Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
February 27, 2024

Administrator
Cerenity Care Center White Bear Lake
1900 Webber Street
White Bear Lake, MN 55110

RE: CCN: 245300
Cycle Start Date: February 16, 2024

Dear Administrator:

On February 16, 2024, a survey was completed at your facility by the Minnesota Department(s) of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), as evidenced by the electronically delivered CMS-2567, whereby significant corrections are required.

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(ies) listed below to the CMS location for imposition. The CMS location 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 March 13, 2024.

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective March 13, 2024. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective March 13, 2024.

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.

The CMS location may determine to impose other remedies such as a Civil Money Penalty.

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 $11,995; 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.

If you have not achieved substantial compliance by March 13, 2024, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Cerenity Care Center White Bear Lake will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from March 13, 2024. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions.

However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. 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" and/or an "E" tag), i.e., the plan of correction should be directed to:

Renee McClellan, Unit Supervisor
Metro A District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
625 Robert Street N
P.O. Box 64975
Saint Paul, Minnesota 55164-0975
Email: renee.mcclellan@state.mn.us
Office: 651-201-4391 Mobile: 651-328-9282

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

We will also recommend to the CMS location and/or the Minnesota Department of Human Services that your provider agreement be terminated by August 16, 2024 if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 488.412 and § 488.456.

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

APPEAL RIGHTS

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

Steven.Delich@cms.hhs.gov

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

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
202-795-7490

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

INFORMAL DISPUTE RESOLUTION (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://forms.web.health.state.mn.us/form/NHDisputeResolution

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245300	A. BUILDING _____ B. WING _____	C 02/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CERENITY CARE CENTER WHITE BEAR LAKE	1900 WEBBER STREET WHITE BEAR LAKE, MN 55110

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E 000	Initial Comments On 2/12/24, to 2/16/24, a survey for compliance with Appendix Z, Emergency Preparedness Requirements for Long Term Care facilities, §483.73 was conducted during a standard recertification survey. The facility was not in compliance. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulation has been attained.	E 000		
E 041 SS=F	Hospital CAH and LTC Emergency Power CFR(s): 483.73(e) §482.15(e) Condition for Participation: (e) Emergency and standby power systems. The hospital must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section and in the policies and procedures plan set forth in paragraphs (b)(1)(i) and (ii) of this section. §483.73(e), §485.625(e), §485.542(e) (e) Emergency and standby power systems. The [LTC facility CAH and REH] must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section. §482.15(e)(1), §483.73(e)(1), §485.542(e)(1),	E 041		3/11/24

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

Electronically Signed | 03/05/2024

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

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E 041	Continued From page 1 §485.625(e)(1) Emergency generator location. The generator must be located in accordance with the location requirements found in the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5, and TIA 12-6), Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4), and NFPA 110, when a new structure is built or when an existing structure or building is renovated. 482.15(e)(2), §483.73(e)(2), §485.625(e)(2), §485.542(e)(2) Emergency generator inspection and testing. The [hospital, CAH and LTC facility] must implement the emergency power system inspection, testing, and [maintenance] requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code. 482.15(e)(3), §483.73(e)(3), §485.625(e)(3),§485.542(e)(2) Emergency generator fuel. [Hospitals, CAHs and LTC facilities] that maintain an onsite fuel source to power emergency generators must have a plan for how it will keep emergency power systems operational during the emergency, unless it evacuates. *[For hospitals at §482.15(h), LTC at §483.73(g), REHs at §485.542(g), and and CAHs §485.625(g):] The standards incorporated by reference in this section are approved for incorporation by reference by the Director of the Office of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may obtain the	E 041		

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E 041	Continued From page 2 material from the sources listed below. You may inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the Federal Register to announce the changes. (1) National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169, www.nfpa.org, 1.617.770.3000. (i) NFPA 99, Health Care Facilities Code, 2012 edition, issued August 11, 2011. (ii) Technical interim amendment (TIA) 12-2 to NFPA 99, issued August 11, 2011. (iii) TIA 12-3 to NFPA 99, issued August 9, 2012. (iv) TIA 12-4 to NFPA 99, issued March 7, 2013. (v) TIA 12-5 to NFPA 99, issued August 1, 2013. (vi) TIA 12-6 to NFPA 99, issued March 3, 2014. (vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011. (viii) TIA 12-1 to NFPA 101, issued August 11, 2011. (ix) TIA 12-2 to NFPA 101, issued October 30, 2012. (x) TIA 12-3 to NFPA 101, issued October 22, 2013. (xi) TIA 12-4 to NFPA 101, issued October 22, 2013. (xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009..	E 041		

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E 041	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to provide emergency generator testing in accordance with the 2012 Edition of Life Safety Code (NFPA 101), section 9.1.3.1, and the 2010 Edition of NFPA 110, Standard for Emergency and Standby Power Systems. Findings include: On 02/13/2024 between11:30 AM and 5:00 PM, it was revealed by a review of available documentation that no documentation was available to be presented for review to confirm the facility diesel generator is being load-bank tested every 36 months for 4 hrs. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	E 041	On 2/29/2024 a 4-hour load bank test was completed on facility natural gas generator. The facility is requesting a temporary waiver for corrections to be completed for tags E041 and K918. The diesel generator is currently functional and in working condition. Work is in progress with the appropriate vendor to replace the fuel valves and pressure sensor of this generator. This work must be completed before the required 4-hour load bank test can be run. The vendor is currently waiting for parts to be delivered to complete this work on the generator. As soon as this work is complete, the 4-hour load bank testing will be completed on the diesel generator. Facility contract with vendor has been updated to include the required 4-hour load bank test to be completed every 36 months. Facility maintenance staff have been educated on the requirements of generator load bank testing. Facility generator testing logs will be audited quarterly. This project and audits will be monitored by the facility Safety Committee and Quality Council. Temporary waiver approved and obtained from LSC with a date of 4/1/24. By this date, fuel valves and pressure sensor parts will have arrived, generator repaired,	

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E 041	Continued From page 4	E 041	and the 4-hour load bank testing will be completed on the diesel generator.	
F 000	INITIAL COMMENTS On 2/12/24 through 2/16/24, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was not in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed with no deficiencies cited: H53009692C (MN00100821) H53009683C (MN00096534) H53009787C (MN00100891) The following complaints were reviewed: H53009682C (MN00096608) Deficient practice was identified related to incidental finding. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F 000		
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer	F 554		3/11/24

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F 554	Continued From page 5 medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure a self-administration of medication assessment (SAM) was completed to allow residents to safely administer their own medications for 2 of 2 residents (R92, R24) observed with medications at the bedside. Findings include: R92 R92's quarterly Minimum Data Set (MDS) dated 1/3/24, indicated R19 had intact cognition and had diagnosis which included non-Alzheimer's dementia and hypertension (elevated blood pressure. Indicated R92 was independent with bed mobility, toileting and transfers. During an observation on 2/12/24 at 2:08 p.m., there were four bottles of medication sitting on a desk in R92's room. During an observation on 2/13/24 at 8:30 a.m., four bottles of medication remain on a desk in R92's room as R92 was self-administering a medication from one of the bottles. R92 stated these are just my vitamins and I have been taking them myself for years. R 92's self-administration of medication assessment (SAM) dated 9/18/23, indicated R92 had no desire to self-administer medications.	F 554	Resident 92 has had a self-administration assessment completed for all medications found in resident□s room. Resident 24 had a self-administration assessment completed for all medications found in resident□s room. Resident 92 and 24 orders and care plan have been reviewed and updated. Resident 92 and resident 24 orders, SAM, and care plans have been updated. All residents have the potential to be affected. All residents reviewed that wish to self-administer medication have had an assessment completed and care plan updated. Facility nurses were educated on proper facility SAM procedure. DON, LNHA, or designee will monitor compliance. Audits will be completed specific to medication observation. Audits will be completed on 5 residents weekly for 4 weeks, then 5 residents twice a month for 2 months. Audits will be presented to Quality Council, who will recommend changes and on-going monitoring/auditing after analysis.	

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F 554	Continued From page 6 Review of R92's care plan dated 1/23/24 lacked any directives for self-medication administration. Review of the four bottles of medication in R92's room revealed the bottles contained Vitamin D 5000 units, whole fruit produce supplement, whole veggie supplement, and Omega XL joint and muscle support. R92's Physician orders dated 2/12/24, were reviewed and lacked an order for any of the above medications. Physician Orders also lacked a self-administration order. During an interview on 2/13/24 at 2:00 p.m., licensed practical nurse (LPN)-A stated was not aware R92 self-administered any medications. LPN-A verified SAM assessment dated 9/18/23, indicated R92 did not desire to self-administer any medications. During an interview on 2/13/24 at 2:05 p.m., nurse manager (NM) verified the four bottles of medication at R92's bedside and stated she was unaware R92 had any medications at his bedside. NM verified SAM assessment dated 9/18/23, indicated R92 did not desire to self-administer medications. NM further stated her expectation was that the SAM would have been updated. During an interview on 2/14/24 at 8:42 a.m., director of nursing (DON) stated when a resident wanted to self-administer medications, an assessment was completed to ensure they are safe to self-administer then an order is obtained from the provider. DON stated her expectation was that the SAM would have been updated to reflect R92's desire to self-administer medications.	F 554		

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F 554	Continued From page 7	F 554		

R24

R24's quarterly Minimum Data Set (MDS) dated 12/28/23, indicated R24 was cognitively intact and had diagnosis which included heart failure, hypertension, and depression. R24 was independent with bed mobility, toileting, and transfers.

During observation and interview on 2/12/24 at 2:10 p.m., R24 was sitting in her wheelchair in her room by herself placing medication from a medication cup into another cup of yogurt and then took medication using a spoon. R24 repeated process of self-administration to take

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F 554	Continued From page 8	F 554		

the rest of the medications. A container of Tums and about nine stacked, empty medication cups were observed on R24's nightstand. R24 stated staff usually leave medication for her to take and the nurse knew what medications she was taking.

During interview on 2/12/24 at 2:30 p.m., licensed practical nurse (LPN)-B stated R24 usually self-administered medication with yogurt and ice water, and staff recently needed to check-in with R24 since R24 was sometimes forgetting to take the medication. R24 was independent, and LPN-B had left the medications in the medication cup in R24's room around 8 a.m. LPN-B stated the clinical manager completed a self-administration assessment and a note was placed in the computer or care plan. LPN-B thought the Tums were okay to be in R24's room. If staff found medications that were not supposed to be in a room, staff were to take and lock up the medication so others could not take the medication.

R24's care plan indicated to administer medication as ordered with start date of 8/9/23 and did not address self-administration of medication.

R24's orders indicated okay to self-administer lactaid 3,000 unit 1 tab oral twice a day with start date of 1/3/24 and okay to keep by bedside estradiol cream 0.01% (0.1 mg/gram) onto external vaginal /urethral area with start date of 1/10/24. Other orders did not indicate self-administration.

R24's Self-Administration of Medication Assessment dated 8/31/23, indicated R24 could self-administer lactaid and stored in resident's

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F 554	Continued From page 9 room. R24's Self-Administration of Medication Assessment dated 12/22/23, indicated R24 could self-administer estrogen cream and stored in resident's room. The SAM lacked evidence of other medications. During interview on 2/15/24 at 3:14 p.m., nurse manager (NM)-B stated staff get an order from a doctor and completed a medication observation for residents to self-administer medication. NM-B expected staff to watch residents take their medications if self-administration process was not completed. A self-administration assessment needed to be completed to show the resident knew how to take medication properly at the right times. During interview on 2/15/24 at 4:47 p.m., the director of nursing (DON) stated staff needed to ensure residents had a self-administration assessment completed prior to leaving prescribed medications at residents' bedside. Residents may be at risk for choking, dumping their medication and not taking them, and staff may not know what medication residents take without a completed self-administration assessment. Review of a facility titled Self- Administration of medications reviewed 2/2/19, indicated residents have the right to self-administer medications if the interdisciplinary team has determined it is clinically appropriate and safe. Further stated self- administered medications must be stored in a safe and secure place, which is not accessible by other residents.	F 554		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v)	F 578		3/11/24

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F 578	Continued From page 10 §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the	F 578		

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F 578	Continued From page 11 appropriate time. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure resident current wishes for resuscitation status were accurately documented in the medical record for 1 of 2 residents R19 reviewed for advanced directives. Findings include: R19's significant change Minimum Data Set (MDS) dated 2/16/23, indicated R19 was cognitively intact and had diagnosis which included hypertension (elevated blood pressure), anemia, and gastro esophageal reflux disease. Identified R19 required staff assistance with activities of daily living (ADL's) which included bed mobility, toileting and transfers. During an interview on 2/12/24 at 5:51 p.m., R19 stated her wishes were to be resuscitated (full code) status. R19's current care plan dated 9/6/23, identified R19's advance directives were for full resuscitation full code status. Review of R19's electronic health record (EHR) identified the following : -R19's physician orders dated 9/29/23, identified R19 had an order for full code status. -R19's banner and face sheet on the computer identified R19's code status was full code. -R 19's Physician Order Life Sustaining Treatment (POLST) dated 4/18/22, identified R19 was a Do Not Resuscitate (DNR). The electronic health record identified a	F 578	Resident 19□s code status was verified to be full code per her preference and physician order. Resident□s inaccurate POLST was removed from the resident□s electronic medical record. All resident□s with a POLST were audited to ensure code status, order, and POLST match. Facility IDT and licensed nurses were educated on resident code status process. DON, LNHA, or designee will monitor compliance. Audits will be completed specific to resident code status. Audits will be completed on 5 residents weekly for 4 weeks, then 5 residents twice a month for 2 months. Audits will be presented to Quality Council, who will recommend changes and on-going monitoring/auditing after analysis.	

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F 578	Continued From page 12 discrepancy of R19's wishes for resuscitation. During an interview on 2/12/24 at 6:51 p.m., licensed practical nurse (LPN)-A stated her usual practice in verifying a resident's code status was to refer to the banner on the computer screen or the physician orders. LPN -A stated there is also a POLST in the computer that is sent to the emergency room with the resident. LPN-A further stated if the banner, physician orders and POLST didn't match She would then follow the physician orders. During an interview on 2/12/24 at 6:54 p.m., registered nurse (RN)-A stated her usual practice in verifying a residents code status was to refer to the banner on the computer screen. RN-A stated however, the POLST in the computer is what is sent to the emergency room when a resident is sent out. During an interview on 2/12/24 at 6:55 p.m., registered nurse RN-B stated her usual practice in verifying a resident's code status was to refer to the banner and the physician orders in the computer. During an interview on 2/12/24 at 6:59 p.m., registered nurse RN-C stated her usual practice for verifying a resident's code status was to refer to the banner. RN-C stated secondly; she would refer to the POLST in the computer. RN-C stated when a resident is transferred to the emergency room the POLST in the chart is sent with the resident to the hospital. RN-C further stated if the banner and the POLST didn't match she would refer to the banner as long as the banner matched the physician orders.	F 578		

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F 578	Continued From page 13 During an interview on 2/13/24 at 1:50 p.m., nurse manager (MN) stated her expectation to verify a resident's code status was to refer to the banner and the physician orders in the computer first and that the POLST would be secondary. NM stated if the banner, physician orders, and POLST did not match her expectation was that staff would follow the physician orders. NM verified there was a discrepancy between the banner, physician orders, and the POLST for R19. NM further stated this was a concern because the POLST is sent with a resident to the emergency room and hospital and that there was a chance that R19's wishes may not have been followed. During an interview on 2/14/24 at 8:42 a.m., director of nursing (DON) confirmed there was a discrepancy in R19's medical record related to advance directive wishes. DON stated her expectation in determining a resident's code status was to refer to the banner or the physician orders since not all residents have a POLST. DON stated she was unsure why R19's old POLST was scanned into R19's medical record. DON further stated her expectation was that when a resident was admitted with a POLST that the POLST and the physician orders would match. Review of a facility policy titled Advance Directives reviewed 10/2/23, indicated on admission and at quarterly care conferences thereafter, residents are informed and provided information concerning the right to formulate an advance directive. Further stated the advance directive will be uploaded into the Matrix Care record under resident documents in the Advance Care Planning or Legal Section.	F 578		

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F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care	F 656		3/11/24

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F 656	Continued From page 15 plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to develop a comprehensive care plan to include assessed risks and interventions with skin care to reduce the risk of complication for 1 of 3 residents (R36) with pressure ulcers reviewed for care planning. In addition, the facility failed to develop a comprehensive person-centered care plan for psychotropic drug use for 1 of 5 residents (R21) reviewed for unnecessary medications. Findings include: R36's admission Minimum Data Set (MDS) dated 1/29/24, indicate R36 had intact cognition and required staff assistance for most activities of daily living(ADL's). further, MDS indicated R36 was at risk for pressure ulcers and R36 had one stage three pressure ulcer and two unstageable pressure ulcers. R36's most recent Braden Scale dated 2/3/24, identified R36 as being bedfast (confined to bed all or most of the time) and having very limited mobility. Braden scale further identified R36 had two venous ulcers. The scale included a scoring system based on points attached to certain issues which could impact skin, and this identified R36 as being "At moderate risk."	F 656	Resident 36□s care plan was updated to include identified skin areas and interventions. Resident 36 passed away on hospice services on 2/14/2024. Resident 21□s Seroquel was discontinued per pharmacist collaborative practice agreement. Resident 21 care plan has been updated to include resident-centered interventions. Residents with pressure injury were audited to ensure care plans include skin areas and interventions. Resident care plans were updated with interventions as needed. Residents triggering for psychotropic drug use were audited to ensure care plans included resident-centered interventions. Resident care plans were updated as needed. Facility nursing staff and IDT have been educated on resident care plan interventions. DON, LNHA, or designee will monitor compliance. Audits will be completed specific to care plan interventions. Audits will be completed on 5 residents weekly	

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F 656	Continued From page 16 R36's Care Area Assessment CAA) dated 2/2/24, identified R36 had two unstageable pressure ulcers and one stage three pressure ulcer. CAA stated to proceed to care plan to prevent further skin breakdown and infection. Review of a nursing progress note dated 2/4/24, identified R36 had a sacral wound that measured 2x1.5x2 cm. a left heel wound that measured 2x1cm. and a right heel wound that measured 3x1.5cm. Review of physician orders dated 2/7/23, identified orders for Medi honey to be applied to sacrum wound daily and calcium Arginade with silver to both heels and cover with ABD and wrap with Kerlix twice per day. During an observation on 2/12/24 at 2:10 p.m., R36 was lying in bed wearing a hospital gown on an air mattress on her right side with a pillow behind her back and her feet were elevated off of the mattress with a pillow. Both heels were wrapped with gauze. R36 was not able to respond to any questions. During an interview on 2/13/24 at 1:10 p.m., nursing assistant (NA)-A stated R36 was bedfast, required total staff assist for all cares and had pressure ulcers on her sacrum and on her heels. NA-A stated she knew that staff were supposed to reposition R36 every two hours but was unaware of any other interventions that were in place for R36. NA-A stated she did not recall seeing any pressure ulcers mentioned or any interventions in R36's care plan to prevent further skin breakdown. Review of R36's comprehensive care plan dated	F 656	for 4 weeks, then 5 residents twice a month for 2 months. Audits will be presented to Quality Council, who will recommend changes and on-going monitoring/auditing after analysis.	

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F 656	Continued From page 17 1/25/24, lacked any identified skin problems and stated R36 was at risk for altered skin status with a goal of not developing any skin alterations. Despite R36's medical record identifying that she had pressure ulcers to her sacrum and both heels The only intervention to prevent further skin breakdown was to apply barrier cream to any dry areas. During an interview on 2/13/24 at 1:41 p.m., nurse manager (MN) confirmed R36 was admitted to the facility with pressure ulcers on her sacrum and both heels on 1/23/24. NM further confirmed R36's care plan lacked information regarding R36's pressure ulcers and interventions to prevent further skin breakdown. NM stated her expectation would have been that R36's care plan would have mentioned the pressure ulcers and provided interventions to prevent further skin breakdown so that all staff were aware of how to care for R36. During an interview on 2/14/24 at 8:42 a.m., director of nursing (DON) confirmed R36 was bedfast and had pressure ulcers upon admission to the facility. DON further confirmed R36's care plan lacked any mention of R36's pressure ulcers or interventions to prevent further skin breakdown. DON stated her expectation was that R36's comprehensive care plan would have mentioned R36's pressure ulcers and would have provided interventions to prevent further skin breakdown.	F 656		

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F 656	Continued From page 18	F 656		

R21's annual Minimum Data Set (MDS) dated 1/17/24, indicated R21 had severe cognitive impairment with diagnoses of dementia (loss of memory, language, problem-solving and other thinking abilities), depression, and anxiety. R21's MDS also indicated he was receiving an antipsychotic on a routine basis and identified the last gradual dose reduction was on 12/13/23. R21's MDS indicated he had activity preferences that were very important to him, including listening to music he liked, being around animals like pets, doing his favorite activities, and participating in religious services or practices. R21's MDS indicated he had activity practices that were somewhat important to him, including going outside to get fresh air when the weather was nice and doing things with groups of people.

R21's Care Area Assessments (CAAs) dated 1/17/24, triggered for psychotropic drug use, psychosocial well-being, cognitive loss and dementia, and behavioral symptoms. The CAAs for psychotropic drug use and psychosocial well-being indicated they would be addressed in R21's care plan.

R21's physician's orders for psychotropic medications included the following:
- Cymbalta (duloxetine) 60 milligrams (mg) capsule, delayed release/enteric coated (DR/EC), Take 60mg oral once a morning for depression

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F 656	Continued From page 19	F 656		

with anxiety, dated 2/9/22.
- Seroquel (quetiapine) 25mg tablet, Take 12.5mg oral at bedtime for dementia with psychotic disturbance, dated 12/13/23.

R21's care plan dated 7/20/23, was reviewed and lacked resident-centered interventions. The care plan identified that R21 was taking a psychotropic medication, Cymbalta, to assist in regulating his mood. The interventions included administer medication as ordered, ask physician to review medication for possible dose reduction every three months, monitor behavior every shift and document significant occurrences as needed, observe for possible side effects of current psychotropic medication, and report pertinent lab results to physician. The care plan lacked a problem, goal, and interventions for the antipsychotic medication Seroquel R21 was taking. The care plan identified R21 had a cognitive deficit with impaired decision making, forgetfulness and confusion related to dementia and Alzheimer's diagnosis, dated 1/16/24. The interventions were not resident-centered and included allowing ample time to absorb and respond to information, assessing for contributing factors, assessing history if impairment, onset and duration, monitoring for any changes or decline in cognitive status, providing a calm, therapeutic environment and structured routine, and requesting a physician consider a psychiatric evaluation as indicated.

During interview on 2/15/24 at 5:10 p.m., the director of nursing (DON) stated for residents taking psychotropic medications, care plans should be developed specific to those types of medications. The DON stated care plans were reviewed quarterly and during care conferences

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F 656	Continued From page 20 with residents and/or representatives to ensure the care plans were resident-centered and specific. The DON reviewed R21's care plan and verified there was no care plan focus in place for the antipsychotic medication Seroquel. The DON acknowledged that R21's care plan was generic. A facility policy titled Comprehensive Assessments and Care Planning dated 7/2/18, stated the facility's purpose was to provide a comprehensive person-centered care assessment of the resident's condition to develop, review and revise the resident's person-centered comprehensive care plan. Furthermore, the policy indicated all person-centered care plans will incorporate the resident's personal and culture preferences. Additionally, the policy stated all person-centered interventions will be implemented by qualified personnel and may be communicated through the electronic health record, resident profile, assignment sheets, and/or verbal communication.	F 656		
F 676 SS=D	Activities Daily Living (ADLs)/Mntn Abilities CFR(s): 483.24(a)(1)(b)(1)-(5)(i)-(iii) §483.24(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that: §483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily	F 676		3/11/24

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F 676	Continued From page 21 living, including those specified in paragraph (b) of this section ... §483.24(b) Activities of daily living. The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living: §483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care, §483.24(b)(2) Mobility-transfer and ambulation, including walking, §483.24(b)(3) Elimination-toileting, §483.24(b)(4) Dining-eating, including meals and snacks, §483.24(b)(5) Communication, including (i) Speech, (ii) Language, (iii) Other functional communication systems. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure a walking program was maintained for 1 of 1 resident (R51) reviewed for ambulation. Findings include: R51's quarterly Minimum Data Set (MDS) dated 1/24/24, indicated R51 was cognitively intact, independent for wheelchair mobility, and required supervision or touching assistance with ambulation. R51's MDS indicated R51 used a walker and manual wheelchair for mobility and had zero days of training and skill practice in	F 676	Resident 51□s walking program and care plan were reviewed and updated. Residents with walking program and care plan were reviewed and updated as needed. Facility nursing staff were educated on completing resident walking programs. DON, LNHA, or designee will monitor compliance. Audits will be completed specific to resident walking programs. Audits will be completed on 5 residents	

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F 676	Continued From page 22 walking during the seven-day look back period. R51's diagnoses included cancer, debility, and cardiorespiratory conditions. R51's care plan dated 2/14/24, indicated R51 was unable to ambulate independently related to unsteady gait and balance. Staff approaches for restorative nursing included documentation of walking program in electronic record and may call family to attempt to encourage resident to participate if refuses. The care plan indicated R51 was at risk for falls and directed staff assist R51 with ambulation program as directed with gait belt and w/c to follow and provide reminders to not ambulate/transfer without assistance. R51's order dated 10/1/23, directed staff to ambulate R51 with walker twice a day to tolerance with gait belt. R51's electronic administration record marked ambulation order as completed every morning and evening shift besides 2/3/24, 2/5/24 and 2/15/24. One of the three times the order was marked as "not administered" was related to resident refusal. The record did not specify distance or minutes ambulated. R51's nursing care sheet dated 2/9/24, directed staff to encourage R51 to walk to destinations and ambulate R51 twice a day and document in POC (point of care) and indicated R51 used a wheelchair and walker. R51's POC ambulation task dated 2/1/24 to 2/15/24, did not contain documentation for the following dates: 2/2/24, 2/7/24, 2/10/24, 2/11/24, and 2/14/24. On days of documentation, the task was marked as "reviewed" and did not include	F 676	weekly for 4 weeks, then 5 residents twice a month for 2 months. Audits will be presented to Quality Council, who will recommend changes and on-going monitoring/auditing after analysis.	

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F 676	Continued From page 23 distance or minutes. R51's progress notes dated 11/15/23 to 2/15/24, indicated R51 refused ambulation approximately 37 times with last note being 1/27/24, approximately three times family assisted resident with ambulation, and one note which stated ambulation not done without further explanation. During interview on 2/12/24 at 4:49 p.m., family member (FM)-D stated R51 was weaker because he was not getting walked and believed less ambulation caused him to have a harder time transferring and increased risk of falls. FM-D stated family often walked with R51 but not the staff. During observation on 2/13/24 at 3:09 p.m., FM-D assisted R51 to ambulate with walker and gait belt in the hallway. During observation and interview on 2/14/24 at 7:56 a.m., R51 opened his door and was sitting in his wheelchair and dressed without socks or shoes. R51 stated he dressed himself. R51's walker was alongside a wall in his bedroom with the gait belt looped around the front bar of the walker. R51 placed his call light on, and nursing assistant (NA)-H came and applied R51's socks and shoes and asked what R51 wanted for breakfast. During interview on 2/14/24 at 12:32 p.m., R51 stated staff had not assisted him with ambulation yet today. During interview on 2/14/24 at 1:01 p.m., NA-F stated maintenance programs, such as	F 676		

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F 676	Continued From page 24 ambulation, was on the team sheets or therapy had instructions in residents' rooms. During interview on 2/14/24 at 1:51 p.m., NA-G stated he did not assist R51 today and thought NA-H assisted R51. During observation on 2/14/24 at 1:54 p.m., R51 was in his recliner and the walker and gait belt were in the same spot. During interview on 2/14/24 at 2:42 p.m., NA-H stated NA-F had R51 on their group. During interview on 2/15/24 at 10:30 a.m., NA-F stated yesterday was busy and would say no one walked with R51. NA-F stated nursing assistants document R51's refusals of ambulation on the computer. During interview on 2/15/24 at 11:24 a.m., NA-G stated he had not seen anyone walk with R51 yesterday. During interview on 2/15/24 at 1:45 p.m., registered nurse (RN)-F stated R51 ambulated when he wanted to and sometimes refused which should be documented. RN-F stated she was not sure if R51 ambulated or not yesterday. RN-F had seen a staff person in R51's room who could have assisted R51 to ambulate around his room but was not sure if R51 was ambulated or not. When asked about nursing documentation yesterday which marked R51's ambulation as complete, RN-F stated she "click, click, click[ed]" at the end of the day. During interview on 2/15/24 at 3:23 p.m., nurse manager (NM)-B expected staff to ask R51 if he	F 676		

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F 676	Continued From page 25 wanted to ambulate on morning and evening shifts. NM-B stated nursing assistants should document the distance and minutes R51 was ambulated, and nurses should indicate if R51 ambulated or refused. NM-B did not know how to look back to review POC documentation. NM-B stated R51 weakens when not ambulated and ambulation was good for R51's strength and endurance, especially since R51 self-transfers. During interview on 2/15/24 at 4:47 p.m., director of nursing (DON) expected staff to follow ambulation programs and offer ambulation. Reduction in current ambulation abilities could result when ambulation programs were not completed or offered. The facility policy Benedictine Restorative Nursing Program dated 6/9/20, indicated registered nurses provided oversight to the program to ensure the restorative interventions were being implemented as planned.	F 676		
F 686 SS=G	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent	F 686		3/11/24

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F 686	Continued From page 26 new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to perform comprehensive skin assessments and implement interventions to promote healing and reduce the risk for further pressure ulcer development for 1 of 1 resident (R100) reviewed for pressure ulcers. This resulted in harm for R100. Findings include: A stage one pressure injury is intact skin with a localized area of redness that is non-blanchable (does not turn white when pressed). A stage two pressure ulcer is partial thickness loss of the skin with exposed dermis, presenting as a shallow open ulcer. A stage three pressure ulcer is full thickness loss of the skin in which subcutaneous fat may be visible. Additionally, slough (non-viable yellow, tan, gray, green or brown tissue; usually moist, can be soft, stringy and mucinous in texture) or eschar (dead or devitalized tissue that is hard or soft in texture; usually black, brown, or tan in color, and may appear scab-like) may be visible but does not obscure the depth of the tissue loss. A stage four pressure ulcer is full thickness loss of the skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer. Slough and or eschar may be visible on some parts of the wound bed. Undermining and or tunneling often occur. If slough or eschar obscures the wound bed, it is an unstageable pressure ulcer.	F 686	Resident 100 has discharged from facility TCU. All residents with wounds were audited will have comp weekly skin assessments and interventions implemented to promote healing and reduce risk for further pressure ulcer development. Facility is investigating contracting with external wound care provider for additional support. Nurses have been educated on comprehensive weekly skin assessments and ensuring care plan skin interventions are in place. DON, LNHA, or designee will monitor compliance. Audits will be completed specific to skin assessments and skin interventions in place. Audits will be completed on 5 residents weekly for 4 weeks, then 5 residents twice a month for 2 months. Audits will be presented to Quality Council, who will recommend changes and on-going monitoring/auditing after analysis.	

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F 686	Continued From page 27 An unstageable pressure ulcer is obscured full thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because the wound bed is obscured by slough or eschar. If slough or eschar is removed, a stage three or stage four pressure ulcer will be revealed. If the anatomical depth of the tissue damage involved can be determined, then reclassified stage should be assigned. A deep tissue pressure injury (DTPI) is intact skin with localized area of persistent non blanchable deep red, maroon, purple discoloration due to damage of underlying soft tissue. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue. This injury results from intense and or prolonged pressure and shear forces at the bone-muscle interface. The wound may evolve rapidly to reveal the actual extent of tissue injury, or may resolve without tissue loss. If necrotic tissue, subcutaneous tissue (deepest layer of skin), granulation tissue (new connective tissue), fascia (connective tissue), muscle or other underlying structures are visible, this indicates a full thickness pressure ulcer. Once a deep tissue injury opens to an ulcer, reclassify the ulcer into the appropriate stage. R100's admission Minimum Data Set (MDS) dated 1/12/24, indicated intact cognition, did not reject care, was dependent on staff for toileting, had lower extremity range of motion impairment on one side, required substantial assistance with bathing and showering, was independent with rolling left and right, had an indwelling catheter, was always incontinent of bowel, had a stage one or greater pressure ulcer, was at risk of	F 686		

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F 686	Continued From page 28 developing pressure ulcers, had one stage one pressure ulcer, did not have other skin problems which included moisture associated skin damage (MASD), open lesions other than ulcers, rashes, cuts, surgical wounds, burns, and skin tears. Skin treatments indicated R100 had a pressure reducing bed, application of a nonsurgical dressing other than to feet. R100's Face Sheet indicated R100 admitted to the facility on 1/6/24, and had the following diagnoses: multiple sclerosis (a condition affecting the central nervous system that can cause muscle weakness, vision changes, numbness, and memory issues), adult failure to thrive, major depressive disorder, type 2 diabetes mellitus, and neuromuscular dysfunction of the bladder. R100's care area assessment (CAA) dated 1/12/24 indicated R100 had multiple sclerosis, weakness, failure to thrive and staff assisted R100 with activities of daily living, transfers, mobility, and toileting. The CAA was edited on 1/18/24, and indicated R100 was admitted with redness to her peri area, and had a dressing to her coccyx on admission and 1/10/24 nursing note indicated a stage 1 pressure ulcer to the left heel. R100's care plan dated 1/7/24, indicated a self care deficit and R100 required 1 to 2 assist with bed mobility, bathing, and transfers. R100's care plan dated 1/7/24, indicated R100 was at risk for alteration of skin due to her disease process and her goal indicated she would not develop any skin alterations. R100's interventions were: barrier cream applied to dry	F 686		

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F 686	Continued From page 29 areas as needed. The care plan was later revised on 2/14/24, to include the following interventions: Braden skin risk evaluations completed on admission and every week for four weeks, then quarterly, annually, and with any significant change, nursing assistants to observe skin and report any abnormalities to the nurse, air mattress placed on the bed, heel protectors in place to protect heels while in bed, may choose to have the head of bed at the lowest elevation as possible to reduce the pressure on bottom, may refuse treatments and interventions, will allow therapy to see as appropriate to assist in wound healing, will be involved in the treatment process, will be monitored for properly fitting footwear and pressure reduction to heels. Will have a podiatrist as appropriate see me if issues, will be reminded to reposition every 2 hours, will have assistance in repositioning every two hours to offload the pressure areas, will maintain good skin hygiene and skin will be moisturized if I have dry skin as needed, my elimination of waste will be addressed in the toileting section of the care plan, my heels will be floated while in bed, my labs and weight will be monitored as ordered, my pain will be controlled as ordered, pressure redistributing mattress is in place on my bed and I have a cushion for my chair, proper notifications will be made if my wounds change, the staff will provide me with adequate nutrition and hydration. Nutritional supplements and vitamins as ordered, the staff will use a lift sheet to move me in bed as needed. R100's care plan dated 2/13/24, indicated R100 had a nutrition goal R100's skin would improve and or heal and approaches included honoring likes and dislikes, and supplements as ordered.	F 686		

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F 686	Continued From page 30 R100's care sheet indicated R100 had an air mattress, report skin findings to the nurse, required assist of 1 for bed mobility, was to be turned and repositioned in bed as tolerated and had a buttocks wound. R100's physician orders indicated the following orders: 1/6/24: Wound care: change dressing every Monday, Wednesday, Friday, and as needed for drainage and saturation. Gently remove previous dressing. Hold skin down as you remove the dressing to prevent further skin tearing and or soak off with NS. Cleanse with wound cleanser; pat skin dry. Protect and treat apply sacral Mepilex silicone foam dressing. Pressure injury prevention: turn and reposition every 2 hours; right and left turns avoid the back. 1/8/24: nystatin powder; 100000 unit/gram; apply topically to groin twice daily 1/9/24: heel pressure relief/floating heels with pillows, boot air fluidized heel aldt std/Z flex heel boot or comparable off loading product. Chair interventions: pressure redistribution seat cushion in place. Keep HOB/Recliner less than 30 degrees, knee gatch elevated on bed unless contraindicated by medical condition. Assess skin under all tubes and devices every shift. 1/9/24: Shower day on Friday a.m., assess skin and document in nursing notes. If any skin concerns noted open an event and notify the physician and family per facility protocol. 1/10/24: Wound care left heel stage one: apply skin prep and allow to dry daily. 1/10/24: Braden score 15: assist with turn and repositioning every 2 hours. 1/11/24: Glucerna 8 ounces daily at bedtime 1/26/24: Activity: up in the wheelchair for not more than 2 hours twice a day	F 686		

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F 686	Continued From page 31 1/10/24: blue boots bilateral feet on at all times except cares. 1/26/24: sacral wound care use Medihoney and foam dressing every day. 1/30/24: Measure wound to buttocks weekly and document in the progress notes. R100's telephone order dated 1/26/24 from nurse practitioner (NP)-C indicated orders for an occupational therapy evaluation (OT) for a Roho cushion, change bed to an air mattress, up in the wheelchair not more than 2 hours, sacrum wound care use Medihoney foam dressing daily. R100's Hospital Admission History and Physical form dated 12/27/23, indicated under the heading, "Assessment/Plan" R100 had a decubitus ulcer that was present on admission. R100's Hospital documents dated 1/6/24 indicated R100's heels were floated off the end of pillows or with heel offloading boots, additionally R100 was out of bed for meals and turned and repositioned every two hours left to right avoiding the back on 1/5/24. Additionally, R100's groin was reddened from a yeast infection. Additionally a note on page (372 of 430) indicated a perineum bilateral pressure injury and surrounding skin was intact, and had a foam dressing, the wound base was open and had a red/pink base. Additionally, on page 373 of 430 had moisture associated dermatitis to skin folds on bilateral legs that were cleansed and a topical product was applied. The progress notes indicated R100 had a bilateral pressure injury to the perineum and bilateral leg moisture associated dermatitis. R100's After Visit Summary 12/27/23, to 1/6/24, indicated care instructions to change coccyx	F 686		

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F 686	Continued From page 32	F 686		

dressing every Monday, Wednesday, and Friday and as needed for drainage saturation. Gently remove previous dressing. Hold skin down as you remove the dressing to prevent further skin tearing and or soak off with normal saline. Cleanse with wound cleanser. Pat skin dry. Protect and treat apply sacral Mepilex silicone foam dressing. Pressure injury interventions included: turn and reposition every 2 hours right/left turns, avoid back, heel pressure relief floating heels with pillows, boot air fluidized heel adlt Std Z flex heel boot or comparable off-loading product, chair interventions; pressure redistribution seat cushion in place, keep head of bed and recliner less than 30 degrees, knee gatch elevated on bed unless contraindicated by medical condition, assess skin under all tubes and devices every shift.

R100's certified wound ostomy continence nurse (CWOCN) note dated 12/28/23, (page 31 of 430) indicated R100's coccyx was reddened and non blanchable and had shallow ulcers to the right and left buttocks that measured 1 cm each. Further, the note indicated orders for pressure injury prevention, wound and skin care were on the chart, and a sacral Mepilex was ordered for R100.

R100's medication administration record (MAR) dated 2/1/24 to 2/13/24 indicated R100 was to have 8 ounces of Glucerna (a nutritional supplement for people with diabetes) daily at bedtime starting on 1/11/24, however, R100 refused the Glucerna 12 times. Additionally, R100 refused the Glucerna 13 times according to the MAR dated 1/11/24 to 1/31/24.

R100's dietician progress note dated 2/13/24,

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F 686	Continued From page 33 indicated R100 was on a consistent carbohydrate diet with intake of 76-100% for 9 of 13 meals monitored since 1/30/24 and R100 received a Glucerna supplement every day at bedtime to provide nutrition in addition to balanced diet including protein at three meals daily to promote healing of open areas and R100's weight, intake, and skin integrity was monitored. R100's breakfast, lunch intake percentages from 1/6/24, to 2/13/24, indicated the breakfast meal was documented 9 times; 6 times R100 ate 76-100%, once R100 ate 51-75%, and R100 ate 26-50% of breakfast twice. The lunch meal was documented 7 times; 6 times R100 ate 76-100%, and once ate 51 to 75%. R100's Skin Risk Observation with Braden Scale form dated 1/6/24, indicated R100 had the following risk factors for developing a pressure injury: an acute condition, chronic incontinence, diabetes, hypothyroidism, multiple sclerosis required assistance for rolling left and right, lying to sitting, sitting to lying, was always incontinent, had lesions and redness to the peri area, had an unhealed pressure injury that was a stage one or higher to the coccyx. The Braden scale score was 15 and indicated R100 was at risk for developing pressure ulcers. Skin and ulcer treatments included a pressure reducing device for the chair and a turning and repositioning program. Additionally, referral that may be appropriate indicated dietary, occupational therapy (OT), and physical therapy (PT). R100's Skin Risk Observation with Braden Scale form dated 2/9/24, indicated R100 had the following risk factors for developing a pressure injury: cardiovascular disease, decreased range	F 686		

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F 686	Continued From page 34 of motion, diabetes, multiple sclerosis, catheter/oxygen/wound vac/ tubing, required partial to moderate assistance to roll left and right, dependent for lying to sitting, and sitting to lying, was always incontinent, had redness to the peri area, had limited mobility, unhealed pressure ulcers to the sacrum, and moisture associated skin damage (MASD). The Braden Scale score was 8, indicating R100 was at very high risk for developing a pressure ulcer. Skin and ulcer treatments included turning and repositioning, and pressure ulcer injury care and under the heading "Indicate Care Plan Action Taken" indicated to continue current care plan. Additionally, referrals that may be appropriate indicated OT and PT. R100's Admission Clinical Documentation note dated 1/6/24, indicated R100 required extensive assistance with bed mobility, was totally dependent on staff for toileting. R100's facility Admission Skin Condition/New Wound Assessment form dated January 7, no year, indicated a diagram with instructions to use the list below to identify (number/letter) on the diagram all skin or body concerns. Further, instructions indicated to document size, depth (in, cms), color and drainage. If an ulcer was present, indicate pressure or non-pressure. The list contained a handwritten circle around the numbers 1, 2, and 8. The number 1 listed "Pressure" next to number 1, the number 2 listed "Reddened" next to number 2, and number 8 listed "wound" next to number 8. The posterior (back) view of the diagram indicated a number 1, and a number 8 next to the coccyx region, and to the left of the coccyx region a circle with a number 1, and 8. On the anterior (front) of the	F 686		

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F 686	Continued From page 35	F 686		

diagram was a circle with the numbers 2, and 3 indicating a reddened bruise. Additionally, there was a circled area with a number 2 indicating a reddened area. Additionally, under a heading, "Comments" indicated the suprapubic site (below the umbilical region) was reddened, there was a small reddened bruise on the left side groin, and a dressing on coccyx and left buttock. The assessment contained no measurements.

R100's Braden Scale for Prediction of Pressure Score Risk form dated 1/24/24, indicated a score of 11. The form included an interpretation of the scores and a score range of 10-12 indicated a high risk for development of a pressure ulcer. Interventions included a pressure reducing device for the chair and a pressure reducing device for the bed. Additionally, referrals that may be appropriate included activities, dietary, nursing rehab, and OT, and the care plan action indicated to continue with the current plan of care.

R100's Skin Integrity Events that was recorded on 1/30/24, for 1/6/24, indicated R100 admitted with pressure/moisture associated wound to right and left buttocks.

R100's transitional care unit (TCU) follow up note dated 1/15/24, indicated nurse practitioner (NP)-C saw R100 who was sitting up in the wheelchair and had fallen the previous Friday and sustained bruising to her back. The note indicated R100 had incontinence associated dermatitis to her bottom and received topical treatment.

R100's TCU follow up note dated 1/18/24, indicated R100 had incontinence associated dermatitis to her bottom, and had fallen with bruising to R100's back.

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F 686	Continued From page 36 R100's TCU follow up note dated 1/23/24, indicated R100 was sitting up in the wheelchair on this day's visit. The note indicated R100 had bruising to the back, and had incontinence associated dermatitis and planned to continue topical treatment. R100's TCU follow up note dated 1/25/24, indicated R100 was sitting up in the wheelchair and had incontinence associated dermatitis. R100's TCU note dated 1/31/24, indicated incontinence associated dermatitis. R100's TCU note dated 2/1/24, indicated R100 had fallen from a lift at the TCU and x-rays were obtained with no acute injury. Additionally, the note indicated R100 had a coccyx ulcer and per reports had moderate slough and eschar. Additionally, the note indicated R100 had incontinence associated dermatitis. R100's TCU follow up note dated 2/13/24, indicated R100 was sitting up in the wheelchair eating lunch and had an appointment 2/15/24 with vascular service to debride her coccyx wound and continued with the Medihoney dressing changes. During exam, R100 was lying in bed and the wound was documented as a deep tissue injury (DTI) to coccyx that was now unstageable. The note also indicated R100 had admitted to the facility with IAD (incontinence associated dermatitis). The note further indicated R100 slipped in the bathroom that resulted in a DTI to the coccyx and over time the area developed into thick eschar. The note indicated the area measured 7 cm by 6 cm by 2 cm of thick eschar, with no peri wound redness. Additionally, there	F 686		

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F 686	Continued From page 37 were four areas to the peri wound with granulation present. R100's emergency department (ED) note dated 2/11/24, indicated R100 was seen for evaluation of a worsening sacral wound and had a CT scan that showed possible cellulitis of the sacral wound, and recommended follow up with the wound clinic. R100's After Visit Summary note dated 2/15/24, indicated new orders to cleanse the buttock wound(s) with normal saline, pat dry with non-sterile gauze, pack wounds with aquacel AG (used for wounds with moderate to heavy drainage) cover with Mepilex. Additionally, the note indicated to offer a supplement three times daily. R100's wound clinic note dated 2/15/24, indicated R100 reported the wound had been present since 10/2023. The note further indicated the wound bed contained necrotic material and the surrounding wound had healthy intact skin. Additionally, the wound had necrotic muscle and was a fairly deep stage four pressure ulcer. The wound pre debridement measurements were 7 cm (centimeters) long by 6.5 cm wide and 1.8 cm deep and total 56 square cm. Further, the note indicated the most important thing to do to support healing was to keep pressure off the wound, R100 should be repositioned every 2 hours around the clock while in bed. Additionally, the physician explained to R100 the importance of protein intake to wound healing and increasing protein intake will speed wound healing and to further speed wound heeling encouraged R100 to take a protein supplement. Further, R100 should only be in the wheelchair for 3 hours a day and	F 686		

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F 686	Continued From page 38 R100 needed to reposition themselves every 15-20 minutes while there are in the wheelchair. R100's Wound Management form indicated there were no wound types identified for the resident. R100's nursing progress notes were reviewed from 1/6/24, to 2/14/24, and indicated the following: No progress note was entered on 1/6/24. 1/8/24 perineal care was completed and there was redness noted on R100's sacrum and cream per order and foam dressing endorsed. The documentation lacked any measurement of the reddened area. 1/9/24 perineal cares were completed and nystatin was applied on redness, and calmo was applied on the sacrum and the foam dressing was changed. The documentation lacked any measurement of the reddened area to the sacrum. 1/10/24 R100 complained of pain to the left heel which was offloaded with a pillow and blanchable redness was observed on the left heel. Nystatin was applied on the groin. The note indicated negative moisture positive redness and peeling skin was noted on the groin. Additionally R100's sacrum was still red and calmo was applied along with a foam dressing. The documentation lacked any measurement of the reddened area to the sacrum. 1/10/24 R100 had a left heel stage 1 ulcer and orders were received to apply skin prep and allow to dry and blue boots both feet at all times except for cares. The documentation lacked a skin assessment of the left heel including measurements. 1/12/24: R100 had a witnessed fall with staff and	F 686		

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F 686	Continued From page 39 was lowered to the ground without injuries, the note indicated R100's legs got weak during a transfer with a Pals lift and it was recommended to change to a Hoyer for safety. 1/13/24: R100 had a bruise on her right buttocks and the site was red with a closed bruise on the redness. The site was covered with a foam protective dressing. The red site was measured at 13 cm by 10 cm. 1/14/24: R100 had calmo on her buttocks, and had bruises on the redness of the sacrum area. Further, the redness on the left heel was prepped and a foam dressing was applied. The heel was not measured. 1/15/24: R100 had bruises on the sacrum with bleeding and peeling skin, and left heel cares were completed. 1/24/24: R100's heel ulcers were documented as assessed and redressed, however there was no documentation of measurements or the assessment. 1/28/24: R100's sacral wound care was completed and slough was noted on the buttocks and was increased in size. The NP was updated who ordered Medihoney and a foam dressing, up in the wheelchair for no more than 2 hours, change bed to an air mattress, and an OT evaluation for a Roho cushion. The note lacked a wound assessment to include any measurements. 1/31/24: R100's total surface area of the sacral wound was 13 by 12 cm and there was no assessment documented on the wound bed. Additionally the left heel pressure wound was red dry and intact, however there were no measurements. 2/1/24: R100's progress note indicated 13.4 cm by 0.1 cm and wound bed was 30% eschar, 30% slough, and 10% superficial tissue loss, 20% non	F 686		

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F 686	Continued From page 40 blanchable irregular edges. The periwound was documented as intact and blanchable and the note indicated R100 was admitted with area. The progress note did not identify the location of the wound. 2/3/24: R100's dressing on sacrum was changed and the eschar measured 5 by 6 cm and the total surface of the wound was 12 by 10 cm. The documentation lacked information on R100's left heel. 2/7/24: R100 had eschar that measured 5 by 6 cm and had a total surface area of 11 by 10 cm and the heel wound was documented as intact with no open areas. The documentation lacked a measurement of the left heel wound, and did not identify the location of the wound with eschar. 2/8/24: R100 had an unstageable area on the sacrum and coccyx that measured 13.5 cm by 13.5 cm by 0.1 cm and the wound bed had 30% eschar, 30% clean non granulated tissue, 10% superficial tissue loss, 20% non blanchable irregular edges and the area of eschar measured 6 cm by 6.8 cm and was unable to determine depth of the wound due to the eschar. The documentation indicated that R100 was admitted with the area. Additionally, R100 had a DTI on the left heel that measured 1.5 cm by 1.8 cm in an L shape that was intact and the surrounding wound was intact and pink. Additionally, the note indicated R100 admitted with area. This was the first time R100's left heel wound had been measured. 2/14/24: R100's sacrum wound had a total surface area of 13.3 by 12 cm and the open wound measured 5.4 by 5.6 cm. The wound had varying wound depth with the deepest measuring 0.9 cm. R100 had a 2nd wound documented at the bottom of the first that measured 1.5 cm by 0.9 cm by 0.5 cm in depth, and an open wound at	F 686		

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F 686	Continued From page 41 6 O' clock on the right bottom that measured 3.8 by 0.6 cm, a wound at 9 O' clock 1.6 by 1.1cm, at 8 O' clock 3 by 0.5 cm, and had left buttocks excoriation 0.3 by 0.3 cm. R100's left heel was intact and measured 1.1 cm by 0.4 cm. During interview and observation on 2/12/24 between 4:40 p.m., and 4:48 p.m., R100 was laying on her back in bed towards her right side. A pillow was under the left side of R100 and a family member stated R100's sore was on the right side of her buttocks. At 4:48 p.m., R100 stated the sore on her bottom started in October and didn't become worse until coming to the facility. During continuous observation on 2/13/24 from 1:44 p.m., to 2:07 p.m., R100 was in a wheelchair and there was a Reliant 450 full body lift located in the hallway. At 2:06 p.m., registered nurse (RN)-A brought the full body lift into R100's room and was awaiting assist and at 2:07 p.m., nursing assistant (NA)-B entered the room. RN-A and NA-B positioned R100 in bed on her back. During interview on 2/13/24 at 2:10 p.m., RN-A and NA-B assisted in providing perineal cares and at 2:22 p.m., boosted R100 up in bed, positioned her on her back and provided the call light. RN-A and NA-B did not offer to lie resident on her side. During interview on 2/13/24 at 2:25 p.m., RN-A stated R100 had a bed sore on her bottom and came with incontinence associated dermatitis and it worsened because of incontinence. RN-A stated they use Medihoney for the area because it helped debride the slough and R100 had an appointment on 2/15/24, for vascular to have the	F 686		

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F 686	Continued From page 42 wound checked. RN-A stated R100 should be kept repositioned on her left and right side and verified R100 was not positioned on her right or left side and further stated the ulcer was all over her buttocks. Additionally, RN-A stated R100's bed sore could worsen being on her back. Further, RN-A stated wound measurements were documented in the progress notes and was not sure how often they were completed. During observation on 2/13/24 at 3:04 p.m., R100 stated she would be willing to lie side to side. R100 had a pillow under her right side, but was still positioned on her back and the head of the bed was elevated about 30 degrees. R100 had a Journey wheelchair cushion in her wheelchair. During observation on 2/14/24 at 7:20 a.m., R100 was lying in bed on her back, her weight was shifted towards the right side but was mostly on her back and the head of the bed was elevated about 20 to 30 degrees. There was no pillow located under the left side of R100. During interview on 2/14/24 at 8:36 a.m., occupational therapist (OT)-F stated a Roho cushion was a gold standard for true pressure relief because it had air in its cells and were wonderful for wound management. OT-F stated if a resident had trouble with core stability, the cushion would be discouraged and in that case would use a foam cushion which still redistributes pressure, but the foam cushion gave more stability to feel secure in the chair. OT-F further stated the Roho worked well on the TCU. OT-F further stated if an order was to evaluate for a Roho, OT would document the evaluation and do a trial and error. The benefit of the doctor ordering a Roho is if we are not getting enough	F 686		

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F 686	Continued From page 43 pressure relief from the redistribution mattress. OT-F stated an evaluation with an order should take place as soon as possible and a TCU patient was very easy to get to right away. OT-F stated R100 was on the TCU side. During interview on 2/14/24 at 9:18 a.m., the rehab director stated their OT was trained in wheelchair positioning and would initiate what they thought was appropriate with or without an order and would document. The rehab director reviewed the OT progress notes and did not locate any documentation of an OT evaluation for a Roho cushion. Further, the rehab director said when there is an order they are notified of the order by nursing staff and the therapist would address the order and would be in their documentation that they looked at the cushion and verified she did not see any documentation R100 was formally assessed for a Roho cushion. The rehab director stated the nurse manager or health unit coordinator would share with therapy anything new to address and stated she got the order and would get it to the appropriate person and was not aware of an order for a Roho cushion and stated she would look through her email. The rehab director also verified physical therapy would not be involved in the Roho cushion and stated if there was an order it would be emailed to her. During observation on 2/14/24 at 9:05 a.m., R100 still had a journey cushion in the wheelchair. RN-G stated R100 had a regular cushion not a Roho cushion. R100 also had a comfort curve cushion and RN-G stated that was not a Roho cushion, but later stated she would have to ask the nurse manager and verified the wheel chair cushion was a Journey wheelchair cushion and	F 686		

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F 686	Continued From page 44 the cushion in R100's recliner was a Comfort Curve cushion. During interview on 2/14/24 at 9:11 a.m., OTR stated R100 did not have difficulty with core stability and when asked if R100 had been evaluated for a Roho cushion stated she thought R100 had a pressure relieving cushion on the chair and stated staff elevate the head of the bed for R100 to eat, but patients should not have the head of the bed elevated for a long period of time. During interview on 2/14/24 at 7:13 a.m., NA-B stated she looks on the care sheet to know what cares a resident requires and stated R100 never refused cares. NA-B further stated R100 was incontinent of stool and her dressing sometimes needed to be changed and stated R100 could not reposition herself and stated they reposition R100 off the area a little bit on the left side and right side. NA-B was not aware R100 had any issues with her heels. During interview on 2/14/24 at 9:37 a.m., the dietician (D)-I stated she monitors a appetites and their weights, and proteins, when a resident has a pressure ulcer. D-I stated if a resident had a stage 1 pressure ulcer she encouraged food and ensure and if a resident had a more serious ulcer, she reviews her supplements a resident may be interested in and added, it won't help if a resident refuses and stated she looks at the electronic medication administration record (EMAR). D-I further stated she looked at point of care to see what the NA's documented and stated they couldn't have an expectation that every single meal was documented, but stated the more documentation, the better. R-I stated Glucerna is made by the company that makes Ensure and is	F 686		

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F 686	Continued From page 45	F 686		

for people with diabetes and it was a protein to help with wounds. D-I stated if residents didn't like Glucerna, they had Arginaide which also helped with wound healing. D-I stated the nurses let her know if a resident was refusing supplements and they document in the EMAR. D-I was familiar with R100 and stated she had Glucerna and had a good intake at meals, and had an unstageable pressure ulcer to the coccyx and also had a pressure ulcer to the left heel, but did not know if the heel was unstageable. D-I stated she had just completed a review on R100 the day prior and reviewed R100's EMAR and verified R100 was not taking the Glucerna and stated she would have to follow up with R100. D-I stated the wound nurse gave report every week and so she could look to see if any changes were needed with supplements and stated people need protein for wound healing.

During interview on 2/14/24 at 10:36 a.m., the therapy director stated she did not locate any emails regarding a Roho OT evaluation for a wheelchair.

During interview and observation between 11:05 a.m., and 12:10 p.m., R100 had a dressing on her left heel and RN-A stated they use an adhesive remover. RN-A stated at 11:10 a.m., that R100's left heel was dark red and was now forming an eschar and stated it was a stage two and measured 1.1 cm long by 0.4 cm wide. At 11:23 a.m., R100 stated she did not like the ensure like supplements. At 11:24 a.m., RN-A stated R100's right foot outer ankle did not have an ulcer, but R100 had redness because her foot tilted to the right so they covered the area with foam. RN-A verified there was an area of redness on the ankle bone that blanched after

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F 686	Continued From page 46 about 3 seconds and RN-A thought the area was about dime sized. R100 had two wounds to the sacral area that contained slough, the large sacral wound had a yellow/black eschar that covered approximately 95% of the wound and RN-A stated the second wound had slough and was located just distal (below) to the large wound on the right sacrum. RN-A stated there was a piece of skin that was hanging on the left buttocks and stated it was like an open area and the area measured 0.3 by 0.3 cm. RN-A verified R100 had 6 open areas on her bottom and filled the open spaces with Medihoney, then stated the dressing had changed the previous day to calcium alginate and filled the areas at 8 and 9 O clock and covered the area with two large silicone foam pads and at 12:10 p.m., RN-A assisted R100 in putting shorts on. During interview on 2/14/24 at 12:57 p.m., OTR-H verified R100 did not have a Roho cushion and stated they were going to look into it. During interview on 2/14/24 at 1:03 p.m., RN-A stated orders were put into the Matrix in the system along with a check box for whom the order is addressed, for example the NP specifically ordered OT to evaluate the Roho and stated she usually updated the nurse manager who would email therapy. RN-A stated she would have expected OT to follow up on the Roho because she spoke with the nurse manager. Additionally, when a resident came to the facility with a pressure ulcer there would always be ordered when the come from the hospital and a skin assessment is completed the date of admission by opening an event for that and was usually completed by the night nurse. RN-A stated wound assessments should consist of	F 686		

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F 686	Continued From page 47 whether the area is excoriated, open, blanchable, include measurements, the location of the wound and we categorize it if its a pressure wound or rashes or whether it is a skin tear. Additionally RN-A stated it was documented in a progress note and if there was a new area, an event is opened and the family, doctor are notified and it is documented in a progress note. RN-A stated residents with a sacral ulcer should be positioned side to side and you should always float the area on one side so it is not touching the bed. RN-A further stated she has seen R100 in bed and the sacral wound is touching the bed. RN-A stated you want to keep it off to prevent more injury to the wound because the pressure plus shearing can cause more injury to the wound and it could get deeper and larger. RN-A further stated R100 came with a pressure ulcer and stated it was incontinence associated dermatitis. RN-A further stated when she first saw the wound it was very big on her buttocks and it was a DTI, and when she came it was already red on the buttocks. RN-A stated R100 had other open areas on her bottom and couldn't tell the exact date, but thought it had been two weeks. RN-A stated the care plan should have had interventions and would have expected an assessment on the six wounds when they first started and if they had a daily dressing change, an assessment should have been documented daily. During interview on 2/15/24 at 9:57 a.m., NP-C stated wounds should be documented according to facility policy. NP-C stated R100 had IAD and then slipped out of a lift and had seen R100 the following Monday and R100 had bruising on the right buttock and stated it became an IAD with a DTI and then turned into a necrotic area. NP-C stated she last saw R100 earlier that week and	F 686		

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F 686	Continued From page 48 stated R100 had a big necrotic area that was unstageable. NP-C stated a DTI was pressure or trauma and R100 fell out of a lift and the area was unstageable. NP-C stated R100 had multiple sclerosis and impaired mobility and was at risk for skin breakdown and had ordered a Roho and wanted therapy to follow through on the Roho. Additionally, NP-C stated with the observations of R100 lying on her back, lack of care plan interventions, and lack of follow up on the nutritional supplement if R100 was refusing, and lack of wound documentation, have contributed to an increase in number of areas and added that's why they do a Braden scale and you have to evaluate the skin to see if a resident is at risk and put interventions in place or it leads to skin breakdown. During interview on 2/15/24 at 12:40 p.m., the director of nursing (DON) stated she expected the nurse to assess the wound and they had a wound nurse who completed weekly rounding and completed the documentation and stated they had a wound management tab and in the TCU they document in a progress note. Director of nursing stated she expected wound documentation on each wound and expected the dietician to review if a resident was refusing so a reassessment could determine what was appropriate and stated they had been working on wound assessments and was identified as something that needed to happen. A policy, Prevention and Treatment of Skin Breakdown dated 9/1/18, indicated resident skin integrity is assessed upon admission and weekly thereafter. A skin risk assessment is completed upon admission and weekly for 4 weeks upon significant change and quarterly thereafter.	F 686		

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F 686	Continued From page 49 Those residents at risk for impaired skin integrity are provided preventative measures to reduce the potential for skin breakdown. Those residents who experience a break in skin integrity or wounds are provided care and service to heal the skin according to professional standards of care. A Braden Skin Risk Assessment is completed upon admission or readmission and weekly for the first 4 weeks post admission or readmission, a resident centered care plan is implemented and updated for skin risk with interventions based upon areas of risk, resident assessment, Braden evaluation score of 15 or less, clinicians assessment evaluation, and resident preferences. Skin integrity is monitored and abnormal findings are documented skin is observed daily with cares and if any concerns are noted they are reported to the licensed nurse. Weekly skin audits are performed by a licensed nurse. If a resident is admitted with impaired skin integrity or a new pressure injury or lower extremity wound develops the licensed nurse implements the following items: documentation of the skin impairment is completed in the medical record. Staging of pressure injury is completed as necessary by trained licensed associates. Standing orders are initiated, notify the attending provider, resident and representative, notify the supervisor, evaluate current pressure reduction interventions and revise resident centered care plan, notify dietitian for nutritional interventions, notify therapy associates and other members of the care team as appropriate. Weekly the licensed nurse will stage, measure, and examine the wound bed and surrounding skin and if the wound bed has deteriorated; notify the provider.	F 686		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)	F 689		3/11/24

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F 689	Continued From page 50 §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to implement care plan interventions for 1 of 1 resident (R263) reviewed with a history of falls. Findings include: R263's face sheet indicated R263 admitted to the facility on 2/8/24, and had the following diagnoses: ORIF (open reduction internal fixation a surgical procedure for repairing fractured bone) to right femur, chronic L2 (lumbar) and L3 burst fractures (when a vertebra is crushed in all directions, the condition is called a burst fracture), periprosthetic fracture (a broken bone that occurs around the implants) around other internal prosthetic joint, dementia, Parkinson's disease with dyskinesia (involuntary, erratic, writhing movements of the face, arms, legs, or trunk), age related osteoporosis with current pathological fracture. R263's Clinical Documentation Admission form dated 2/8/24, indicated R263 rarely or never understood under the heading, "Ability to express ideas and wants, consider both verbal and non-verbal expression." Additionally, under the heading, "Ability to understand others" indicated	F 689	Resident 263 care plan was updated to include fall interventions. Resident 263 fall interventions are being followed. All residents with falls in the last 30 days have had care plan reviewed to ensure fall interventions in place. All current fall interventions being followed. Facility nursing staff have been educated on resident fall interventions being in place. DON, LNHA, or designee will monitor compliance. Audits will be completed specific to fall interventions. Audits will be completed on 5 residents weekly for 4 weeks, then 5 residents twice a month for 2 months. Audits will be presented to Quality Council, who will recommend changes and on-going monitoring/auditing after analysis.	

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F 689	Continued From page 51 R263 rarely or never understood. The form indicated R263 had adequate vision, had a short-term, and long-term memory problem, had severely impaired cognitive skills for daily decision making. Additionally, R263 required extensive assist for bed mobility, transfers, toileting, and had a history of falling in the last month, 2-6 months, had a fracture related to a fall in the last 6 months prior to admissions, and occasionally had bladder incontinence. The form also indicated R263's prior device used prior to the current illness, exacerbation, or injury included a mechanical lift. A wheelchair and walker were unchecked. R263's physician orders form included the following orders dated 2/8/24: occupational therapy (OT) evaluate and treat continuous, and physical therapy (PT) evaluate and treat. On 2/9/24, R263's physician order included speech therapy (ST) evaluate and treat. R263's physician orders dated 2/8/24, indicated R263 could bear weight as tolerated on the right lower extremity with a walker. R263's care plan dated 2/9/24, indicated R263's goal was to return to the community and interventions included see also therapy plan of care. R263's care plan dated 2/9/24, indicated R263 required therapy services due to a diagnosis of weakness. Interventions included a therapy care plan that included PT, OT, and SLP (speech language pathologist), and the number of days per week was undocumented. R263's care plan dated 2/9/24 indicated R263	F 689		

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F 689	Continued From page 52 was at risk for falls due to weakness, and the goal was R263 would not sustain a fall related injury through the review date. Two interventions were listed on the care plan: grab bar, tab alarm. Interventions were later added on 2/14/24, that included: keep in supervised areas during the day for increased supervision, plan to move patient to room closer to desk for increased supervision as soon as available, PT (physical therapy) OT (occupational therapy) per physician orders, sensor alarm at all times. Nursing assistant care sheets provided on 2/12/24, did not include R263 on the care sheet, however, the director of nursing (DON) provided a care sheet via email on 2/15/24, and indicated the care sheet was from 2/12/24. The care sheet indicated R263 was at high risk for falls and was to be in supervised areas when out of bed, and had an alarm, but did not specify the type of alarm. R263's Occupational Therapy Evaluation and Plan of Treatment form dated 2/9/24, was reviewed and R263's prior level of functioning indicated R263 lived in an assisted living facility and required stand by assist (SBA) with activities of daily living (ADLs) with a walker, and had a front wheeled walker and wheelchair for prior equipment. R263's Occupational Therapy Treatment Encounter Notes forms dated 2/9/24, 2/10/24, 2/13/24, 2/14/24, were reviewed and lacked information regarding the height position of R263's bed, location of the walker, and wheelchair when R263 was in bed. R263's Physical Therapy Evaluation and Plan of Treatment form dated 2/9/24, indicated R263's prior level of functioning indicated R263 lived in	F 689		

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F 689	Continued From page 53 an assisted living facility and required stand by assist (SBA) with activities of daily living (ADLs) with a walker, and had a front wheeled walker and wheelchair for prior equipment. Physical Therapy Treatment Encounter Notes forms dated 2/9/24, 2/10/24, 2/11/24, 2/12/24, 2/14/24, were reviewed and lacked information regarding the height position of R263's bed, location of the walker, and wheelchair when R263 was in bed. R263's Physical Therapy Treatment Encounter Note dated 2/12/24, indicated R263 had fallen over the weekend and nursing indicated it was not ok for R263 to be in the room alone anymore and must be in communal areas during the day. R263's Therapy Screen form dated 2/9/24, indicated under a heading, "Speech Therapy Areas" included swallowing, memory, cognition, and communication and an order was requested for ST due to new admission with a medical history significant for Parkinson's and dementia. R263's Event Report form dated 2/11/24, indicated R263 had a witnessed fall in her room and had walked to get her clothes and was in bed prior to the fall. Immediate actions taken included first aid and an emergency room visit. A bed alarm was in use at the time of the fall. The report indicated R263 had been evaluated by PT/OT/ST for falls. Further, the nurse was notified by the cleaning lady R263 was on the ground and R263 stated she hit her head with a bump on the left side of her head and was sent to the emergency department for an unwitnessed fall. R263 returned around 5:40 p.m., and was situated in bed and her alarm went off at 6:00 p.m., and was found on the floor trying to get her purse.	F 689		

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F 689	Continued From page 54 R263's Event Report form dated 2/11/24, indicated R263 fell in her room and was trying to walk just prior to the fall. Additionally, R263 was in bed prior to the fall. Immediate measures taken include a bed alarm and the on call nurse practitioner was updated. The report indicated R263 had not been evaluated by PT/OT/SLP for falls and the event was still open. R263's Emergency Medicine Visit Note dated 2/11/24, indicated R263 was in the emergency department for evaluation of a mechanical fall and the note indicated a new osseous (bone) fragment superior (upper) to the right lesser trochanter (a bony projection from the shaft of the femur), likely new displaced fracture fragment. Orthopedics was consulted and recommended weight bearing as tolerated. During interview on 2/13/24 at 9:51 a.m., family member (FM)-E stated R263 had fallen a couple of times she she had been at the facility. FM-E stated R263 fell at the other facility as well and broke her leg and was at the current facility for rehab. FM-E stated they hadn't stated they were going to do anything different from falling. During interview and observation on 2/14/24 from 7:34 a.m. to 7:47 a.m., R263's door was closed and the call light was on. No staff were in the room upon entrance and resident stated she had to go home and go to the bathroom. R263 was in a gown and the bed was in the low position. R263's walker was across the room. Nursing assistant (NA)-C entered the room at 7:35 a.m. and stated R263 had a bed alarm that sounded when R263 got up. At 7:37 a.m., NA-C took the wheelchair out of the bathroom and placed it next	F 689		

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F 689	Continued From page 55 to the bed and locked the brakes and raised the bed up to assist R263 in a transfer. A personal alarm was located in R263's reclining chair and NA-C verified the personal alarm in the chair should be in the chair. At 7:38 a.m., NA-C assisted R263 to stand and the bed alarm began to alarm. At 7:39 a.m., NA-C assisted R263 to the toilet. NA-C stated they have a team sheet to know what cares a resident required. At 7:44 a.m., NA-C locked the wheel chair and assisted resident back into bed and at 7:46 a.m., turned the alarm on again. At 7:47 a.m. NA-C raised the bed from the floor up where the top of the mattress was approximately three feet from the floor. Then at 7:50 a.m., NA-C lowered the bed to the floor and put the wheelchair by the door by the walker which were both out of the resident's reach. At 7:54 a.m. NA-C stated the door should be left open and left the room. At 7:56 a.m., NA-C answered R263's light that was just turned on. During observation on 2/14/24 at 8:01 a.m., R263's call light was on and could hear resident asking about talking to family. During observation on 2/14/24 at 8:10 a.m., an unknown staff person came up the stairs and walked past R263's room and did not answer the light. During observation on 2/14/24 at 8:13 a.m., two staff members were at the end of the hallway but did not answer R263's light. During observation on 2/14/24 at 8:14 a.m., registered nurse (RN)-E entered R263's room and R263 asked her about calling her mother.	F 689		

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F 689	Continued From page 56 During interview on 2/14/24 between 8:15 a.m. and 8:36 a.m., RN-E stated R263 came from memory care the end of the week prior and they planned to move R263 to another room because she had a couple of falls and they wanted her closer to the desk. RN-E stated she thought the tab alarm should be on at all times and further stated the team sheets would indicate alarm, but did not always specify which type of alarm. RN-E stated if they identify a resident can remove an alarm independently a sensor alarm is put on the care sheet, but RN-E stated she did not know whether R263 could remove the tab alarm and stated R263 at least had the sensor alarm which should be sufficient. RN-E further stated she hadn't gotten feedback from staff regarding R263's transfers and stated with her cognition, the walker and wheelchair should not be close to her when in bed because sometimes residents will want to pop up and use them. RN-E stated R263 had two falls on the 2/11/24. RN-E further stated staff did not add a lot of information when they entered the care plan. RN-E further stated the minimum data set (MDS) nurses used to update care plans and they dropped MDS nurse hours and the nurse on the floor puts in the initial and then RN-E updates the care sheet and tries to do as much as she can on the care plan. RN-E stated she expected care plans to be updated and stated she would clarify the type of alarm. RN-E further stated R263's bed should be kept in a regular height position, and stated she expected the walker and wheelchair location should be on the care plan so it was individualized per patient and stated it would be important for staff to know. RN-E verified the care plan had not been updated since it was initially added.	F 689		

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F 689	Continued From page 57 During interview on 2/14/24 at 1:58 p.m., NA-D stated they had care sheets to know what cares a resident required. When asked if R263's wheelchair or walker should be by her when in bed, NA-D stated she thought the wheelchair should be by her because she knew R263 was at risk for falling. NA-D further stated the beds were always supposed to be in the lowest position. NA-D stated the care sheet didn't always give her that information and added the little bit she worked with R263, she did not know. NA-D stated she thought they discontinued the tab alarm and now had a pad alarm. During interview on 2/14/24 from 2:06 p.m. to 2:19 p.m., licensed practical nurse (LPN)-E stated when a resident falls, they used a cheat sheet so you didn't miss anything. LPN-E stated R263 had confusion, was impulsive and forgetful and didn't remember to use the call light. LPN-E further stated she looked at care plans and stated R263's call light was on from 6:20 to 6:35 and had the light on seven times in a period of 15 minutes and instructed staff R263 needed to come out here for her safety. LPN-E stated the bed is supposed to be in a regular position versus a low position. LPN-E stated she did not think the wheelchair or the walker should be by the bedside. LPN-E stated she expected the alarm types and when to use the alarms be care planned and on the care sheets and the position of the walker and wheelchair whether placed by the bed or pulled away. LPN-E further stated if a resident falls you are supposed to apply an intervention and the care plan should be updated after a fall and verified the care plan had not been updated after the fall at the time of the fall. During interview on 2/14/24 at 2:35 p.m., NA-E	F 689		

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F 689	Continued From page 58 stated she was agency staff and stated they looked at the care plan. NA-E would need to see R263's face and thought the bed should be in the lowest position if a resident was a fall risk, and stated she would assume if a resident was at risk for falling the wheelchair and walker would be placed against the wall unless the care plan indicated otherwise. NA-E verified her care sheet did not specify type of alarm, nor the location of the wheelchair and walker when resident was in bed. During interview on 2/14/24 at 2:51 p.m., the director of nursing (DON) stated when a resident falls, the nurses on the floor completes an assessment and an event notification, calls the DON, updates the provider and the nurse management team takes data and does a follow up plan. DON further stated they expected nurses on the floor to do something but they wouldn't add a care plan in the system, but would document interventions. DON further stated she expected the care plan to be updated within 24 hours. Additionally the intervention would go on the nursing assistant care sheets. DON stated if the resident is cognizant and can remove the tab then they would use the pad alarm. DON further stated interventions were determined based on what the resident was attempting to do. DON verified the care plan had not been updated until 2/14/24, and stated she expected interventions to be on the care plan and added R263 was brand new and they would have to learn and additionally nursing hadn't done an assessment on where she should have equipment and therapy would do their assessment and offer insight. A policy, Integrated Fall Management dated 8/24/17, indicated residents were assessed for	F 689		

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F 689	Continued From page 59 their risk of falls upon admission, significant change, and quarterly thereafter. Residents with risk for falling will have interventions implemented through the resident centered care plan. When a resident falls, a licensed nurse assesses the residents condition, provides care for, safety and comfort. A fall risk assessment is completed within 48 hours of admission to the community, residents at risk for falls have an individualized resident centered care plan developed. care plan interventions are based on the finding of the fall risk assessment. Additional professionals may be contacted to provide assessment and or interventions regarding fall risk and prevention, including but not limited to the attending physician/provider, pharmacist, physical therapist, occupational therapist, and speech therapist. When a resident falls the environment of the fall is evaluated for possible contributing factors and addressed, the interdisciplinary team reviews the fall and care plan changes and may, if needed, implement additional interventions.	F 689		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and	F 755		3/11/24

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F 755	Continued From page 60 biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure appropriate collaboration with providers and pharmacy in the transcription of orders for 3 of 3 (R7, R56, and R66) reviewed for medications. Findings include: R7's face sheet printed on 2/15/24, included diagnosis of Alzheimer's disease and dysphagia (difficulty swallowing). During medication administration observation on 2/14/24 at 8:05 a.m., registered nurse (RN)-E prepared R7's medications. Medications included the following: -amlodipine 10 mg tablet -famotidine 20 mg tablet -aspirin 81 mg enteric coated tablet	F 755	Resident 7 and resident 56 medications were reviewed by a pharmacist to ensure all medications are ok to crush. Resident 66's physician orders were reviewed by a provider, signed, and dated. These signed orders were uploaded and electronically signed in the resident□s medical record. Resident 7's orders and care plan were reviewed and updated to include crushing of medications. Resident 56 orders and care plan were reviewed and updated to include crushing of medications. Resident 66's medications on the physician order report, the physician progress notes, and care plan were reviewed. Facility will ensure that all residents	

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F 755	Continued From page 61 -calcitriol 0.25 mcg capsule -vitamin d 25 mcg capsule (capsule ordered but RN-E gave tablet) -Centrum multivitamin tablet -senna plus tablets RN-E placed all R7's in an envelope and then placed envelope into a pill crusher to crush R7's medications. RN-E placed crushed medications in pudding and administered to R7. R7's physician order review, dated 2/15/24, lacked an order to crush medications. R7's care plan, dated 2/15/24, lacked indication or preference of how R7 takes medications (i.e., whole or crushed). Review of R7's progress notes for period of 8/15/23 to 2/15/24, lacked any notification to pharmacy of R7 taking crushed medication or notification to the provider. Upon further review of EMR, no indications of pharmacy being notified of R7 taking medications crushed. R7's administration notes for the MAR indicate on 2/4/24, "medication crush with pudding pureed diet". Entry previously on 12/13/23, indication "medication whole". R56's annual Minimum Data Set (MDS), dated 12/7/23, identified a diagnosis of dementia and had impaired cognition. It further identified that R7 is on a mechanically altered and therapeutic diet. The assessment further identified no signs and symptoms of possible swallowing disorder. R56's face sheet printed on 2/15/24, included diagnosis of dementia and dysphagia.	F 755	providers are updated if standing orders are utilized and that provider orders will match the medical records. All residents who received crushed medications physician orders and care plans were reviewed. Pharmacy was updated with changes and care plans updated as needed. Facility nurses educated on use of standing orders, updating providers, and need for obtaining order of necessary. DON, LNHA, or designee will monitor compliance. Audits will be completed specific to use of standing orders and physician notification. Audits will be completed on 5 residents weekly for 4 weeks, then 5 residents twice a month for 2 months. Audits will be presented to Quality Council, who will recommend changes and on-going monitoring/auditing after analysis.	

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F 755	Continued From page 62 During medication administration observation on 2/14/23 at 7:55 a.m., registered nurse (RN)-E prepared R56's medications. RN-E placed R56's morning medication which included acetaminophen 325 mg two tablets scheduled, senna plus two tablets scheduled, and senna plus two tablets prn (as needed) were crushed together prior to administration and given to R56 in pudding. RN-E indicated the administration notes on the medication administration record indicated to crush medications. R56's physician order report, dated 2/15/24, lacked an order to crush medications. R56's care plan, printed 2/15/24, lacked indication of how R56 takes medications (i.e., whole or crushed). R56's administration notes for the MAR indicate that on 2/4/24 to "crush pills". Entry previously was on 3/9/23 indication "pills whole with thickened water or juice". R66's quarterly MDS, dated 12/5/23, identified a diagnosis of dementia and had impaired cognition. It identified R56 is on a mechanically altered diet and identified no signs and symptoms of possible swallowing disorder. Review of R66's progress notes for period of 8/15/23 to 2/15/24, lacked any notification to pharmacy of R66 taking crushed medication or notification to the provider. Upon further review of EMR, no indications of pharmacy being notified of R56 taking medications crushed. R66's physician note, dated 12/27/23, identified	F 755		

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F 755	Continued From page 63 R66 current medications as follows: -acetaminophen 325 mg tablet -albuterol 108 microgram/actuation (mcg/act) -albuterol 2.5 mg/3 milliliter (ml) 0.083% neb solution -senna-docusate 8.6-50 mg tablet R66's physician order report, dated 2/15/24, identified the following orders as of 12/27/24: -senna plus 8.6-50 mg take 2 tablets by mouth once a morning start date 11/20/2020 -Tylenol 325 mg take two tablets oral every 4 hours as needed start date 8/19/21 -albuterol sulfate solution for nebulization 2.5 mg/3 ml (0.083%) 1 vial inhalation three times a day as needed start date 10/26/23 -Dulcolax delayed release tablet 10mg by mouth once a day as needed start date 12/1/23 -hyoscyamine sulfate elixir 0.125 mg tablet oral one tablet sublingual every 4 hours for secretions as needed start date 12/1/23 -morphine concentrate solution 100mg/5 mL take 0/.25 mL by mouth every hour as needed start date 12/1/23 -ipratropium-albuterol solution for nebulization 0.5 mg-3 mg (2.5 mg base)/3 ml 1 vial inhalation three times a day start date 12/1/23 Upon review, the medications on the physician order report and the physician progress note do not match. R66's care plan printed 2/15/24, included diagnoses of insomnia. R66's provider note, dated 1/17/24, included an order for trazodone 50 milligrams (mg) tablet take 50 mg by mouth at bedtime and calcium carbonate (TUMS) 500 mg chewable tablet take 200 mg by mouth four times daily. The provider	F 755		

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F 755	Continued From page 64 note is electronically signed by provider. R66's physician order report, dated 2/15/24, lacked an order for trazodone 50 mg by mouth at bedtime. The identified an order for calcium carbonate 200 mg one tablet four times a day prn [as needed] for indigestion per SHO [standing house orders]. R66's standing house orders, signed 1/2024, indicate an order for calcium carbonate 500 mg one tablet PO [by mouth] four times a day prn [as needed] for three days. R66's electronic medical record (EMR) included a discontinue order for trazodone 50 mg on 1/10/24. R66's quarterly MDS, dated 12/6/23, indicated intact cognition. It identified that R66 is on a therapeutic diet and identified no signs and symptoms of possible swallowing disorder. Upon review, the medications on the physician order report and the physician progress note do not match. During an interview on 2/14/24 at 1:05 p.m., nurse manager (NM)-B stated if a resident was having difficulty swallowing then a speech evaluation would be requested. They indicated if a resident takes their medications crushed, an administration note was added to the MAR. They stated they do not put an order in for crushed medications. NM-B stated the physicians are notified "some of the time" and believes the pharmacy consultant can see the administrant notes. NM-B stated on certain medications, it was indicated not to crush the medications. NM-B	F 755		

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F 755	Continued From page 65 stated nurses were expected to know what medications can be crushed. During an interview on 2/14/24 at 1:20 p.m., NM-B provided standing house orders that indicated medications can be crushed unless contraindicated. During an interview on 2/14/24 at 2:22 p.m., RN-C stated floor nurses or the health unit coordinators (HUC)/health information manager (HIM) put physician orders into Matrix (EMR). RN-C stated floor nurses were not responsible to view the provider notes after visits as if there was a change in medication then a new order is written. RN-C stated they do not compare the medication on the physician notes to the medications in the facility EMR. RN-C verified they can use the physician notes for signed orders if needed. During an interview on 2/14/24 at 2:34 p.m., HIM-A indicated part of their role was to enter physician orders. HIM-A stated physician progress notes were used as signed orders and were uploaded after visits. HIM-A stated it was not within their scope to review all the medications on the physician notes as this would be out of their scope. HIM-A indicated they do not review the physician notes for accuracy of medications or compare medications list to what was in facility EMR system as a HIM was not qualified to do this. During an interview on 2/14/24 at 2:42 p.m., NM-A stated physician progress notes were reviewed for accuracy and the providers get the medication from the facility. NM-A stated the providers were not routinely printed a facility	F 755		

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F 755	Continued From page 66 medication list during visits. During an interview on 2/15/24 at 9:00 a.m., RN-F stated typically all residents have standing house orders signed by the provider upon admission. They indicated the were in the "background" meaning they were only to be used when needed and on a temporary basis. RN-F stated if you were using the standing house orders for more than a couple of days, then you must notify the provider. RN-F stated if a resident starts taking their medications crushed, a progress note would be put in and the provider would be updated. RN-F did not say anything about notifying the pharmacy. RN-F stated they know what medications can and cannot be crushed. RN-F stated an order for crushed was not put into the EMR and an administration note was added indicating how the resident takes their medications. During an interview on 2/15/24 at 10:42 a.m., nurse practitioner (NP)-A stated that physician orders were in both matrix [facility EMR] and Epic [provider EMR]. They indicated they do a comparison of medications but primarily use the facility medication list as this was what was being administered. NP-A indicated on the provider notes there was a statement "all meds and allergies reviewed in the record at the facility and is the most up-to date". NP-A stated the provider notes were sent over to the facility automatically and believes they were being reviewed as they have heard them being referenced during care conference. NP-A stated the most up to date medication was in the facility EMR. NP-A stated would expect to be notified if a resident was changed to crushed medications due to swallowing concerns. NP-A stated the pharmacy	F 755		

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F 755	Continued From page 67 should be reviewing the medications prior to crushing any medication to ensure they can be crushed. If the pharmacy identified an issue with a certain medication being crushed, a new order would be given. During an interview on 2/15/24 at 11:42 a.m., director of nursing (DON) stated if an order was used off the standing house orders, then we would update the provider. It would be on-going communication with the provider as these were used more for a temporary basis. DON stated if medications were being crushed, it would be the expectation to notify the provider as further evaluation would need to be done. DON stated we use the administration notes section to indicate how residents take their medications for example: crushed, or whole in applesauce. DON stated nurses do not get specific training on what medications can or cannot be crushed as it would be expected they know this information, use the drug books available in the nursing office or use online resources. DON stated some medication cards have labels on them that the medications cannot be crushed. DON stated previously had the pharmacist review medication that can be crushed for "special" cases, but this was not the standard practice. DON was unsure if the pharmacist can see the administration notes on the MAR. DON stated the provider notes were used to sign medication orders. She stated the current process to verify the provider medication list matches the facility list isn't solid at this time. DON stated the process needs to be reviewed. She verified there were medications on the provider notes (were being used as signed orders) were not being administered at the facility. DON stated we need to solidify this process.	F 755		

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F 755	Continued From page 68 During an interview on 2/15/24 at 4:00 p.m., consulting pharmacist (CP)-A stated was not notified if a resident takes crushed medications. CP-A stated was not notified when a resident was taking their medications crushed and does not see the medication administration notes on the MAR. CP-A verified would only know if a resident was taking crushed medications was if a physician order was put in. CP-A verified it was important a pharmacist reviews medications prior to the medications being crushed to ensure they can be crushed. Per standing house orders, record indicates on the top "All orders initiated from standing orders should be communicated to the provider". A facility policy regarding ensuring accurate collaboration between providers was requested and not received. A facility policy titled Medication Administration, revision date 8/14, was provided. The policy indicates that medications are administered as prescribed. It further indicates that crushing tablets may require a physician's order, per facility policy. No additional facility policy was provided.	F 755		
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by:	F 759		3/11/24

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F 759	Continued From page 69 Based on observation, interview, and document review, the facility failed to ensure they were free of a medication error rate of five percent or greater. The facility had a medication error rate of 8% with 2 errors out of 25 opportunities involving 1 of 5 residents (R7) who were observed during medication administration. Findings include: R7's face sheet printed on 2/15/24, included diagnosis of gastro-esophageal reflux disease without esophagitis (GERD-acid reflux), R7's physician progress note, dated 1/10/24, included diagnoses of gastro-esophageal reflux disease without esophagitis (GERD-acid reflux), coronary artery disease, hypertension (high blood pressure), congestive heart failure, chronic kidney disease. R7's medication administration summary (MAR) for February 2024, identified the following orders included: - start date 12/8/22, aspirin 81 mg enteric coated tablet take one tablet by mouth once a morning -start date 12/8/22, calcitriol 0.25 mcg capsule take one capsule by mouth once a morning During an observation and interview on 2/14/24, at 8:05 a.m., registered nurse (RN)-E was preparing R7's medications. RN-E put all medications into a plastic envelope and placed the envelope into the pill crusher proceeding to crush the medications. RN-E placed R7's crushed medications in pudding and administered. During interview on 2/14/24, at 8:08 a.m., RN-E	F 759	Resident 7 medication orders and care plan were reviewed. Resident was not affected by medication error. All residents who have an order for crushed med were reviewed by pharmacist to ensure they are on the appropriate form of medication. Facility nurses were educated on Medication Administration policy concerning crushing of medications. DON, LNHA, or designee will monitor compliance. Audits will be completed specific to crushing of medications and appropriate form of medication. Audits will be completed on 5 residents weekly for 4 weeks, then 5 residents twice a month for 2 months. Audits will be presented to Quality Council, who will recommend changes and on-going monitoring/auditing after analysis.	

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F 759	Continued From page 70 stated R7 takes all their medications crushed. RN-E stated was unsure if there was an order for crushed medications but there was an administration note indicating t R7 takes medications crushed. RN-E indicated the capsule can be crushed as it will get "goopy" and mix with the other medications. R7's physician order review, dated 2/15/24, lacked an order to crush medications. R7's orders indicated an order for minced and moist texture for food and thin liquid with a start date of 2/22/23. R7's care plan, dated 2/15/24, lacked indication of how R7 takes medications (i.e. whole or crushed). R7's administration notes on MAR indicated "medications whole" dated 12/13/23, with a change on 2/4/24, to "medication crush with pudding pureed diet". During interview on 2/14/24, at 1:05 p.m., nurse manager (NM)-B stated it was indicated not to crush on certain medication packages. NM-B stated nurses were expected to know what medications can be crushed. NM-B verified enteric coated medications and capsules should not be crushed. During an interview on 2/15/24 at 10:42 a.m., nurse practitioner (NP)-A stated the pharmacy should be reviewing the medications prior to crushing any medication to ensure they can be crushed. If the pharmacy identified an issue with a certain medication being crushed, a new order would be given. During an interview on 2/15/24 at 11:42 a.m., director of nursing (DON) stated nurses do not	F 759		

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F 759	Continued From page 71 get specific training on what medications can or cannot be crushed as it would be expected they know this information, use the drug books available in the nursing office or use online resources. DON stated some medication cards have labels on them that the medications cannot be crushed. DON verified capsules and enteric coated medications should not be crushed. DON verified was made aware of this medication error. During an interview on 2/15/24 at 4:00 p.m., consulting pharmacist (CP)-A stated taking either enteric coated aspirin crushed or calcitriol 0.25mcg capsule could cause a stomachache. CP-A stated, "thinks the manufacturer says do not crush" regarding the calcitriol capsule. A facility policy titled Medication Administration Preparation and General Guidelines, dated 12/17, was provided. The policy indicates long-acting or enteric-coated dosage forms should not be crushed: an alternative should be sought. It further indicates to check with the pharmacist before opening any capsules.	F 759		
F 804 SS=D	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by:	F 804		3/11/24

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F 804	Continued From page 72 Based on observation, interview, and document review, the facility failed to ensure food was served at a palatable and appetizing temperature for 3 of 3 residents (R16, R19, R96) reviewed for dining services. Findings include: R16 R16's annual Minimum Data Set (MDS) dated 1/18/24, indicated R16 was cognitively intact and required set-up or clean-up assistance with eating. On 2/12/24 at 5:21 p.m., R16 was eating their meal while sitting up in bed and stated they ate meals in their room. R16 stated the food was cold "more than it should be". R19 and R96 R19's significant change Minimum Data Set (MDS) dated 12/16/23, identified R19 was cognitively intact and was independent with eating after set up. R96's significant change Minimum Data Set (MDS) dated 1/25/24. Identified R96 was cognitively intact and was independent with eating. During an interview on 2/12/24 at 12:58 p.m., R19 stated it doesn't seem to matter if I eat in my room or in the dining room the food was never hot it was always luke warm. During an interview on 2/12/24 at 2:46 p.m., R96 stated the food was not very good and the hot	F 804	Resident 19 and 96 were not negatively affected by food temperature. All residents have the potential to be affected. Facility will ensure food temps are within appropriate range. Culinary staff will ensure food temperatures are within appropriate range by temping food at kitchenette before serving and document on temperature logs. Facility culinary staff education on proper holding temperatures of hot food. DON, LNHA, or designee will monitor compliance. Audits will be completed specific to temperatures of meals served. Audits will be completed on 5 residents weekly for 4 weeks, then 5 residents twice a month for 2 months. Audits will be presented to Quality Council, who will recommend changes and on-going monitoring/auditing after analysis.	

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F 804	Continued From page 73 food was usually cold. On 2/12/24 at 5:20 p.m., during the evening meal R19 was seated in her wheelchair in the dining room with a plate in front of her that contained macaroni and cheese with hot dogs and broccoli. R19 stated her food was cold and requested a turkey sandwich. On 2/12/24 at 5:23 p.m., R 96 had finished eating his meal and as he left the dining room, he stated his supper was cold but he ate it because he was hungry. On 2/12/24 at 5:30 p.m., as the last tray was being dished up a test tray was requested from the dietary assistant (DA-A) from the steam table. The meal consisted of macaroni and cheese with hot dogs and broccoli. The temps were noted to be as follows: -macaroni and cheese was 105 degrees fahrenheit (F) -Hot dog was 115 degrees F. -Broccoli was 94 degrees F. DA-A tasted the items and confirmed the macaroni and cheese and broccoli were cold and the hot dog was barely luke warm. During an interview on 2/12/24 at 5:37 p.m., DA-A stated all the food should have been at least 135 degrees F. DA-A further stated the food should not have been served to the residents until the temperature was at least 135 degrees F. During an interview on 2/13/24 at 2:24 p.m., culinary director (CD) indicated was aware of the	F 804		

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F 804	Continued From page 74 residents' concerns regarding the cold food. CD stated was new to the facility however; the expectation was all hot food should be at least 135 degrees or warmer before being served. During an interview on 2/14/24 at 842 a.m., director of nursing DON stated was aware the residents had concerns regarding the food being cold. DON stated expectation was the food would be at proper temperatures before being served. Review of a facility policy titled Maintaining Proper Food Temp During Food Service undated, indicated food served will be maintained at proper hot and cold temperatures prior to and during meal service to assure food quality and tastiness/ palatability as well as food safety. Further indicated the temperature of hot food will be at 135 degrees F or higher during tray assembly.	F 804		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying,	F 880		3/11/24

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F 880	Continued From page 75 reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the	F 880		

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F 880	Continued From page 76 corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure proper glove use for 1 of 2 resident (R103) reviewed for blood sugar checks and failed to ensure appropriate hand sanitization between glove use for 1 of 2 resident (R100) reviewed during incontinence cares. Findings include: R103 R103's OBRA (omnibus budget reconciliation act) admission assessment dated 1/18/24, included diagnosis of stroke (occurs when blood supply to the brain is reduced or blocked) and diabetes mellitus. R103's orders directed staff to take R103's blood sugars four times a day with start date of 1/12/24. During observation on 2/15/24 at 11:58 a.m., licensed practical nurse (LPN)-C did not have gloves on and used lancet to prick R103's finger on left hand and obtained blood sample on the glucometer machine. During interview on 2/15/24 at 2:07 p.m., LPN-C	F 880	Resident 103 was not affected by deficient practice. Resident did not experience signs or symptoms of negative affects from deficient practice. R100 has discharged from facility. Resident did not experience negative affect from deficient practice. LPN-C and RN-A were educated on proper hand washing procedures. Nursing staff have been educated on proper glove use during blood glucose checks. Nursing staff have been educated on proper hand washing procedures. DON, LNHA, or designee will monitor compliance. Audits will be completed specific to hand washing. Audits will be completed specific to glove use during blood glucose checks. Audits will be completed on 5 residents weekly for 4 weeks, then 5 residents twice a month for 2 months. Audits will be presented to Quality Council, who will recommend changes and on-going monitoring/auditing after analysis.	

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F 880	Continued From page 77 stated staff wear gloves when in contact with bodily fluids, such as when assisting with peri-cares, wound care, and oral care. LPN-C agreed they did not wear gloves when checking R103's blood sugar and stated they were not in contact with R103's blood and regularly had to squeeze R103's fingers on the left hand to get enough blood out for the blood glucose reading. LPN-C stated they wore gloves when obtaining a blood sample from R103's right hand because more blood came out from R103's right hand and blood would touch staff's finger. During interview on 2/15/24 at 4:47 p.m., director of nursing (DON) stated they expected staff to wear gloves when completing blood glucose checks. Not wearing gloves was an infection control issue and caused a risk of bloodborne pathogens. The facility's procedure Performing a Blood Glucose Test dated July 2017, directed staff to put on gloves prior to washing resident's hands or wiping resident's finger with alcohol wipe to prepare finger to be lanced and to remove gloves after disposal of gauze/cotton ball and testing strip. R100's admission Minimum Data Set (MDS) dated 1/12/24, indicated intact cognition, did not reject cares, was dependent on staff for toileting hygiene, had an indwelling catheter, and was always incontinent of bowel. Further, the MDS indicated R100 had the following medical	F 880		

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F 880	Continued From page 78 diagnoses: multiple sclerosis (an autoimmune disease that affects the nervous system), depression, chronic cystitis (inflammation of the bladder usually caused by a bladder infection) without hematuria (blood in urine), and neuromuscular dysfunction of the bladder. R100's care sheet provided on 2/12/24, indicated R100 had a suprapubic catheter. R100's care plan dated 1/7/24, indicated R100 had a self care deficit with activities of daily living (ADLs), and bowel and bladder. The care plan lacked information R100 had a suprapubic catheter. R100's physician orders dated 1/9/24, indicated to cleanse suprapubic stoma (opening) site with normal saline and dry. Apply Bacitracin twice a day and cover with a drain sponge. R100's nurse practitioner note dated 2/13/24, indicated R100 had recurrent urinary tract infections (UTI) and orders indicated to continue bactroban twice daily with drain sponge for status post suprapubic catheter placement. During interview and observation on 2/13/24, between 2:10 p.m., and 2:25 p.m., registered nurse (RN)-A and nursing assistant (NA)-B assisted R100 with incontinent cares. At 2:10 p.m., both RN-A and NA-B donned gloves. At 2:11 p.m., R100 was incontinent of stool that spread to the front of her brief. At 2:12 p.m., RN-A cleaned around R100's suprapubic catheter and threw the gloves in the trash and grabbed new gloves and did not wash hands and grabbed four by four gauze and applied a skin prep to the area around the suprapubic catheter. RN-A	F 880		

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F 880	Continued From page 79 grabbed a new split sponge and took off her gloves and grabbed new gloves and donned the new gloves without sanitizing hands and secured the split gauze with tape and then continued to assist in cleaning resident's peri area. RN-A stated R100 was treated a couple of weeks ago for a UTI and further stated gloves were supposed to be changed as much as you can if they are soiled and when going to a clean surface and equipment and verified she did not sanitize hands between changing gloves and stated there was a risk of infection when not sanitizing hands between glove use. During interview on 2/15/24, at 9:57 a.m., nurse practitioner (NP)-C stated she treated R100 for a UTI with the suprapubic catheter and expected staff to sanitize between incontinence care and the suprapubic catheter cares. During interview on 2/15/24 at 12:40 p.m., the director of nursing stated she expected staff sanitize hands between cares and gloves for infection control and to not allow germs to the suprapubic site. A policy, Hand Hygiene, dated June 2017, indicated infection prevention begins with basic hand hygiene. By following proper hand hygiene practices, associates will reduce the spread of potentially deadly germs, as well as reduce the risk of healthcare provider colonization caused by germs acquired from the residents. Hand hygiene simply means cleaning hands using either handwashing (washing hands with soap and water), or antiseptic hand rub (i.e. alcohol-based hand sanitizer, including foam or gel). Times to perform hand hygiene included before and and after assisting a resident with	F 880		

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F 880	Continued From page 80 personal cares, before and after changing a dressing, before and after assisting a resident with toileting wash hands with soap and water, after contact with resident's mucous membranes and body fluids or excretions, after handling soiled or used linens, dressing, bedpans, catheters and urinals, after removing gloves or aprons.	F 880		
F 883 SS=E	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal.	F 883		3/11/24

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F 883	Continued From page 81 §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to have a method or system in place to ensure the facility offered or provided 3 of 5 residents (R9, R92, R103) updated vaccines to residents per Centers for Disease Control (CDC) vaccination recommendations. This had the ability to affect all 117 residents. Findings include: Review of the current CDC pneumococcal vaccine guidelines located at	F 883	Residents 9, 92, and 103 have been offered the current pneumococcal vaccine. All residents have been audited for eligibility of receiving the pneumococcal vaccine per CDC vaccination recommendations. All residents who have not been offered or received the current pneumococcal vaccine per CDC vaccination recommendations have been offered the current pneumococcal	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 883	Continued From page 82 https://www.cdc.gov/vaccines/vpd/pneumo/hcp/pneumo-vaccine-timing.html, identified for: 1) Adults 19-64 years old with specified immunocompromising conditions, staff were to offer and/or provide: a) the PCV-20 at least 1 year after prior PCV-13, b) the PPSV-23 (dose 1) at least 8 weeks after prior PCV-13 and PPSV-23 (dose 2) at least 5 years after first dose of PPSV-23. Staff were to review the pneumococcal vaccine recommendations again when the resident turns 65 years old. 2) Adults 65 years of age or older, staff were to offer and/or provide based off previous vaccination status as shown below: a) If NO history of vaccination, offer and/or provide: aa) the PCV-20 OR bb) PCV-15 followed by PPSV-23 at least 1 year later. b) For PPSV-23 vaccine ONLY (at any age): aa) PCV-20 at least 1 year after prior PPSV-23 OR bb) PCV-15 at least 1 year after prior PPSV-23 c) For PCV-13 vaccine ONLY (at any age): aa) PCV-20 at least 1 year after prior PCV13 OR bb) PPSV-23 at least 1 year after prior PCV13 d) For PCV-13 vaccine (at any age) AND PPSV-23 BEFORE 65 years: aa) PCV-20 at least 5 years after last pneumococcal vaccine dose OR bb) PPSV-23 at least 5 years after last pneumococcal vaccine dose e) Received PCV-13 at Any Age AND	F 883	vaccine. Facility nurse leaders including infection control preventionist have been educated on facility Pneumococcal Vaccines policy. DON, LNHA, or designee will monitor compliance. Audits will be completed specific to offering of pneumococcal vaccine to residents. Audits will be completed on 5 residents weekly for 4 weeks, then 5 residents twice a month for 2 months. Audits will be presented to Quality Council, who will recommend changes and on-going monitoring/auditing after analysis.	

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	245300	A. BUILDING _____ B. WING _____	C 02/16/2024

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F 883	Continued From page 83 PPSV-23 AFTER Age 65 Years: aa) Use shared clinical decision-making to decide whether to administer PCV20. If so, the dose of PCV-20 should be administered at least 5 years after the last pneumococcal vaccine. Review of 3 of 5 sampled residents for vaccinations identified: 1) R9 was 91 years old and admitted to the facility in June of 2023. R9 had received the PCV-13 on 4/13/15, and the PPSV-23 on 2/13/17 prior to her admission. Per CDC guidelines, the facility failed to initiate a shared clinical decision-making discussion to decide whether to administer one dose of PCV20 at least 5 years after the last pneumococcal vaccine dose. Regardless of whether PCV20 is administered, R9's pneumococcal vaccinations were complete. 2) R92 was 77 years old and admitted to the facility in August of 2023. R92 had received the PCV-13 on 8/24/15, and the PPSV-23 on 7/9/17 prior to his admission. Per CDC guidelines, the facility failed to initiate a shared clinical decision-making discussion to decide whether to administer one dose of PCV20 at least 5 years after the last pneumococcal vaccine dose. Regardless of whether PCV20 is administered, R92's pneumococcal vaccinations were complete. 3) R103 was 74 years old and admitted to the facility in January of 2024. R103 had received the PCV-13 on 4/2/15, and the PPSV-23 on 10/12/17 prior to his admission. Per CDC guidelines, the facility failed to initiate a shared clinical decision-making discussion to decide whether to administer one dose of PCV20 at least 5 years	F 883		

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F 883	Continued From page 84 after the last pneumococcal vaccine dose. Regardless of whether PCV20 is administered, R103's pneumococcal vaccinations were complete. During interview on 2/14/24 at 8:36 a.m., registered nurse (RN)-D explained to keep vaccination statuses updated, a report was run twice weekly on newly admitted residents and vaccine status was reviewed with each resident. If a resident was due for a particular vaccination, RN-D would discuss this the resident, gain consent or declination and update their electronic health record (EHR). RN-D would administer the vaccination if the resident consented and update an internal spreadsheet. RN-D stated the facility used the CDC's 2024 guidelines to determine if a resident was due for a pneumococcal vaccination, and the facility currently implementing a new process of driving the conversation between providers and residents and/or representatives if due for a pneumococcal vaccination. During interview on 2/15/24 at 9:06 a.m., RN-D reiterated the facility was in the process of implementing a new system to identify residents who were eligible for additional doses of the pneumococcal vaccination based on shared clinical decision-making. RN-D reviewed the internal spreadsheet and was able to identify R103 as flagged for review to initiate the shared clinical decision-making discussion. RN-D verified that R9 and R92 were not flagged on the spreadsheet and stated they would be flagged. Facility policy titled Pneumococcal Vaccines for Residents dated 3/18/22, indicated the facility's policy was to provide education and	F 883		

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F 883	Continued From page 85 administration of the PPSV23 and PCV13 to the residents of the facility according to CDC recommendations.	F 883		

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	245300	A. BUILDING **01** B. WING _____	**02/13/2024**

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 02/13/2024. At the time of this survey, CERENITY CARE CENTER WHITE BEAR LAKE was found NOT in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.	K 000		

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

Electronically Signed | 03/05/2024

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

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K 000	Continued From page 1 Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. CERENITY CARE CENTER WHITE BEAR LAKE is a 2-story building with no basement. The building was constructed at 3 different times. The original building was constructed in 1957 and was determined to be of Type II(222) construction. In 1974, addition was constructed to the West Wing that was determined to be of Type	K 000		

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K 000	Continued From page 2 II(222) construction. In 1983, another addition was constructed to the West Wing that was determined to be of Type II (222) construction. In 2013, a new 2 story addition was constructed to the west as a TCU unit. The building is automatic sprinkler protected 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. The facility has a capacity of 138 beds and had a census of 116 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 291 SS=D	Emergency Lighting CFR(s): NFPA 101 Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to maintain, test and inspect the emergency lighting fixtures per NFPA 101 (2012 edition) Life Safety Code, sections 19.2.9.1, 7.9.3 This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 02/13/2024 between11:30 AM and 5:00 PM, it was revealed during documentation review that	K 291	Facility emergency lighting has been inspected and tested as of 3/1/2024. Facility maintenance staff have been educated on proper emergency lighting inspection procedures. Facility emergency lighting testing will be performed per requirement. Facility emergency lighting inspection and testing will be audited quarterly. Audits will be monitored by the facility Safety	3/11/24

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K 291	Continued From page 3 the no documentation was present for review that emergency light(s) are being tested. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 291	Committee and Quality Council.	
K 324 SS=F	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the	K 324	All power has been disconnected to	3/11/24

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K 324	Continued From page 4 facility failed to maintain proper safety and security measures related to a residential cooking device in accordance with NFPA 101 (2012 edition), Life Safety Code, section 19.3.2.5.3(9)(10). This deficient condition could have a widespread impact on the residents within the facility. Findings Include: On 02/13/2024 between11:30 AM and 5:00 PM, it was revealed by observation that the all-residential cooktop and wall ranges located neighborhood kitchenettes were not outfitted with lock-out, disconnect, 120 min max timeout hardware. An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K 324	residential cooking devices in all facility kitchenettes. Power to these units is in a locked electrical panel and is only accessible by key from the Maintenance Director. An external vendor was secured to initiate work on all residential cooking devices to install lock-out, disconnect, 120 min max timeout hardware. External vendor has begun work that will be completed as soon as possible on all units. Work will be complete by 3/11/2024. All power will remain fully disconnected from all residential cooking devices until the timeout hardware is fully installed. This project will be monitored by the facility Safety Committee and Quality Council.	
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 observation and staff interview, the facility failed to maintain and test the fire alarm system per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.4.1, 9.6.1.3, and NFPA 72	K 345	Facility fire alarm sensitivity testing was completed on 2/20/2024. Facility reviewed current contract with fire	3/11/24

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K 345	Continued From page 5 (2010 edition), National Fire Alarm and Signaling Code, section 14.4.5.3, 14.4.5.3.2. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 02/13/2024 between11:30 AM and 5:00 PM, it was revealed during documentation review that the no documentation was present for review that sensitivity testing is current. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 345	alarm system company to assure contract includes required sensitivity testing. Facility maintenance staff have been educated on proper fire alarm system testing requirements. Facility fire system testing will be audited quarterly. Audits will be monitored by the facility Safety Committee and Quality Council.	
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced	K 353		3/12/24

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K 353	Continued From page 6 by: Based on observation, documentation review, and staff interview the facility failed to inspect and maintain the sprinkler system in accordance with NFPA 101 (2012 edition), Life Safety Code, sections 4.6.12, 9.7.5, 9.7.6, NFPA 25 (2011 edition) Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, section(s), 5.2.1.1.1, 5.2.1.1.2(5), 5.2.2.2. These deficient findings could have a widespread impact on the residents within the facility. Findings include: 1. On 02/13/2024 between11:30 AM and 5:00 PM, it was revealed during documentation review that the no documentation was present for review to confirm that sprinkler system quarterly inspection occurred in Q1 - 2023. 2. On 02/13/2024 between11:30 AM and 5:00 PM, it was revealed by observation that the sprinkler head servicing the Kitchen walk-in cooler had retracted into the cooler wall and would not operate properly if activated. 3. On 02/13/2024 between11:30 AM and 5:00 PM, it was revealed by observation that in the following locations sprinkler heads and escutcheons were covered with paint: 2ND FL - RM 2201, 2ND FL - RM 2215, 1ST FL - Admin Office. 4. On 02/13/2024 between11:30 AM and 5:00 PM, it was revealed by observation that in the following locations sprinkler heads exhibited signs of loading and/or oxidation: Evergreen Trail Kitchenette, Cyprus Kitchenette, Main Kitchen /	K 353	External facility vendor was contacted to correct all affected sprinkler heads. All sprinkler heads and escutcheons that were affected have been corrected and/or replaced. All other sprinkler heads and escutcheons have been audited and corrected as needed. Facility contract with external vendor has been updated to include quarterly inspection of sprinkler system. Facility maintenance staff have been educated on proper sprinkler system testing requirements. Facility sprinkler system inspections will be audited quarterly. Audits will be monitored by the facility Safety Committee and Quality Council.	

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K 353	Continued From page 7 Dishwashing areas. An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K 353		
K 511 SS=F	Utilities - Gas and Electric CFR(s): NFPA 101 Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to properly secure electrical panel(s) per NFPA 101 (2012 edition), Life Safety Code, section 19.5.1.1, 9.1.2, NFPA 70 (2011 edition), National Electrical Code, section 110.27. This deficient condition could have a widespread impact on the residents within the facility. Findings include: On 02/13/2024 between11:30 AM and 5:00 PM, it was revealed by observation that in the following locations electrical panels were found to be unsecured and readily accessible to unqualified individuals: 2ND FL - Oak Crossing, 2ND FL - Oak Crossing Kitchenette, 2ND FL - 2L3A.	K 511	All electrical panels found to be unsecured were locked and secured on 2/13/2024. Facility maintenance staff have been educated on properly securing electrical panels. Facility electrical panels will be audited to assure all panels are secured. Audits will be completed weekly for 4 weeks, then twice a month for 2 months, then quarterly thereafter. Audits will be monitored by the facility Safety Committee and Quality Council.	3/11/24

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K 511	Continued From page 8 An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K 511		
K 761 SS=F	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This REQUIREMENT is not met as evidenced by: Based on document review and staff interview the facility failed to inspect and test doors per NFPA 101 (2012 edition), Life Safety Code, sections 7.2.1.15, and NFPA 80 (2010 edition), sections 5.2.1. This deficient condition could have a widespread impact on the residents within the facility. Findings include: On 02/13/2024 between11:30 AM and 5:00 PM, it was revealed by review of available documentation that there was no documentation presented to confirm that the facility is conducting	K 761	Annual maintenance, inspection, and testing of doors was completed by 3/11/2024. Facility maintenance staff have been educated on maintenance, inspection, and testing of doors. Facility maintenance, inspection, and testing of doors will be performed per requirement. Inspection and testing logs of doors will be audited quarterly. Audits will be monitored by the facility Safety Committee and Quality Council.	3/11/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245300	A. BUILDING **01** B. WING _____	**02/13/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CERENITY CARE CENTER WHITE BEAR LAKE	**1900 WEBBER STREET** **WHITE BEAR LAKE, MN 55110**

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K 761	Continued From page 9 annual maintenance, inspection and testing of doors. An interview with Maintenance Director verified this deficient finding at the time of discovery.	K 761		
K 914 SS=F	Electrical Systems - Maintenance and Testing CFR(s): NFPA 101 Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to accurately document electrical receptacle testing in resident rooms per NFPA 99 (2012 edition), Health Care Facilities Code, section(s) 6.3.3.2, 6.3.4, 6.3.4.2. These deficient findings could have a widespread	K 914	Annual electrical receptacle testing in resident rooms was completed by 3/11/2024. Facility maintenance staff have been educated on completion of testing annual	3/11/24

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K 914	Continued From page 10 impact on the residents within the facility. Findings include: On 02/13/2024 between11:30 AM and 5:00 PM, it was revealed by a review of available documentation that the documentation presented for review identified that annual testing was last completed - 01/16/2023. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 914	electrical testing. Facility electrical receptacle testing will be performed per requirement. Inspection of electrical receptacle testing will be audited quarterly. Audits will be monitored by the facility Safety Committee and Quality Council.	
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a	K 918		3/11/24

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K 918	Continued From page 11 program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to test the on-site emergency generator system per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.4.1.1, 6.4.4.1.1.4, 6.4.4.2, and NFPA 110 (2010 edition), Standard for Emergency and Standby Power Systems, section 8.4. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 02/13/2024 between11:30 AM and 5:00 PM, it was revealed by a review of available documentation that no documentation was available to be presented for review to confirm the facility diesel generator is being load-bank tested every 36 months for 4 hrs. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 918	On 2/29/2024 a 4-hour load bank test was completed on facility natural gas generator. The facility is requesting a temporary waiver for corrections to be completed for tags E041 and K918. The diesel generator is currently functional and in working condition. Work is in progress with the appropriate vendor to replace the fuel valves and pressure sensor of this generator. This work must be completed before the required 4-hour load bank test can be run. The vendor is currently waiting for parts to be delivered to complete this work on the generator. As soon as this work is complete, the 4-hour load bank testing will be completed on the diesel generator. Facility contract with vendor has been updated to include the required 4-hour load bank test to be completed every 36 months.	

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K 918	Continued From page 12	K 918	Facility maintenance staff have been educated on the requirements of generator load bank testing. Facility generator testing logs will be audited quarterly. This project and audits will be monitored by the facility Safety Committee and Quality Council.	
K 920 SS=F	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the	K 920	All appliances connected to relocatable	3/11/24

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K 920	Continued From page 13 facility failed to manage usage electrical devices in accordance with NFPA 99 (2012 edition), Health Care Facilities Code, section 10.2.3.6, 10.2.4, 10.5.2.3 and NFPA 70, (2011 edition), National Electrical Code, sections 110.3(B), 400.8 (1) and UL 1363. These deficient findings could have a widespread impact on the residents within the facility. Findings include: 1. On 02/13/2024 between11:30 AM and 5:00 PM, it was revealed by observation that in the following location appliances were found connected to relocatable power taps: 1ST FL TCU - Director of PT Office, 1ST FL TCU - Social Services Office, 1ST FL TCU - MDS Office, 2ND FL - Clinical Mgr. Office, 1ST FL - Clinical Mgr. Office. 2. On 02/13/2024 between11:30 AM and 5:00 PM, it was revealed by observation that on the 1ST FL - Riser Room that extension cords were found in use connected to a relocatable power tap. 3. On 02/13/2024 between11:30 AM and 5:00 PM, it was revealed by observation that in the following locations relocatable power taps were found daisy-chained together - in use: 1ST FL TCU - Nurses Station; 1ST FL - Chapel. 4. On 02/13/2024 between11:30 AM and 5:00 PM, it was revealed by observation that on the 2ND FL in RM 212 a 1-to-3 plug electrical outlet adapter was found in use. An interview with the Maintenance Director verified these deficient findings at the time of	K 920	power taps have been corrected. All extension cords found in use connected to relocatable power tap have been corrected. The power taps found daisy-chained together have been corrected. The 1-to-3 plug electrical outlet adapter was removed from the resident□s room. Facility nursing, culinary, environmental services, and IDT staff have been educated on proper use of electrical devices. Audits will be completed to ensure proper use of electrical devices. Audits will be completed weekly for 4 weeks, then twice a month for 2 months, then quarterly thereafter. Audits will be monitored by the facility Safety Committee and Quality Council.	

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K 920	Continued From page 14 discovery.	K 920		
K 923 SS=F	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored	K 923		3/11/24

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K 923	Continued From page 15 in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain proper medical gas storage and management per NFPA 99 (2012 edition), Health Care Facilities Code, section 5.1.3.3.2(2), 11.3.2. Thls deficient finding could have a widespread impact on the residents within the facility. Findings include: 1. On 02/13/2024 between11:30 AM and 5:00 PM, it was revealed by observation that the Med Gas (O2) Room was found unsecured. 2. On 02/13/2024 between11:30 AM and 5:00 PM, it was revealed by observation that in the Med Gas (O2) Room combustible storage was found. An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K 923	The medical gas storage rooms have been secured. All shelving and combustible storage was removed from the medical gas room. Facility maintenance and nursing staff have been educated on proper storage of oxygen. Audits will be completed to ensure the medical gas rooms are secure and proper storage practices are being used. Audits will be completed weekly for 4 weeks, then twice a month for 2 months, then quarterly thereafter. Audits will be monitored by the facility Safety Committee and Quality Council.	

PART III – RECOMMENDATION FOR WAIVER OF SPECIFIC LIFE SAFETY CODE PROVISIONS

For each item of the Life Safety Code recommended for waiver, list the survey report form item number and state the reason for the conclusion that: (a) the specific provisions of the code, if rigidly applied, would result in unreasonable hardship on the facility, and (b) the waiver of such unmet provisions will not adversely affect the health and safety of the patients. If additional space is required, attach additional sheet(s).

PROVISION NUMBER(S)	JUSTIFICATION
K918 SS=F This STANDARD is not met as evidenced by: Based on bservation and staff interview, the facility failed to test the on-site emergency generator system per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.4.1.1, 6.4.4.1.1.4, 6.4.4.2, and NFPA 110 (2010 edition), Standard for Emergency and Standby Power Systems, section 8.4. This deficient finding could have a widespread impact on the residents within the facility. On 02/13/2024 between 11:30 AM and 5:00 PM, it was revealed by a review of available documentation that no documentation was available to be presented for review to confirm the facility	On 2/29/2024 a 4-hour load bank test was completed on facility natural gas generator. The facility is requesting a temporary waiver for corrections to be completed for tags E041 and K918. The diesel generator is currently functional and in working condition. Work is in progress with the appropriate vendor to replace the fuel valves and pressure sensor of this generator. This work must be completed before the required 4-hour load bank test can be run. The vendor is currently waiting for parts to be delivered to complete this work on the generator. As soon as this work is complete, the 4-hour load bank testing will be completed on the diesel generator. Facility contract with vendor has been updated to include the required 4-hour load bank test to be completed every 36 months. Facility maintenance staff have been educated on the requirements of generator load bank testing. Facility generator testing logs will be audited quarterly. This project and audits will be monitored by the facility Safety Committee and Quality Council. Completion Date:4/1/24

Surveyor *(Signature)*	Title	Office	Date
Fire Authority Official *(Signature)* *Travis J. Ahrens 49207*	Title Fire Safety Supervisor	Office MN State Fire Marshal Div.	Date 3/6/24

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
April 2, 2024

Administrator
Cerenity Care Center White Bear Lake
1900 Webber Street
White Bear Lake, MN 55110

RE: CCN: 245300
Cycle Start Date: February 16, 2024

Dear Administrator:

On February 27, 2024, we notified you a remedy was imposed. On March 22, 2024 the Minnesota Departments of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of March 12, 2024.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective March 13, 2024 did not go into effect. (42 CFR 488.417 (b))

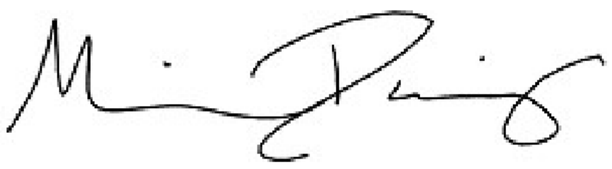
In our letter of February 27, 2024, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from March 13, 2024 due to denial of payment for new admissions. Since your facility attained substantial compliance on March 12, 2024, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

The CMS Location may notify you of their determination regarding any imposed remedies.

Correction of the Life Safety Code deficiency cited under K918 at the time of the February 16, 2024 standard survey, has not yet been verified. Your plan of correction for this deficiency, including your request for a temporary waiver with a date of completion of April 1, 2024, has been forwarded to the the Centers for Medicare and Medicaid Services (CMS) Location for their review and determination. Failure to come into substantial compliance with this deficiency by the date indicated in your plan of correction may result in the imposition of enforcement remedies.

Feel free to contact me if you have questions.

Sincerely,



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