or restricts freedom of movement. All residents with noted behaviors would be discussed at the inter-disciplinary team (IDT) meeting to determine if a restraint would be acceptable for a short-term intervention, which would be care planned, with follow up and MD/NP input as to continued need. The policy did not indicate if assessments for restraints were needed or the frequency of assessments.	F 604		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to assess 1 of 5 residents (R8) who was identified as having a significant weight gain on the Minimum Data Set (MDS). Findings include: R8's quarterly MDS dated 6/1/21, identified severe cognitive impairment with no behaviors. R8's diagnoses included Alzheimer's disease, depression and hypothyroidism (deficiency of hormones which can disrupt all aspects of metabolism and weight). The MDS identified R8 had an increase in weight of 5% or more in the past month or 10% or more in the last six months and was not on a physician-prescribed weight-gain regimen. R8's admission Care Area Assessment (CAA) dated 3/9/21, for nutrition identified R8 had	F 641	A comprehensive assessment of weight gain was completed for R8. Appropriate individualized interventions were developed based on the results of the comprehensive assessment. All residents with significant weight gain have the potential to be affected by this deficient practice. Nutritional assessment□s will be completed on all residents who have significant weight loss or gain. Procedure regarding changes in resident weight was reviewed and revised to include weight gain as well as weight loss. CDM, NTL□s and all licensed nursing staff were educated regarding procedure changes. Audits will be completed to ensure that assessments are completed, accurate, and appropriate interventions are put into place. These will be completed on 3 resident□s weekly X4 weeks, then 1	10/5/21

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F 641	Continued From page 32 hypothyroidism and to maintain current level of function. R8's dietary assessment dated 6/8/21 did not address the weight gain noted in the MDS dated 6/1/21, identified R8 had a liberalized geriatric/house diet with regular portions. R8's care plan dated 6/8/21 indicated no nutritional problem at this time, she has actually gained 15 pounds (lbs.) from admission. R8 had a dementia dianosis and forgot she had eaten and got very upset when you tell her, so she does eat multiple times a day. R8's interventions included. -continue to orientate to the facility's meal plan and times as she had a very poor memory; dated 3/17/21. -Food intake monitoring as needed; dated 3/9/21. -Preferred eating at a shared table; dated 5/17/21. -Encourage resident to make choices at all meals and snacks. She likes Cheerios, toast, and milk for breakfast; dated 6/8/21. R8's admission weight on 2/26/21, was 169.9 lbs. and on 8/22/21, was 193.8 lbs. which was a 23.9 lbs. or 14% weight gain in the past 6 months. R8 had one dietary progress note from 3/25/21, done by the registered dietician and identified R8 had potential for alteration in nutritional status due to dementia with no current nutrition concerns. During interview on 8/27/21, at 11:14 a.m. the certified dietary manager (CDM) stated the registered dietician did the initial assessment on 3/25/21, and did not have any concerns. The quarterly assessments are done by the CDM. The	F 641	resident weekly X 2 months. Audit results will be brought to QAPI for review and recommendations.	

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F 641	Continued From page 33 CDM stated it was identified on 6/8/21, that R8 had a 15 lbs. or 9% weight gain since admit and this was entered on the care plan, The CDM stated R8 ate multiple meals each day and was hard to redirect. Her meals are "toned down" and the weight gain was addressed in the care plan. The dietary assessment was not done on 6/8/21, due to it being addressed on the care plan and the care plan updated to include to encourage resident to make food choices. The CDM did not think she had to address concerns on the dietary assessment and only needed to update it on the care plan. The facility's Residents Nutritionally At-Risk policy dated 5/21/21, did not address concerns or procedures for identifying significant weight increases in residents.	F 641		
F 684 SS=J	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure 2 of 2 residents (R40 and R46) reviewed for diabetic management were provided adequate care in accordance with current standards of practice and facility standing orders. This practice included lack of monitoring	F 684	The facility failed to monitor for signs and symptoms of hypoglycemia following episodes of low glucose below 70 mg/dL as directed in the facility standing orders. After review of the current standing orders, it was determined that the facility	10/5/21

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F 684	Continued From page 34 of low diabetic blood glucose (sugar) readings and lack of physician notification, which resulted in an immediate jeopardy (IJ) for R40 and R46. The Immediate Jeopardy (IJ) began on 6/2/21, when R40 had a blood glucose reading of 40 milligrams per decilitre (mg/dl) without physician notification for further evaluation of diabetic management, and further lack of continued monitoring of R40's blood glucose (BG) until R40's BG was 70 mg/dl , or higher. The administrator and director of nursing (DON), were notified of the IJ on 8/26/21, at 6:03 p.m. The IJ was removed on 8/27/21, at 2:40 p.m. but noncompliance remained at the lower scope and severity level of D, no actual harm with the potential for more than minimal harm that is not IJ. Findings include: R40's Admission Record printed 8/27/21, indicated R40's diagnoses included Diabetes Mellitus (DM) type 2 with hyperglycemia (low blood sugar), chronic atrial fibrillation, cardiomyopathy (a disease of the heart muscle that makes it harder for your heart to pump blood to the rest of the body), and dementia. R40's quarterly Minimum Data Set (MDS) dated 8/3/21, identified R40 had intact cognition, exhibited no behaviors or rejection of care, and received insulin injections. R40's care plan revised 8/5/21, indicated R40 had the potential for adverse side effects from insulin use and directed staff to observe for any signs and symptoms of hyperglycemia (elevated blood sugars) or hypoglycemia (low blood sugars) of	F 684	standing orders needed to be updated to include monitoring. The failure to ensure proper documentation and follow up was a lack of education provided to staff. All resident who are currently being monitored for blood glucose will be reviewed to ensure orders are accurate. To ensure staff have been educated on current process and facility revised standing orders. All nurses/TMA were provided education on updated standing orders of the facility on 8/27/2021 or prior to next working shift. Facility standing orders were updated to include monitoring of resident to ensure appropriate glucose levels are obtained and treatment is given. Specifics of the standing orders include: 1. If Resident is able to consume liquids safely and blood sugar is <70mg/dl, give 4 oz. juice or 15gm Glucose Gel. 2. If blood sugar is <50mg/dl, give 8 oz. juice or 30gm Glucose Gel and update MD/NP. If Resident is unwilling or unable to consume liquids give Glucagon 1mg IM injection from E-Kit & call MD/NP. 3. Repeat accu-checks in 15 minutes following treatment of low blood sugar. 4. Repeat steps 1-3 until blood sugar is above or equal to 70 mg/dl. 5. If no change in blood sugar or blood sugar has decreased after repeating steps 1-3 twice, call MD/NP. New standing orders include glucose checks every 15 minutes after treatment and again until appropriate glucose levels are reached. Education for all nurses was provided on medication administration; avoiding common errors, diabetes; the	

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F 684	Continued From page 35 slurred speech, loss of consciousness, confusion, increased lethargy, sweating, increased thirst and urination. R40's Physician Orders dated 5/25/21, indicated R40 had orders for blood glucose (BG) checks four times a day (q.i.d.) before meals and at bedtime. Facility standing orders dated 6/2020, indicated if a resident is able to consume liquids safely and blood sugar is less than 70[milligrams] [per deciliter] mg/dl, give four ounces juice or 15 gm [grams] glucose gel. If blood sugar is less than 50 mg/dl give 8 oz. juice or 30 gm glucose gel and update physician/nurse practitioner (NP). If resident is unwilling or unable to consume liquids give Glucagon 1 mg IM [intramuscular] injection from [emergency kit] E-Kit [contains medications that are used to control sudden symptoms] and call physician/NP-C. Repeat accu-checks [blood sugar] in 15 minutes following treatment of low blood sugar. If no change in blood sugar or blood sugar has decreased, call physician/NP. R40's Physician Orders dated 8/13/21, indicated R40 had an order for Glucagon (a hormone that can treat severe low blood sugar) 1 mg intramuscularly (IM) to be kept in the medication cart as needed for follow up on standing orders for hyperglycemia protocol and to administer for low blood glucose, and not able to swallow. R40's Physician Orders dated 8/24/21, indicated R40 had orders for Humalog (a rapid acting insulin) 8 units in the morning, and 5 units with supper. Review of R40's medical record revealed the	F 684	basics and managing blood glucose levels. All nursing staff with the potential to administer or check blood glucose will be educated prior to their next working shift. To ensure staff are educated prior to the shift, their building access will be deactivated and will need to speak to department manager and complete education to return to the floor. The facility/ Director of Nursing will also complete audits on all blood glucose readings for the next week beginning with overnight shift starting 10:30p on 08/26/2021. If compliance is met with all audits in first week, audits will decrease to three (3) days a week for 2 weeks. The audits will determine if any reading <70 mg/dL had proper documentation that the standing order was followed correctly. Audits will be reviewed at the next quality council meeting to determine compliance or if further action is needed. Audits will continue on one resident per day/3 days per week X1 month, results will be brought to QAPI for review and recommendation.	

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F 684	Continued From page 36	F 684		

following:

R40's blood glucose readings less than 50 mg/dl for the months of June, July and August 2021 were as follows:
6/2/21, at 8:00 p.m.: 40 mg/dl
6/11/21, at 4:24 p.m.: 41 mg/dl
7/27/21, at 4:04 p.m.: 36 mg/dl
8/4/21, at 4:29 p.m.: 41 mg/dl
8/16/21, 4:38 p.m.: 49 mg/dl
8/19/21, at 4:10 p.m.: 44 mg/dl

R40's progress notes from 6/2/21 to 8/19/21 revealed the following:

- 6/2/21, BG of 40 at bedtime (8:54 p.m.), was confused and unable to fully communicate. R40's progress note lacked documentation R40's physician or NP were notified of R40's BG below 50 as directed in the facilities standing orders. In addition, R40's progress note indicated R40's BG was not checked again until 9:24 p.m. with a BG of 60 and then not again until 7:33 a.m. the next day.

- 6/11/21, BG was 41 at 4:24 p.m., lacked documentation R40's physician or NP were notified and R40's BG was not checked again until 9:35 p.m.

-7/27/21, BG was 36 at 4:02 a.m. R40's extremities were shaking and flailing, and diaphoretic. R40 was administered a tube of oral glucose gel (medicine to treat low blood sugar) and a glass of orange juice. R40's BG rechecked at 4:20 p.m. was 51, at 4:51 p.m. was 59. R40's BG was not checked again until 6:01 p.m. R40's progress lacked documentation R40's physician or NP were notified of R40's BG below 50.

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-8/4/21, BG was 41 at 4:29 p.m., lacked documentation of monitoring R40's medical status for signs or symptoms of hypoglycemia, and if interventions to treat hypoglycemia were implemented. R40's progress note further lacked documentation R40's physician or NP were notified of R40's BG of 41.

-8/16/21, BG of 49, at 4:38 p.m. and showed no signs or symptoms of hypoglycemia. R40's BG was not checked again until 8:39 p.m. R40's progress note lacked documentation R40's physician or NP was notified of R40's BG below 50.

-8/19/21, BG of 44 at 4:10 p.m. and was given a Glucagon orally. A R40's BG was 59 at 5:15 p.m. and not rechecked again until 6:55 p.m. Although R40's NP was notified, the facility failed to continue to monitor R40's BG according the facility standing orders.

For the months of 6/21, 7/21 and 8/21, R40 had the following blood glucose levels below 70 mg/dl:

-6/4/21, at 8:29 p.m. BG 68. R40's medical record lacked documentation of monitoring R40's medical status for signs or symptoms of hypoglycemia, and if interventions to treat hypoglycemia were implemented. R40's BG was not rechecked until 10:01 p.m.

-6/6/21, at 4:43 p.m. BG 61. R40's medical record lacked documentation of monitoring R40's medical status for signs or symptoms of hypoglycemia, and if interventions to treat hypoglycemia were implemented. R40's BG was

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not rechecked until 8:57 p.m.

-6/7/21, at 8:27 p.m. BG 66. R40's medical record lacked documentation of monitoring R40's medical status for signs or symptoms of hypoglycemia, and if interventions to treat hypoglycemia were implemented. R40's BG was not rechecked until 6/8/21 at 8:05 a.m.

-6/13/21, 11:37 a.m. BG 63. R40's medical record lacked documentation of monitoring R40's medical status for signs or symptoms of hypoglycemia, and if interventions to treat hypoglycemia were implemented. R40's BG was not rechecked until 6/13/21, at 4:38 p.m.

-6/17/21, at 9:15 p.m. BG was 53 and 65. R40's medical record lacked documentation of monitoring R40's medical status for signs or symptoms of hypoglycemia, and if interventions to treat hypoglycemia were implemented. R40's BG was not rechecked until 8/18/21, at 1:15 a.m.

- 6/30/21, at 4:41 p.m. BG was 67. R40's medical record lacked documentation of monitoring R40's medical status for signs or symptoms of hypoglycemia, and if interventions to treat hypoglycemia were implemented. R40's BG was not rechecked until 6/30/21, at 9:10 p.m.

-7/5/21, at 4:30 p.m. BG was 55, at 5:05 p.m. R40 had a fall and R40's progress notes lacked recheck of R40's BG at the time of fall was was not rechecked until 9:15 p.m.

-7/9/21, at 4:49 p.m. BG was 64. R40's medical record lacked documentation of monitoring R40's medical status for signs or symptoms of hypoglycemia, and if interventions to treat

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hypoglycemia were implemented. R40's BG was not rechecked until 9:47 p.m.

-7/21/21, at 4:38 p.m. BG was 55. R40's medical record lacked documentation of monitoring R40's medical status for signs or symptoms of hypoglycemia, and if interventions to treat hypoglycemia were implemented. R40's BG was not rechecked until 8:29 p.m.

-7/24/21, at 4:47 p.m. BG was 67. R40's medical record lacked documentation of monitoring R40's medical status for signs or symptoms of hypoglycemia, and if interventions to treat hypoglycemia were implemented. R40's BG was not rechecked until 9:01 p.m.

-7/25/21, at 4:41 p.m. BG was 58. R40's medical record lacked documentation of monitoring R40's medical status for signs or symptoms of hypoglycemia, and if interventions to treat hypoglycemia were implemented. R40's BG was not rechecked until 9:03 p.m.

-7/30/21, at 8:01 p.m. BG was 64. R40's medical record lacked documentation of monitoring R40's medical status for signs or symptoms of hypoglycemia, and if interventions to treat hypoglycemia were implemented. R40's BG was not rechecked until 11:54 a.m.

-8/3/21, at 8:45 p.m. BG was 63. R40's medical record lacked documentation of monitoring R40's medical status for signs or symptoms of hypoglycemia, and if interventions to treat hypoglycemia were implemented. R40's BG was not rechecked until 8/4/21, at 8:48 a.m.

-8/5/21, at 4:57 p.m. BG was 53. R40's medical

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record lacked documentation of monitoring R40's medical status for signs or symptoms of hypoglycemia, and if interventions to treat hypoglycemia were implemented. R40's BG was not rechecked until 9:57 p.m.

- 8/7/21, at 8:26 a.m. BG was 65. R40's medical record lacked documentation of monitoring R40's medical status for signs or symptoms of hypoglycemia, and if interventions to treat hypoglycemia were implemented. R40's BG was not rechecked until 11:40 a.m.

- 8/10/21, at 9:51 p.m. BG was 64. R40's medical record lacked documentation of monitoring R40's medical status for signs or symptoms of hypoglycemia, and if interventions to treat hypoglycemia were implemented. R40's BG was not rechecked until 8/11/21, at 8:36 a.m.

- 8/11/21, at 4:44 p.m. BG was 65. R40's medical record lacked documentation of monitoring R40's medical status for signs or symptoms of hypoglycemia, and if interventions to treat hypoglycemia were implemented. R40's BG was not rechecked until 8:16 p.m.

-8/14/2021, at 4:36 p.m. BG was 63. R40's medical record lacked documentation of monitoring R40's medical status for signs or symptoms of hypoglycemia, and if interventions to treat hypoglycemia were implemented . R40's BG was not rechecked until 9:16 p.m.

- 8/15/2021, at 4:36 p.m. BG was 52. R40's medical record lacked documentation of monitoring R40's medical status for signs or symptoms of hypoglycemia, and if interventions to treat hypoglycemia were implemented. R40's

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BG was not rechecked until 9:11 p.m.

Review of R40's physician progress note dated 8/20/21, revealed R40 had significant hypoglycemic episodes. R40's physician note further indicated R40 had hypoglycemia unawareness (is a condition in which a person with diabetes does not experience the usual early warning symptoms of hypoglycemia) and staff needed to monitor R40 closely.

On 8/25/21, at 12:58 p.m. registered nurse (RN)-E stated R40's BG levels had been all over and lately had been running extremely low which required R40 to be administered Glucagon IM. RN-E stated the night shift nurse reported R40 had questionable behavior and was showing signs of confusion. RN-E stated R40's BG on 8/25/21, at approximately 7:00 a.m. was 68 and R40 was given a glass of orange juice. RN-E stated she did not recheck R40's BG after 15 minutes because R40 was going to eat breakfast.

On 8/26/21, at 12:52 p.m. the director of nursing (DON) verified R40's blood glucose on 8/24/21, at 4:20 p.m. was 58 and R40's BG had not been checked again until 8:50 p.m. The DON stated R40 was not symptomatic, was able to take in juice, and ate 76-100% of her meal, so it was not necessary to recheck R40's BG. The DON further stated the nurses used nursing judgement on when to recheck a BG and she would expect R40's BG to have increased after given juice and eating supper. The DON stated the facility standing orders for low BG were in place for when a resident was given a rescue medication or if a resident was unable to consume liquids then rechecking the BG in 15 minutes would be necessary.

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F 684	Continued From page 42 On 8/27/21, at 2:50 p.m. NP-C stated R40 had hypoglycemia unawareness and was unable to recognize when her BG levels were low, so monitoring R40's BG closely was important. The NP-C stated R40's BG had no pattern and could go from BG levels of 40 to 600, and the low BG levels were more detrimental than the highs. The NP-C stated she would expect staff to follow the facility standing orders and monitor a residents BG level below 70 every 15 minutes until the BG was 70 or higher. NP-C further stated, residents could drop even after a treatment was given so it was important to recheck BG every 15 minutes regardless if it was around meal time or a meal was consumed. NP-C stated she would expect to be notified with any BG levels below 50 or when the resident was not responding to the interventions. NP-C stated she relied on staff's documentation in the resident's chart to see the history of the resident's BG levels, interventions used and the residents response to determine further treatment. R46's Admission Record printed 8/26/21, indicated R46's diagnoses included Diabetes Mellitus (DM) type 2, atherosclerotic heart disease, hypertension (a condition in which the force of blood against the artery walls is too high), neurogenic bladder (lack of bladder control), hyperlipidemia, anxiety, depression and post traumatic stress disorder. R46's quarterly Minimum Data Set (MDS) dated 8/11/21, identified R46 had a mild cognitive impairment and required extensive assistance for transfers, bed mobility, dressing, toileting and personal hygiene.	F 684		

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R46's care plan dated 8/23/21, indicated R46 was to have blood sugar checks as ordered, and directed staff to observe and report any signs and symptoms of hyperglycemia (elevated blood sugars) or hypoglycemia (low blood sugars).

Facility Standing Orders for hypoglycemia for R46 dated 6/2020, indicated that if a resident was able to consume liquids safely and BG was less than 70 mg/ml, give four ounces of juice or 15 grams glucose gel. If BG was less than fifty mg/dl. give eight ounces of juice or thirty grams glucose gel and update MD/NP. If resident was unwilling or unable to consume liquids give Glucagon 1 mg intramuscular (IM) injection from e-kit and call MD/NP. Repeat accu-checks in 15 minutes following treatment of low BG. If no change in BG or BG has decreased, call MD/NP.

R46's Physician Orders dated 6/2/21, indicated R46 had an order to check BG four times daily, before mealtimes and at bedtime with nursing staff.

R46's Physician Orders dated 6/21/21, indicated that R46 had an order to begin BG check on 6/22/21,at 2:00 a.m. The order further directed not to give a snack unless the BG was less than 90 and resident was symptomatic.

R46's Physician Orders dated 7/7/21, included orders for Humalog (a rapid acting insulin) 8 units three times a day (TID) with meals, continue sliding scale, metformin, Trulicity (a non-insulin option that helps the body release the insulin it's already making) and Lantus (a long-acting insulin). Will continue metformin, Trulicity and Lantus as ordered. R46 receives his Lantus in the

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morning. Would like an update again in a week.

R46's medical record revealed blood sugars less than 70 mg/dl were as follows:

On 6/9/21, at 1:58 a.m.: 67 mg/dl. Although this BG was under 70, there was no documentation of an assessment, a BG recheck or that any interventions were implemented regarding R46's medical status or symptoms of hypoglycemia. There was also no indication if the MD/NP was notified.

7/4/21, at 7:12 p.m.: 61 mg/dl. Although this BG was under 70, there was no documentation of an assessment, a BG recheck done in a timely manner or that any interventions were implemented regarding R46's medical status or symptoms of hypoglycemia. There was also no indication if the MD/NP was notified.

7/4/21, at 9:28 p.m.: 56 mg/dl. Although this BG was under 70, there was no documentation of an assessment, or a BG recheck. R46 refused a snack at 9:54 p.m. There was also no indication if the MD/NP was notified.

7/5/21, at 3:45 a.m.: 69 mg/dl. Although this BG was under 70, there was no documentation of an assessment or that any interventions were implemented regarding R46's medical status or symptoms of hypoglycemia. There was also no indication if the MD/NP was notified.

7/5/21, at 8:11 p.m.: 68 mg/dl. Although this BG was under 70, there was no documentation of an assessment, a BG recheck or that any interventions were implemented regarding R46's medical status or symptoms of hypoglycemia.

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There was also no indication if the MD/NP was notified.

7/12/21, at 9:03 p.m.: 68 mg/dl. Although this BG was under 70, there was no documentation of an assessment, or a BG recheck. R46 refused a snack 9:54 p.m. There was also no indication if the MD/NP was notified.

7/13/21, at 5:38 a.m.: 68 mg/dl. Although this BG was under 70, there was no documentation of an assessment, a BG recheck or that any interventions were implemented regarding R46's medical status or symptoms of hypoglycemia. There was also no indication if the MD/NP was notified.

7/15/21, at 2:25 a.m.: 66 mg/dl. Although this BG was under 70, there was no documentation of an assessment or a BG recheck. R46 ate seventy six to one hundred percent of his snack. There was also no indication if the MD/NP was notified.

7/24/21, at 7:31 p.m.: 60 mg/dl. Although this BG was under 70, there was no documentation of an assessment, a BG recheck or that any interventions were implemented regarding R46's medical status or symptoms of hypoglycemia. There was also no indication if the MD/NP was notified.

8/12/21, at 1:52 a.m.: 66 mg/dl. Although this BG was under 70, there was no documentation of an assessment or that any interventions were implemented regarding R46's medical status or symptoms of hypoglycemia. There was also no indication if the MD/NP was notified.

8/21/21, at 8:08 p.m.: 69 mg/dl. Although this BG

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was under 70, there was no documentation of an assessment or a BG recheck. R46 ate seventy six to one hundred percent of his snack. There was also no indication if the MD/NP was notified.

8/25/21, at 8:19 p.m.: 69 mg/dl. Although this BG was under 70, there was no documentation of an assessment or a BG recheck. R46 ate seventy six to one hundred percent of his snack. There was also no indication if the MD/NP was notified.

R46's progress note dated 7/4/21, at 9:28 p.m. indicated that R46 refused a snack, BG dropped to 56. R46 then agreed to a glass of regular Coke and two graham crackers after all other options were refused. There was also no indication if the MD/NP was notified.

R46's progress note dated 8/12/21, at 2:36 a.m. indicated staff was to obtain a 2:00 a.m. BG. Reading at 2:00 a.m. was 66. RN-D asked resident if he would like a snack. R46 declined and stated he felt fine. There was also no indication if the MD/NP was notified.

On 08/26/21, at 10:33 a.m. licensed practical nurse (LPN)-A stated if the BG was under 100, she would look to see what R46 had eaten, if R46 had not eaten LPN-A would call the provider and still give the Lantus, LPN-A would consult with a registered nurse (RN) on duty or with RN-B if a good meal was eaten, to see what was recommended.

On 08/26/21, at 11:10 a.m. RN-B stated depending on what the BG reading was, she would offer a snack, hold the insulin, call the provider and document in the progress note or Treatment Administration Record (TAR). RN-B

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stated she would have expected staff to follow the standing orders and hold the insulin.

On 8/26/21, at 4:27 p.m. the director of nursing (DON) was interviewed. The DON stated if a resident's blood sugar was low and if the resident was alert and able to consume food she would have expected staff to use food instead of a rescue medication. The DON further stated if the resident had eaten, she would expect the BG to go up and she would not expect staff to recheck a blood sugar. The DON stated the standing orders were to be followed when a rescue medication such as Glucagon and/or orange juice needed to be used. The DON stated her expectation was if a rescue medication were used, then the BG would be rechecked after 15 minutes. The DON acknowledged that the instructions on the standing order should have been clearer.

On 8/27/21, at 2:41 p.m. nurse practitioner (NP)-C stated during a telephone interview, that R46 was on multiple diabetic medications due to his erratic BG levels. Trulicity was added and R46 responded well initially, and the Lantus does was decreased. R46's Trulicity had since been increased to the maximum dose of 4.5 milligrams weekly. The NP stated she would expect staff to follow the facility standing orders for diabetics. The NP further stated she would expect treatment and monitoring every 15 minutes if a resident was symptomatic or at least until their BG was above 70. In addition, the NP stated it was her expectation staff would notify her anytime a resident was not responding to interventions.

The facility's Blood Glucose Monitoring Policy recognizing symptoms of altered BG dated 1/15/21, indicated hypoglycemia was a condition

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F 684	Continued From page 48 resulting when the blood glucose levels drop below the specified limits less than 72 milligrams per deciliter (mg/dl). The policy directed staff, when confirmed hypoglycemia, to implement the facility Standing Orders (SO). SO for hypoglycemia was glucose 15 gel 40%, or hypoglycemia Glucagon 1 mg, located in the emergency kit, then update MD/NP. The deficient practice was corrected on 8/27/21, at 2:40 p.m. after the facility developed and implemented corrective action to include updating the facility standing orders to include glucose checks every 15 minutes after treatment and again until appropriate glucose levels of 70 mg/dl or above. All nursing staff with the potential to administer or check blood glucose would be educated on medication administration; avoiding common errors, diabetes; the basics and managing blood glucose levels, and the updated facility standing orders prior to their next working shift. To ensure staff were educated prior to the shift, their building access would be deactivated and would need to speak to the department manager and complete education to return to the floor. On 8/27/21, all TMA's and licensed staff working were interviewed and verified the changes to the updated facility standing orders.	F 684		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic;	F 758		10/5/21

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F 758	Continued From page 49 (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for	F 758		

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F 758	Continued From page 50 the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a gradual dose reduction (GDR) for an antidepressant medication (Celexa) was attempted or contraindicated to dose reduction for 1 of 5 residents (R36) reviewed who received antidepressant medication. Findings include: R36's quarterly Minimum Data Set (MDS) dated 7/21/21, identified severe cognitive impairment with inattention and disorganized thinking, no behaviors noted. Diagnoses were Alzheimer's disease, non-Alzheimer's dementia, and wandering. During the assessment period, R36 took antidepressants daily. R36's Psychotropic Drug Care Area Assessment (CAA) dated 1/20/21, indicated R36 took Celexa daily related to long standing depression. R36's care plan indicated potential for adverse side effects related to anti-depressant medication citalopram hydrobromide (Celexa) dated 3/15/19. An intervention dated 11/22/18, included observe for increased lethargy, increased heart rate, confusion, increased behaviors, restlessness, agitation, dizziness, and changes in gait patternand to review medicatoins on rounds with medical doctor (MD)/nurse practitioner(NP) for any changes. R36's orders for medications included Celexa Tablet, give 20 milligrams (mg) by mouth one time a day related to major depressive disorder	F 758	R36 chart reviewed and use of psychotropic medication and contraindication for reduction was addressed at least every 2 months on routine rounding and documented in provider progress notes. All residents on psychotropic medications have the potential to be affected by this deficient practice. All residents on psychotropic medications have been reviewed to assure that appropriate GDR□s have been attempted unless clinically contraindicated. Medical records reviewed for adequate documentation of clinical contraindication. Providers updated with any recommendations based on the review. Psychotropic Medication policy was reviewed and revised based on current standard of practice. All nursing staff were educated on policy and procedure regarding psychotropic medications, identifying target behaviors, documentation of behaviors as well as side effect monitoring in relation to psychotropic medications. NTL□s will provide GDR tracking tool to provider when completing routine rounds to assist in identifying when a GDR would need to be attempted. DON or designee will audit gradual dose reductions in psychotropic medications auditing 5 charts per week X2 weeks, then 3 charts per week X2 weeks, and 1 chart weekly X 2 months. Audit results will be brought to QAPI for review and	

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F 758	Continued From page 51 was started 5/10/19. R36's pharmacy reviews for past 12 months did not identify any irregularities or any recommendations. R36's pharmacy review dated 11/16/19, indicated the last time the Celexa was assessed for a gradual dose reduction (GDR) was greater than 6 months ago. The provider responded 11/21/19, and wrote "see documented visit note dated 9/17/2019. No dose reduction/not appropriate". R36's provider note from 9/17/19, identified R36 was on Celexa for many years and has been doing well with little somnolence (tiredness) and few behaviors. On occasion she would have days where she was weepy, but these were rare. R36's progress notes identified the following: - 7/28/21, care conference was held, and mood was controlled with current psychotropic medication use. - 7/21/21, takes Celexa 20 mg daily. Symptoms included anger, hitting, and kicking staff and weepiness. Continue to review medications use on rounds. - 7/7/21, R36 takes Celexa 20 mg daily for major depressive disorder without psychotic features. Her symptoms included hitting, grabbing yelling, and crying. Current regimen is effective for symptom relief. - 6/9/21 R36 takes Celexa 20 mg daily for major depressive disorder without psychotic features. Her Symptoms included hitting, grabbing yelling, and crying. Identified behaviors in the past month include crying once, physical behaviors twice and hallucination once. Current regimen is effective for symptom relief.	F 758	further recommendation.	

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F 758	Continued From page 52	F 758		

- 5/13/21 R36 didn't have any behaviors in past month. Take Celexa 20 mg daily for depression. Symptoms include hitting at staff, crying, and yelling out. Medication is effective for symptom relief.

During interview on 8/26/21, at 8:50 a.m. registered nurse (RN)-C stated R36's last GDR was done on 5/1/19, which indicated the Celexa was decreased from 20 mg to 10 mg and resident failed the dose reduction and was placed back on 20 mg and indicated further GDR's for R36 could cause psychiatric instability and could cause suffering or distress for R36. RN-C stated the MD notes of 7/21/21, indicated the family does not want to do dose reductions. She stated the resident was currently tolerating the current dosage and it was working well for R36, and due to the past year of COVID-19 it was not recommended for a dose reduction. The providers do review R36's medication every other month and the pharmacist does it monthly and she would rely on their input. RN-C stated R36 had not had a dose reduction addressed since 11/21/19, when the provider indicated it would be contraindicated.

The facility's policy for Medications: Psychotropic Medications dated 8/23/17, indicated efforts to reduce dosage or discontinue of psychotropic medications would be ongoing, as appropriate, for the clinical situation. The MD/NP would attempt a GDR or discontinuation of psychotropic medications after six months unless clinically contraindicated. GDR's would be attempted annually after the first year, encourage reviews every six months thereafter of as the residents clinical condition warrants.

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F 812	Continued From page 53	F 812		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure proper hand hygiene and proper handling of drinking cups and glasses for 15 of 41 residents served in the dining room (R20, R19, R47, R37, R154, R39, R35, R22, R28, R8, R17, R14, R5, R13, R1). This had the potential to affect all 51 residents who received food from the kitchen. Findings include: R20's Face Sheet printed 8/30/21, indicated R20's diagnoses included dementia, chronic kidney disease, dysphagia (swallowing problems), and heart failure.	F 812	R20, R19, R47, R37, R154, R39, R35, R22, R28, R8, R17, R14, R5, R13, R1 had no adverse effects from deficient practice. All resident who received food from the kitchen had the potential to be affected. DA-A was immediately educated on hand hygiene procedure and how to properly handle dish wear. DA-B was immediately educated on hand hygiene procedure when assisting residents. Hand hygiene policy was reviewed and modified to specify when hand washing vs. hand sanitizer should be used in relation to meal service. All staff were	10/5/21

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F 812	Continued From page 54 R19's Face Sheet printed 8/30/21, indicated R19's diagnoses included atrial fibrillation, hyperlipidemia (high cholesterol) and rheumatoid arthritis. R47's Face Sheet printed 8/30/21, indicated R47's diagnoses included dementia, diverticulitis (inflammation of pouches in the digestive tract) and hyperlipidemia (high cholesterol). R37's Face Sheet printed 8/30/21, indicated R37's diagnoses included chronic kidney disease, diabetes and hyperlipidemia (high cholesterol). R154's Face Sheet printed 8/30/21, indicated R154's diagnoses included heart failure and diabetes. R39's Face Sheet printed 8/30/21, indicated R39's diagnoses included Alzheimer's disease, dementia and anemia. R35's Face Sheet printed 8/30/21, indicated R35's diagnoses included diabetes, hypertension (high blood pressure), and major depressive disorder. R22's Face Sheet printed 8/30/21, indicated R22's diagnoses included chronic obstructed pulmonary disease, major depressive disorder, heart failure. R28's Face Sheet printed 8/30/21, indicated R28's diagnoses included atrial fibrillation, chronic kidney disease and aphasia (loss of the ability to understand or express speech). R8's Face Sheet printed 8/30/21, indicated R8's	F 812	educated on hand hygiene policy. Dining room audits to assure that hand hygiene is completed according to policy will occur 1 meal per day X 1 week, 3 meals per week X3 weeks, then weekly X 2 months. Audit results will be brought to QAPI for review and further recommendation.	

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F 812	Continued From page 55	F 812		

diagnoses included Alzheimer's disease, dementia, major depressive disorder, hyperlipidemia (high cholesterol).

R17's Face Sheet printed 8/30/21, indicated R17's diagnoses included chronic obstructive pulmonary disease, anemia, peripheral vascular disease.

R14's Face Sheet printed 8/30/21, indicated R14's diagnoses included Parkinson's disease, paranoid schizophrenia, osteoarthritis.

R5's Face Sheet printed 8/30/21, indicated R5's diagnoses included heart failure, atrial fibrillation, cardiomyopathy (heart muscle disease).

R13's Face Sheet printed 8/30/21, indicated R13's diagnoses included heart failure, chronic obstructive pulmonary disease, pulmonary hypertension and chronic kidney disease.

R1's Face Sheet printed 8/30/21, indicated R1's diagnoses included diabetes, chronic kidney disease, dementia, cerebral ischemia (not enough blood flow to the brain).

On 8/23/21, at 5:00 p.m. during the supper meal dietary aide (DA)-A was observed wearing gloves and serving drinks and meals to multiple residents without changing gloves or performing hand hygiene in between. DA-A touched plates, coffee cup rims, drinking glass rims, opened cupboards, and the beverage refrigerator with gloved hands while preparing to serve meals to residents. DA-A then went into the kitchen to make a sandwich, touched multiple objects in the kitchen, after serving the sandwich to the resident DA-A removed his gloves, washed his hands, and

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F 812	Continued From page 56	F 812		

replaced his gloves.

On 8/23/21, at 5:10 p.m. during the supper meal DA-B was observed placing clothing protectors on three residents (R15, R16, R25) at table 10. DA-B sat down next to R16 and assisted with the meal. DA-B did not sanitize her hands between assisting residents.

On 08/23/21, at 5:18 p.m. DA-A stated he had never been told he needed to sanitize his hands between assisting residents. DA-A further stated that he had been trained to handle cups by the handle and glasses by the sides; he stated he was nervous and forgot to handle the items how he was taught.

On 8/23/21, at 5:21 p.m. DA-B stated she had been trained to sanitize her hands between assisting residents and had just forgotten.

On 8/26/21, at 1:03 p.m. the dietary manager (DM) stated she would have expected staff to handle drinking utensils without touching the rim.

On 08/26/21, at 1:07 p.m. the DM was interviewed regarding hand hygiene during dining. The DM declined to answer any questions regarding staff hand hygiene and glove use during dining and elected to just provide the hand hygiene policy.

On 08/27/21, at 10:08 a.m. the director of nursing (DON) was interviewed. The DON stated that if staff have touched anything in the resident's environment, they should be performing hand hygiene. The DON verified she would expect staff to perform hand hygiene after assisting residents.

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F 812	Continued From page 57 The facility policy Hand Hygiene Compliance Plan dated 7/7/19, directed staff to wash hands with soap and water before and after eating or handling food, before and after assisting a resident with meals. Staff was directed they should use hand sanitizer before and after direct resident contact, before and after assisting a resident with personal care	F 812		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law;	F 842		10/5/21

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F 842	Continued From page 58 (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the	F 842	R46□s order was transcribed correctly	

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F 842	Continued From page 59 facility failed to ensure physician orders were transcribed accurately, for 1 of 5 residents, (R46) reviewed for unnecessary medications. Findings include: R46's Admission Record printed 8/26/21, indicated R46's diagnoses included diabetes mellitus (DM) type 2, atherosclerotic heart disease, hypertension, neurogenic bladder, hyperlipidemia, anxiety, depression and post-traumatic stress disorder (PTSD). R46's quarterly Minimum Data Set (MDS) dated 8/11/21, identified R46 had a mild cognitive impairment and required extensive assistance for transfers, bed mobility, dressing, toileting and personal hygiene. R46's care plan dated 8/23/21, indicated R46 was to have blood sugar checks as ordered, and directed staff to observe and report any signs and symptoms of hyperglycemia (elevated blood sugars) or hypoglycemia (low blood sugars). On 2/15/21, at 8:40 a.m. R46's physician orders directed staff to increase Humalog (a fast-acting insulin) to 12 units subcutaneous (SQ) with meals, hold Humalog if accu-check was less than 100 or not eating. On 5/5/21, time not legible, physician orders indicated to decrease Humalog to eight units SQ at breakfast and seven units SQ at lunch and supper. The orders further directed to hold if not eating, update nurse practitioner (NP) on accu-checks readings. On 8/30/21, at 1:55 p.m. RN-B stated R46's order	F 842	into EMR. All resident□s have the potential to be affected if orders are not transcribed correctly. Policy regarding medical records/transcription of orders was created outlining proper procedure for transcribing/processing provider orders. All business office staff as well as licensed nursing staff were re-educated on procedure of processing provider orders, including required double check of all orders processed. DON/designee will audit 5 orders per day X 1 week, then 5 orders per day 3 Week X 3 weeks, then 5 orders weekly X 2 months to assure correct transcription of order. Audit results will be brought to QAPI for review and recommendation.	

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F 842	Continued From page 60 on 5/5/21, was not transcribed accurately. R46's physician order still read "hold Humalog if accu-check is less than 100 or not eating" when it should have read, "hold Humalog if not eating and update NP on accu-checks readings". A Medical Records/Transcribing policy was requested but not received.	F 842		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AICOTA HEALTH CARE CENTER	**850 SECOND STREET NORTHWEST** **AITKIN, MN 56431**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Aicota Health Care Center 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) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care, and the 2012 edition of the Health Care Facilities Code (NFPA 99). 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	K 000		

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

Electronically Signed | 09/30/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245363	A. BUILDING **01 - AICOTA NURSING HOME** B. WING _____	**08/25/2021**

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K 000	Continued From page 1 DEFICIENCIES (K TAGS) TO: HEALTH CARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 445 MINNESOTA STREET, SUITE 145 ST. PAUL, MN 55101-5145, or By e-mail to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. The facility was inspected as one building. Aicota Health Care Center is a 1-story building with no basement. The original building was constructed in 1969 and was determined to be of Type II(111) construction. In 1983 an addition was constructed to the building that was determined to be of Type II(111) construction. In 2007 an assisted living facility was attached that is	K 000		

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K 000	Continued From page 2 properly 2-hour fire rated separated. Because the original building and its additions meet the construction type allowed for existing buildings, this facility was surveyed as a single building. The building is fully sprinkled throughout. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification. Other hazardous areas have either heat detection or smoke detection that are on the fire alarm system in accordance with the Minnesota State Fire Code. The facility has a capacity of 65 beds and had a census of 51 at the time of the survey. The requirements at 42 CFR, Subpart 483.70(a) are NOT MET as evidenced by:	K 000		
K 132 SS=D	Multiple Occupancies - Contiguous Non-Health CFR(s): NFPA 101 Multiple Occupancies - Contiguous Non-Health Care Occupancies Non-health care occupancies that are located immediately next to a Health Care Occupancy, but are primarily intended to provide outpatient services are permitted to be classified as Business or Ambulatory Health Care Occupancies, provided the facilities are separated by construction having not less than 2-hour fire resistance-rated construction, and are not intended to provide services simultaneously for four or more inpatients. Outpatient surgical departments must be classified as Ambulatory Health Care Occupancy regardless of the number of patients served.	K 132		10/5/21

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K 132	Continued From page 3 18.1.3.4.1, 19.1.3.4.1 This REQUIREMENT is not met as evidenced by: Based on observations and staff interview, it was revealed that 1 of 2 - two-hour fire-rated separations was found not in compliance with NFPA 101 "The Life Safety Code" 2012 edition (LSC) sections 8.2.1.3 and 19.1.3.4. This deficient condition could have an isolated impact on the residents within the facility. Findings include: On 08/25/2021, at 10:52 AM, during the facility tour, it was observed that above the cross-corridor doors located by mechanical room 101, there was a through penetration around an electrical conduit in the 2-hour fire barrier. This deficient condition was verified by a Maintenance Supervisor.	K 132	Facility failed to ensure proper fire barrier was maintained in corridor with fire rated caulk. Deficiency was corrected immediately. All corridors will be checked to ensure proper compliance with fire barrier and placed in electronic monitoring system on a quarterly schedule to ensure compliance. Facility will be in compliance by 10/5/2021.	
K 345 SS=F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation	K 345	Facility failed to maintain proper fire	10/5/21

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K 345	Continued From page 4 and staff interview, the facility failed to test and maintain the fire alarm per NFPA 101 (2012 edition), Life Safety Code, section 9.6.1.3, and NFPA 72 (2010 edition) National Fire Alarm Code, sections 14.5.3. and 14.6.2.4. This deficient condition could have a widespread impact on the residents within the facility. Findings include: On 08/25/2021 at 9:45 AM, during a review of all available fire alarm tests and inspection documentation and an interview with the Maintenance Supervisor, it was revealed that the facility could not provide any current documentation verifying that a semiannual inspection of all initiating devices had been completed. This deficient condition was verified by a Maintenance Supervisor.	K 345	alarm tests inspection documentation in accordance with NFPA 101 by not ensuring current documentation was completed which verified that the semiannual inspection of all initiating devices had been completed. Facility conducted an annual inspection of all initiating devices. To ensure compliance, facility will add semiannual initiating device inspection to the electronic monitoring system. Facility will be in compliance by 10/5/2021.	
K 351 SS=D	Sprinkler System - Installation CFR(s): NFPA 101 Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area	K 351		10/5/21

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K 351	Continued From page 5 of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to install and maintain the fire sprinkler system in accordance with NFPA 101 "The Life Safety Code" 2012 edition (LSC) section 9.7.1.1, and NFPA 13 - 2010 edition, Section 6.2.9.1. This deficient condition could have an isolated impact on the residents within the facility. Findings include: On 08/25/2021 at 11:20 AM, observation revealed that there were several spare sprinkler heads that were not secured and protected from damage within the fire sprinkler spare head box located at the main sprinkler riser. This deficient condition was verified by a Maintenance Supervisor.	K 351	Facility failed to maintain proper storage of sprinkler heads in accordance with NFPA 101 by not securing spare sprinkler heads in proper locations within storage box. To ensure compliance, facility has had second storage box installed and all new spare sprinkler heads provided in proper storage locations. Facility will maintain compliance by adding quarterly checks on spare sprinkler head storage into the electronic monitoring system. Compliance checks will be brought to Safety Committee for further recommendations on monitoring.	
K 712 SS=F	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of	K 712		10/5/21

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K 712	Continued From page 6 established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to conduct fire drills per NFPA 101 (2012 edition), Life Safety Code, sections 19.7.1.2 and 19.7.1.4. This deficient condition could have a widespread impact on the residents within the facility. Findings include: 1. On 08/25/2021, at 9:50 AM., during the review of all available fire drill documentation and interview with the Maintenance Supervisor, it was revealed that the facility did not vary the times of the 2nd shift fire drill by conducting 3 of 4 drills in the 3 PM hour. 2. On 08/25/2021, at 9:50 AM., during the review of all available fire drill documentation and interview with the Maintenance Supervisor, it was revealed that the facility did not vary the times of the 3rd shift fire drill by conducting 3 of 4 drills in the 5 AM hour. These deficient conditions were verified by a Maintenance Supervisor.	K 712	Facility failed to maintain proper fire drill schedule in compliance with NFPA 101 by not scheduling drills to be in variating times throughout the year. To ensure compliance going forward, the facility will create schedule and log all fire drills into electronic monitoring system in order to track times of drills and proper variation. This will be monitored by the Director of Plant Operations for compliance. Audits on fire drills will be conducted for the next quarter and brought to the Safety Committee to discuss further recommendations of monitoring. Facility will be in compliance by 10/5/2021.	