Electronically delivered
September 22, 2022

Administrator
Tuff Memorial Home
505 East 4th Street
Hills, MN 56138

RE: CCN: 245548
Cycle Start Date: September 9, 2022

Dear Administrator:

On September 9, 2022, 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 widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), 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 Region V Office for imposition. The CMS Region V Office concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective October 22, 2022.

- Directed plan of correction (DPOC), Federal regulations at 42 CFR § 488.424. Please see electronically attached documents for the DPOC.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective October 22, 2022. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective October 22, 2022.

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.

This Department is also recommending that CMS impose:

- Civil money penalty (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

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 $11,292; 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 October 22, 2022, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Tuff Memorial Home will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from October 22, 2022. 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:

Nicole Osterloh, RN, Unit Supervisor
Marshall District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
1400 East Lyon Street, Suite 102
Marshall, Minnesota 56258-2504
Email: nicole.osterloh@state.mn.us
Office: 507-476-4230
Mobile: (507) 251-6264 Mobile: (605) 881-6192

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 Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by March 9, 2023 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:

Tamika.Brown@cms.hhs.gov

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

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

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

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

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

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

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

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health

Licensing and Certification Program
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

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	245548	A. BUILDING _____ B. WING _____	C 09/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TUFF MEMORIAL HOME	505 EAST 4TH STREET HILLS, MN 56138

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E 000	Initial Comments Surveyor: 38687 On 9/6/22 through 9/9/22, a survey for compliance with Appendix Z, Emergency Preparedness Requirements for Long Term Care facilities, §483.73(b)(6) was conducted during a standard recertification survey. The facility was NOT in compliance. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulation has been attained.	E 000		
E 039 SS=F	EP Testing Requirements CFR(s): 483.73(d)(2) §416.54(d)(2), §418.113(d)(2), §441.184(d)(2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2), §483.475(d)(2), §484.102(d)(2), §485.68(d)(2), §485.625(d)(2), §485.727(d)(2), §485.920(d)(2), §491.12(d)(2), §494.62(d)(2). *[For ASCs at §416.54, CORFs at §485.68, OPO, "Organizations" under §485.727, CMHCs at §485.920, RHCs/FQHCs at §491.12, and ESRD Facilities at §494.62]: (2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following:	E 039		10/2/22

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

Electronically Signed | 10/02/2022

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 039	Continued From page 1	E 039		

(i) Participate in a full-scale exercise that is community-based every 2 years; or
(A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or
(B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event.
(ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following:
(A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or
(B) A mock disaster drill; or
(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.
(iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed.

*[For Hospices at 418.113(d):]
(2) Testing for hospices that provide care in the patient's home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the following:

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E 039	Continued From page 2 (i) Participate in a full-scale exercise that is community based every 2 years; or (A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full scale community-based exercise or individual facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (3) Testing for hospices that provide inpatient care directly. The hospice must conduct exercises to test the emergency plan twice per year. The hospice must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual facility-based functional exercise; or (B) If the hospice experiences a natural or	E 039		

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E 039	Continued From page 3 man-made emergency that requires activation of the emergency plan, the hospice is exempt from engaging in its next required full-scale community based or facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop led by a facilitator that includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the hospice's emergency plan, as needed. *[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):] (2) Testing. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the [PRTF, Hospital, CAH] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next	E 039		

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E 039	Continued From page 4 required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the [facility's] emergency plan, as needed. *[For PACE at §460.84(d):] (2) Testing. The PACE organization must conduct exercises to test the emergency plan at least annually. The PACE organization must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the PACE experiences an actual natural or man-made emergency that requires activation of the emergency plan, the PACE is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency	E 039		

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E 039	Continued From page 5 event. (ii) Conduct an additional exercise every 2 years opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the PACE's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the PACE's emergency plan, as needed. *[For LTC Facilities at §483.73(d):] (2) The [LTC facility] must conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The [LTC facility, ICF/IID] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. (B) If the [LTC facility] facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required a full-scale community-based or individual, facility-based functional exercise	E 039		

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E 039	Continued From page 6 following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [LTC facility] facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [LTC facility] facility's emergency plan, as needed. *[For ICF/IIDs at §483.475(d)]: (2) Testing. The ICF/IID must conduct exercises to test the emergency plan at least twice per year. The ICF/IID must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or. (B) If the ICF/IID experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID is exempt from engaging in its next required full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based	E 039		

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E 039	Continued From page 7 functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the ICF/IID's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID's emergency plan, as needed. *[For HHAs at §484.102] (d)(2) Testing. The HHA must conduct exercises to test the emergency plan at least annually. The HHA must do the following: (i) Participate in a full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise every 2 years; or. (B) If the HHA experiences an actual natural or man-made emergency that requires activation of the emergency plan, the HHA is exempt from engaging in its next required full-scale community-based or individual, facility based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or	E 039		

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E 039	Continued From page 8 (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the HHA's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the HHA's emergency plan, as needed. *[For OPOs at §486.360] (d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following: (i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. If the OPO experiences an actual natural or man-made emergency that requires activation of the emergency plan, the OPO is exempt from engaging in its next required testing exercise following the onset of the emergency event. (ii) Analyze the OPO's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. *[RNCHIs at §403.748]: (d)(2) Testing. The RNHCI must conduct exercises to test the emergency plan. The RNHCI must do the following:	E 039		

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E 039	Continued From page 9 (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the RNHCI's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the RNHCI's emergency plan, as needed. This REQUIREMENT is not met as evidenced by: Surveyor: 38687 Based on interview and document review, the facility failed to conduct an additional second exercise to test the Emergency Preparedness (EP) Plan that include a potential second full-scale exercise, a mock disaster drill, or an additional tabletop exercise and analyze the facility's response to that additional exercise. This had the potential to affect all 37 residents, along with facility staff. Findings include: Review of the August 2022, EP Plan identified there was no mention of how the facility would ensure they had completed an additional exercise to test their plan in the event of an emergency and/or disaster. Interview and EP plan review with the administrator on 9/08/22 at 11:35 a.m., identified there was no documentation to support an additional exercise had been performed in the EP plan documentation. The administrator agreed all EP required components needed to completed.	E 039	The following represents the plan of correction for the alleged deficiencies cited during a state survey that was conducted on September 6-9th, 2022. The completion and execution of this plan of correction does not constitute an admission of guilt or wrongdoing on the part of the nursing facility, its owners, operators, employees or agents or an agreement with any of the facts set forth in the Statement of Deficiencies. The plan of correction is completed in good faith and in keeping with the facility's commitment to quality outcomes for the residents. In addition, this plan of correction is completed as required by law. Tag 0039 - 483.73(d)(2) EP Testing Requirements (Emergency Preparedness) Resident(s) Affected: All residents and staff had the potential to be affected. Immediate Corrective Action: Staff completed process documentation on a	

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E 039	Continued From page 10	E 039	derecho they experienced earlier in the year. This documentation was completed as of 9/30/2022. In conjunction with a tabletop exercise performed earlier in the year, this will satisfy the requirement of the two emergency preparedness plan tests. Methods to Ensure Compliance: Revision of the emergency preparedness plan to include two scheduled emergency drills annually, with these revisions approved as of 9/30/2022 by the Administrator. The first drill will be completed in January and the other will be completed in June; the method and type of drill will be determined by the facility's Administrator and Emergency Preparedness Coordinator based upon weather, availability of local emergency personnel, and other factors. It is the goal of this facility to exercise at least one community-based emergency exercise annually. This revision also states thorough documentation must be completed any time the emergency preparedness plan is activated. This documentation must include a review of the effectiveness of the emergency guidelines that were applicable as well as the level of preparedness of the staff members involved. Responsibility: It is the responsibility of the facility Administrator and the facility's Emergency Preparedness Coordinator to ensure that two emergency preparedness drills are scheduled and executed	

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E 039	Continued From page 11	E 039	annually, with all staff being present during at least one drill or being provided with equivalent education. Monitoring: Any documentation regarding the activation of the facility's emergency plan will be reviewed by the facility's Emergency Preparedness Coordinator, the Director of Nursing, and the Administrator in order to see if more training or education has to be conducted. Additionally, the emergency preparedness plan will be reviewed twice annually prior to each scheduled drill in order to ensure that all information remains up to date, accurate, and meets regulations. Employees will sign off on any emergency preparedness drills conducted to show that they have underwent the training. If employees take part in a scenario wherein the emergency plan had to be activated, they will sign off on that as well. If there is an employee who has not taken part in either a drill or an activation of the emergency plan will be assigned equivalent education.	
F 000	INITIAL COMMENTS Surveyor: 39988 On 9/6/22 through 9/9/22, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities.	F 000		

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F 000	Continued From page 12 The following complaints were found to be SUBSTANTIATED: H55484384C (MN83551), H55484396C (MN84106), and H55484397C (MN86061) with a deficiency cited at F689. 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 689 SS=E	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Surveyor: 34083 Based on interview and document review the facility failed to perform a root cause analysis and identify or implement appropriate interventions to prevent multiple recurrent falls for 3 of 3 residents (R1, R7 and R35).	F 689	Tag 0689 - 483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices (LONG TERM CARE FACILITIES) Residents Affected: R1, R7, and R35. Residents with the Potential to be Affected: The facility has determined that	10/2/22

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F 689	Continued From page 13 Findings include: R1 Review of the 8/18/22 at 8:35 a.m., report to the State Agency (SA) identified R1 had an unwitnessed fall on 8/17/22 at 3:05 p.m. in R1's room. R1 was found on the right side of his recliner with his head/back underneath the bedside table leaning up against the wall. R1 was wearing shoes, the floor was dry, and he was seated in the recliner prior to the fall. R1's wheelchair was in the hall and his walker was positioned at the end of the bed. R1 had severe cognitive impairment and a history of 2 previous falls without injury since the previous assessment. R1 was transferred into bed and complained of pain in his right leg and hip, was transferred to the Emergency Department (ED) where he was found to have a fractured right hip. The report noted it was unknown if the facility had completed a root cause analysis of the falls to implement individualized interventions to prevent reoccurrence of falls. Review of the 8/22/22 at 4:28 p.m., 5-day report noted the fall policy had been followed and had no effect on the cause of the fall with significant injury. The report identified the fall committee was to meet in the furuture to assess the fall and potential interventions, but there was no documented analysis of the fall with action taken to prevent reoccurrence of a fall was to encourage R1 to use his call light and reassess the level of care needed upon his readmission. The report further identified R1 had experienced 3 falls in the last 6 months all unwitnessed and without injury. R1's 8/29/22, Significant change Minimum Data Set (MDS) assessment identified he had severe	F 689	all residents have the potential to be affected. Immediate Actions taken for Identified Residents: All documentation for future resident falls will include all information necessary to conduct a root cause analysis as well as identifying which intervention(s) were put into place immediately to protect the resident from additional falls. R1: Resident has not experienced any additional falls since 8.17.2022. Resident's care plan will be reviewed and any ineffective interventions that are still listed will be removed prior to November 1st. Resident's behavior continues to be monitored, and changes will be made to care plan as needed. If any additional falls occur, a medication review will also be conducted. R7: Informed family and physician about resident's frequent falls. Immediate interventions are being conducted after each fall, and ineffective interventions are being removed from the care plan are they are being deemed ineffective. Interventions for resident are being reviewed more than once a week in order to analyze the effectiveness of any newly implemented interventions. R7 has a history of not utilizing provided interventions. Staff has been informed that thorough documentation is required whenever any resident refuses an intervention and/or an intervention is removed. Medication review requested for	

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F 689	Continued From page 14 cognitive impairment, had physical behaviors and other behaviors 4-6 days during the assessment period identified as interfering with resident care. The MDS identified R1's, behaviors had worsened from the previous assessment. R1's activities of daily living (ADLs) required Extensive assistance of 1-2 staff and limited assistance for eating. R1 had diagnoses of a right femur fracture, high blood pressure, and non-Alzheimer's dementia. R1's undated care plan identified episodes of hollering out regarding needing to use the bathroom or letting out loud bellows and sighs without expressing his needs. Interventions included distraction techniques and to anticipate R1's needs. R1 had ADL self-care performance deficit r/t Impaired balance, cognitive decline, memory deficit, and a right hip fracture r/t fall on 8/17/22. Interventions in place prior to his fall with fracture included gripper at his bedside and in front of his recliner in addition to offering toileting every (Q) 2 hours (H). R1 had experienced 3 previous falls because of attempts of self-transferring. Interview on 9/08/22 at 8:33 a.m., with nursing assistant (NA)-A reported safety measures in place were frequent checks when passing room and at least hourly, but she did not think there were scheduled documented checks, but she did check on him when she was passing his room. NA-A reported R1's bed was placed in the low position, and prior to his fall he required limited assistance with his ADLs. NA-reported R1 did not consistently use his call light and would yell out and attempt to self-transfer when he wanted to transfer from either the bed or chair.	F 689	R7 on 9/30/2022. Care plan will be revised based upon these findings. R35: Restorative therapy completed an assessment for R35 on 9.30.2022. R35's care plan will be updated to reflect findings. R35 has not had any recent falls; care plan will be reviewed to ensure all interventions listed are current. Range of motion exercises are to be implemented daily and a review of therapy will be conducted between the Administrator, Director of Nursing/Restorative Therapy, and Occupational Therapy/Physical Therapy to assess what types of exercises would be most beneficial for resident and most conducive to preventing further falls. After R35's last fall, an intervention was put in place to have a body pillow in her bed to prevent her sliding off or getting too close to the edge. This intervention appears to have been effective. Methods to Ensure Compliance: Existing policy and documentation have been revised and approved as of 9.20.2022 to ensure that documentation for any fall includes the information necessary to conduct a root cause analysis as well as to implement an effective intervention to prevent further falls. Nursing staff are to review these documents and provide their signature to signify that they have read and understand the changes in the facility's fall policies. Nursing staff have completed this review as of 9.26.22. All interventions and their outcomes must be documented in Point Click Care.	

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F 689	Continued From page 15 Interview on 9/08/22 at 8:48 a.m., with trained medication aid (TMA)-A identified R1 had a history of yelling out for any needs rather than using his call light and he would attempt to self-transfer at times or would yell out for his spouse who was in the room next door. Interview on 9/08/22 at 11:26 a.m., with registered nurse (RN)-A reported R1 had fallen on 8/17/22 when he attempted to self-transfer from his recliner and was found lying on the floor of his room. R1 was sent to the emergency room for evaluation and diagnosed with a right hip fracture. RN-A reported she was not aware of what had happened with previous falls, or any additional interventions put into place, but stated R1 had self-transferred previously when he decided he wanted to go to the bathroom. RN-A reported she thought R1 had a wander guard but was not aware of any motion monitors in place prior to his fall with fracture. . Interview on 9/08/22 at 1:30 p.m., with the director of nursing (DON) identified she had become aware of the incident when R1 was transferred to the hospital and spoken with the administrator who advised her to wait to report the incident to the SA until the ED evaluation was completed. The DON stated she had not been notified of the results of R1's ED evaluation and did not become aware of his fracture until the morning of 8/18/22. The DON reported she understood the administrator was responsible for making a report to the SA and thought he would have done so following the fall on 8/17/22. The DON identified the facility did not complete a full investigation of incidents to determine the root cause and implement interventions to prevent a repeat fall. She reported her documentation	F 689	Additional nursing staff were granted the ability to report falls with injuries in order to ensure that they are reported within regulatory time constraints. Education will also be provided on this process, to be and has been completed for the nursing staff who are able to report as of 9.26.22. Monitoring: It is the goal of this facility for a fall committee consisting of the Administrator, the Director of Nursing, the MDS Coordinator/Assistant Director of Nursing, a staff member from restorative therapy, at least one CNA, the Charge Nurse on shift, and the Social Services Director to meet within 48 hours after any fall to discuss interventions. At minimum, this committee will meet once a week. If no falls have occurred since the previous meeting, a review of current interventions will be conducted and interventions that are no longer in place or that have been deemed ineffective will be removed from the care plan. The Administrator will provide oversight of this committee and retain records of their meetings. Issues addressed during fall committee meetings will be reviewed during monthly QAPI meetings, as well as any errors revealed during the audit. It is the policy of this facility that the Administrator and Director of Nursing are informed immediately of any fall, whether or not an injury resulted from the fall. For residents who fall frequently, care plans and interventions should be reviewed monthly. It is the policy of this	

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F 689	Continued From page 16 provided lacked details of the incident which would have been beneficial in the identification of possible causes and interventions. The DON identified the facility had a fall committee that previously met every Thursday at 2:00 p.m. for review of falls that have occurred since the previous meeting. These meetings had not been occurring on a weekly basis and was something she "wanted to get started again". Interview on 9/08/22 at 2:18 p.m., the facility administrator agreed R1's fall with fracture should have been reported within the 2-hour time frame due to significant injury and it had not been reported until the following morning. Surveyor: 39988 R7 Review of the 6/7/22, report to the State Agency (SA) identified the trained medication aide (TMA) notified the nurse that R7 was on the floor in her room next to the bed at 7:20 p.m. on 6/6/22. R7 had been moving between her chair and the bed and last seen sitting on her bed prior to the fall. R7 was unable to say how or why she fell. R7 range of motion was intact however, she complained of pain on her right lower side and then right lower mid shoulder. R7's first POA was contacted and notified of fall and ice had been applied to right lower back and shoulder. POA had told staff to wait until tomorrow before sending to see how resident was doing. Second POA arrived at the facility to visit and agreed to send resident into hospital for an evaluation. Ambulance arrived at 8:50 p.m., and resident stood with 2 staff assistance and transferred onto the stretcher with complaints of pain. R7 was taken to emergency room in Luverne, MN. At 1:00 a.m., Luverne Sanford called and reported that R7 was being transported to Sanford Sioux	F 689	facility to include family members and the resident's physician in the intervention process when residents experience a significant increase in falls or fail to experience a reduction in the frequency of falls. For all residents, care plans and interventions are reviewed by the MDS Coordinator for their care conferences as well as quarterly, at minimum. Any change in the care plan must be dated. The Administrator, who is part of the governing body, and Director of Nursing will jointly perform an audit to ensure the following: " Families, physicians, the Director of Nursing, and the Administrator are informed of falls " Root cause analysis and proper documentation is completed for every fall " Paperwork is completed in a timely manner " Immediate interventions are being enacted after a fall " Medications are being reviewed if a resident begins to fall frequently " Interventions are specific to the resident and their needs " Fall committee is meeting both routinely and within 48 hours of a fall The audit schedule will be two times a week for four weeks, then once a week for eight weeks. If no errors are found	

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F 689	Continued From page 17 Falls with rib fractures and hemothorax. The 5 day investigation noted R7 was found on the floor next to her bed with no shoes on, wearing her socks. R7 had been moving between her chair and bed and last seen sitting on end of her bed. Her weight was not directly on the bed pad alarm due to her sitting at end of bed with resulted in the alarm not sounding over the nursing assistance radios system when she stood up. No abuse or neglect suspected. Action taken to prevent reoccurrence the fall committee will continue to meet and attempt to come up with interventions to prevent falls. Facility will evaluate when R7 returns from hospital. The investigation identified 5 falls in last 6 months with no major injuries. R7's 3/31/22, admission Minimum Data Set (MDS) assessment identified R7 had severe cognitive impairment. R7 had no behaviors and needed supervision with cares including transfers and ambulation. R7 was identified to have no falls since admission or prior to admission. R7's undated, current care plan identified beginning 3/25/22, R7 was at risk for falls related to unsteady balance, new environment, and history of falls at assisted living. The current care plan for falls had last been updated on 7/3/22. Interventions prior to fall on 6/6/22, included call light within reach, encourage to use walker for balance and stability often forgets, silent bed pad alarm on bed to alert to staff radio, resident often removes alarm from bed and throws on floor or places on another piece of furniture, and use cotton fabric bedspreads on bed. Falls since admission 5/4/22, 5/8/22, 5/22/22, 5/24/22, 5/25/22, then 6/6/22 with additional falls on 7/6/22, 7/7/22, 7/25/22, 7/30/22, and 8/27/22. New interventions after 6/6/22, fall included	F 689	during the first phase of the audit schedule, audits will move to a monthly basis. Responsibility: It is the joint responsibility of the Administrator, the Director of Nursing, and the MDS Coordinator/Assistant Director of Nursing to ensure that the fall committee meets regularly and that policies regarding falls are kept up to date and staff is informed of all changes. It is the responsibility of the aforementioned parties to ensure that care plans are reviewed regularly and kept up to date. The charge nurse becomes an additional responsible party in the effort to ensure all documentation is completed in a manner that is timely and accurate when a fall occurs during their shift.	

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F 689	Continued From page 18 adhesive gripper strips on floor by bed, chair, and in bathroom. Additional interventions following that included remove black slip-on shoes and lipped mattress with exit opening. The current care plan also identified R7 was independent bed mobility, dressing, personal hygiene, toileting, and transfers. R7 had a restorative program and was able to ambulate to all destinations with encouragement to use walker. R7's Fall Investigative Summary following each fall identified the same information that was entered on the fall report. There was no indication that staff completed a thorough investigation and analyzed the information to obtain a root cause for the falls to identify why the fall had happened. The fall committee information was a copy of the fall report and the investigative summary that was completed by the nurse on duty at the time. There was no indication that the fall was further investigated during the fall committee meeting or if interventions were reviewed and/or changed if needed. Observation on 9/7/22 at 12:49 p.m., R7 was walking with her walker in the hallway independently, staff approached her and asked if she needed anything, and she stated she was just going back to her room. Interview on 9/7/22 at 2:19 p.m., with nursing assistant (NA)-E identified R7 wanders up and down the halls, staff redirect her, staff make sure she has her walker with her and that she is safe. She reported R7 had a bed alarm that alerts to staff radio, so they knew when she was getting up from her bed. She confirmed she was independent while in her room and staff attempt to walk with her out in the hallway, but she can	F 689		

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F 689	Continued From page 19 walk on her own there also. Observation on 9/8/22 at 7:33 a.m., R7 was sitting at breakfast table in dining room with her walker parked next to her. Observation on 9/8/22 at 10:48 a.m., R7 was laying on her bed with her walker parked next to her. Interview on 9/8/22 at 1:42 p.m., with registered nurse (RN)-C who was also the MDS nurse identified that the facility had a fall committee of department managers including herself that review falls and what happened prior to the fall. She confirmed R7 had multiple falls and stated she felt the facility had done multiple interventions revealing she did not know what else the facility could do. She confirmed that the provider was made aware and they review falls during their QAPI meetings. Interview on 9/9/22 at 11:30 a.m., with director of nursing (DON) agreed that the facility had not completed a thorough investigation and that there had not been any root cause analyses identified for R7's falls. She stated that she was already working with the interim administrator on revising the process and obtaining a new form for the charge nurse to follow. She revealed the process needed to be revised so that the charge nurse on duty would complete interviews at the time of the fall and finding out why the fall potentially occurred by asking specific questions. R35 R35's 5/31/22, quarterly Minimum Data Set (MDS) assessment identified R35 had severe cognitive impairment and required extensive	F 689		

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F 689	Continued From page 20 assist of two staff for bed mobility, transfers, and toileting. R35 used a walker or wheelchair for mobility. There were no recent falls identified. R35's undated, care plan identified on 3/1/22, fall intervention of a TAB's alarm on bed. The care plan listed all falls since admission with the 6/30/22 fall and the previous fall being on 5/24/21 over a year prior. R35's 6/30/22, Un-witnessed fall report identified that staff entered R35's room to don hand grips and found R35 laying on her right side on floor next to bed. There was no alarm sounding and the alarm was not located on the bed frame. R35 was assessed by the nurse and found to have no injuries. R35 was assisted back into bed with a mechanical lift and three staff. The report identified staff placed the TAB's alarm on the resident and would be obtaining a body pillow as well. Manager review on 7/1/22, identified that the TAB's alarm was not on bed frame, staff were educated to not move alarms from surface to surface, and a body pillow next to resident when in bed was added. Interview on 9/7/22 at 10:12 a.m., with trained medication aide (TMA)-B identified that R35 had falls in the past and that was why she had a TAB's alarm to alert staff she was getting up however, she has now declined and does not really attempt to get up any longer. Interview on 9/7/22 at 4:26 p.m., with RN-C who was the MDS nurse confirmed that staff had not followed R35's care plan on 6/30/22 as they failed to place the TAB's alarm on the bed that evening. RN-C identified there was an educational reminder in the staff communication book but	F 689		

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F 689	Continued From page 21 also education was done at time of fall with the staff on duty. RN-C revealed that the fall intervention of a TAB's alarm on the bed had been initiated on 3/1/22, and would have expected staff to follow the care plan. Review of 8/22/22 Comprehensive Care Plans policy identified staff were to implement personalized developed care plans to meet the residents needs. The 8/2021, Fall Risk Assessment policy identified would provide supervision along with assistive devices to each resident to prevent avoidable accident. Staff were to complete a risk assessment that identified environmental hazards, the resident's risk, if supervision was needed and care plan accordingly. Staff were to monitor effectiveness of care plan interventions and modify as needed in accordance with current standards of practice. The August 2021, Fall Prevention Program policy identified staff were to assess resident fall risk and individualize services to minimize the likelihood of falls. The nurse was to reference the facility high risk or low risk for falls protocol when determining fall interventions. Staff were to place a star indicator on the resident door frame of their room if they were at risk for falls. The nursing staff were to assess any resident who experienced a fall and document on a fall report, notify physician and family along with documenting all assessments and actions taken. There was no mention that the facility would complete a root cause analysis or review of the interventions to ensure interventions were appropriate.	F 689		

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F 758	Continued From page 22	F 758		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or	F 758		10/2/22

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F 758	Continued From page 23 prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Surveyor: 39988 Based on interview and document review, the facility failed to ensure as-needed (PRN) antipsychotic medications were limited to 14 days of use or re-evaluated in-person by the medical provider to ensure necessity and reduce the risk of complications for 1 of 5 resident's (R23). In addition, the facility failed to ensure target behaviors were identified for psychoactive medications for 2 of 5 resident's (R7 and R26) reviewed for psychotropic medication use. Findings include: R23's Admission Record printed 9/8/22, indicated R23 was admitted on 4/28/22, with the diagnosis of dementia with behavioral disturbance, adult failure to thrive, atrial fibrillation, weakness, insomnia, low back pain, and osteoarthritis (degenerative joint disease). R23's 5/5/22, admission Minimum Data Set (MDS) assessment identified R23 severe cognitive impairment, had behaviors 1 to 3 days of physical and verbal behaviors directed towards	F 758	Tag 0758 - 483.45(c)(3)(e)(1)-(5) Free from Unnec Psychotropic Meds/PRN Use (LONG TERM CARE FACILITIES) Residents Affected: R23, R7 Immediate Actions taken for Identified Residents: R23:Psychotropic medication use has been discontinued until a review can be completed. R7: A medication review has been requested for R7 as of 9/30/2022. Care plan will be updated based upon results. R26: Psychotropic medication use has been discontinued until a review can be completed. Methods to Ensure Compliance: Existing policy and documentation have been revised and approved as of 9/30/2022 to ensure that the use of psychotropic medications has a valid associated	

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F 758	Continued From page 24 others and other behavioral symptoms not directed towards others. The behaviors interfered with R23's cares but did not interfere with other residents. R23 rejected care 4-6 days during the assessment period. R23 required limited assist of one staff with cares and ambulation. R23 had no psychiatric/mood disorder identified as a diagnosis on the MDS however, took an antipsychotic daily during the assessment period. R23's 7/26/22, MDS assessment identified R23 had severe cognitive impairment, had no behaviors, no psychiatric/mood disorder identified however, took an antipsychotic daily during the assessment period. Review 7/6/22, provider in-person visit identified PRN antipsychotic's were discussed. Review of 7/20/22, fax to the provider related to a 14-day evaluation due to PRN Haldol with provider who responded to continue Haldol for another 14 days via fax without completing an in-person evaluation. R23's Medication Review Report dated 7/27/22, identified an in-person routine visit however, there was no documentation that the provider reviewed the PRN Haldol to ensure necessity and reduce the risk of complications. Review of 8/3/22, fax to provider with update of PRN Haldol use, provider responded to discontinue the PRN Haldol. Provider completed an in-person visit the next day. R7's Admission Record printed 9/8/22, identified admission date of 3/25/22, with the diagnosis of hyperlipidemia, major depressive disorder,	F 758	diagnosis or valid targeted behaviors, that the removal or addition of such pharmacological interventions is valid and necessary, and that the condition would not be manageable through the use of non-pharmacological interventions. Documentation must also include the resident's reactions to the medication; this portion of the documentation must prove that its use has been beneficial to the resident. The dose and duration of use will be considered when analyzing resident reactions. All reactions, whether beneficial or adverse, must be documented. The Social Services Director will ensure that proper documentation of existing diagnosis is obtained during the admission process for new residents. While the attending physician is responsible for the medication management of a resident, these medications and the associated documentation must be reviewed by the Director of Nursing and the Administrator to ensure any conditions are properly documented and that the use of psychotropic medications is valid in each instance they are being utilized. The comprehensive care plan policy has also been revised and approved as of 9/30/2022 to reflect more concrete guidance on when to re-evaluate resident care plans and who should be involved in creating care plans. Any updates to a resident's care plan must be dated. PRN orders require the same documentation as orders for long-term	

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F 758	Continued From page 25 insomnia, carpal tunnel syndrome right limb, hypertension, irritable bowel syndrome, rosacea, spinal stenosis, chronic kidney disease, osteoporosis, and osteoarthritis. On 5/4/22, R7 was identified with a new diagnosis of vascular dementia with behavioral disturbance, and delusional disorders. R7's 6/21/22, significant change Minimum Data Set (MDS) assessment identified R7 had severe impaired cognition, with no behaviors exhibited. R7 required limited assistance from staff for all care needs, R7's balance was not steady but R7 was able to stabilize without staff assistance. Section I Active diagnoses identified depression and psychotic disorder. Section N 0410 Medications identified R7 had antipsychotic 7 days during the assessment period. R7 diagnosis list identified on 5/4/22, a new diagnosis of delusional disorder and vascular dementia with behavioral disturbance. R7's September 2022, medication administration and treatment record identified to chart mood and behaviors for psychotropic medication and changes every shift related to delusional disorder. There were no target behaviors identified as to what the medication was being used for. R7's undated, care plan identified R7 used antidepressant medication Zoloft related to depression. There were no identifying target behaviors for use of Zoloft. Care plan addressed be free form discomfort or adverse reactions related to antidepressant use. The care plan further identified R7 used a psychotropic medication of Seroquel related to vascular dementia and depression. There were no	F 758	use, but PRN usage of psychotropic medications must only continue for a limited duration of fourteen days. It is the goal of the facility that, whenever possible, non-pharmacological interventions will be utilized in place of pharmacological interventions. Residents should be assessed regularly to determine whether or not medication needs have changed or whether medication use can be decreased or discontinued. Reviews of medication use should be conducted monthly by the facility pharmacist and on a regular basis by the attending physician as determined by the physician and the Director of Nursing. The interval for evaluation by the attending physician may vary based on resident need and condition. If a resident experiences a significant change in condition, whether physical or mental, a new evaluation must be conducted by the attending physician. Medications must not be used as a form of chemical restraint or to the benefit of anyone besides the resident. Any review conducted by the attending physician must include a face-to-face appointment with the resident in question. Approval by the attending physician to continue the use of PRN medication must also include a face-to-face appointment with the resident in question. The MDS coordinator will review resident care plans and medications to ensure that PRN usage does not exceed fourteen days without a face-to-face review by the resident's physician and that the resident	

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F 758	Continued From page 26 identified target behaviors for use of Seroquel. The care plan identified R7 will be/remain free of psychotropic drug related complications. Staff were to monitor mood and behaviors and report them to the charge nurse. R26 Admission Record printed 9/8/22, identified admission date of 2/17/22 and diagnosis of atrial fibrillation, chronic obstructive pulmonary disease, malignant neoplasm of larynx, hypothyroidism, anxiety, hypertension, heart attack, urine retention, encounter for attention tracheostomy, and long-term use of anticoagulants. R26's 9/1/22, significant change of condition MDS assessment identified intact cognition, no behaviors, required extensive assist with cares, had anxiety disorder, took an antianxiety medication 6 days, and took antidepressant 7 days during assessment period. R26's September 2022, medication administration and treatment record identified R26 took Alprazolam (Xanax) daily in the evening and Venlafaxine (Effexor) every morning. Neither medication had target behaviors identified as to what the medication was being used for. R26's undated, care plan identified R26 took an antianxiety medication related to anxiety there were no target behaviors identified for use of the anxiety medication. There was no antidepressant identified with target behaviors for use of the antidepressant medication. Interview on 9/8/22 at 8:56 a.m., with the director of nursing (DON) revealed she was unaware that the provider needed to evaluate a resident on a PRN antipsychotic medication in-person every 14	F 758	may not have more benefit utilizing non-pharmacological interventions. MDS coordinator will perform audit weekly for four weeks and biweekly for eight weeks. If no errors are present, she will shift to monthly reviews. The MDS coordinator will sign an agreement showing she understands and agrees to this audit schedule. Audit reports will be reviewed by the Director of Nursing to ensure they are being completed in full. The MDS coordinator will be present at all QAPI meetings and will discuss her findings. Responsibility: It is the responsibility of the Social Services Director and MDS Coordinator to ensure that proper documentation of existing diagnosis is obtained during the admission process for new residents and that any evaluations performed on the resident upon admission are documented. It is the responsibility of the attending physician to develop, monitor, and modify medication regiments in collaboration with residents, their families and/or representatives, other professionals, and the interdisciplinary team. It is the responsibility of the attending physician to provide proper documentation regarding the reason for psychotropic medication use and regarding any associated diagnoses. It is the responsibility of the Administrator, Director of Nursing, and the MDS Coordinator to ensure that proper documentation is maintained regarding any diagnoses that are linked to the use of	

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F 758	Continued From page 27 days to evaluate the necessity of the medication and to reduce the risk of complications to continue the PRN medication. She further revealed she was unaware the provider needed to document the rational for use. She confirmed that the facility MDS nurse had been faxing the provider to continue the PRN antipsychotic orders between routine visits to continue the order for an additional 14 days. Interview on 9/8/22 at 1:46 p.m., with registered nurse (RN)-C who is also the MDS nurse confirmed there were not target behaviors for either R7 or R26 that identified why the psychoactive medication was prescribed and what behaviors the medication was to be improving. She identified she must have missed adding the target behaviors as she normally would do that. She further agreed that without having target behaviors identified it would be hard to tell if the medication was working or not. Interview on 9/9/22 at 11:30 a.m., with director of nursing agreed that R7 and R26 did not have target behaviors identified for the psychoactive medication ordered as to why it had been ordered and what behaviors the medication was intended to improve. She confirmed all residents that use psychoactive medications should have identified target behaviors that the medication was to treat to enable a thorough review to see if the medication was effective or not. The 7/29/21, Psychotropic Medication policy identified medication that are used only as needed, would have side effects monitored and ensure the family was made aware of risk/benefit of those medications. The policy identified ordered PRN antipsychotic medication will have	F 758	psychotropic medications as well as ensuring targeted behaviors are listed in the resident's care plan. Tag 0759 - 483.45(f)(1) Free of Medication Error Rts 5 Prcnt or More (LONG TERM CARE FACILITIES) Residents Affected: All residents had the potential to be affected. R33, R26, and R13 were observed. Review of manufacturer specifications for the medications taken by R33, R26, and R13 has been completed and the administration of their medication now reflects those specifications. Methods to Ensure Compliance: Existing policy and documentation have been revised and approved as of 9/30/2022 to ensure that medication specifics are reviewed prior to administering medication. In-Service education will be required annually on preventing medication errors. Additionally, the Administrator is working to obtain access to a system wherein staff can type in the medication name and receive all information about the medication (instructions on how to take medication, steps to take after administering medication, and more). This service should also highlight any possible interactions between medications. Until the medication information system is online, staff will consult medication books that will be stationed at both medication cards, the nurse's desk, and the Administrator's office. Updated medication	

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F 758	Continued From page 28 the effectiveness, non-pharmacological interventions, and side effect monitored at 14 days, one month and two months. The nurse when entering an order for a PRN psychotropic medication will enter a stop date at 14 days. The provider will be contacted before the 14 days on antidepressants, antianxiety, and hypnotics only the antipsychotic orders are reviewed every 14 days with a mandatory stop date, refer to drug class in this policy. There was no attached drug class reference in the policy. The policy lacked identification that an in-person evaluation was required to continue a PRN antipsychotic medication. The policy further lacked identification that target behaviors should be identified for use of psychoactive medication orders to monitor for effectiveness.	F 758	books should arrive by the end of October. Facility pharmacist, Julie Harsma, will review medications and notes weekly for four weeks and biweekly for eight weeks to ensure that medications are being properly administered, stored, and that there are no drug interactions. If no errors are present, she will return to her normally scheduled monthly reviews. Pharmacist has been informed of this change and will sign an agreement to conduct the audit. The pharmacist is present at quarterly QAPI meetings, and her findings will be reviewed at the monthly QAPI meeting. If a medication is requested by the family or by the resident to be taken at a different time than recommended by the manufacturer specifications, this must be approved by the pharmacist and attending physician. Responsibility: It is the responsibility of the Pharmacist to conduct a monthly review and ensure that medications are being properly administered. It is the responsibility of the staff administering medications to review manufacturer specifications prior to administering any medication.	
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-	F 759		10/2/22

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F 759	Continued From page 29 §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Surveyor: 39988 Based on observation, interview, and document review, the facility failed to administer medication according to manufactures instructions during 3 of 25 observations, resulting in a 12% medication error rate. Findings include: Observation and on 9/7/22 at 8:53 a.m., of R33's medication pass with trained medication aide (TMA)-B who gathered R33's medications including her Levothyroxine (thyroid medication) 50 micrograms (mcg) and administered her medications. Observation on 9/7/22 at 9:10 a.m., of R26's medication pass with TMA-B who gathered R26's medications including his Levothyroxine 12 mcg and administered his medications. Interview on 9/7/22 at 9:52 a.m., with TMA-B confirmed that R33 and R26 had already received their breakfast before getting their morning medications. TMA-B was unaware of any medications that needed to be given on an empty stomach. TMA-B revealed medications that are given on an empty stomach would be given by the nurse. Interview on 9/7/22 at 10:00 a.m., with registered nurse (RN)-B identified Levothyroxine should be given on an empty stomach and the facility usually gives at 5:00 a.m. unless the resident	F 759	Tag 0759 - 483.45(f)(1) Free of Medication Error Rts 5 Prcnt or More (LONG TERM CARE FACILITIES) Residents Affected: All residents had the potential to be affected. R33, R26, and R13 were observed. Review of manufacturer specifications for the medications taken by R33, R26, and R13 has been completed and the administration of their medication now reflects those specifications. Methods to Ensure Compliance: Existing policy and documentation have been revised and approved as of 9/30/2022 to ensure that medication specifics are reviewed prior to administering medication. In-Service education will be required annually on preventing medication errors. Additionally, the Administrator is working to obtain access to a system wherein staff can type in the medication name and receive all information about the medication (instructions on how to take medication, steps to take after administering medication, and more). This service should also highlight any possible interactions between medications. Until the medication information system is online, staff will consult medication books that will be stationed at both medication cards, the nurse's desk, and the Administrator's office. Updated medication	

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F 759	Continued From page 30 does not want to be woken up then it is given before breakfast. RN-B confirmed that both R33 and R26 had eaten their breakfast before TMA-B had administered their medication. RN-B revealed R33's Levothyroxine was scheduled at 8:00 a.m. and R26's Levothyroxine was scheduled at 9:00 a.m. and both should be scheduled before breakfast time. Observation on 9/8/22 at 8:06 a.m., of R13's medication pass with TMA-A who gathered R13's medications including Levothyroxine 75 mcg and administered her medications. Interview on 9/8/22 at 8:13 a.m., with TMA-A identified the only medications she was aware of that needed to be given on an empty stomach was Docycycline. TMA-A confirmed R13 had already eaten breakfast prior to getting her morning medications. TMA-A then revealed thyroid medication used to be scheduled to be given before breakfast but the facility had quit doing that. Interview on 9/9/22 at 10:58 a.m., with consultant pharmacist who agreed that Levothyroxine should be administered on an empty stomach unless the medical provider specifically ordered the medication to be given at an alternative time. She was unaware of R13, R33, or R26 having an order to give their Levothyroxine at a different time and she confirmed the medication worked best if given on an empty stomach prior to breakfast. Review of the manufacturer's instructions located at https://www.drugs.com/levothyroxine.html, identified Levothyroxine worked best if taken on an empty stomach, 30 to 60 minutes before	F 759	books should arrive by the end of October. Facility pharmacist, Julie Harsma, will review medications and notes weekly for four weeks and biweekly for eight weeks to ensure that medications are being properly administered, stored, and that there are no drug interactions. If no errors are present, she will return to her normally scheduled monthly reviews. Pharmacist has been informed of this change and will sign an agreement to conduct the audit. The pharmacist is present at quarterly QAPI meetings, and her findings will be reviewed at the monthly QAPI meeting. If a medication is requested by the family or by the resident to be taken at a different time than recommended by the manufacturer specifications, this must be approved by the pharmacist and attending physician. Responsibility: It is the responsibility of the Pharmacist to conduct a monthly review and ensure that medications are being properly administered. It is the responsibility of the staff administering medications to review manufacturer specifications prior to administering any medication.	

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F 759	Continued From page 31 breakfast. Staff were to follow doctor's dosing instructions and try to take the medicine at the same time each day. Review of August 2021, Medication Administration policy identified medications were to be given as ordered by the physician and in accordance with professional standards of practice. Staff were to administer medications as ordered in accordance with the manufacturer specifications.	F 759		
F 812 SS=D	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Surveyor: 34083 Based on observation, interview, and document	F 812	Tag 0812 - 483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary (LONG TERM CARE FACILITIES)	10/2/22

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F 812	Continued From page 32 review the facility failed to ensure appropriate infection control technique was maintained during 1 of 1 meal service when a room tray that had been served to 1 of 1 resident (R3) was returned to serving line and not disposed of in the dirty sink area in the kitchen. Findings include: Observation on 9/6/22 at 5: 08 p.m., during serving of the supper meal service with cook-A identified an area of concern when at 5:22 p.m., nursing assistant (NA)-B returned to the dining room with a plate containing the casserole and bread that had been plated by cook-A and served on a room tray. Cook- A took the plate with her gloved hands and placed it on the counter beside the steam table. She did not change her gloves and continued to dish the supper meal, and place slices of buttered bread on each plate with her contaminated gloved hands that had handled both the plate and cover. Cook-A did not remove her gloves and perform hand hygiene until she had finished serving the meal. Cook-A then removed her gloves, washed her hands, and retrieved a can of soup to prepare for the resident who had requested an alternate food choice. Interview on 9/06/22 at 5:43 p.m., with NA-B identified she had served the room tray to R3 and had placed the tray on her lap as she had requested. R3 lifted the plate cover, replaced it, and stated she wanted something different. NA-B took the plate from the R3 and carried the covered plate in her gloved hands, back to the serving window where she handed it through the serving window to cook-A, who took it from her and set the plate on the serving counter. NA-B reported this was her usual practice if a resident	F 812	Residents Affected: R3. All residents had the potential to be affected. Immediate Actions: All part-time and full-time staff have undergone this education as of 9/22/2022. PRN staff will complete education prior to their next shift. Monitoring: The Dietary Manager will conduct an audit wherein they monitor staff in the dining room and kitchen twice a week for four weeks, once a week for eight weeks, and then once a month. The Dietary Manager will bring their findings to QAPI. The Administrator will also conduct random observations of the actions of staff to ensure they are following proper sanitary protocols. Responsibility: It is the responsibility of all staff to remain informed on policies relating to their position and it is the responsibility of the Administrator and the Dietary Manager to ensure that staff are provided with the proper education. It is the responsibility of all parties to always comply with such policies. It is the responsibility of the Dietary Manager to conduct the audit process.	

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F 812	Continued From page 33 didn't want what was served. She was not aware once food left the kitchen it should not be returned to the clean serving area of the kitchen and should have returned the plate to the soiled dish area. Interview on 9/06/22 at 5:39 p.m., with the certified dietary manager (CDM) confirmed when a plate of food was taken from the kitchen, it could not be returned to the serving area, but had to be returned to the dish room. The CDM reported cook-A should not have accepted the plate and directed NA-B to take it to the dishwashing area. Interview on 9/6/22 at :50 p.m., with cook-A reported she should have known not to take the plate back into the serving area but had not thought about it when she accepted the plate and set it on the counter. She reported she had not thought about needing to change her gloves or performing hand hygiene. Review of the undated, Sanitation an Infection Control policy identified food returned on a soiled plate should be immediately disposed of, but there was no information on infection control about handling and how it was to be managed.	F 812		
F 880 SS=F	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.	F 880		10/2/22

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F 880	Continued From page 34 §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be 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	F 880		

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F 880	Continued From page 35 disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Surveyor: 38687 Based on observation, interview, and document review, the facility failed to 1) include all employee illness into their infection control program surveillance and perform daily, cumulative surveillance for COVID-19. This has the ability to affect all 37 residents. 2) In addition, the facility failed to appropriately disinfect 2 of 2 whirlpool tubs. This had the ability to affect 35 of 37 residents who received tub baths. 3) The facility also failed to ensure 1 of 1 paraffin wax warmer was appropriately cleaned and disinfected after resident use and identified appropriate for multi-resident use. 4) Furthermore, the facility failed to store lab specimen in a designated biohazard refrigerator awaiting lab transfer and not co-mingled in 1 of 1 medication refridgerator.	F 880	Tag 0880 - 483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control (LONG TERM CARE FACILITIES) Residents Affected: All residents could be affected. Immediate Actions: Director of Nursing updated the infection control binder to include all infectious diseases in staff members and relocated it so that it is easily accessible to other staff members. A root cause analysis was performed by the Administrator by interviewing the Infection Control nurse and her predecessor, which determined that the prior Director of Nursing who had overseen Infection Control had not been keeping records correctly. The new	

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F 880	Continued From page 36 SURVEILLANCE Review of the current August and September infection control surveillance and Staff COVID Testing Forms identified nurse aide (NA)-C and the social services designee (SSD) were noted to be positive for COVID-19 on 8/31/22. On 9/4/22, 1 staff, laundry aide (LA)-A was identified as positive for COVID-19. No staff were included in the facility infection control surveillance program data. Interview and document review on 9/07/22 at 5:12 p.m., with the infection preventionist /director of nursing (IP/DON) of the IC surveillance and employee illness sheets identified there was no daily, cumulative, surveillance of staff included into the infection control (IC) surveillance program. If staff were out ill, or when they were identified to be positive for COVID, she had not added to the tracking log to identify they were included in with the daily, cumulative surveillance. The IP/DON identified she had no documentation to support staff who were noted to be ill were kept out of work for an appropriate amount of time if they had potential symptoms of COVID. The IP/DON agreed she needed to include staff in the facility IC program surveillance. Review of the 2020, Infection Prevention and Control policy identified the intent of surveillance was to identify possible communicable diseases or infections before they can spread to other persons in the facility. The facility was to have established a system, based upon national standards of practice and the facility assessment to closely monitor all residents who exhibit signs/symptoms of infection through ongoing surveillance including a systematic method for collecting, analyzing and interpretation of data,	F 880	Infection Control nurse had been trained by her. Previous Infection Control nurse admitted that she had not been aware of the proper way to maintain records and that the previous Administrator of this facility had never corrected her process. QAPI Committee reviewed this information and seconded the finding. COVID-19 policy updated and approved as of 9.30.2022 by Administrator, who is part of the facility's governing body, to include specifics on monitoring residents and staff and the dissemination of information regarding COVID-19 positive results to family members and staff. A tracking log has been implemented for staff who have symptoms of COVID-19 or who are not working due to a COVID-19 positive result. Policy regarding the sanitization and cleaning of the whirlpool tub has been updated and approved as of 9.30.2022 by the facility. A root cause analysis was conducted by the Director of Nursing by interviewing bathing staff. Bathing staff reported that they all had been trained by the same senior staff member. Interview with senior staff member revealed that she was originally trained improperly and therefore passed down that incorrect method as she trained new staff. She had been educated originally via a policy that had not stated that the whirlpool must be cleaned before and after each use as well as disinfected. The QAPI Committee seconded these findings on 10.11.22 after reviewing the prior policy, and also determined that this improper cleaning	

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F 880	Continued From page 37 followed by dissemination of that information to identify infections, infection risks and outbreaks to those who can improve the outcomes for quality. There was no mention of including staff, volunteers, visitors, and other individuals providing services into the surveillance program. WHIRLPOOL TUB CLEANING Observation, interview, and document review on 9/08/22 at 9:40 a.m., of bath aide (BA)-A during a whirlpool tub cleaning identified she removed the gel cushion off the whirlpool bath chair, and wiped the top side with a Sani-cloth and hung it on the handicap grab-bar mounted to the wall. The Sani-cloth chemical was observed to have dried on the gel cushion in approximately 10 seconds. BA-A was unaware how long the Sani-cloth chemical had to remain wet to disinfect the surface of an object. The label on the Sani-cloth container indicated a wet contact time of 2 minutes was required to disinfect a surface. BA-A indicated she was unaware she should disinfect all sides of a gel cushion as a residents skin comes into contact with that. BA-A then described her process as she began the cleaning process of the whirlpool tub. She only performs the cleaning process between resident use and would not perform disinfection until the end of the day. BA-A was the main bath aide and routinely used both whirlpool tubs in the facility for all 35 of 37 residents who bathed. Review of the infection control audits identified the last time the whirlpool tub cleaning and disinfection had been audited was in July of 2021. Review of the undated, Apollo Advantage Seated Bathing System Bath Cleaning and Disinfection process was not clear for staff that cleaning only	F 880	resulted from staff being trained improperly and being provided with the incorrect information. QAPI Committee, Director of Nursing, and Administrator determined that staff must undergo education. Staff who perform baths will be instructed to read this new guidance, complete a quiz that requires an 80% score or above to pass, and then demonstrate the process in front of the Infection Control Director. As of 10.15.22, all bathing staff had completed this process. An audit will be performed wherein the Infection Control Director will monitor staff who perform baths every day for a week. The following week will be four days. The third week will be three days. The fourth week will contain two days of auditing. After that time period, the Infection Control Director will conduct two audits per month on staff members for four months. If staff is being compliant, these audits will shift to being at random after that four-month period. These audits will be documented and presented at QAPI meetings. Audits will be reviewed by the Administrator, who is a member of this facility's governing body, to ensure the process is being performed correctly. The paraffin wax machine has been replaced and a new cleaning schedule has been created based upon recommendations given in the owner's manual. This wax machine will only be utilized by one resident. Cleaning logs will be maintained for the wax machine. The updated policy that was approved on 9/30/2022 also includes information on	

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F 880	Continued From page 38 removed bio-film and debris, but disinfection would be required to kill potential infectious disease in between resident use. Interview on 9/08/22 at 11:40 a.m., with the DON identified she was unaware the whirlpool tub had not been routinely disinfected between resident use. She agreed all 35 residents who used the whirlpool tub had increased risk of infection due to improper disinfection. PARAFFIN WAX SYSTEM Observation, interview, and Hot Wax Cleaning policy review on 9/08/22 at 8:24 a.m., in the therapy room with the DON identified a paraffin wax system was kept in a wooden cupboard and used for therapy residents. Warm, liquid wax was inside. At the bottom of the wax, there were specs of dirt and debris observed in the bottom of the unit. The DON identified the unit was only cleaned 1 x per month. She was only aware of 1 resident using the wax for therapy but agreed it would be used on other residents if they wished without being appropriately disinfected. She had no manual on the paraffin wax system, but staff had an old, undated policy that stated the wax was only to be changed monthly unless visibly soiled. She agreed the wax appeared visibly soiled. She was unaware of any standard of practice for infection control to prevent cross-contamination if residents were to place thier hands or feet in the liquid wax that another resident had dipped thier hands or feet in. Review of the current, Minnesota Board of Cosmetologist Examiner, State Rule 2105.0375, located at https://mn.gov/boards/assets/Infection_Control_and_Salon_Prohibitions_Summary_tcm21-261490.	F 880	how frequently to replace wax, temperature requirements, and cleaning procedures. Staff who utilize the wax machine have reviewed this information and signed as of 10.18.2022 that they will follow this schedule and fill out the required paperwork. A root cause analysis performed by the Administrator discovered that this error occurred due to the facility not having the manual for the machine to confirm that the existing policy was accurate and an interview with the previous Infection Control nurse revealed she had believed she did not need to confirm the policy with an owner's manual as she had taken information about other wax machines to create the policy. The current Infection Control nurse had not known the policy was not verified and that the facility did not have an owner's manual. QAPI Committee seconded these findings and that replacement of the wax machine and having a policy written based on the new owner's manual would remedy the situation as long as it was paired with education. A policy has been created regarding the facility's One Call Now system that is utilized to inform staff and resident families when there is a positive COVID-19 case in the facility. When a positive staff member or resident is identified, the Social Services Director, the Director of Nursing, or the Administrator will complete the form on One Call Now and send it out by 5 p.m. the following day. A log of these notifications and who sent them will be kept in the Infection	

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F 880	Continued From page 39 pdf, identfied professional standards when using paraffin wax systems: "You must dispense paraffin wax in a manner that prevents contamination of the unused supply, such as in a bag or other container for the client to use as single-service". There was no user manual or manufacturer's instructions for the paraffin wax system available. Surveyor: 39988 Lab Specimen Storage Observation on 9/9/22 at 9:38 a.m., of the medication room with director of nursing (DON) revealed a cooler was in the medication refrigerator that contained an urine sample. Interview on 9/9/22 at 9:45 a.m., with DON identified that the maintenance director took all lab samples over to the hospital lab when he had time during the day. She revealed the protocol had always been to place urine samples in the cooler located in the medication fridge until they could be transported to the hospital lab. The DON further confirmed all blood laboratory specimens drawn at the facility were also placed in the medication refrigerator until they could be taken to the hospital lab. The DON agreed storing specimens in the medication refridgerator had the high potential for cross-contamination and they should be stored within their own refridgerator in a soiled utility room. There was no policy pertaining to appropriate storage of laboratory specimens.	F 880	Control COVID-19 binder. These logs will be reviewed at QAPI to ensure they match the number of positive cases that month. The Administrator will review after each case is identified to confirm the One Call was sent. Prior to this policy being written, it was assumed by the previous Administrator that only cases that had high-risk exposures in the facility needed to be reported. An interview between the existing administrator and the previous administrator was performed for the root cause analysis. Information was confirmed by the former Administrator in this interview and QAPI Committee seconded these findings. The new policy states that all cases must be reported. Responsibility: It is the responsibility staff who perform baths to stay up to date on all policies relating to their position and it is the responsibility of the Infection Control Director to ensure that these staff are provided with the proper education. It is the responsibility of all parties to always comply with such policies. It is the responsibility of the Director of Nursing to maintain records of all infectious diseases in the facility in a manner and location that it is easily accessible by other staff members. It is the responsibility of any staff member utilizing the wax machine to fill out cleaning logs as necessary and to complete the required education component. It is the responsibility of the Administrator, Social Services Director, or the Director of Nursing to send out One	

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F 880	Continued From page 40	F 880	Call Now notifications regarding new positive cases of COVID-19 in the facility by 5 p.m. the day after a positive case is identified. It is also their responsibility to ensure that these notifications are added to the log that will kept in the COVID-19 Infection Control binder.	
F 885 SS=F	Reporting-Residents,Representatives&Families CFR(s): 483.80(g)(3)(i)-(iii) §483.80(g) COVID-19 reporting. The facility must— §483.80(g)(3) Inform residents, their representatives, and families of those residing in facilities by 5 p.m. the next calendar day following the occurrence of either a single confirmed infection of COVID-19, or three or more residents or staff with new-onset of respiratory symptoms occurring within 72 hours of each other. This information must— (i) Not include personally identifiable information; (ii) Include information on mitigating actions implemented to prevent or reduce the risk of transmission, including if normal operations of the facility will be altered; and (iii) Include any cumulative updates for residents, their representatives, and families at least weekly or by 5 p.m. the next calendar day following the subsequent occurrence of either: each time a confirmed infection of COVID-19 is identified, or whenever three or more residents or staff with new onset of respiratory symptoms occur within 72 hours of each other. This REQUIREMENT is not met as evidenced by: Surveyor: 38687	F 885	Tag 0885 - 483.80(g)(3)(i)-(iii)	10/2/22

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TUFF MEMORIAL HOME	505 EAST 4TH STREET HILLS, MN 56138

(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 885	Continued From page 41 Based on interview and document review, the facility failed to appropriately inform residents, their representatives, and families by 5:00 p.m. the next calendar day following the occurrence of a single confirmed COVID-19 infection, or when 3 or more residents or staff with new-onset of respiratory symptoms occurring within 72 hours of each other during the facility's outbreak. This had potential to affect all 37 residents residing in the facility, their families, and representatives. Interview on 9/08/22 at 11:35 a.m., with the administrator identified the facility utilized a one-call type system to notify residents and families of positive cases. Review of the Staff COVID Testing Forms identified on: 1) 8/9/22, nurse aide (NA)-F was identified as positive for COVID. 2) 8/31/22, NA-C and the social services designee (SSD) were noted to be positive for COVID. 3) 9/4/22, laundry aide (LA)-A was identified as positive for COVID. Review of the August and September, 2022 notification log identified for august 2022, there was no mention of the 8/9/22 positive case notification being sent to residents and families. Only 1 staff was identified as positive for COVID on 8/31/22 and reported through the one call system. There was no notification sent on 9/4/22 for the positive case identified that day. No policy regarding notifications was provided by the end of the survey.	F 885	Reporting-Residents,Representatives&Families (LONG TERM CARE FACILITIES) Residents Affected: All residents could be affected. Immediate Actions: A policy has been created regarding the facility's One Call Now system that is utilized to inform staff and resident families when there is a positive COVID-19 case in the facility. When a positive staff member or resident is identified, the Social Services Director, the Director of Nursing, or the Administrator will complete the form on One Call Now and send it out by 5 p.m. the day after a positive case is identified. A log of these notifications and who sent them will be kept in the Infection Control COVID-19 binder. These logs will be reviewed at QAPI to ensure they match the number of positive cases that month. The Administrator will review after each case is identified to confirm the One Call was sent. Prior to this policy being written, it was assumed by the previous Administrator that only cases that had high-risk exposures in the facility needed to be reported. This policy states that all cases must be reported. Responsibility: It is the responsibility of the Administrator, Social Services Director, or the Director of Nursing to send out One Call Now notifications regarding new positive cases of COVID-19 in the facility by 5 p.m. the day after a positive case is	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245548	A. BUILDING _____ B. WING _____	C 09/09/2022

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TUFF MEMORIAL HOME	505 EAST 4TH STREET HILLS, MN 56138

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F 885	Continued From page 42	F 885	identified. It is also their responsibility to ensure that these notifications are added to the log that will kept in the COVID-19 Infection Control binder.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245548	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**09/07/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TUFF MEMORIAL HOME	**505 EAST 4TH STREET** **HILLS, MN 56138**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 09/07/2022. At the time of this survey, Tuff Memorial Home was found in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, the Health Care Facilities Code. Tuff Memorial Home was constructed as follows: The original building was constructed in 1959, is one-story, has a partial basement, is fully fire sprinkler protected and is of Type II(111) construction; The 1st Addition was constructed in 1962, is one-story, has no basement, is fully fire sprinkler protected and is of Type II(111) construction; The 2nd Addition was constructed in 1975, is one-story, has no basement, is fully fire sprinkler protected and is of Type II(111) construction; The 3rd Addition was constructed in 1988, is one-story, has a full basement, is fully fire sprinkler protected and is of Type V(111) construction; The 4th Addition was constructed in 1998, is one-story, has no basement, is fully fire sprinkler protected and is of Type V(000) construction. The facility has smoke detection at smoke barrier doors and in spaces open to the corridor, which are monitored for automatic fire department	K 000		

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

Electronically Signed | 10/02/2022

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245548	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**09/07/2022**

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K 000	Continued From page 1 notification. The facility is fully fire sprinkler protected. The facility has a capacity of 48 beds and had a census of 38 at time of the survey. The requirements at 42 CFR, Subpart 483.70(a), are MET.	K 000		