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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: RSG4

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00930

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245313**
2.STATE VENDOR OR MEDICAID NO.
(L2) **306920600**

3. NAME AND ADDRESS OF FACILITY
(L3) **MEADOW LANE RESTORATIVE CARE CENTER**
(L4) **2209 UTAH AVENUE**
(L5) **BENSON, MN** (L6) **56215**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **11/01/2020**

6. DATE OF SURVEY **08/27/2021** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 03 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **56** (L18)
13.Total Certified Beds **56** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	37	19		
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Susan Bachleitner, HFE - NE II 10/25/2021 (L19)

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

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
05/01/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
01111
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Electronically delivered
September 21, 2021

Administrator
Meadow Lane Restorative Care Center
2209 Utah Avenue
Benson, MN 56215

RE: CCN: 245313
Cycle Start Date: August 27, 2021

Dear Administrator:

On August 27, 2021, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be 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 21, 2021.

- 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 21, 2021. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective October 21, 2021.

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 $11,160; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by October 21, 2021, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Meadow Lane Restorative Care Center will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from October 21, 2021. 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" tag), and emergency preparedness deficiencies (those preceded by an “E” tag), i.e., the plan of correction should be directed to:

LeAnn Huseth, RN, Unit Supervisor
Fergus Falls District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
1505 Pebble Lake Rd., Suite 300
Fergus Falls, Mn. 56537
Email: leann.huseth@state.mn.us
Office: (218) 332-5140 Mobile: (218) 403-1100

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 February 27, 2022 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,

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

cc: Licensing and Certification File

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
September 21, 2021

Administrator
Meadow Lane Restorative Care Center
2209 Utah Avenue
Benson, MN 56215

Re: State Nursing Home Licensing Orders
Event ID: RSG411

Dear Administrator:

The above facility was surveyed on August 23, 2021 through August 27, 2021 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

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

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

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

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

LeAnn Huseth, RN, Unit Supervisor
Fergus Falls District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
1505 Pebble Lake Rd., Suite 300
Fergus Falls, Mn. 56537
Email: leann.huseth@state.mn.us
Office: (218) 332-5140 Mobile: (218) 403-1100

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

Please note it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Please feel free to call me with any questions.

Sincerely,

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

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00930	A. BUILDING: _____ B. WING _____	C 08/27/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOW LANE RESTORATIVE CARE CENTEI	2209 UTAH AVENUE BENSON, MN 56215

(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) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 8/23/21, to 8/27/21, a licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found NOT in compliance with the MN State Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you have reviewed	2 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 000	Continued From page 1	2 000		

these orders and identify the date when they will be completed.

The following complaints were found to be SUBSTANTIATED:
H5313059C (MN00055846), with a licensing order issued at L920 .
H5313061C (MN00073747), with a licensing order issued at L920 and L830.

AND
The following complaint was found to be UNSUBSTANTIATED:
H5313060C (MN00055887).

Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction

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2 000	Continued From page 2 is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 800	MN Rule 4658.0510 Subp. 1 Nursing Personnel; Staffing requirements Subpart 1. Staffing requirements. A nursing home must have on duty at all times a sufficient number of qualified nursing personnel, including registered nurses, licensed practical nurses, and nursing assistants to meet the needs of the residents at all nurses' stations, on all floors, and in all buildings if more than one building is involved. This includes relief duty, weekends, and vacation replacements. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure sufficient staffing to provide routine assistance with activities of daily living (ADL's) of grooming, personal hygiene and dressing for 7 of 7 residents (R1, R18, R11, R14, R6, R1, R21 and	2 800	"corrected"	10/11/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 800	Continued From page 3	2 800		

R22) who required assistance and were dependent on staff for ADL's. This deficient practice had the potential to affect all 25 residents who resided in the facility.

Findings include:

R1

R1's quarterly Minimum Data Set (MDS) dated 8/17/21, identified R1 had diagnoses of dementia, depression weakness and peripheral neuropathy (numbness/tingle in extremities.) The MDS identified R1 had severe cognitive impairment and required extensive assistance with activities of daily living (ADL's) of dressing, personal hygiene, and bathing.

R1's care plan revised 7/12/21, revealed R1 had impaired cognition, function, thought process and required extensive assistance with personal hygiene, dressing and bathing. R1's care plan lacked direction for facial hair removal.

On 8/23/21, at 1:43 p.m. R1 was observed lying in bed, eyes closed, covered with a blanket from her feet to mid chest. R1's hands were rested on her abdomen above the blanket. R1 had several dozen four (4) to five (5) millimeters (mm) long, thick black coarse facial hairs along her upper lip, chin and jaw line. R1 had several six (6) to ten (10) mm long white wispy facial hairs along both corners of her mouth and chin.

On 8/24/21, at 8:50 a.m. R1 was observed seated in a wheelchair in the dining room at a squared table next to another resident. R1's hair was combed straight to her head and she continued to have several dozen 4 to 5 mm long, thick black coarse facial hairs along her upper lip, chin and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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MEADOW LANE RESTORATIVE CARE CENTEI	2209 UTAH AVENUE BENSON, MN 56215

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2 800	Continued From page 4 jaw line. R1 had several 6- 10 mm long white wispy facial hairs along both corners of her mouth and chin. On 8/25/21, at 8:24 a.m. R1 was observed seated in a wheelchair in her room, her eyes were closed, head was tilted back and her mouth was open. R1 continued to have several dozen 4 to 5 mm long, thick black coarse facial hairs along her upper lip, chin and jaw line. R1 had several 6- 10 mm long white wispy facial hairs along both corners of her mouth and chin. At that time, nursing assistant (NA)-E confirmed R1's facial hair and indicated she did not have a razor to remove her facial hair. On 8/25/21, at 8:30 a.m. NA-E stated she had assisted R1 with morning cares and had not removed R1's facial hair. NA-E indicated R1 did not have a razor to remove the facial hair and further indicated she would not have had time that morning to shave R1 since they were short staffed that morning. NA-E indicated she felt she was not able to provide R1 with standard cares due to insufficient staffing. NA-E indicated that morning an NA did not show up for the day shift and a NA from the night shift had stayed over that was not familiar with morning cares. On 8/25/21, at 10:21 a.m. trained medication aid (TMA)-A indicated R1 was dependent on staff for all of her ADL's and felt R1 was not able to verbalized her needs. TMA-A stated R1's facial hair should have been removed as needed and was not aware if R1 had a razor. TMA-A indicated she felt the NA's did not have time for routine cares, such as shaving, routinely due to lack of sufficient staff. TMA-A stated she would help on the floor as she was able between medication pass and when there were call ins. She indicated	2 800		

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the facility had been using pool staff for the past few months which had been helpful. TMA-A stated this past week, they had a call in approximately daily and had not been able to find replacements.

R18

R18's quarterly Minimum Data Set (MDS) dated 7/21/21, indicated R18 had diagnoses of chronic obstructive pulmonary disease, arthritis, anxiety and was severely cognitively impaired. The MDS indicated R18 was independent with bed mobility, transfers, dressing, toileting, eating and personal hygiene.

R18's care plan revised on 3/23/20, indicated R18 had a physical functioning deficit related to self care impairment and mobility impairment. The care plan indicated R18 required assistance from staff for set up, assist as needed and assist of one for shower for personal hygiene.

During observations on 8/23/21, at 2:38 p.m. R18 was walking around the nursing home independently with her walker. R18's hair was noted to be uncombed, and her hair was pasted to the back of her head and to the right side of her head. R18's hair was also sticking straight up on the back side of her head and the right side of her head.

During observations on 8/24/2,1 at 9:41 a.m. R18 was standing up at the nurses station with her walker talking to the trained medication aid (TMA)-A and hair was uncombed, pasted to the back and left side of her head. R18's hair was sticking straight up on the left and back of her head.

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2 800	Continued From page 6 During observations on 8/25/21, at 10:38 a.m., R18 walked down the hallway independently with her walker and sat down in a chair in the main entrance area. R18's hair was uncombed, pasted to the back and left side of her head. R18's hair was sticking straight up on the left and back of her head. During observations on 8/26/21, at 11:13 a.m. R18 walked down the hallway independently with her walker and R18's hair was uncombed and hair sticking straight up all over. On 8/26/21, at 11:11 a.m. nursing assistant (NA)-A indicated she worked as a casual NA-A and was not familiar with R18's needs. She stated she had access to resident care guides which were stored at the nurses station in a binder. NA-A attempted to retrieve the binder, and was unable to locate it at the nurses station. NA-A indicated that day she had been pulled from medical records to work on the floor due to a call in. NA-A located R18's plan of care in the facility's electronic medical record (MR) system, and indicated R18 required staff assistance with ADL's. NA-A did not identify why R18 was not assisted with grooming that morning. R11 R11's annual MDS dated 6/11/21, indicated R11 had diagnoses which included seizure disorder, depression, muscle weakness and was severely cognitively impaired. The MDS indicated R11 was independent with bed mobility, transfers, dressing, toileting, eating and personal hygiene. R11's care plan revised on 2/10/21, indicated R11 had ADL self care performance deficit related to confusion and impaired balance. The care plan	2 800		

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2 800	Continued From page 7 indicated R11 required limited assistance from staff for dressing and personal hygiene. During observations on 8/23/21, at 4:53 p.m. R11 was seated in the chair in her room, wore a white turtle neck with blue snow flakes and a pair of blue shoes. R11's shirt had several soiled white/brown spots on the chest area and her shoes had several soiled white spots on the top of the shoes. - at 5:08 p.m. R11 walked independently in the hallway with her walker and back to her room. R11 wore a light blue pair of denim jeans with light brown colored stain noted on the inside of her legs, half way to her knees and over her entire buttocks area. The outer ring of the stain was darker brown in color and no odor was noted. R11 sat down in her chair in her room independently, while visiting with her, multiple flies buzzed around and landed on her and her clothing. R11 had several white long hairs on her chin and neck area measuring approximately 1/4 to 1/2 inch long. - at 6:42 p.m. R11 walked down the hallway independently with her walker, continued to wear the same soiled shirt and pants and R11's facial hair remained the same. During observations on 8/24/21, at 1:09 p.m. R11 was seated out in the activity room playing bingo with several other residents. R11 wore the same clothing from yesterday, her shirt had several soiled red/brown spots on her chest and belly area and facial hair remained the same. During observations on 8/25/21, at 11:59 a.m. R11 was seated in the dining room and continued to wear the same shirt from Monday, 8/23/21,	2 800		

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with a pair of yellow pants. R11's shirt continued to be soiled and stained with red/brown spots on her chest and belly area and R11's facial hair remained the same.

During observations on 8/26/21, at 12:20 p.m. R11 walked independently with her walker to the dining room area, continued to wear the same shirt from Monday 8/23/21, with the same pair of yellow pants. R11's shirt continued to be soiled and stained with red/brown spots on her chest and belly area and R11's facial hair remained the same.

R11 was observed to wear the same soiled shirt for four days and the same soiled pants for two days and had not been shaven in four days.

On 8/26/21, at 11:21 a.m. NA-A indicated she worked as an NA on a causal basis and was not familiar with R11's needs. She stated she had access to resident care guides which were stored at the nurses station in a binder. NA-A attempted to retrieve the binder, and was unable to locate it at the nurses station. NA-A indicated that day she had been pulled from medical records to work on the floor due to a call in. NA-A located R11's plan of care in the facility's electronic MR system, and indicated R11 required staff assistance with ADL's. NA-A did not identify why R11 was not assisted with grooming that morning.

R14

R14's quarterly MDS dated 7/13/21, indicated R14 had diagnoses which included depression, poly-arthritis, lymphedema (swelling of the legs) and was severely cognitively impaired. The MDS indicated R14 required two staff assistance with bed mobility, transfers, dressing, toileting, one

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2 800	Continued From page 9 staff for personal hygiene and supervision with eating. R14's care plan revised on 2/9/21, indicated R14 had physical functioning deficit related to mobility impairment. The care plan indicated R14 required one staff to assist with oral care and personal hygiene. During observations on 8/23/21, at 5:05 p.m. R14 was noted to have her hair uncombed, matted to the back of her head and sticking straight up on the back of her head. R14 had several long white chin hairs approximately 1/4 inch long. During observations on 8/24/21, at 8:18 a.m. R14 was seated in her wheel chair in her room and R14 continued to have several long white chin hairs approximately 1/4 inch long. During observations on 8/25/21, at 8:17 a.m. R14 was in bed on her back, NA-B entered her room, began to make R14's room mates bed, straightened up the room, collected the garbage and soiled linen. NA-B left R14's room with the garbage and soiled linen and walked down the hallway on the other end of the nursing home. NA-B entered the utility room, placed the linen and garbage in the proper bins and washed her hands. During an observation on 8/25/21, at 9:03 a.m. NA-B wheeled R14 out of her room, down the hallway towards the dining room. R14 continued to have several long white chin hairs approximately 1/4 inch long. NA-B was not observed to offer or provide oral cares or shaving to R14. On 8/25/21, at 9:14 a.m. NA-B stated R14	2 800		

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required assistance with all of her cares. NA-B indicated she forgot to provide R14 with oral cares and shaving that morning, stated she had stayed over from the night shift due the facility was short staffed. She stated she was not familiar with morning care routines and indicated she had difficulty finding supplies to provide cares with, such as oral cares and shaving.

R6

R6's quarterly MDS dated 5/27/21, indicated R6 had diagnoses which included diabetes mellitus, anxiety, schizophrenia and was cognitively intact. The MDS indicated R6 required extensive assistance of one staff with bed mobility, toileting, personal hygiene, limited assistance with dressing and supervision with transfers.

R6's care plan revised on 8/25/21, indicated R6 had ADL self care performance deficit related to aggressive behavior, confusion, impaired balance and pain. The care plan identified R14 required one to two staff assistance with dressing, personal hygiene and toileting.

During observations on 8/25/21, 7:33 a.m. R6 was seated in her room in a wheelchair and a strong, pungent, heavy odor of urine was permeating from her room. R6's bed and bedding were completely saturated with urine and a strong odor of urine was noted. Clinical Manager (CM)-A and NA-E removed R6's incontinent brief which was completely saturated with urine and had a streak of bowel in it. R6's buttocks were wet, pink, puckered and wrinkled, with markings noted from the soiled brief. CM-A and NA-E proceeded to assist R6 with peri-cares and transferred R6 back into the wheelchair. R6 refused the rest of her morning cares and

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wheeled herself out of the room. NA-E indicated she had not received report that morning from the night shift and stated she never received report. Both NA-E and CM-A stated they were not aware when the last time R6 had been checked or changed or offered assistance with toileting.

- at 7:41 a.m. CM-A reviewed R6's MR, to see the last time R6 had been checked and changed. CM-A reported R6 had last been checked and changed at 3:40 a.m. and was incontinent at that time of urine.

R6's MR lacked any further documentation when R6 had last been checked and changed since 3:40 a.m..

R21

R21's significant change Minimum Data Set (MDS) dated 8/4/21, identified R21 had significant cognitive impairment and diagnoses which included: Alzheimer's disease, muscle weakness and thyroid disorder. R21's MDS indicated R21 required total assistance with transfers and extensive assistance with bed mobility, dressing and personal hygiene.

R21's care plan revised 7/12/21, identified R21 required extensive assistance with dressing, personal hygiene and R22 did not use the toilet, however was expected to be checked and changed periodically. R21's care plan identified R21 had impaired thought processes related to Alzheimer's disease. R21's care plan did not include specific instructions for facial hair removal.

On 8/23/21, at 2:31 p.m. R21 was observed seated in her wheelchair in her room. R21 had

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multiple long wispy white hairs on her chin and neck ranging from 1/8 inch with 4-5 hairs up to 3/4 inches long.

On 8/24/21, at 8:13 a.m. R21 was observed seated in her wheelchair in her room. R21 continued to have multiple facial hairs, white in color on her chin and neck, ranging from 1/8 inch long to 3/4 inch long.

On 8/25/21, at 11:45 a.m. R21 was observed seated in her wheelchair in the activity room with multiple other residents and staff members present. R21 continued to have facial hairs present as before, with multiple white wispy hairs up to 3/4 inch long on her chin and neck.

On 8/25/21, at 12:09 a.m. nursing assistant (NA)-E indicated she did not usually assist R21 with cares however had helped another staff member with R21's cares that morning.

R22

R22's significant change Minimum Data Set (MDS) dated 8/6/21, identified R22 had significant cognitive impairment and diagnoses which included: dementia, arthritis and hypertension (high blood pressure). R22's MDS further indicated R22 required extensive assistance with bed mobility, dressing, and personal hygiene.

R22's care plan revised 8/13/21, identified R22 had an activities of daily living (ADL) self-care performance deficit related to advanced dementia and limited mobility. R22's care plan interventions included extensive assistance of one staff for dressing, personal hygiene and oral care.

On 8/25/21, at 7:36 a.m. to 8:16 a.m. NA-B

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assisted R22 with morning cares, then assisted in her wheelchair out into the hallway after the cares were completed. During the observation, NA-B had not completed oral cares for R22.

On 8/25/21, at 9:37 a.m. during an interview, NA-B indicated her typical shift was working the night shift, 10:30 p.m. to 6:00 a.m., however within the last few weeks the facility had direct care staff calling in sick or just not showing up for their morning shifts. NA-B stated upon shift start, several residents were routinely saturated with urine and would require complete bed changes, which included R1, R6 and several other residents. NA-B indicated she felt the facility had been struggling with staffing for several months, had improved some when pool staff came in a couple of months ago and had been worsening again the last several weeks. She indicated when the facility had a call in or a no show for the morning shift, either someone from the night shift would stay or the day shift would work with only one NA. NA-B indicated the usual staffing patterns would include at least two NA's on each shift. She stated there had been several times within the last few months when she had to work alone at night and other NA's had worked alone on the day and evening shifts. NA-B stated this occurred most recently as the week prior and indicated she was the only NA scheduled for that night. NA-B indicated when she worked alone, it was expected she would provide care for residents who were care planned for two assist for repositioning, transfers, or checking and changing which included R16, R4, and R9. NA-B stated some of the nurses would help with resident cares and some would not and felt the only way residents would receive needed cares was for her to complete them herself. NA-B indicated she had spoken with facility

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administration and the director of nursing (DON) as recently as that day regarding concerns with sufficient staffing and had been informed the facility was working on a solution.

On 8/25/21, at 10:06 a.m. during a follow up interview, NA-B stated she typically did not perform R22's morning cares and was unfamiliar with her morning routine. NA-B stated no, she had not completed oral cares for R22 that morning, but indicated her usual practice would be to complete oral cares. NA-B indicated she had stayed over from the night shift that morning due to a no call no show.

On 8/24/21, at 1:32 p.m. during an interview NA-C indicated the facility usually had two NA's and two nurses each shift. NA-C indicated within the last few weeks, there had been call-ins, holes in the schedule and they would end up working short nursing assistants. NA-C stated almost daily, when they started their shift, residents would be soaked with urinary incontinence and felt the prior shift was not able to keep up routine cares with one NA. NA-C stated they would not take a break during their eight hour shift, as there would be no one to answer resident call lights. NA-C indicated they made sure residents were repositioned but when they were short staffed they would not be able to give residents baths and cares and essential cares would be provided, such as repositioning and toileting. NA-C indicated shaving, showering and hair care would not generally be included in essential cares. NA-C indicated the charge nurse and DON were aware of the staffing concerns and as recently as that day, had indicated they were working on it.

On 8/24/21, at 2:32 p.m. during an interview, NA-G stated the usual staffing was for two NA's

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on each shift and two nurses. NA-G indicated there were several times an NA had called in and they would be responsible for working the floor alone. NA-G stated the nurses would help as they were able, but oftentimes they were responsible for getting residents up for meals and all routine cares. NA-G indicated this occurred as recently as that week and the week prior. NA-G stated she felt residents did not receive quality of care during times when they were short staffed, however felt they did they best they could. NA-G stated the facility had pool staff come in several months ago, which had helped though call-ins still occurred, usually with the NA's. NA-G indicated they had reported to the DON and charge nurse concerns with staffing as recently as that day and had been told the facility was working on it.

On 8/25/21, at 12:39 p.m. the facility administrator stated the facility schedule was developed by herself and the DON and stated they were working through significant process changes with staffing currently. The administrator indicated the facility had a high staff turnover within the last few months, with several long term staff having been let go and shifts in management/leadership. She indicated the facility was currently using pool agency staff and had been using the service for the past few months. The administrator stated they had moved all of their board and care residents up to one wing of the skilled nursing side while renovations took place in the board and care, which also helped to consolidate the staff. She indicated within the last week or so, the facility has had an increase in staff not coming in for their shifts and call ins. She stated the facility had recently implemented a staffing coordinator who was responsible for data entry and posting/staff notification of open shifts. The administrator indicated she was aware of the

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current weeks staffing shortages and had replaced the open shifts with licensed staff and NA's from other shifts.

On 8/26/21, at 10:21 a.m. during an interview, licensed practical nurse (LPN)-A indicated that day an NA had called in for the day shift, therefore the clinical manager had helped on the floor in the morning until one of the evening NA's arrived early. LPN-A stated this occurred almost daily, the prior day the facility had a no call no show NA and that had been a problem off and on the last few months. LPN-A indicated most of the time, the facility was able to mandate an NA to stay from the previous shift when there was a call in, though there were occurrences when there was only one NA from nights and that NA had also worked the evening shift. He indicated on those days, he felt residents would not receive the quality of care they would like and may not have received cares or medications timely. LPN-A stated he had received no complaints from residents or family members regarding lack of sufficient staffing however staff had voiced concerns about resident care due to lack of staff, as recently as that day. LPN-A indicated he was able to help answer call lights and assist with cares at times however he was expected to administer medications in a timely manner as well. LPN-A stated he had voiced concerns to the facility DON and assistant director of nursing (ADON) as recently as the day prior regarding lack of sufficient staff on the day shift and indicated they had promised to resolve the issue.

On 8/26/21, at 1:37 p.m. during an interview NA-F indicated the facility's usual staffing pattern for NA's was two per shift and that day one of the NA's had not shown up for her shift. NA-F stated that occurred weekly and the facility routinely

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scrambled to find staff to piece a shift together. NA-F indicated there had been several occasions where upon starting her shift there had been only one NA on the prior shift and several residents had appeared to have not gotten out of bed at all including R1. NA-F stated it had occurred as recently as the day prior. NA-F stated she felt within the last few months the facility routinely did not have sufficient staff to provide resident cares in a timely manner. NA-F indicated as recently as that day, they had spoken with the facility administrator and DON regarding staff routinely calling in for shifts and/or not showing up at all. NA-F indicated the facility management had indicated they were aware of the issue and were working to resolve it.

On 8/26/21, at 2:01 p.m. during an interview, NA-E indicated the NA that was scheduled to work with her that day during the day shift had not shown up for work and the night NA had stayed to help. NA-E indicated this occurred weekly, almost every time she worked. NA-E stated there were times when an NA did not come in for the day shift, the facility was unable to replace the NA then the facility had one of the charge nurses work the floor. NA-E indicated when she arrived for work in the morning, several residents including R6, R9, R16 and R1 were routinely wet and required complete bed changes. NA-E stated she felt it occurred when there was only one NA on the night shift. She indicated the usual staffing patterns for NA's was two per shift, however she stated more frequently they only had one NA during the nights. NA-E stated she spoke to the DON and administration regarding staffing as recently as that day and had been told "things will start looking up soon."

On 8/26/21, at 3:15 p.m. the facility activity

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director (AD) stated she had been asked to work the floor that day and on prior days when the facility was short staffed. She indicated she was not routinely scheduled on the floor, though had maintained her NA certification so she was able to help when needed.

On 8/27/21, at 9:53 a.m. the clinical manager (CM)-A indicated the facility had frequent ill calls/ no shows for direct care staff or NA's routinely and was responsible for filling the shift and assisting with cares on the floor. CM-A stated she worked the floor at a minimum of weekly and was concerned for the scheduled NA's who were required to work alone. CM-A indicated she had not received any complaints from residents or family members regarding staffing however several staff members voiced concerns that residents cares were not being routinely provided such as incontinence cares, grooming, oral cares and bathing. She stated oftentimes the facility would piece shifts, for example if a day NA did not show up for work, such as the day prior, the night aid would stay and they would try to get an evening NA to come in early, or find one to pick up the whole shift. CM-A stated at times there was only one NA on nights who had already worked the evening shift and would not be able to stay for the day shift, then the CM was expected to help on the floor. CM-A indicated she spoke to the facility DON as recently as the day prior regarding lack of sufficient staffing and had been told they were working on it.

On 8/27/21, at 10:13 a.m. during a follow up interview, the AD stated she helped out on the floor approximately a few times a week at varying times due to lack of direct care staff. She indicated she felt the facility administrator and DON had been doing all they could to hire new

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2 800	Continued From page 19 staff and they continued to use agency pool staff to help meet resident needs. On 8/27/21, at 11:46 a.m. during a joint interview with the facility administrator and DON, the administrator stated they were aware of the facility staffing concerns and were currently in the process of hiring direct care staff. The DON indicated she felt the facility's staffing had overall improved within the last few months, though indicated this past week staffing had ben a challenge with call ins and unfilled holes in the schedule. The administrator indicated the facility had implemented daily charge nurses who were responsible for the daily work flow which included staffing and were responsible to help on the floor in the event of a call in or no show. The administrator stated at those times, the charge nurse was also responsible for attempting to fill the shift. The administrator indicated in the last several months the facility had several direct care staff hired, they went through some orientation and then never came back. She indicated the facility was currently hiring for several NA's positions and had hiring bonuses and incentives in place for for staff who picked up extra shifts. The DON stated she felt now that the facility had a management/leadership team established with clinical managers, charge nurses, ADON the overall workflow would improve. She indicated she planned to have nursing leadership on the floor to ensure resident cares were completed routinely. The current staffing pattern was identified: - day shift; one licensed staff were scheduled for 12 hour shifts 5:00 a.m. to 5:00 p.m., a TMA from 6:00 a.m. to 2:00 p.m. and two NA's from 5:30 a.m. to 2:00 p.m., goal with full census would be three NA's.	2 800		

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2 800	Continued From page 20 - evening; TMA 2:00 p.m. to 10:30 p.m. (or licensed nurse) and two NA's from 1:30 p.m. to 10:00 p.m., goal with full census would be three NA's. - nights; licensed nurse 5:00 p.m. to 5:00 a.m. and two NA's from 10:00 p.m. to 6:30 a.m. Both the facility administrator and the DON confirmed the facility did not routinely have the identified required staff on each shift available for resident cares during the week of survey, though both stated they felt it was a fluke and staffing had been improving within the last few months. On 8/27/21, at 1:55 p.m. the staffing coordinator stated he had just started the role of staffing coordinator, was provided the staffing data from the facility administrator and DON, such as staffing pattern and developed the schedule for the month. The staffing coordinator indicated he posted the openings for the month for staff to pick up. He indicated he was not responsible for filling open shifts caused by a call in or a no show, and indicated it was the charge nurses responsibility to find a replacement in those situations. Review of the facility staffing schedule from 8/17/21, to 8/27/21, identified the following unfilled shifts: -8/22/21, revealed unfilled 5:30 a.m. to 2:00 p.m. NA shift. -8/25/21, revealed unfilled 1:30 p.m. to 10:00 p.m. NA shift. Review of the facility daily schedule for the week of survey 8/17/21, to 8/27/21, identified the	2 800		

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2 800	Continued From page 21 following unfilled shifts/open shifts: -8/17/21, revealed unfilled 10:00 p.m. to 6:30 a.m. NA shift -8/20/21, revealed unfilled 10:00 p.m. to 6:30 a.m. NA shift -8/21/21, revealed unfilled 6:00 a.m. to 2:00 p.m. TMA shift -8/22/21, revealed unfilled 6:00 a.m. to 2:00 p.m. TMA shift -8/23/21, revealed unfilled 10:00 p.m. to 6:30 a.m. NA shift -8/24/21, revealed unfilled 10:00 p.m. to 6:30 a.m. NA shift -8/25.21, revealed call in NA on 5:30 a.m. to 2:00 p.m., one night NA stayed from previous shift, unfilled 1:30 p.m. to 10:00 p.m. NA shift and a 10:00 p.m. to 6:30 a.m. NA shift. -8/26/21, revealed call in NA on 5:30 a.m. to 2:00 p.m., CM was pulled to the floor, and evening NA in at 10:00 a.m., unfilled 10:00 p.m. to 6:30 a.m. NA shift. -8/27/21, revealed unfilled 5:30 a.m. to 2:00 p.m. NA shift, one night NA stayed from previous shift. Review of Meadow Lane Restorative Care Center facility assessment updated 7/25/21, identified the facility was licensed for 37 skilled nursing beds, 19 board and care beds, for a total of 56 beds, had an average daily census of 34. The facility assessment identified the following staffing plan:	2 800		

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2 800	Continued From page 22 -day shift, two licensed nurses, one for eight hours and one for six and a half hours, TMA for eight hours and three NA's for eight hours each. -evening shift, two licensed nurses for four hours each and one for eight hours, TMA for eight hours and three NA's for eight hours each. -night shift, one licensed nurse for eight hours and two NA's for eight hours each. SUGGESTED METHOD OF CORRECTION: Facility administration and the director of nursing could utilize employee, resident and family input to evaluate staffing patterns and identify times/ places where those staffing patterns could/should be adjusted and implement those adjustments in order to meet all resident needs in a timely manner. Facility policies and procedures for sufficient staffing could be reviewed/ revised. Pertinent employees could be retrained on those policies/ practices. Audit tools could be developed to observe for timely and complete care, meeting all resident needs as identified in their care plan. The facility's Quality Assessment & Assurance committee could review those findings and develop/ implement corrective actions for any patterns or root/cause determinations for on-going compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 800		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and	2 830		10/11/21

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2 830	Continued From page 23 custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to conduct comprehensive fall assessments to determine root cause, identify patterns of falls and effective interventions for 1 of 1 resident (R16) who had repeated falls. Further, the facility failed to routinely implement interventions to prevent further falls for 2 of 3 residents (R16 and R21) who had repeated falls in the facility and remained at high risk for falls. Findings include: R16's significant change of status (SCSA) Minimum Data Set (MDS) dated 7/15/21, identified R16 had diagnoses which included dementia, polymyalgia rheumatica (inflammatory disorder causing muscle pain and stiffness around the shoulders and hips) and psychosis. The MDS identified R1 had severe cognitive impairment and required extensive assistance with activities of daily living (ADL's) of bed mobility, transfers and toileting. The MDS indicated R16 had disorganized thinking, inattention, altered levels of consciousness and	2 830	"corrected"	

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delirium. The MDS identified R16 was unable to maintain her balance during transition without physical assistance and had one fall since the last MDS assessment.

R16's SCSA Care Area Assessment (CAA) dated 7/15/21, identified R16 had a significant change in her ability to perform her ADL's independently and required extensive assistance, had been referred to both occupational and physical therapies though R16 refused services. The CAA's revealed R16 had one in the last quarter, remained at risk for falls due to incontinence, impaired mobility and need for assistance with ADL's. The CAA listed fall interventions which included, gripper socks, keeping environment free of clutter and her call light was to be within reach.

Review of R16's resident fall risk assessment form dated 8/21/21, identified a check list type form that listed several headings and subsets of conditions/factors which had the potential to affect R16's fall risk. The checklist assessment form identified R16 had the following conditions/risk factors present: intermittent confusion, 1-2 falls in the last three months, 1-2 medications that had possible side effects which could increase risk for falls, and three or more predisposing diseases, circulatory, cognitive condition, etc. The form identified R16 had a score of 17, however the form did not identify or define what the score meant in relation to R16's fall risk.

R16's care plan revised 7/12/21, revealed R16 had cognitive impairment, was at risk for falls, required extensive assistance with ADL's and used a full body mechanical lift for transfer. The care plan listed various interventions for fall

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prevention which included: mat on the floor by R16's bed, gripper socks to be worn or non-skid footwear and directed staff to keep her room free of clutter and ensure her call light was within reach.

On 8/24/21, 9:07 a.m. during a telephone interview with R16's family member (FM)-C, he stated R16 had been declining overall in the last few months, had fallen a few days ago and had sustained a bump on her forehead. FM-C stated R16 had severe dementia, was not able to voice her needs or concerns and felt she was not able to remember to call for help when she needed to get out of bed. FM-C stated he had visited R16 the evening of 8/23/21, at approximately 8:00 p.m. During the half hour long visit, R16 had attempted to get out of bed by placing her legs/feet towards the floor and attempting to pull herself up with the grab bar. He indicated R16 was barefooted and he had notified staff of R16's attempts to get out of bed. FM-C stated staff was responsive to his request for help, had come into R16's room, placed her legs back into bed and reminded her to stay laying down. FM-C indicated he felt R16 would have fallen if she had been able to sit up on her own and stated he was not aware of what the facility was currently doing to decrease R16's risk for falls.

Review of R16's falls incident reports from 1/27/21, to 8/21/21, revealed the following:

- on 1/27/21, at 7:15 p.m. the incident report identified R16 had called for help and had been lowered to the ground by a trained medication aid (TMA) while transferring from toilet to the wheelchair. The report revealed R16 had indicated her legs had given out and she couldn't stand. The incident report revealed a check list

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type assessment with several areas to assess which included; injuries, pain, mental status at the time of the incident, post incident, predisposing environmental, physiological, and situational factors. The report revealed R16 was confused, had a gait imbalance, impaired memory and had been incontinent.

- on 1/29/21, a follow up note revealed therapy would screen resident to see if she would be a candidate and staff would offer to assist resident with laying down in the afternoon. The report lacked any analysis of the fall, current fall interventions, potential patterns and newly implemented interventions.

R16's medical record lacked any therapy evaluation following the fall on 1/27/21.

- on 6/25/21, at 11:34 p.m. the incident report identified R16 had been heard calling for help from her room and had been found on the floor near her bed. The note revealed R16 was independent with transfers at the time of the fall, had indicated she had tried to transfer herself from her bed to the wheelchair and fell. The note revealed R16 had one gripper stocking on and one bare foot. The report listed R16 was oriented to person, place, time, situation and revealed R16 was not able to walk, but was able to transfer to and from the toilet without assistance. The incident report revealed R16 likely slid out of bed, however the report lacked any analysis of R16's fall interventions, potential patterns or newly implemented interventions.

Review of R16's fall follow up note dated 6/27/21, identified R16 was alert, oriented, was able to make her needs known and had no complications from the fall in her room on 6/25/21.

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2 830	Continued From page 27 R16's medical record lacked a therapy evaluation following the fall on 6/25/21. -on 8/21/21, at 7:20 p.m. the incident report identified R16 had been found on the floor of her room lying on her right side by the doorway. The incident report revealed R16 was last seen at approximately 6:30 p.m. when she wheeled herself out of the dining room following the evening meal, to her and had been waiting for staff to help her get ready for bed. The report identified R16 was alert, confused and was not able to identify what had happened. The report revealed R16 had a bump on her forehead, ice was applied and neurological checks were started (assessment of neurological status to help determine possible brain impact from a head injury.) The report identified R16 was recently started on a new medication of Ativan (anti-anxiety) and had received a dose at 7:00 p.m. that day. The incident report lacked any analysis of R16's fall, interventions, potential patterns or newly implemented interventions. Review of R16's progress notes from 5/30/21, to 8/27/21, revealed the following: - on 6/26/21, a follow up fall note revealed R16 was alert, oriented and had no new injuries or complications from the fall on 6/25/21. The note revealed R16 had difficulties with moving from a lying to sitting position, with transfers and had been using her call light for assistance. The note revealed R16 needed a therapy evaluation. - on 6/28/21, a progress note revealed R16 was alert, oriented, had episodes of hallucinations and had not needed to call for help with transfers.	2 830		

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2 830	Continued From page 28 -on 6/29/21, a progress note revealed R16 had troubles transferring, could not pick her bottom more than a couple of inches from the chair. The note revealed a fax communication was sent to R16's primary provider for therapy evaluation. -on 7/1/21, a progress note revealed R16's primary physician had ordered a therapy evaluation for R16's difficulties with bed mobility and transfers. -on 7/2/21, a progress note revealed R16 continued having difficulty performing ADL's and needed assistance with transferring from her wheelchair to the toilet. -on 7/5/21, a progress note revealed R16 moved from the facility board and care to the skilled nursing side of the facility due to increased confusion and needing more assistance. -on 7/14/21, a social service note revealed R16's BIMS (test to assess cognition) had significantly declined from cognitively intact, to severe cognitive impairment. -on 7/15/21, a progress note revealed R16 was seen on a routine visit by her primary doctor for increased confusion and diarrhea. -on 7/28/21, a progress note revealed R16 was sent to the local emergency room for change of condition of lethargy, not able to transfer and was not answering questions. A later note revealed R16 was returned to the facility from the emergency room with a diagnosis of congestive heart failure and was ordered diuretic medication (medication used to help released excess fluid from the body)	2 830		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 29 -on 8/8/21, a progress note revealed R16 was sent to the local emergency room for lethargy and difficulty breathing. -on 8/9/21, a progress note revealed R16 returned to the facility and was expected to receive hospice services. -on 8/10/21, a progress note revealed R16 required total assistance of 1-2 staff for all cares. -on 8/19/21, a progress note revealed R16 was anxious, exit seeking, was seen by hospice and an anti-anxiety medication (Ativan) was ordered for twice daily and as needed for anxiety. -on 8/22/21, a progress note revealed R16 had a fall in her room on 8/21/21, at 7:20 p.m., R16 had a painful bump on her forehead and had required the use of oxygen. The note revealed R16 was checked on frequently. -on 8/23/21, a progress note revealed R16 had been calm, the bump to her forehead had resolved and she had no changes in her range of motion. A later note revealed R16 had been calm and was repositioned every two hours. R16's progress notes lacked any documentation R16 had been assessed by therapy or any recommendations by therapy following her fall on 1/27/21, and 6/25/21. On 8/23/21, at 2:35 p.m. R16 was observed lying on her back in a low bed, she had a grab bar affixed to the left side of her bed (faced the doorway,) her bare feet hung off of the lower end of the bed, towards the floor. R16 had a rug on the floor next to her bed towards the head of her bed. R16's bare feet hovered over laminate	2 830		

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flooring. At 2:36 p.m. R16 reached towards the grab bar with both her right and left hands and attempted to pull herself upwards while moving her bare feet towards the laminate flooring. R16 was unable to pull herself up, she began to rock back and forth in a momentum type motion and attempted to pull herself up with the assist bar. R16 was not able to pull herself up, she let go of the bar and moved her legs in and out of the bed again.

-at 2:38 p.m. R16 was observed lying in bed on her back in a low bed, at that time nursing assistant (NA)-G entered the room, lifted R16's barefooted feet into the bed, raised the head of her bed and left the room. R16 remained barefooted.

-at 2:46 p.m. R16 was observed lying in bed on her back, R16 then reached her left arm up and grabbed onto the grab bar, moved her legs over the side of the bed and attempted to sit up. R16 rocked back and forth several times. R16 moved her legs back into bed and let go of the grab bar.

-at 2:54 p.m. R16 was observed lying on her back, eyes were closed, blanket was off of her feet and remained around her waist. R16 moved her legs and bare feet off the bed, towards the flooring. She made no attempt to grab the bar on the side of her bed. R16 had a call light button on the right side of her upper body. She moved her feet back into bed.

-at 4:29 p.m. R16 was observed lying on her back in a low bed, her eyes were closed and call light was on. At that time, NA-G entered R16's room, picked up yellow gripper socks from the floor and placed on her bare feet. R16's eyes remained closed, though she moved her left arm towards

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the grab bar, swung her legs out of the bed, NA-G told R16, "you gotta stay in bed, it's okay." NA-G indicated R16 had remained in bed following a fall over the weekend and was on "comfort cares." NA-G indicated R16 had been up and about on her own a few weeks ago, and had recently moved to the skilled living side of the facility. NA-G proceeded to assist R16 with incontinent cares, placed R16's flat call light on her chest and left her room.

-at 5:55 p.m. R16 was observed lying in bed, on her back, moved her legs and bare feet out of bed towards the floor, took hold of the grab bar with her left hand and attempted to sit up. R16 was unable to sit up, let go of the bar and shut her eyes. At that time, NA-G entered R16's room, picked up the yellow gripper socks from the floor, indicated R16 was restless and stated she had told the nurse about R16's restlessness. NA-G left the room and R16's legs remained out of bed.

-at 5:59 p.m. R16 was observed lying in bed, reached her left arm up and her right arm over her chest, took hold of the grab bar and attempted to sit up, R16 fell back against the pillows and closed he eyes. Her legs/bare feet remained hanging off the side of her bed.

-at 6:05 p.m. R16 was observed lying in a low bed on her back, eyes were closed, and her legs hung over the side of the bed with her bare feet visible. At that time, NA-H entered R16's room, picked up her legs and placed them in bed and covered R16 with a pink blanket. R16 remained without gripper socks on.

-at 6:37 p.m. R16 was observed lying in a low bed on her back, eyes were closed, her body was

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2 830	Continued From page 32 covered with a sheet, a pink blanket covered her lower body. -at 7:10 p.m. R16 was observed lying in bed, she had a pillow tucked between her body and the grab bar, her bare feet were visible, call light was within reach. On 8/24/21, at 8:35 a.m. R16 was observed lying in a low bed, on her back, pillows were positioned on her right side, she had a blanket covering her legs and body up to her mid chest. R16's feet were exposed, no gripper socks were observed. -at 11:26 a.m. R16 was observed lying in bed on her back, pillows were positioned on the right and left sides of R16. Her eyes were closed, she was covered from her feet to her mid chest. -at 1:27 p.m. R6 was observed lying in bed on her back, her eyes were closed, covered from her feet to her mid chest, at that time NA-C entered her room, asked if she was alright, lifted up her blanket, looked at her feet which revealed yellow gripper socks and covered R16 back up. NA-C left R16's room. On 8/25/21, at 7:06 a.m. R16 was observed lying in bed on her back, covered with a sheet, eyes were closed, she had pillows placed on both her right and left sides and underneath her legs. R16 made no attempt to move her legs out of bed or to try to sit up. -at 9:05 a.m. R16 was observed lying in bed on her back, eyes were closed, pillows were placed on either side of her upper body, at that time trained medication aid (TMA)-A and hospice nurse entered R16's room. TMA-A and the hospice nurse removed the blanket from R16 and	2 830		

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proceeded to assist R16 with morning cares, positioned R16 on her right side with pillows. At that time, the hospice nurse indicated R16 had been kept in bed since her fall on 8/21/21, for comfort per facility report.

On 8/23/21, at 5:55 p.m. during an interview with NA-G, she stated R16 was totally dependent on staff for all of her ADL's and had been rapidly declining over the past couple of weeks. NA-G indicated R16 had a fall over the past weekend and had remained in bed since the fall. She indicated she was not aware if R16 had any injuries or if there were any changes with her plan of care other than keeping her in bed.

On 8/24/21, at 1:32 p.m. during an interview with NA-C, indicated R16 was totally dependent on staff for all of her needs. NA-C indicated R16 had recently fallen and had been in bed since then for her comfort. NA-C indicated R16 was not able to tell staff of her needs and indicated she needed routine cares of repositioning and checking and changing. NA-C indicated R16 would attempt to get out of bed at times, though felt she did not have the strength to get out of bed on her own anymore. NA-C further stated R16 had fall prevention interventions of a low bed, gripper socks and making sure her call light was by her.

On 8/25/21, at 7:47 a.m. during an interview the hospice nurse indicated she felt R16 remained at risk for falls and should have fall interventions in place, such as gripper socks should R16 try to get out of bed. However, the hospice nurse stated she did not feel R16 had the strength to get out of bed on her own in her current state.

On 8/25/21, at 11:45 a.m. the certified occupational therapy assistant (COTA) stated

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2 830	Continued From page 34 R16 was currently not receiving therapy and had not within the last few months. COTA stated R16 had been referred in the past, however she refused any treatment and likely evaluation. She stated she could not recall the last time R16 had been seen by therapies. On 8/26/21, at 10:21 a.m. during an interview with licensed practical nurse (LPN)-A, indicated R16 had been declining within the last couple weeks and had recently fallen in her room. LPN-A stated R16 had been in bed since the fall on the 8/21/21, did not appear to be in pain, but was lethargic and overall was not eating well. LPN-A indicated the night R16 had fallen, he was not able to recall what footwear R16 was wearing or if she had her call light within reach. LPN-A stated at the time of R16's fall, she was independent with transfers and mobility, though had been having weakness and was unable at times to transfer herself. LPN-A indicated following R16's fall on 8/21/21, frequent checks were done for the remainder of the shift. LPN-A was not sure what other interventions had been implemented following the fall. On 8/26/21, at 2:01 p.m. during an interview with NA-E, indicated R16 was totally dependent on staff for all of her ADL's. NA-E stated R16 had been independent approximately a month ago and had moved over from the board and care as she needed increased help with her cares. NA-E stated R16 had been in bed since her fall on 8/21/21, was not sure if it was for her comfort or because R16 could no longer hold herself up. NA-E indicated R16 had been observed trying to get out of bed that morning and was redirected to lay back down. NA-E stated she had told the nurse and the nurse had given something to R16 to help her relax and since she had not attempted	2 830		

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2 830	Continued From page 35 to get out of bed. NA-E stated R16 was supposed to wear gripper socks, have her bed in the low position and have a mat on the floor by her bed for fall prevention. On 8/26/21, at 2:34 during an interview with NA-F, indicated R16 was totally dependent on staff for all ADL's and had been rapidly declining in her overall condition in the last few weeks. NA-F stated R16 had fallen the past weekend and no longer was helped out of bed. NA-F indicated she had thought R16 was in bed for her comfort and overall she was not able to hold herself up anymore. She stated R16 still attempted to get out of bed, which occurred that morning, though was not able to get herself into a sitting position. NA-F indicated she did not feel R16 had the strength to make it out of bed. NA-F indicated R16 had fall interventions in place of gripper socks, low bed, mat on the floor by her bed and call light within reach. On 8/27/21, at 9:43 during an telephone interview clinical manager (CM)-A stated she had been back to work at the facility for several weeks off and on, and had not completed R16's post fall assessment. CM-A stated she would expect R16's fall to have been assessed for causative factors, review all falls to see if a pattern and to review current interventions and implement an immediate and longer term intervention with the interdisciplinary team (IDT) as appropriate. CM-A stated R16 had been in bed since her fall for comfort and her weakness. CM-A indicated she would expect R16 to wear gripper socks when in bed for safety, in case R16 was able to get herself into a sitting position. On 8/27/21, at 10:07 a.m. during a telephone interview with R16's primary physician, medical	2 830		

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doctor (MD)-A, she indicated R16 had been rapidly declining within the last few weeks and had been notified of R16's two falls since June. She indicated she had ordered a therapy evaluation following the fall in June, but did not feel R16 would be compliant with therapy based on previous attempts from therapy to work with R16. She indicated she would expect the facility to look at other interventions that R16 would have been complaints with, and felt R16 should have footwear in place that prevents slipping. She further stated she would expect the facility to complete a comprehensive assessment following R16's falls to help determine causative factors, evaluate current interventions and implemented appropriate fall interventions post fall.

R21

R21's significant change Minimum Data Set (MDS) dated 8/4/21, identified R21 had significant cognitive impairment and diagnoses which included Alzheimer's disease, muscle weakness and thyroid disorder. R21's MDS further identified R21 required total assistance with transfers, and extensive assistance with bed mobility, dressing and personal hygiene. R21's MDS identified R21's balance during surface to surface transfer was not steady, and unable to stabilize without human assistance. R21's MDS identified R21 had no falls since prior assessment.

R21's Care Area Assessment (CAA) dated 8/5/21, identified R21 was at risk for falls and had a history of falls since admission and was dependent on staff for all transfers with a full body lift for all transfers. R21's CAA identified R21 required extensive assistance from staff for all repositioning. R21's CAA indicated interventions

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included gripper socks and to proceed to R21's care plan.

R21's care plan revised 7/12/21, identified R21 required extensive assistance with dressing, personal hygiene and required extensive assistance with transfers using a full body lift for all transfers. R21's care plan identified R21 had impaired thought processes related to Alzheimer's disease. R21's care plan indicated R21 was at high risk for falls and the following interventions included: bedside mat during naps, ensuring R21 wore appropriate footwear no skid footwear when transferring or mobilizing in wheelchair and R21 was to be up in wheelchair during periods of wakefulness.

R21's kardex dated 8/27/21, identified interventions for safety included: ensure R21 wore appropriate footwear no skid footwear when transferring or mobilizing in wheelchair and R21 to be up in wheelchair during periods of wakefulness.

R21's Resident Fall Risk assessment dated 8/4/21, identified R21 was disorientated X 3 at all times, had 3 or more falls in the past 3 months and was wheelchair bound. R21's assessment score was 19, which was high risk for falls.

On 8/23/21, at 2:19 p.m. R21 was observed lying on her back, slightly onto her right side, covered with a sheet and blanket, with her feet hanging over the edge of he bed, trained medication aide (TMA)-B entered R21's room, with a glass of ice water, and assisted R21 to put her feet back onto the bed. R21's bed was in low position, had a concave mattress with a mat on the floor next to the bed. At 2:25 p.m. R21's feet were again out of the bed, eyes open, alert, informed TMA-B who

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was outside of R21's room. TMA-B asked R21 if she wanted to get up, or was uncomfortable and assisted R21 to put her feet back into bed. R21's response to TMA-B could not be heard. At 2:26 p.m. R21's eyes were open and her feet were touching the mat next to her bed and the head of her bed was slightly elevated. At 2:30 p.m. R21 was lying on her right side, her head resting on the pillow, covered with blanket and sheet and R21's feet were again noted to be out of the bed. R21 moved her left arm to her mouth and back in front of her face. At 2:34 p.m. nursing assistant (NA)-G entered R21's room, told her she was going to put her feet up, then quickly moved R21's feet to her bed, while R21 said "ow" and NA-G exited R21's room. At 2:41 p.m. R21's feet were on the floor and she was in a partial sitting position. NA-H entered the room and told R21 it was not time to get up. NA-H raised R21's bed up, told R21 he would come to get her when it was time to get up, pulled R21's sheet down, checked her brief, placed R21's bed back in place, raised up her head of bed slightly and lowered her bed back down. NA-H told R21 he would come back to check on her and instructed R21 to not attempt to get up on her own. At 2:54 p.m. R21's feet were wrapped up tightly in her blanket and sheet and were hanging from the side of the bed. R21's eyes were noted to be open and she was lying on her right side. NA-H exited a room across the hallway however did not look into R21's room. At 2:55 p.m. NA-G entered R21's room, asked if she could turn her again and put her feet back into the bed. R21 made a noise, NA-G told her to keep her feet up, asked her if it hurt and R21 said my legs. NA-G raised R21's head of bed up, the bottom of her bed slightly and exited the room. NA-G was not observed reporting R21's complaint of pain to nurse or wakefulness and feet out of bed after incident. At

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3:03 p.m. R21 moved her feet off of the bed, NA-H walked by R21's room twice and did not look into the room. NA-H was observed looking into R21's room again, said Oh, getting down again. At 3:05 p.m. NA-H entered R21's room and NA-H told R21 he was going to put her feet back into bed, assisted her to put feet back into bed, then he untangled her sheets from around her feet and legs. At 3:08 p.m. NA-H told R21 he would come check on her again then left the room. At 4:34 p.m. NA-H entered R21's room, with the mechanical lift and TMA-B. NA-H told surveyor they were getting R21 up for supper, then closed the door. At 4:39 p.m. R21 was sitting up in her wheelchair with her feet on the foot pedals, sitting in her room. R21 had no socks or shoes on, her feet had leg ace wraps, (elastic strips of cloth used for dressings and swelling of he legs) with her toes exposed.

ON 8/25/21, at 11:45 a.m. R21 was in the activity room, sitting in her wheelchair, no slipper socks or shoes on, with toes exposed and feet wrapped with ace wrap.

On 8/25/21, at 12:09 a.m. NA-E indicated she usually did not take care of R21 and was not aware if she had any falls. NA-E stated R21 had a mat by her bed, but did not wear any socks, just her leg wraps.

On 8/26/21, at 10:37 a.m. NA-F stated she did not usually work with R21, but stated she does put her feet out, and NA-F said she would check to make sure she was dry. NA-F stated if R21 kept putting her feet out of he bed, she would get her up at that time.

On 8/26/21, at 12:54 p.m. during a phone interview, NA-H stated yes, R21 kept getting out

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of bed on 8/23/21. NA-H said he kept putting her feet back into bed, and no, he did not get her up at that time. NA-H indicated he usually worked the night shift, and he would just straighten R21 out in bed, and his usual intervention did not include getting her up from her bed when she was awake. NA-H said R21 was to have gripper socks on, before he got her out of bed. NA-H stated on 8/23/21, R21's socks would fall off her feet while she was in bed and was the reason they were not on after she was up in her wheelchair. NA-H stated he had checked R21 for incontinence at one time 8/23/21, when R21 had her feet out of the bed but had not gotten her up at that time.

On 8/27/21, at 11:47 a.m. NA-G stated she remembered R21 attempted to get out of bed on 8/23/21. NA-G said R21 kept getting up, so they would readjust her and check on her more often. NA-G indicated she was not aware that one of R21's interventions included to get her up when she was awake. NA-G said she was aware R21 was to have gripper socks on over her wraps, but did not realize R21 did not have them on.

On 8/26/21, at 2:42 p.m. licensed practical nurse (LPN)-A stated R21's interventions for falls included her bed always low, check on her often and keep her door open. LPN-A sated R21 was also to have slipper socks on, but R21 did not walk. LPN-A stated if R21 kept trying to get up out of bed, they should get R21 up, and if she kept putting her feet out of the bed, R21 should be checked for pain, discomfort or incontinence and should be repositioned. LPN-A stated for safety reasons following R21's care plan he would get R21 up, no leave her in bed, because she could roll out of the bed.

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2 830	Continued From page 41 On 8/27/21, at 10:29 a.m. during a phone interview, clinical manager (CM)-A indicated R21 often would hang her feet over the bed, floating in air. CM-A confirmed if R21 was awake, and attempted to get up, they should address R21's needs, get her up and not tell R21 to stay in bed. CM-A confirmed she would expect R21 to have slipper socks when she was up in the wheelchair also. On 8/27/21, at 1:29 p.m. director of nursing (DON) reviewed R21's care plan in her electronic medical record. DON confirmed R21's care plan stated R21 was to be up in wheelchair during periods of wakefulness and R21 was to have gripper socks on when she was up in her wheelchair. DON stated she expected staff to follow R21's care plan. DON stated she was unaware if R21 had a history of falls, but indicated she believed R21 has had no falls since she began at the facility. R21's facility incident report identified R21 was observed lying on the floor next to her bed in low position on 3/27/21, at 11:00 a.m., no injuries noted at time of incident. Interdisciplinary team (IDT) reviewed the fall dated 3/30/21, and included a new intervention for a fall mat next to bed while occupied. R21's facility incident report identified R21 was found by staff lying on the fall protection mattress on 3/30/21, at 3:32 p.m. , no injuries noted at time of incident. IDT review of fall dated 3/31/21, included an intervention of a concave mattress to assist with fall risk, with plan to get R21 twice a day for activities. Also the incident report intervention implemented a wake/sleep schedule. R21's facility incident report identified R21 was	2 830		

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2 830	Continued From page 42 found by staff sitting on floor in front of bed on 4/7/21, at 9:44 p.m. , no injuries noted at time of incident. Notes on report dated 4/26/21, identified intervention for 3 day trial of Tylenol (pain medication) to assess for neuropathy pain. Noted resident likes to have feet hanging over bed. R21's primary physician's progress note dated 4/1/21, identified R21 continued to have frequent falls out of bed, and had been switched to a concave mattress to try to help with that. R21's primary physician's progress note dated 4/15/21, identified R21 had 5 falls in the past 30 days. R21's falls were at different times with no apparent pattern. R21's physician note further identified the facility had tried multiple prevention methods and were trying a concave mattress as multiple falls occurred when R21 rolled out of bed. On 8/27/21, at 10:34 a.m. during an interview, the director of nursing (DON) confirmed R16's care plan, fall prevention interventions included mat to the floor, call light within reach, keep environment free of clutter and directed staff to ensure gripper socks/non-skid footwear was worn. The DON stated since R16 was no longer getting out of bed, she would expect gripper socks to be worn. She indicated with R16's current state, she did not feel R16 had the strength to get out of bed on her own and felt R16 may have been uncomfortable vs wanting to get up and out of bed. The DON stated she would have expected staff to ask R16 what she was trying to do when she attempted to get out of bed. R16's fall incidents were reviewed with the DON, she confirmed R16's medical record lacked a comprehensive analysis of R16's falls on 1/27/21,	2 830		

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2 830	Continued From page 43 6/25//21, and 8/21/21, further R16's medical record lacked any documentation R16 was followed up by therapy after her fall on 6/25/21. The facility's physical therapist was not available for interview. A facility policy titled, Falls and Fall Risk Managing, dated 3/17/21, identified the facility staff would identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling. The policy directed facility staff to implement resident centered fall prevention plan and monitoring for subsequent falls and fall risk. The policy lacked information on a comprehensive fall assessment. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could review policies and procedures, train staff, and implement measures to prevent and/or minimize the risk for falls for residents at risk to assure they are receiving the necessary treatment/services. The director of nursing or designee, could conduct random audits of the delivery of care; to ensure appropriate care and services are implemented; to better ensure implementation of treatment. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		
2 920	MN Rule 4658.0525 Subp. 6 B Rehab - ADLs Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that: B. a resident who is unable to carry out	2 920		10/11/21

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2 920	Continued From page 44 activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to provide assistance with routine grooming which included facial hair removal and oral cares for 7 of 7 residents (R18, R11, R14, R6, R1, R21, R22) who were dependent on facility staff for activities of daily living (ADL's). Further, the facility failed to provide routine incontinence cares and changing of soiled clothing for 1 of 1 resident (R6) reviewed for routine checking and changing cares. Findings include: R18 R18's quarterly Minimum Data Set (MDS) dated 7/21/21, identified R18 had severe cognitive impairment and had diagnoses which included: chronic obstructive pulmonary disease, arthritis and anxiety. The MDS indicated R18 was independent with bed mobility, transfers, dressing, toileting, eating and personal hygiene. R18's care plan revised on 3/23/20, indicated R18 had physical functioning deficit related to self care impairment and mobility impairment. The care plan indicated R18 required assistance from staff for set up, assist as needed and assist of one for shower and personal hygiene. During observations on 8/23/21, at 2:38 p.m. R18 was walking around the nursing home independently with her walker. R18's hair was	2 920	"corrected"	

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2 920	Continued From page 45	2 920		

noted to be uncombed and her hair was pasted to the back of her head and to the right side of her head. R18's hair was also sticking straight up on the back side of her head and the right side of her head.
- at 4:32 p.m. R18 was seated on the edge of her bed and her hair continued to be uncombed.
- at 4:34 p.m. R18 walked out of her room independently with her walker and her hair continued to be uncombed.
- 5:26 p.m. R18 walked into the dining room area independently with her walker and her hair continued to be uncombed.

During observations on 8/24/21, at 9:41 a.m. R18 was standing up at the nurses station with her walker talking to the trained medication aid (TMA)-A and her hair was uncombed, pasted to the back and left side of her head. R18's hair was sticking straight up on the left and back of her head.

During observations on 8/25/21, at 10:38 a.m. R18 walked down the hallway independently with her walker and sat down in a chair in the main entrance area. R18's hair was uncombed, pasted to the back and left side of her head. R18's hair was sticking straight up on the left and the back of her head.
- 11:39 a.m. R18 was seated in the dining room area drinking pop and her hair continued to be uncombed.

During observations on 8/26/21, at 11:13 a.m. R18 walked down the hallway independently with her walker and her hair was uncombed and sticking straight up all over.

On 8/26/21, at 11:11 a.m. nursing assistant (NA)-A confirmed R18 needed staff assistance

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2 920	Continued From page 46	2 920		

and verbal reminders to complete ADL's and personal hygiene tasks. NA-A indicated staff should have followed R18's care plan and should have ensured her personal hygiene tasks had been completed and her hair was combed.

On 8/26/21, at 2:07 p.m. the director of nursing (DON) confirmed the above findings and indicated staff should have been following the care plan. The DON indicated her expectations were for staff to ensure the residents were properly groomed and hair combed.

R11

R11's annual MDS dated 6/11/21, identified R11 had severe cognitive impairment and had diagnoses which included: seizure disorder, depression and muscle weakness. The MDS indicated R11 was independent with bed mobility, transfers, dressing, toileting, eating and personal hygiene.

R11's care plan revised on 2/10/21, indicated R11 had ADL self care performance deficit related to confusion and impaired balance. The care plan identified R11 required limited assistance from staff for dressing and personal hygiene.

During observations on 8/23/21, at 4:53 p.m. R11 was seated in the chair in her room. R11 was noted to be wearing a white turtle neck shirt with blue snow flakes and a pair of blue shoes. R11's shirt had several soiled white/brown spots on the chest area and her shoes had several soiled white spots on the top of the shoes.
- at 5:08 p.m. R11 walked independently in the hallway with her walker and back to her room. R11 wore a light blue pair of denim jeans and the

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2 920	Continued From page 47 inside of her legs, half way to her knees and her entire buttocks area had a light brown colored stain. The outer ring of the stain was darker brown in color and no odor was noted. R11 sat down in her chair in her room independently. Multiple flies flew around R11 and landed on her and her clothing. R11 had several white long hairs on her chin and neck area measuring approximately 1/4 to 1/2 inch long. - at 6:42 p.m. R11 walked down the hallway independently with her walker and continued to be wearing the same soiled shirt, pants and R11's facial hair remained unchanged. During observations on 8/24/21, at 1:09 p.m. R11 was seated in the activity room playing bingo with several other residents. R11 was noted to be wearing the same clothing from yesterday. R11's shirt had several soiled red/brown spots on her chest and belly area and facial hair remained the same. -at 1:34 p.m. R11 stood up up independently with her walker and walked around the nursing home. R11 continued to wear the same light blue pair of denim jeans and on the inside of her legs, half way to her knees and her entire buttocks area a light brown colored stain remained. The outer ring of the stain was darker brown in color and no odor was noted. - at 1:56 p.m. R11 was seated out in the activity area and her clothing remained unchanged. During observations on 8/25/21, at 11:59 a.m. R11 was seated in the dining room and continued to wear the same shirt from Monday and had a pair of yellow pants on. R11's shirt continued to be soiled and stained with red/brown spots on her chest and belly area and R11's facial hair remained unchanged.	2 920		

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2 920	Continued From page 48 During observations on 8/26/21, at 12:20 p.m. R11 walked independently with her walker to the dining room area. R11 continued to wear the same shirt from 8/23/21, and the same pair of yellow pants from 8/25/21. R11's shirt continued to be soiled and stained with red/brown spots on her chest and belly area and R11's facial hair remained. R11 continued to wear the same soiled shirt for four days and the same soiled pants for two days and had not been shaved in four days. On 8/26/21, at 11:21 a.m. NA-A confirmed R11 required staff assistance with ADL's, shaving and personal hygiene. NA-A indicated R11 needed verbal reminders to change her clothes and staff should have supervised her to ensure her clothes were neat and clean. NA-A indicated R11 had not refused cares and staff should have followed her care plan. On 8/26/21, at 2:07 p.m. DON confirmed the above findings and indicated R11 needed staff assistance with her ADL's. The DON indicated she expected staff to assist residents with shaving, grooming, personal hygiene, changing of their clothes and staff should have followed the care plan. R14 R14's quarterly MDS dated 7/13/21, indicated R14 had severe cognitive impairment had diagnoses which included: depression, poly-arthritis, lymphedema. The MDS indicated R14 required two staff assistance with bed mobility, transfers, dressing, toileting and one staff assistance with personal hygiene and supervision with eating. R14's care plan revised on 2/9/21, indicated R14 had physical functioning deficit related to mobility	2 920		

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impairment. The care plan indicated R14 required one staff to assist with oral care and personal hygiene.

During observations on 8/23/21, at 5:05 p.m. R14's hair uncombed, matted to the back of her head and sticking straight up on the back of her head. R14 had several long white chin hairs approximately 1/4 inch long or longer.
- at 5:45 p.m. R14 was seated in her wheel chair in the dining room area with several other residents. R14 hair remain uncombed and her facial hair remained the same.

During observations on 8/24/21, at 8:18 a.m. R14 was seated in her wheelchair in her room and continued to have several long white chin hairs approximately 1/4 inch long or longer.
- at 11:29 a.m. R14 was seated in her wheel chair in the activity room with several other resident and her hair continued to be matted to the back of her head and sticking straight up.
- at 1:07 p.m. R14 was seated in her wheel chair in the activity room with several other residents and her hair continued to be the same.
- at 2:22 p.m. R14 was in bed resting and R14 continued to have several long white chin hairs approximately 1/4 inch long.

During observations on 8/25/21, at 8:17 a.m. R14 was in bed on her back and NA-B entered her room and said good morning. NA-B removed R14's covers and unhooked R14's incontinent brief. NA-B washed R14's hands and face, tucked R14's brief on the left side and began to wash R14's peri area. NA-B asked R14 to roll to the right while she washed her buttocks area, removed the wet soiled brief and threw it in the garbage. NA-B placed a clean incontinent brief under R14, assisted her to roll to the left and

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applied the incontinent brief. NA-B walked to the closet and picked out clothes for R14.
- at 8:39 a.m. NA-B brought over the clothes and R14 chose what she wanted to wear. NA-B obtained R14's pants, donned the pants and applied ace wraps to her lower legs. NA-B placed slippers on R14's feet, removed her gown, applied deodorant and donned her shirt over her head. NA-B assisted R14 to roll to the left and to the right while straightening her clothes and placing the lift sling under her.
- at 8:52 a.m. NA-B went out into the hallway to ask for assistance and returned to the room. NA-B positioned the mechanical lift over R14 and hooked the sling to the lift while TMA-A entered the room. NA-B and TMA-A transferred R14 via mechanical lift from her bed to her wheel chair, unhooked the lift from the sling and TMA-A washed her hands and immediately left R14's room. NA-B applied peddles to R14's wheelchair, placed her feet on the peddles, combed her hair and placed her glasses on her face. NA-B collected the soiled linen, washed her hands, put R14's supplies away and washed her hands again at the sink. NA-B grabbed a blanket and covered R14's legs with it.
- at 9:03 a.m. NA-B wheeled R14 out of her room area, down the hallway towards the dining room. Several residents were seated in the dining room area. R14 continued to have several long white chin hairs approximately 1/4 inch long. NA-B was not observed to offer or attempt to provide R14 oral cares or assist her with shaving.
- at 9:36 a.m. R14 remained seated in the dining room area and continued to have several long white chin hairs approximately 1/4 inch long.

On 8/25/21, at 9:14 a.m., NA-B confirmed the above findings and indicated R14 required assistance with all ADL's. NA-B confirmed she

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2 920	Continued From page 51 had not offered or provided R14 oral cares or facial hair removal. On 8/26/21, at 2:07 p.m. DON confirmed the above findings and indicated R14 required staff assistance with her ADL's. The DON indicated she expected staff to assist residents with shaving, oral care, personal hygiene, grooming and staff should have followed the care plan. R6 R6's quarterly MDS dated 5/27/21, indicated R6 was cognitively intact and had diagnoses which included: diabetes mellitus, anxiety and schizophrenia. The MDS identified R6 required extensive assistance of one staff with bed mobility, toileting, personal hygiene, limited assistance with dressing and supervision with transfers. Further, the MDS identified R6 was always incontinent of bowel and frequently incontinent of bladder, and was not on a bowel or bladder toileting program. R6's care plan revised on 8/25/21, indicated R6 had ADL self care performance deficit related to aggressive behavior, confusion, impaired balance and pain. The care plan identified R14 required one to two staff assistance with dressing, personal hygiene and toileting. During observations on 8/23/21, at 2:12 p.m. R6 was in bed and NA-D assisted R6 into her wheelchair using a gait belt. NA-C entered the room with a cup of coffee and asked R6 if she wanted to go to the dining room and R6 agreed. NA-D wheeled R6 down to the dining room area in her wheelchair and gave her the cup of coffee to drink. R6 was wearing a purple sweat shirt with flowers on it and the shirt was wet and had	2 920		

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several soiled white spots on R6's chest area .
- at 2:28 p.m. R6 wheeled herself around the nursing home using her feet to peddle herself and her shirt remained the same.
- at 4:25 p.m. R6 was seated in her wheelchair out in the front lobby area and was asking for a piece of pizza. R6's shirt remained the same.
- at 5:20 p.m. R6 was seated in her wheelchair in the dining room area and her shirt continued to be wet with several soiled white spots. R6 had several flies buzzing around her and landing on the chest of her shirt.
- at 7:14 p.m. R6 wheeled herself around the nursing home using her feet to peddle herself and her shirt remained the same. Nursing staff were not observed to offer or provide R6 with assistance to change her soiled shirt.

During observations on 8/25/21, at 7:03 a.m. R6 was awake lying in bed, covered up with blankets, her call light was within reach and she said good morning.
- at 7:24 a.m. R6 remained in bed.
- at 7:25 a.m. R6 turned her call light on and proceeded to transfer herself to her wheelchair. R6 was wearing a gown and a sweater over it.
- at 7:27 a.m. clinical manager (CM)-A entered R6's room, asked R6 if she needed assistance and R6 was noted to have a very strong pungent odor of urine on her. CM-A washed her hands and informed R6 it was time to get washed up and changed. R6 stated she was last changed at four o'clock. CM-A retrieved a pair of pants out of the closet and placed them on R6 up to he knees while she sat in her wheelchair. CM-A said R6 needed her bedding changed and began to collect the linen. R6's bed and bedding was completely saturated with urine and flies were buzzing around and landing on her bed and bedding. R6's entire room was noted to have a

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MEADOW LANE RESTORATIVE CARE CENTEI	2209 UTAH AVENUE BENSON, MN 56215

(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) COMPLETE DATE
2 920	Continued From page 53 pungent odor of urine. - at 7:31 a.m. NA-E entered the room to assist CM-A and spoke to R6 about using the bathroom. R6 agreed after staff encouraged her and CM-A placed the gait belt around her waist while she sat in her wheelchair. - at 7:33 a.m. CM-A wheeled R6 into the bathroom, CM-A and NA-E placed gloves on their hands and assisted R6 to stand while using the gait belt. CM-A and NA-E removed R6's incontinent brief which was completely saturated with urine and had a streak of bowel in it as well. R6's buttocks were wrinkled, pink in color and no skin breakdown was noted. R6's plastic wheelchair cushion was noted to have urine present on it. CM-A proceeded to cleanse R6's buttocks and peri area with wipes while NA-E wiped R6's plastic wheelchair cushion off with wipes and dried it with a paper towel. NA-E and CM-A placed a clean incontinent brief on R6, pulled up her pants and assisted her to sit in her wheelchair. R6 refused the rest of her morning cares and peddled herself out of her room. NA-E indicated she had not received report that morning from the night shift. NA-E and CM-A stated they were not aware when the last time R6 had been checked, changed or offered assistance with toileting. - at 7:41 a.m. CM-A reviewed R6's medical record (MR) to review the last time R6 had been checked and changed and indicated R6 had last been checked and changed at 3:40 a.m. and was incontinent of urine at that time. R6's MR lacked any documentation of R6 being checked and changed by staff or offered toileting from 3:40 a.m. to 7:33 a.m. for a total of 3 hours and 53 minutes. On 8/25/21, at 9:24 a.m. NA-B confirmed R6 was	2 920		

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2 920	Continued From page 54	2 920		

routinely incontinent of bowel and bladder and needed to be checked/changed every two hours. NA-B indicated he thought she had last checked and changed R6 around 4:15 a.m. and thought she was dry at the time but could not remember.

On 8/26/21, at 1:57 p.m. CM-A confirmed the above finding and indicated R6 was incontinent of bowel and bladder and required staff assistance with toileting. CM-A stated staff were to check and change R6 every two hours and indicated she expected staff to follow her care plan.

On 8/26/21, at 2:07 p.m. DON confirmed the above findings and indicated R6 needed staff assistance with her ADL's. The DON indicated she expected staff to assist R6 with personal hygiene, grooming and incontinence cares. The DON indicated staff should have been checking and changing R6 per her care plan and if she refused to re-approach her at a later time.

R1

Findings include:

R1's quarterly Minimum Data Set (MDS) dated 8/17/21, identified R1 had diagnoses of dementia, depression weakness and peripheral neuropathy (numbness/tingle in extremities.) The MDS identified R1 had severe cognitive impairment and required extensive assistance with activities of daily living (ADL's) of dressing, personal hygiene, and bathing. The MDS identified R1 had no rejection of cares during the assessment period.

R1's care plan revised 7/12/21, revealed R1 had impaired cognition, function, thought process and required extensive assistance with personal

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2 920	Continued From page 55 hygiene, dressing and bathing. R1's care plan lacked direction for facial hair removal. R1's nursing assistant care guide dated 8/26/21, revealed R1 required extensive assistance with personal hygiene. On 8/23/21, at 1:43 p.m. R1 was observed lying in bed, eyes closed, covered with a blanket from her feet to mid chest. R1's hands were rested on her abdomen above the blanket. R1 had several dozen four (4) to five (5) millimeters (mm) long, thick black coarse facial hairs along her upper lip, chin and jaw line. R1 had several six (6) to ten (10) mm long white wispy facial hairs along both corners of her mouth and chin. - at 6:08 p.m. R1 was observed seated in a wheelchair, wheeled down the hall by nursing assistant (NA)-H towards the dining room. R1's hair was sticking up on the back of her head and along the sides. R1 continued to have several dozen 4 to 5 mm long, thick black coarse facial hairs along her upper lip, chin and jaw line. R1 had several 6- 10 mm long white wispy facial hairs along both corners of her mouth and chin. On 8/24/21, at 8:50 a.m. R1 was observed seated in a wheelchair in the dining room at a squared table next to another resident. R1's hair was combed straight to her head and she continued to have several dozen 4 to 5 mm long, thick black coarse facial hairs along her upper lip, chin and jaw line. R1 had several 6- 10 mm long white wispy facial hairs along both corners of her mouth and chin. - at 11:32 a.m. R1 was observed seated in a wheelchair in the facility activity room with several other residents. R1 continued to have several	2 920		

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2 920	Continued From page 56	2 920		

dozen 4 to 5 mm long, thick black coarse facial hairs along her upper lip, chin and jaw line. R1 had several 6- 10 mm long white wispy facial hairs along both corners of her mouth and chin.

- at 11:36 a.m. R1 was observed seated in a wheelchair, was wheeled out of the activity room towards her bedroom by NA-D. At that time, NA-D indicated another NA would need to assist to transfer R1 into bed. NA-C entered R1's room, provided R1 with her call light and indicated she needed to go find the other NA to assist R1 to bed and NA-D exited R1's room. At 11:43 a.m. R1 had remained seated in her wheelchair in her room, at that time NA-D and NA-C entered R1's room and proceeded to assist R1 to bed and with her cares. R1 was covered with a blanket, provided her call light and both NA-D and NA-C left R1's room. R1 continued to have several dozen 4 to 5 mm long, thick black coarse facial hairs along her upper lip, chin and jaw line. R1 had several 6- 10 mm long white wispy facial hairs along both corners of her mouth and chin.

On 8/25/21, at 8:24 a.m. R1 was observed seated in a wheelchair in her room, her eyes were closed, head was tilted back and her mouth was open. R1 continued to have several dozen 4 to 5 mm long, thick black coarse facial hairs along her upper lip, chin and jaw line. R1 had several 6- 10 mm long white wispy facial hairs along both corners of her mouth and chin. At that time, NA-E confirmed R1's facial hair and indicated she did not have a razor to remove her facial hair.

- at 10:17 a.m. R1 was observed seated in a wheelchair, wheeled by trained medication aid (TMA)-A towards her room. TMA- A proceeded to assist R1 to transfer from her wheelchair to bed with a full mechanical lift. R1 continued to have

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2 920	Continued From page 57 several dozen 4 to 5 mm long, thick black coarse facial hairs along her upper lip, chin and jaw line. R1 had several 6- 10 mm long white wispy facial hairs along both corners of her mouth and chin. On 8/24/21, at 11:48 a.m. NA-C indicated R1 was totally dependent on staff for all ADL's and was not able to tell staff of her needs. On 8/25/21, at 8:30 a.m. NA-E stated she had assisted R1 with morning cares and had not removed R1's facial hair. NA-E indicated R1 did not have a razor to remove the facial hair and further indicated she would not have had time that morning to shave R1 since they were short staffed that morning. NA-E indicated she felt she was not able to provide R1 with standard cares due to insufficient staffing. NA-E indicated that morning an NA did not show up for the day shift and a night aid had stayed over that was not familiar with morning cares. On 8/25/21, at 10:21 a.m. TMA-A indicated R1 was dependent on staff for all of her ADL's and felt R1 was not able to verbalized her needs. TMA-A indicated R1's facial hair should have been removed as needed and was not aware if R1 had a razor. TMA-A indicated she felt the NA's did not have time for routine cares, such as shaving, routinely due to lack of sufficient staff. On 8/26/21, at 10:44 a.m. a telephone call was placed to R1's family member and a message was left. On 8/26/21, at 2:32 p.m. NA-F indicated R1 was dependent on staff for all of her ADL's, which included personal hygiene and grooming. NA-F indicated she oftentimes would see residents unshaved and felt there was not enough direct	2 920		

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2 920	Continued From page 58 care staff available on a routine basis to ensure standard cares, such as facial hair removal, were provided to residents, which included R1. On 8/27/21, at 9:50 a.m. the director of nursing (DON) stated she expected R1's facial hair to be removed on a routine basis. The DON stated she was not aware R1 or any other residents were in need of shavers. R21 R21's significant change Minimum Data Set (MDS) dated 8/4/21, identified R21 had significant cognitive impairment and diagnoses which included Alzheimer's disease, muscle weakness and thyroid disorder. R21's MDS indicated R21 required total assistance with transfers, extensive assistance with bed mobility, dressing and personal hygiene. R21's care plan revised 7/12/21, identified R21 required extensive assistance with dressing, personal hygiene and R22 did not use the toilet, but was to be checked and changed periodically. R21's care plan identified R21 had impaired thought processes related to Alzheimer's disease. R21's care plan did not include specific instructions for facial hair removal. On 8/23/21, at 2:31 p.m. R21 was sitting in her wheelchair in her room. R21 had multiple long wispy white hairs on her chin and neck ranging from 1/8 inch with 4-5 hairs up to 3/4 inches long. On 8/24/21, at 8:13 a.m. R21 was sitting in her wheelchair in her room. R21 continued to have multiple facial hairs, white in color on her chin and neck, ranging from 1/8 inch long to 3/4 inch long.	2 920		

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2 920	Continued From page 59 On 8/25/21, at 11:45 a.m. R21 was in her wheelchair in the activity room with multiple other residents and staff members present. R21 continued to have facial hairs present as before, with multiple white wispy hairs up to 3/4 inch long on her chin and neck. On 8/25/21, at 12:09 a.m. nursing assistant (NA)-E indicated she had assisted another staff member with R21's cares earlier that morning. NA-E stated she had noticed R21's facial hair that morning and indicated the facility needed to provide a razor for R21. NA-E indicated none of the female residents in the facility had any razors and thus staff were unable to shave them. NA-E stated she had informed clinical educator (CE)-A that morning of the need to purchase razors and was told the facility would obtain some razors for the female residents. NA-E indicated all the male residents had their own razors. On 8/27/21, at 11:16 a.m. CE-A confirmed she had been informed by staff the female residents did not have any razors. CE-A stated the administrator would be obtaining razors and the facility would discuss the need to purchase razors with family members at care conferences. On 8/27/21, at 11:33 a.m. during a phone interview family member (FM)-B stated she used to remove R21's facial hair for her. FM-B stated removing R21's facial hair was important to her. ON 8/27/21, at 10:29 a.m. during a phone interview, clinical manager (CM)-A confirmed she expected all female residents to have their facial hair removed. CM-A indicated they would work on obtaining razors for the female residents so their facial hair would be removed.	2 920		

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2 920	Continued From page 60 On 8/27/21, at 1:29 p.m. director of nursing (DON) confirmed she expected staff to remove the residents' facial hair to maintain their dignity and for personal hygiene purposes. R22 R22's significant change Minimum Data Set (MDS) dated 8/6/21, identified R22 had significant cognitive impairment and diagnoses which included: dementia, arthritis and hypertension (high blood pressure). R22's MDS indicated R22 required extensive assistance with bed mobility, dressing, and personal hygiene. R22's care plan revised 8/13/21, identified R22 had an activities of daily living (ADL's) self-care performance deficit related to advanced dementia and limited mobility. The care plan interventions indicated R22 required extensive assistance of one staff with dressing, personal hygiene and oral cares. On 8/25/21, at 7:36 a.m. to 8:16 a.m. NA-B assisted R22 with morning cares and wheeled her in her wheelchair into the hallway after the cares were completed. At 8:09 a.m. trained medication aide (TMA)-A entered the room, washed her hands and assisted NA-B to transfer R22 out of the bed into her wheelchair using a gait belt. TMA-A exited the room and NA-B combed R22's hair. NA-B was not observed to complete oral cares for R22. At 8:16 a.m. NA-B wheeled R22 in her wheelchair out of her room into the hallway. From 8:16 a.m. to 8:40 a.m. R22 was observed propelling herself up and down the hallways and no oral cares were observed to be provided during that time. At 9:06 a.m. R22 was observed in the dining room with CE-A feeding her. At 9:19 a.m. CE-A assisted R22 to the	2 920		

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2 920	Continued From page 61 hallway near the nursing desk, where R22 began to self propel herself in her wheelchair down the hallway. On 8/25/21, at 10:06 a.m. NA-B stated she typically did not perform R22's morning cares and usually worked the night shift. NA-B confirmed she had not completed oral cares for R22 that morning. On 8/26/21, at 10:44 a.m. NA-E confirmed she had not completed oral cares for R22. On 8/27/21, at 10:19 a.m. during a phone interview, CM-A stated she expected staff to perform oral cares on R22 which should have been completed by swabbing R22's mouth with toothettes. CM-A indicated oral cares were especially important for R22 as she had the tendency to pocket food. On 8/27/21, at 12:24 p.m. DON confirmed she expected staff would complete oral cares on R22. DON indicated oral cares were important to keep the mouth clean, prevent infections or sores, and remove food. The facility policy titled Activities Of Daily Living (ADLs), Supporting dated 3/17/21, identified residents would be provided with care, treatment and services to ensure that their ADLs did not diminish unless the circumstances for their clinical condition(s) demonstrate that diminishing ADLs are unavoidable. The policy also identified that appropriate care and services would be provided for residents who were unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care, which included: hygiene (bathing, dressing, grooming, and oral care), mobility, elimination,	2 920		

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2 920	Continued From page 62 dining and communication. The facility policy titled Shaving The Resident, dated 3/17/21, identified the purpose was to promote cleanliness and to provide skin care. The policy instructed staff to review the resident's care plan to assess for any special needs of the resident. The policy further instructed staff to notify the supervisor if the resident refused the procedure or other information in accordance with the facility policy and professional standards of practice. The facility policy titled Dressing And Undressing, Assisting The Resident With Level II dated 3/17/21, identified the purpose of this procedure was to assist the resident as necessary with dressing and undressing to promote cleanliness. The policy further instructed staff to notify the supervisor if the resident refused the procedure or other information in accordance with the facility policy and professional standards of practice. The facility policy titled Mouth Care dated 3/17/21, identified the purpose of the procedure was to keep the resident's lips and oral tissues moist, to cleanse and freshen the resident's mouth, and to prevent oral infection. The equipment and supplies listed that would be necessary included: toothbrush, toothpaste, emesis basin, and applicators or gauze sponges. The policy further instructed staff to notify the supervisor if the resident refused the mouth care or other information in accordance with the facility policy and professional standards of practice. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could develop and implement policies and procedures related to resident assistance activities of daily	2 920		

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2 920	Continued From page 63 living. The DON or designee, could provide training for all nursing staff related assisting residents activities of daily living. The quality assessment and assurance committee could perform random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 920		
2 965	MN Rule 4658.0600 Subp. 2 Dietary Service -Nutritional Status Subpart. 2. Nutritional status. The nursing home must ensure that a resident is offered a diet which supplies the caloric and nutrient needs as determined by the comprehensive resident assessment. Substitutes of similar nutritive value must be offered to residents who refuse food served. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a comprehensive nutritional assessment and interventions were implemented to prevent significant weight loss for 1 of 1 residents (R6) reviewed for significant weight loss. Findings include: R6's admission Minimum Data Set (MDS) dated 2/24/21, indicated R6 had severe cognitive impairment and had diagnoses which included: diabetes mellitus, anxiety and schizophrenia. The MDS indicated R6 required extensive assistance	2 965	"corrected"	10/11/21

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2 965	Continued From page 64 of one staff with transfers, dressing, toileting, personal hygiene, limited assistance with bed mobility and supervision with eating. The MDS identified R6's most recent weight was 168 pounds (lbs) and her height was 66 inches. The MDS further indicated R6 had no signs or symptoms of a swallowing disorder and had not had a five (5) percent or more weight loss in the last month and/or had 10% weight loss in the last six months. R6's admission Care Area Assessment (CAA) dated 2/24/21, identified R6 had severe cognitive impairment and had diagnoses which included: anemia, diabetes mellitus and schizophrenia. The CAA indicated R6 required extensive assistance of staff for transfers, dressing, toilet use, personal hygiene, limited assistance with bed mobility and supervision with eating. The CAA indicated R6 had no swallowing disorders, weight was 168 lbs, height was 66 inches and R6 had not had a five (5) percent or more weight loss in the last month and/or had 10% weight loss in the last six months. The CAA identified R6 was not receiving any nutritional approaches. The CAA indicated the nutritional status care area was triggered related to R6's body mass index (BMI) (a person's weight in kilograms divided by the square of height in meters). BMI can be used to screen for weight categories that may lead to health problems but it is not diagnostic of the body fatness or health of an individual. The CAA identified R6's BMI was 27.1 which identified RR in an overweight range, however, indicated with R6's advanced age, she was at a "healthy weight." The CAA indicated R6 received a consistent carbohydrate diet, consumed 75 plus % of daily meals and occasional snacks through out the day, required set up help with meals and R6 was able to feed self.	2 965		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 965	Continued From page 65 R6's quarterly MDS dated 5/27/21, indicated R6 was cognitively intact and had diagnoses which included: diabetes mellitus, anxiety and schizophrenia. The MDS indicated R6 required extensive assistance of one staff with bed mobility, toileting, personal hygiene, limited assistance with dressing and supervision with transfers. The MDS identified R6 was independent with eating and required set up help only from staff. The MDS indicated R6's most recent weight was 168 lbs and her height was 66 inches. The MDS identified R6 had no signs or symptoms of a swallowing disorder and was unknown if R6 had a five (5) percent or more weight loss in the last month and/or had 10% weight loss in the last six months. Review of R6's admission Nutritional Data form dated 1/26/21, identified R6's admission weight was 170 lbs and her weight at the time of the completion of the form was 170 lbs. The assessment revealed R6 had no change in her weight, did not use adaptive equipment and averaged 65 plus % of her meal intakes per day. R6's nutritional assessment revealed her estimated nutrition needs as 1500 to 1600 kcal (kilocalorie (Cal or kcal) per day, estimated protein 90-95 grams per day and estimated fluid needs were 2000 milliliters (ml) per day. R6's medical record (MR) lacked any further nutritional assessments. Review of R6's signed physician order revealed an order dated 8/4/21, Doxycycline (antibiotic) 100 milligrams (mg) one tablet by mouth twice a day for urinary tract infection and start 2 Cal supplement 120 milliliters (ml) twice a day for weight loss. Which had been started on 8/4/21.	2 965		

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2 965	Continued From page 66 Review of R6's signed Order Summary Report dated 8/5/21, revealed an order was received to discontinue R6's Metformin, Fosamax, Simvastatin, Sitagliptin and to consult hospice if not improving due to diagnoses of dementia with weight loss and hypoalbumenia. Review of R6's Problem Sheet dated 8/7/21, revealed staff had notified R6's primary doctor requesting an order for adaptive dining utensils to assist R6 with eating. R6's primary doctor gave order on 8/9/21, for R6 to be evaluated and treated by occupational therapy (OT) for adaptive equipment. The MR lacked any documentation of an OT evaluation being completed. Review of R6's medication administration record (MAR) from 8/1/21, to 8/25/21, revealed the following: - R6 had received her 120 ml of 2 Cal supplement everyday and had refused it twice during this time. R6's care plan revised on 8/25/21, indicated R6 had a nutritional problem or potential nutritional problem and was at risk for dehydration with an altered state of mind, age and decrease mobility. The care plan indicated staff were to follow diet as ordered by medical doctor, monitor fluid intake, monitor for signs and symptoms of dehydration, record daily intake, weights per facility protocol and snacks per R6's preference. The care plan identified R6 required set up help from staff for eating. Review of R6's weights from 2/17/21, to 8/23/21, revealed the following:	2 965		

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2 965	Continued From page 67 - 2/17/21, - 168 lbs - 5/3/21, - 168 lbs - 8/4/21, - 140.8 lbs - 8/16/21, - 141.6 lbs - 8/23/21, - 142 lbs R6's MR lacked any weights from 5/3/21, to 8/4/21. Review of R40's progress notes from 8/4/21, to 8/10/21, revealed the following: - 8/4/21, medical doctor noted having increased lethargy and very poor appetite. R6 was weighed today and had lost 28 lbs in the last 2 months. Nursing reports she had refused nourishments saying she just ate and was increasingly confused. R6 had a strong odor to her urine and severe protein calorie malnutrition. Difficult to obtain labs due to behaviors, start Doxyclycline 100 mg twice a day to cover pulmonary and urinary symptoms and start 2 Cal supplement 120 ml by mouth twice a day. - 8/4/21, R6 seen by nurse practitioner for rounds due to change in condition, more tired, confused, agitated and not eating as well. Suspected urinary tract infection, R6 had lost 30 lbs since January when she admitted. New orders received for Doxyclycline 100 mg twice a day for 7 days for UTI and 2 Cal supplement 120 ml by mouth twice a day for weight loss. - 8/7/21, R6 had trouble feeding herself and spilled a lot of her meals. Tried lipped plate with sippy cup and worked well. Faxed medical doctor for orders for OT to evaluate and treat for adaptive dining utensils. - 8/10/21, R6 refused to eat.	2 965		

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2 965	Continued From page 68 R6's MR lacked any other documentation of R6's unplanned significant weight loss of 28 lbs from her admission, 16.47% of her body weight within the last 6 months. During observations on 8/26/21, at 12:09 p.m. R6 was seated at the dining room table waiting for lunch. Dietary staff brought R6 a plate of food, set it down in front of her, asked her if she needed any help, R6 declined and said she was ok. R6 had beans, diced potatoes, country fried steak with gravy on her plate, a cup of coffee and a cup of tea. R6 began to eat her potatoes independently with a silver spoon. - at 12:22 p.m. R6 continued to eat her fried steak with gravy independently. - at 12:25 p.m. licensed practical nurse (LPN)-A came over and asked R6 how she was doing and R6 responded ok. LPN-A asked R6 if she wanted him to cut up her steak, R6 agreed and LPN-A cut up her fried steak for her. R6 indicated she wanted a cola, LPN-A went to the kitchen and brought R6 a can of cola back while R6 continued to eat and drink her food independently. - at 12:28 p.m. dietary staff asked R6 if she would like a piece of cake or pudding for dessert and R6 said she wanted cake. Dietary staff brought R6 a piece of chocolate cake and she began to eat her cake independently. R6 ate all of her potatoes, 75% of her beans and approximately 75% of her country fried steak with gravy. On 8/24/21, at 2:47 p.m., dietary manager (DM)-A indicated nutritional assessments were to be completed on admission, quarterly and with a significant change. DM-A stated weights were reviewed daily in the MR and the reports would trigger out a 5% weight loss in one month or 10% in 6 months. DM-A indicated he believed registered dietician (RD)-A was covering the	2 965		

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2 965	Continued From page 69	2 965		

facility until recently when the facility hired RD-B. DM-A stated when a significant weight change was identified, the expectation was for staff to contact the RD.

On 8/25/21, at 12:37 p.m. in a follow up interview via phone R6's MR was reviewed with DM-A. DM-A verified R6 received a diabetic diet, received 120 ml of 2 Cal supplement twice a day and started the supplement on 8/4/21, due to weight loss. DM-A confirmed R6 had a significant weight loss from May 2021, to August 2021. DM-A reported the MR had revealed R6 had lost 24 lbs from February 2021, to August 2021, which was a 15% weight loss in 6 months. DM-A confirmed the last nutritional assessment was completed in January 2021, when R6 was admitted and verified no other nutritional assessments had been completed since that time. DM-A stated nutritional assessments should have been completed on R6 upon admission, quarterly and with any significant change of condition. DM-A stated he believed R6's weight loss would have been identified sooner if the assessments and R6's weights had been completed as indicated. DM-A indicated the normal process was to notify the RD and the doctor of any changes in weight loss and to start the residents on a supplement. DM-A confirmed the above findings and indicated he expected staff to complete R6's weights weekly on her bath day and to notify the nurses, DM whenever a weight loss is identified.

On 8/25/21, at 11:44 a.m. NA-E indicated R6 required one to two staff assistance with activities of daily living (ADL's) for dressing, personal hygiene and toileting. NA-E stated R6 was able to feed herself after staff set up her tray and they supervised her. NA-E indicated she believed R6

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2 965	Continued From page 70	2 965		

had good intake and was not aware if she received snacks during the day. NA-E stated she was not aware if R6 received nutritional supplements.

On 8/25/21, at 12:09 p.m. LPN-A indicated R6 required extensive assistance of one staff for her ADL's and sometimes needed two staff during times when she was weaker. LPN-A stated R6 was independent with eating however staff were to supervise and encourage her to eat. LPN-A indicated R6 received snacks through out the day and additionally received 2 Cal supplement 120 ml twice a day. LPN-A stated R6 consumed the supplement the majority of the time however did refuse at times. LPN-A indicated when R6 refused the supplement staff were expected to re-approach her or offer an alternative. LPN-A stated staff were expected to weigh the residents on their weekly bath day, if a significant weight loss is identified or when dietary staff request the weight.

On 8/25/21, at 1:56 p.m. in an interview via the phone RD-A indicated she had resigned from the facility.

On 8/25/21, at 2:01 p.m. in an interview RD-B indicated she was asked by the facility to provide a little input, worked full time at another facility and as a result did not have the ability to be the facility's RD or consultant. RD-B stated she had not been informed R6 had a significant weight loss. RD stated she expected staff to contact the RD for recommendations, provide supplements and review again in a week when a weight loss had been identified. RD-B indicated she expected staff would be completing weekly weights, monitoring intakes daily and to document the findings. RD-B stated if a resident had refused

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2 965	Continued From page 71	2 965		

meals, it was expected staff would start nutritional supplement. The RD-B indicated nutritional assessments should have been completed on admission by the DM and quarterly after thereafter. RD-B stated the DM should have notified RD of R6's weight loss and put interventions in place to stabilize the weight loss which would include completing weekly weights for four weeks. In a follow up interview on 8/27/21, at 11:03 a.m. RD-B confirmed she had no written contract with the facility to provide dietician services.

On 8/25/21, at 2:15 p.m. OT assistant (OTA)-A confirmed R6 had not been receiving OT services and stated she had not received any orders to evaluate R6. OTA-A indicated Physical therapist assistant (PTA)-A received the orders from nursing staff and PTA-A then communicated the need to evaluate and treat residents.

On 8/26/21, at 10:27 a.m., MDS consultant (MDSC) spoke with PTA-A via the phone and confirmed PT-A was not aware of the order to evaluate and treat R6. MDSC indicated PTA-A stated OT would evaluate R6 on 8/30/21.

On 8/26/21, at 10:27 a.m., during an interview via phone PTA-A confirmed OT had not evaluated or treated R6 yet for use of adaptive eating equipment and had scheduled the evaluation to be completed on 8/30/21.

On 8/26/21, at 1:57 during an interview via phone clinical manager (CM)-A stated R6 needed staff assistance with all of her activities of daily living. CM-A indicated R6 would miss the spoon and would spill her food on herself due to having issues with her plate. CM-A stated when orders were obtained for therapy, nursing staff placed

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2 965	Continued From page 72	2 965		

the order in the computer and would email therapy staff the new order. CM-A indicated staff were expected to process orders immediately and OT should have evaluated R6 soon after to ensure R6 received the adaptive equipment she needed to eat her meals.

On 8/27/21, at approximately 9:50 a.m. via phone call medical doctor (MD)-A indicated she recently assumed the role of R6's primary physician and confirmed R6 had recently experienced weight loss. MD-A stated R6 had diagnoses of advanced dementia with schizophrenia and the combination caused her weight loss. MD-A indicated lately R6 had a poor appetite, refused labs and R6 had been progressing to later stages of her dementia. MD-A stated she had ordered 2 Cal supplement 120 ml twice a day for R6 and indicated she expected OT to evaluate residents within 2 weeks from the order. MD-A stated she expected staff and the RD to comprehensively assess R6, monitor her weights weekly and update her with any changes.

On 8/27/21, at 12:34 p.m. the director of nursing (DON) confirmed the above findings and indicated she was just made aware of R6's significant weight loss. The DON indicated she expected staff to monitor intakes, to offer snacks ,to report nutritional changes to the nurse, dietary team and MD. The DON stated she expected staff to monitor weights weekly, report changes to the RD and MD and follow up on MD orders. The DON indicated she expected staff to complete a comprehensive nutritional assessment, review medications and find out the root cause of the problem. The DON verified R6's OT order to evaluate and treat had not been processed as ordered. The DON indicated the facility did not have RD on staff and RD-B was trying to assist

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2 965	Continued From page 73 the facility. Review of facility policy titled, Nutritional Assessment dated 3/17/21, identified a nutritional assessment, which included current nutritional status and risk factors for impaired nutrition, should have been conducted for each resident. The policy identified the dietician in conjunction with the nursing staff and healthcare practitioners, were to conduct a nutritional assessment for each resident upon admission, and as indicated a change in condition that placed the resident at risk for impaired nutrition. The policy revealed resident nutritional assessments included at least the following components: usual body weight, current height and weight, usual intake, food preferences, usual meal and intake patterns, general appearance and clinical conditions and resident usual routine. The policy revealed residents current conditions and risk factors were to be assessed, then analyzed and an individual care plan was to be developed to address and minimize further nutritional complications. SUGGESTED METHOD FOR CORRECTION: The Director of Nursing (DON) or designee could develop and implement policies and procedures to ensure residents at nutritional risk received timely comprehensive assessments and appropriate interventions to maintain nutrition as determined necessary by their individualized assessment. The DON or her designee could educate all appropriate staff on the policies and procedures. The DON could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	2 965		

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2 980	Continued From page 74	2 980		
2 980	MN Rule 4658.0605 Subp. 2 Director of dietary service; Director Subp. 2. Director of dietary service. If a qualified dietitian is not employed full time, the administrator must designate a director of dietary service who is enrolled in or has completed, at a minimum, a dietary manager course, and who receives frequently scheduled consultation from a qualified dietitian. The number of hours of consultation must be based upon the needs of the nursing home. Directors of dietary service hired before May 28, 1995, are not required to complete a dietary manager course. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to designate a qualified person to serve as the director of food service to oversee the dietary department in the absence of a full time dietitian. This had the potential to affect all 25 residents, visitors and staff who consumed food from the kitchen. Findings include: The facility was unable to provide any documentation to support dietary manager (DM)-A and DM-B were certified to be the manager of the food service position. On 8/23/21, at 12:50 p.m. during the initial tour of the kitchen, DM-A indicated DM-B was being trained in by him to take over the DM position in the kitchen. On 8/24/21, at 2:47 p.m. DM-A confirmed the above findings and indicated registered dietician	2 980	"corrected"	10/11/21

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2 980	Continued From page 75 (RD)-A was covering for the facility until they hired RD. DM-A explained RD-A came to the facility every two weeks to assess the residents and RD-B recently assumed this role to cover for the facility. On 8/25/21, at 12:37 p.m. in a follow up interview DM-A confirmed she was not certified to be a DM. On 8/25/21, at 7:56 a.m. DM-B confirmed she was not certified and was in the midst of new employee training. On 8/25/21, at 1:56 p.m. via phone call RD-A indicated she recently resigned from the facility and was not overseeing the facility. RD-A stated she had offered to fill in until the facility hired a RD however the facility had not followed up with her regarding the offer. On 8/25/21, at 2:01 p.m. via phone call RD-B indicated she was only asked to provide the facility a little input and to help them out. RD-B indicated she worked full time at another facility and did not have the capacity to be their RD or consultant. On 8/26/21, at 12:07 p.m. the administrator confirmed the above findings and indicated DM-A and DM-B were not certified. The administrator verified the facility had no written contract with RD-B and that it was only a verbal agreement between the owner and RD-B. On 8/27/21, at 11:30 a.m. in a follow up interview RD-B confirmed there was no written contact between her and the facility. Review of facility policy titled, Director of Food and Nutrition Services Responsibility undated,	2 980		

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2 980	Continued From page 76 indicated the director of food and nutritional services would be responsible for providing safe foods to all individuals. SUGGESTED METHOD OF CORRECTION: The Administrator or designee could develop, review, and/or revise policies and procedures to ensure the Dietary Manager has the proper qualifications for the position. The Administrator or designee could educate all appropriate staff on the policies and procedures. The Administrator or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 980		
21000	MN Rule 4658.0610 Subp. 4 Dietary Staff Requirements-Hygiene. Subp. 4. Hygiene. Dietary staff must thoroughly wash their hands and the exposed portions of their arms with soap and warm water in a hand washing facility before starting work, during work as often as is necessary to keep them clean, and after smoking, eating, drinking, using the toilet, or handling soiled equipment or utensils. Dietary staff must keep their fingernails clean and trimmed. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to serve food in a safe and sanitary manner to prevent the spread of cross contamination. This deficient practice had the potential to affect all 13 residents who currently resided in the facility and received food	21000	"corrected"	10/11/21

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21000	Continued From page 77 from the Blue Horizon kitchenette. Findings include: During observations on 8/23/21, at 6:01 p.m. dietary cook (DC)-A was serving the supper meal from the steam table in the main dining room area. DC-A had her hands gloved, she grabbed a plate, placed a scoop of turkey, a scoop of gravy on the turkey and a scoop of baked beans on the plate. DC-A grabbed a handful of raw carrots with her gloved hand, placed them on the plate and set the plate on the steam table to be delivered. - DC-A proceeded to touch the menu slips with her gloved hands, grabbed a hot dog bun out of the package setting on the back counter and placed it on the plate. DC-A grabbed the tongs, placed a hotdog in the bun, put a scoop of baked beans on the plate and set the plate on top of the steam table to be delivered. - at 6:05 p.m. DC-A touched the menu slips on top of the steam table with both gloved hands, grabbed a plate, grabbed two hot dog buns out of the package, placed them on the plate and used tongs to place hotdog's inside the buns. DC-A poured chips onto the plate, grabbed the hotdog's on the plate and moved them over on the plate, touched the menu slips with her gloved hands, placed a scoop of baked beans on the plate and set the plate on top of the steam table to be served. - at 6:08 p.m. DC-A removed her gloves, set the dirty gloves on the back counter near her raw carrots, buns and chips. DC-A then grabbed a plastic container of cereal out of the cupboard, gloved her hands, grabbed a bowl and poured cereal into it. DC-A grabbed a plate, placed the	21000		

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MEADOW LANE RESTORATIVE CARE CENTEI	2209 UTAH AVENUE BENSON, MN 56215

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bowl of cereal on it, set the plate down on top of the steam table to be served. DC-A grabbed the menu slips off the top of the steam table with her gloved hands and began to review them. DC-A proceeded to grab a plate, place a scoop of pureed turkey on the plate, a scoop of gravy on the turkey, obtained bowls out of cupboard and set them on the counter behind her. DC-A removed her gloves and set the dirty gloves on the back counter near the raw carrots, buns and chips. DC-A gloved her hands, put a scoop of pureed beans in a bowl, set the bowl on a plate, placed a scoop of pureed turkey on the plate with a scoop of gravy and placed it on top of the steam table to be delivered.

- at 6:11 p.m. DC-A grabbed a plate, placed a scoop of pureed turkey, scoop of gravy and a scoop of pureed beans on the plate and set it up on top of the steam table to be delivered. DC-A grabbed a plate, placed a scoop of pureed turkey, gravy and mashed potatoes on the plate and placed it on top of the steam table to be served. DC-A proceeded to grab a plate, grabbed a hot dog bun out of the package, placed it on the plate and used tongs to place a hotdog inside the bun. DC-A continued to serve in this manner until she was done serving at 6:31 p.m.

On 8/24/21, at 4:41 p.m. dietary manager (DM)-A confirmed the above findings and indicated staff were expected to change gloves, wash their hands and start over with a clean pair of gloves when contaminated. The DM-A stated the menu slips were completed in the resident rooms and indicated the slips were contaminated. DM-A indicated dietary staff should not have been touching the menu slips while serving food and touching ready to eat foods thereafter. DM-A stated staff were expected to use utensils to

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21000	Continued From page 79 serve with and to not use dirty gloved hands. Review of facility policy titled, General Food Preparation and Handling undated, indicated bare hands should never touch ready to eat raw food directly. Food would have been prepared and served with clean tongs, scoops, forks, spoons, spatulas, or other suitable implements to avoid manual contact of prepared foods. SUGGESTED METHOD OF CORRECTION: The Director Of Nursing and the Dietician could review and revise food service policies and procedures to assure that food is served in a sanitary manner. Staff could be trained as necessary. The Certified Dietary Manager could monitor the service of food on a periodic basis to ensure staff are following safe food handling practices. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	21000		
21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure appropriate personal protective equipment (PPE) was worn properly which had the potential to affect all 25 residents who resided in the facility. In addition,	21375	"corrected"	10/11/21

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the facility failed to assure appropriate hand hygiene and glove use while providing assistance with incontinence cares to prevent the spread of infection for 2 of 5 residents (R22, R14) observed during personal cares.

MASK USE

On 8/25/21, at 7:19 a.m. housekeeper (HK)-A was in the hallway with his mask worn loosely, which hung below his nose. While HK-A spoke, HK-A's mask would drop down to below. At 7:20 a.m. HK-A entered R21's and R6's room when both R21 and R6 were in the room while his mask continued to hang loosely below his nose. HK-A walked to R6's side of the room and spoke to R6 who was in bed, while he removed garbage from her room. HK-A continued to walk around the room and gathered supplies periodically from the cart outside the doorway. At 7:27 a.m. HK-A stood next to R21 who was in bed in her room, when clinical manager (CM)-A entered the room. HK-A's mask remained below his nose. HK-A spoke to CM-A while his mask remained loosely fitted on his face and falling below his mouth while he spoke. At 7:28 a.m. HK-A walked down the hallway towards the housekeeping closet, put his cart away, walked to the basement door and entered the door. HK-A's mask continued to hang loosely down below his nose. At 11:36 a.m. HK-A entered room 147, while R13 was sitting in his room. HK-A's mask continued to hang loosely under his nose and when he spoke to R13, his mask fell down below his mouth. HK-A cleaned various items in R13's room while R13 remained in his room.

On 8/25/21, at 11:50 a.m. during an interview HK-A's mask continued to hang down below his nose. When HK-A spoke his mask fell down

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below his mouth HK-A positioned his mask up to his nose. HK-A stated he was aware his mask was below his nose and indicated it kept falling and fogging up his glasses. HK-A indicated some residents stated they had a difficult time hearing him when his mask was over his mouth. HK-A said he had received education this week and last week about proper mask use however indicated he pulled it down since it fogged up his glasses. HK-A confirmed he had not received the COVID 19 vaccination yet.

On 8/26/21, at 9:29 a.m. housekeeping manager (HM)-A confirmed there had been concerns of improper mask use by staff. HM-A indicated his mask would tend to slip down as well. HM-A stated he had reminded his staff to keep their nose and mouth covered with the mask and indicated it was important due the COVID-19 pandemic concerns.

R22

R22's significant change Minimum Data Set (MDS) dated 8/6/21, identified R22 had significant cognitive impairment and diagnoses which included: dementia, arthritis and hypertension (high blood pressure). R22's MDS further indicated R22 required extensive assistance with bed mobility, dressing, and personal hygiene.

R22's care plan revised 8/13/21, identified R22 had an activities of daily living (ADL) self-care performance deficit related to advanced dementia and limited mobility. R22's care plan interventions included: extensive assistance of one staff for dressing, personal hygiene, and bed mobility.

On 8/25/21, at 7:37 a.m. nursing assistant (NA)-B entered R22's room and informed R22 she would

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provide R22's morning cares. NA-B was not observed to complete hand hygiene when she entered R22's room. NA-B filled a basin of water in the sink and started to remove R22's gown while R22 sat on the edge of the bed. After R22's gown was removed, NA-B assisted R22 to lie down and unfastened the tabs on R22's brief. NA-B folded the brief down between her legs and placed her bare hand onto the brief to check for wetness. NA-B's goggles were noted to be on the top of her head and not covering her eyes. NA-B was not observed to perform hand hygiene. NA-B lowered R22's bed, walked to the counter and proceeded to open multiple drawers. While NA-B was opening the drawers, NA-B touched the drawer handles and multiple items in the drawers. NA-B located some towels and socks and placed them on the counter top. NA-B put the washcloth into the basin of water, returned to R22's bed and placed the basin of water on the bed side table near R22's bed. NA-B began to wash R22's face and assisted her to wash her hands and arms. NA-B pulled R22's brief back down, touched the inside of her brief with her bare hands and proceeded to complete perineal cares with her bare hands. NA-B walked to the closet, touched the handle of the closet, removed a new brief and returned to R22's bed. NA-B assisted R22 to turn to her side, washed R22's buttock, removed R22's soiled brief and placed the new brief under her. At this point, NA-B placed gloves on, applied skin protective ointment to R22's buttocks and perineal area. NA-B pulled up R22's brief and fastened the tabs on the sides. NA-B removed her gloves and was not observed to sanitize her hands. NA-B's goggles remained on the top of her head during the time cares were provided to R22. NA-B walked to the closet, touched the closet door handle, opened the door and removed R22's clothing. At 7:55 a.m. NA-B

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assisted R22 to sit up, applied R22's shirt, pants, socks and shoes. NA-B went to the counter, opened multiple drawers and the closet and stated she was searching for the gait belt. NA-B located the gait belt on top of R22's chair, attempted to transfer R22 her self and stated she needed assistance. NA-B stopped the transfer attempt, opened R22's door and asked trained medication aid (TMA)-A for assistance. TMA-A entered the room, washed her hands in the sink and assisted NA-B to transfer R22 from her bed to her wheelchair. TMA-A washed her hands in the sink once the task was completed and exited the room. NA-B removed R22's gait belt and rinsed out R22's basin in the sink. NA-B wet R22's comb, combed her hair and placed R22's hair in a bun. At 8:16 a.m. NA-B washed her hands in the sink for the first time. NA-B's goggles remained on top of her head throughout the entire time. NA-B was observed in R22's room for 39 minutes.

On 8/25/21, at 9:32 a.m. during interview NA-B confirmed she had not washed her hands before she began R22's cares. NA-B stated she should have washed her hands however had not thought about it due to the fact staff were running late with cares. NA-B stated she only worked the morning shift when she was mandated to stay or a shift opened up she was available to cover. NA-B indicated she was aware of the importance of wearing gloves and stated should have worn gloves when she worked on perineal cares for R22. NA-B d indicated she had been "called on it" in the past when she had not work gloves while providing cares. NA-B stated about 50% of the time she wore gloves when providing incontinence cares at night since the staff she worked with at night worked very quickly. NA-B confirmed she had touched multiple items in

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R22's rooms without washing her hands after perineal cares and indicated she was aware that action breach in infection control practices. NA-B confirmed she had only washed her hands after she was done with R22's morning cares. NA-B confirmed she had worn her goggles on the top of her head during R22's cares as they kept fogging up.

On 8/27/21, at 10:19 a.m. during a phone interview clinical manager (CM)-A confirmed she expected hand hygiene to be completed when staff entered resident's rooms, gloves were to worn during perineal cares and hands should have been washed or sanitized after gloves were removed. CM-A indicated proper hand hygiene and glove use were important to prevent the spread of infection.

On 8/25/21, at 7:12 a.m. (HK)-A walked down the west hallway towards the end of the hall, facemask was underneath his nose. HK-A walked into resident room 115, which the resident was seated in a wheelchair at a table by the wall. HK-A spoke with the resident, approximately three feet from her, his mask remained underneath his nose. HK-A wiped the floor, then left the room.

-at 7:12 a.m. HK-A was observed in the west hallway, his mask underneath his chin, nose and mouth exposed.

-at 7:49 a.m. HK-A was observed in the west hallway, walked towards the nurses station, his face mask was below his nose and mouth.

-at 8:06 a.m. HK-A was observed in the west hallway and walked towards the end of the hallway. HK-A's face mask was below his nose

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and upper lip. HK-A walked past licensed practical nurse (LPN)-A and trained medication aid (TMA)-A and neither staff member directed him to cover his nose with his mask.

R14

R14's quarterly MDS dated 7/13/21, indicated R14 had severe cognitive impairment and had diagnoses which included: depression, poly-arthritis and lymphedema. The MDS identified R14 required two staff assistance with bed mobility, transfers, dressing, toileting, one staff for personal hygiene and supervision with eating.

During observations on 8/25/21, at 8:17 a.m. R14 was in bed on her back when nursing assistant (NA)-B entered her room and her eye protection was noted to be on the top of her head. NA-B proceeded to make R14's room mates bed, straightened up the room, collected the garbage and soiled linen. NA-B exited R14's room with the garbage and soiled linen and walked down the hallway on the other end of the nursing home while her eye protection remained on top of her head. NA-B entered the utility room, placed the linen and garbage in the proper bins and washed her hands.
- at 8:26 a.m. NA-B walked out of the utility room and down the hallway while her eye protection remained on top of her head. NA-B grabbed a tissue at the nurses desks, pulled down her mask with her hand and blew her nose while she walked down the hallway to R14's room. NA-B entered R14's room, threw the tissue in the garbage, grabbed her mask, pulled it back over her nose and mouth area and washed her hands. NA-B approached R14 while she was laying in bed and said good morning. NA-B removed R14's

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covers while her eye protection remained on top of her head and there were flies buzzing around and landing on R14 while NA-B collected her supplies. NA-B unhooked R14's incontinent brief, touched the soiled surface with her bare hands and indicated R14 was wet. NA-B obtained a wet wash cloth, washed R14's hands and face, tucked R14's brief on the left side and began to wash R14's peri area with her bare hands. NA-B asked R14 to roll to the right while she washed her buttocks area, removed the wet soiled brief with her bare hands and threw it in the garbage. NA-B placed a clean incontinent brief under R14, rolled her to the left and hooked the incontinent brief. NA-B walked over to the closet and picked out some clothes for R14.
- at 8:39 a.m. NA-B brought over clothes and R14 chose what she wanted to wear. NA-B grabbed R14's pants, donned the pants and applied ace wraps to her lower legs. NA-B placed slippers on R14's feet, removed her gown, put deodorant under her armpits and donned her shirt over her head. NA-B rolled R14 to the left then to the right straightening her clothes and placing the lift sling under her. NA-B continued to have her eye protection on the top of her head while she provided cares.
- at 8:52 a.m. NA-B went out into the hallway to ask for assistance and continued to have the eye protection on top of her head. NA-B came back into the room, positioned the mechanical lift over R14 and hooked the sling to the lift while trained medication aid (TMA)-A entered the room. NA-B and TMA-A transferred R14 via mechanical lift from her bed to her wheel chair, unhooked the lift from the sling and TMA-A washed her hands and immediately left R14s room. NA-B applied peddles to R14's wheelchair, placed her feet on the peddles, combed her hair and placed her glasses on her face. NA-B collected the soiled

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linen, washed her hands, put R14's supplies away and washed her hands again at the sink. NA-B grabbed a blanket and covered R14's legs with it. - at 9:03 a.m. NA-B wheeled R14 out of her room area, down the hallway towards the dining room with her eye protection on top of her head. Several residents were seated in the dining room area.

On 8/25/21, at 9:14 a.m., NA-B confirmed the above findings and indicated R14 required assistance with all of her cares. NA-B verified she wore her eye protection on top of head due to they fogged up and she had difficulty seeing the residents. NA-B indicated staff were to wear their eye protection at all times and during cares. NA-B stated she should have worn gloves and washed her hands while providing peri cares to prevent the spread of infection.

R6

R6's quarterly MDS dated 5/27/21, indicated R6 was cognitively intact and had diagnoses which included: diabetes mellitus, anxiety and schizophrenia. The MDS identified R6 required extensive assistance of one staff with bed mobility, toileting, personal hygiene, limited assistance with dressing and supervision with transfers.

During observations on 8/25/21, at 7:25 a.m., R6 was seated in her wheel chair and wheeling herself towards the door. Housekeeper (HK)-A was sweeping R6's room and was wearing a surgical mask. HK-A's surgical mask was down on the top of his chin with his mouth and nose exposed while R6 looked in her closet for clothes. At 7:27 a.m. registered nurse (RN)-A entered R6's room to assist her and HK-A left the room.

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- at 7:41 a.m. R6 had soiled her bed and needed it to be cleaned by housekeeping. RN-A left R6's room to inform HK-A.
- at 7:59 a.m. HK-A cleaned R6's bed while R26 was sleeping in bed. HK-A was wearing a surgical mask. HK-A's surgical mask was down on the top of his chin with his mouth and nose exposed.
- at 8:06 a.m. R26 slept while HK-A continued to clean R6's room. HK-A mask continued the same exposing his nose and mouth area.

On 8/27/21, at 1:19 p.m. director of nursing (DON) confirmed she expected gloves to be worn during perineal cares and hand hygiene to be completed between glove changes and when appropriate. DON stated it was important to prevent the spread of infection, prevent cross contamination and for basic hygienic purposes.

On 8/27/21, at 2:47 p.m. during a joint interview with DON and MDS consultant (MDSC)-A DON confirmed staff were expected to wear masks at all times and the masks were to cover the nose and mouth properly. DON stated these practices were important to prevent the spread of infection, respiratory illness and COVID-19. DON confirmed she expected goggles to be worn correctly at all times for the same reasons previously stated.

On 8/27/21, at 3:13 p.m. during a phone interview infection preventionist (IP)-A confirmed staff were expected to wear their masks and goggles at all times. IP-A stated it was important to keep the staff and residents safe and prevent them from being exposed to COVID 19 or any other respiratory illness.

The facility policy titled Perineal Care, dated 3/17/21, identified the purpose was to provide cleanliness and comfort to the resident, and to

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prevent infection and skin irritation, and to observe the resident's skin condition. The policy instructions to staff included: to wash and dry their hands thoroughly and put on gloves, and once completed to remove gloves and to wash and dry hands thoroughly.

The facility policy titled Handwashing/Hand Hygiene, dated 3/17/21, identified the facility considered hand hygiene the primary means to prevent the spread of infection. The policy identified all personnel would be trained and regularly in-serviced on the importance of hand hygiene to prevent the transmission of health care-associated infections and all personnel followed the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents and visitors. The policy instructed alcohol-based hand rub or alternatively soap and water to be used in the following situations which included: before and after direct contact with residents, before moving from a contaminated body site to a clean body site during resident care and after removing gloves.

The facility policy titled Personal Protective Equipment-Using Gloves, dated 3/17/21, identified the use of gloves listed, included to prevent the spread of infection. The policy instructed staff to wash hands after removing gloves. The policy identified when gloves were to be worn when touching excretions, secretions, blood, body fluids, mucous membranes, or non-intact skin.

SUGGESTED METHOD OF CORRECTION:
The director of nursing or designee, could review infection control practices during personal care and educate staff. The director of nursing or

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21375	Continued From page 90 designee, could conduct random audits of the delivery of care to ensure appropriate care and services are implemented in order to reduce the risk of infection. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21375		
21530	MN Rule 4658.1310 A.B.C Drug Regimen Review A. The drug regimen of each resident must be reviewed at least monthly by a pharmacist currently licensed by the Board of Pharmacy. This review must be done in accordance with Appendix N of the State Operations Manual, Surveyor Procedures for Pharmaceutical Service Requirements in Long-Term Care, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system. It is not subject to frequent change. B. The pharmacist must report any irregularities to the director of nursing services and the attending physician, and these reports must be acted upon by the time of the next physician visit, or sooner, if indicated by the pharmacist. For purposes of this part, "acted upon" means the acceptance or rejection of the report and the signing or initialing by the director of nursing services and the attending physician. C. If the attending physician does not concur with the pharmacist's recommendation, or does not provide adequate justification, and the pharmacist believes the resident's quality of life is being adversely affected, the pharmacist must refer the matter to the medical director for review if the medical director is not the attending physician. If the medical director determines that	21530		10/11/21

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21530	Continued From page 91 the attending physician does not have adequate justification for the order and if the attending physician does not change the order, the matter must be referred for review to the quality assessment and assurance committee required by part 4658.0070. If the attending physician is the medical director, the consulting pharmacist must refer the matter directly to the quality assessment and assurance committee. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure the pharmacy consultant (PC) identified and reported an irregularity related to the lack of a rational for gradual dose reduction (GDR) for a psychotropic medication for 2 of 5 residents (R10 and R22,) and physician ordered laboratory for 1 of 5 residents (R10) reviewed for unnecessary medications. Findings include: R10's quarterly Minimum Data Set (MDS) dated 6/11/21, identified R10 had diagnoses which included cerebral vascular disease, depression, chronic pain, arthritis and depression. The MDS identified R10 had severe cognitive impairment and required extensive assistance with activities of daily living (ADL's.) The MDS revealed R10 received daily antipsychotic and antidepressant medications and identified a gradual dose reduction had not been attempted in the last quarter. R10's care plan revised 7/12/21, revealed R10 had behavior problems (alcohol abuse) related to depression and chronic pain. The care plan listed various interventions which included:	21530	"corrected"	

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administering medications as ordered, monitor/document side effects and effectiveness. R6's care plan revealed R6 received antidepressants, psychotropic medications and listed several interventions which included pharmacy review monthly or per protocol.

R10's Consultant Pharmacist's Medication Review dated 6/9/21, identified R10 had been taking a current dose of Trazodone 50 milligrams (mg) at bedtime since 12-2019. CMS guidelines require at least quarterly assessment of sedatives/hypnotics for continued need and trial dose reduction consideration. The form's suggested course of action included to assess R10 for continued use of Trazodone 50 mg at bedtime for sleep. If a dose reduction was not appropriate at the time, provide clinical rational for continuing current dose. The physician signed the form on 7/15/21, with a handwritten "ok", and underline of "continuing current dose" in message above. The form lacked a rationale for continuing current dose. The form was signed by director of nursing (DON) on 7/20/21.

R10's signed Order Summary dated 6/3/21, identified the following orders:

-Trazodone (antidepressant medication) 50 mg by mouth at bedtime related to insomnia, start date 12/12/19.

R10's Medication Administration Record (MAR) for August of 2021, revealed R10 had received the following medications:

-Trazodone 50 mg by mouth one time daily at bedtime for insomnia, started 12/12/19.

R10's progress note dated 5/26/21, revealed R10

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had received orders for comprehensive metabolic panel (CMP) and complete blood count (CBC) lab draws to check patients liver and heart function due to increased in abdominal girth and pain.

On 8/26/21, at 11:25 a.m. the DON confirmed a fax communication had been sent to R10's primary physician, in response an order had been received for labs of a CBC and CMP to be drawn. The DON stated she would have expected the labs to be done at the next available visit, which would have been the following day. The DON confirmed the pharmacy consultants request to have R10's Trazodone reviewed for a GDR had not been sufficiently addressed by R10's primary physician.

On 8/26/21, at 11:31 a.m. the regional MDS coordinator, confirmed R10's GDR for Trazodone had not been addressed by R10's primary physician, and indicated an "ok" was not sufficient rationale for continued use.

On 8/27/21, at 10:04 a.m. during a telephone interview R10's primary physician stated she had not ordered the labs on 5/24/21, and would have remembered to check on them, however would have expected R10's labs to have been drawn during the next available visit. R10's physician stated she had not felt R10 was a candidate for a gradual dose reduction for his Trazodone.

On 8/27/21, at 1:37 p.m. during a telephone interview, the PC stated she expected her recommendations to be addressed within 30 to 60 days after being written. She stated R10 had been seen by psychiatry within the last few months and she had reminded the facility to have one of R10's providers address his Trazodone GDR. The PC stated she did not feel an "ok" in

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response to a GDR was a sufficient rationale and had voiced this to the facility nursing management in the past. The PC stated she was not aware of R10's lab order on 5/25/21, for a CBC and CMP. The PC confirmed had she been aware of the lab orders and she would have recommended the facility obtain them.

R22

R22's significant change Minimum Data Set (MDS) dated 8/6/21, identified R22 had significant cognitive impairment and diagnoses which included: dementia, arthritis and hypertension (high blood pressure). R22's MDS further indicated R22 required extensive assistance with bed mobility, dressing, and personal hygiene. R22's MDS identified R22 received antipsychotic and antidepressant medications 7 of the last 7 days.

R22's care plan revised 8/13/21, identified R22 had an activities of daily living (ADL) self-care performance deficit related to advanced dementia and limited mobility. R22's care plan interventions included: extensive assistance of one staff for dressing, personal hygiene, and bed mobility. R22's care plan identified R22 received antidepressant medication, Trazodone (antidepressant) related to dementia with behavioral disturbance and an aid to sleep. R22's care plan indicated R22 received psychotropic medications, risperidone (antipsychotic) related to behavior management.

R22's Consultant Pharmacist's Medication Review dated 6/9/21, identified R22 had been taking current dose of Trazodone 25 mg at bedtime since 2/2021. CMS guidelines required at least quarterly assessment of

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sedatives/hypnotics for continued need and trial dose reduction consideration. The form's suggested course of action included to assess R22 for continued use of Trazodone 25 mg at bedtime for sleep. If a dose reduction was not appropriate at the time, provide clinical rational for continuing current dose. The physician signed the form on 7/15/21, with a handwritten "ok", and underline of "continuing current dose" in message above. The form lacked a rationale for continuing current dose. The form was signed by director of nursing (DON) on 7/21/21.

R22's Order Summary Report signed 4/15/21, included the following:

-lorazepam (antianxiety medication) tablet 0.5 mg (milligram). Give 0.5 mg by mouth every 6 hours as needed for anxiety and agitation, start date of 8/23/21.

-risperidone (antipsychotic medication) tablet 1 mg. Give 1 mg by mouth every morning and at bedtime related to unspecified dementia with behavioral disturbance, start date of 2/18/21.

-Trazodone hydrochloride (HCl) tablet. Give 25 mg by mouth at bedtime related to unspecified dementia with behavioral disturbance, start date of 12/4/20.

R22's physician progress note dated 4/15/21, identified R22 was currently on Trazodone 25 mg at bedtime, and if R22 appeared fatigued the next day it would be discontinued. No rationale for continued use of Trazodone was included and no orders to discontinue Trazodone were found.

On 8/27/21, at 1:19 p.m. DON indicated she expected the PC to review medications and

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gradual dose reductions. DON reviewed R22's recommendations from 6/9/21, and the response by her primary physician of "Ok" and said nursing should have gotten clarification from the doctor. DON stated R22's primary physician was not very specific on pharmacy recommendation follow ups and indicated the facility needed to have a conversation with R22's primary physician. DON identified the facility was inconsistent with their follow-up of pharmacy recommendations prior to June. DON confirmed she expected the PC's recommendations to be followed up on and if the physician's response was unclear, nursing were to contact the physician to clarify.

On 8/27/21, at 1:45 p.m. during a phone interview PC-A confirmed her expectation was for the facility to follow up on her recommendations within 30-60 days. PC-A indicated she was reviewing her documentation and had noted on 7/15/21, the facility identified they would have had R22's primary care physician document about the recommendation on 8/13/21, however could not locate the documentation. PC-A stated she planned to add the required rationale for continuing R22's Trazodone during her next visit in September. PC-A stated a response from R22's primary care physician of "ok" was not an acceptable rationale for continued use.

SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON) and consulting pharmacist could review and revise policies and procedures for proper monitoring of pharmacy consultant recommendations. Nursing staff could be educated as necessary to the importance of the pharmacist's review. The DON or designee, along with the pharmacist, could audit medication reviews on a regular basis to ensure compliance.

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21530	Continued From page 97 TIME FRAME FOR CORRECTION: twenty-one (21) days.	21530		
21730	MN Rule 4658.1415 Subp. 11 Plant Housekeeping, Operation, & Maintenance Subp. 11. Insect and rodent control. Any condition on the site or in the nursing home conducive to the harborage or breeding of insects, rodents, or other vermin must be eliminated immediately. A continuous pest control program must be maintained by qualified personnel. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide and maintain a safe, functional, sanitary, and comfortable environment for 2 of 2 residents (R4 and R9) who expressed concern about the pest control of flies, for 4 of 4 residents (R16, R11, R14 and R6) observed to have flies on them while eating, during cares and while sleeping. In addition, the facility failed to ensure a pest free environment related to flies landing on food during meal service. This deficient practice had the potential to affect all 25 residents in the facility. Findings include: R4 R4's quarterly Minimum Data Set (MDS) dated 5/31/21, identified R4 had diagnoses which included multiple sclerosis (progressive neurological condition affecting all bodily systems,) paraplegia, diabetes and depression.	21730	"corrected"	10/11/21

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21730	Continued From page 98 The MDS identified R4 was cognitively intact and required extensive assistance with activities of daily living (ADL's) of bed mobility, transfers and toileting. The MDS indicated R4 had limited range of motion to both her bilateral upper and lower extremities. On 8/25/21, at 1:16 p.m. during a resident council meeting, R4 stated she was bothered by all of the flies in the facility but was not able to swat at them herself. R4 stated, "I couldn't hit the broad side of a barn," when asked if she had been provided with a fly swatter. R4 indicated she felt the staff should have been aware of all of the flies as they were all over the facility. R4 stated she had not specifically reported to staff the flies had bothered her. R9 R9's quarterly MDS, dated 6/9/21, identified R9 had diagnoses which included, chronic heart failure, diabetes, arthritis and depression. The MDS identified R9 was cognitively intact and required extensive assistance with ADL's of bed mobility, transfers and toileting. The MDS identified R9 had limited range of motion of bilateral lower extremities. On 8/24/21, at 8:38 a.m. during an interview with R9, several dozen flies were observed in his room, flying around, landing on his lower legs, arms, on his table, bed and on his walls. At that time, R9 stated he had a fly swatter, though he was too weak at that time to be able swat at the flies. R9 stated the flies drove him crazy, and he felt there was a higher number of flies than the average at that time of the year. R9 stated one of the nursing assistants (NA) helped him kill the flies when he asked, however the NA could not	21730		

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remain in his rooms killing flies when he had to care for other residents. R9 stated he felt the facility staff should have been aware there were flies in the building as there were so many and indicated he had not "formally" complained to anyone about the flies.

R16

R16's significant change of status (SCSA) Minimum Data Set (MDS) dated 7/15/21, identified R16 had diagnoses which included: dementia, polymyalgia rheumatica (inflammatory disorder causing muscle pain and stiffness around the shoulders and hips) and psychosis. The MDS identified R1 had severe cognitive impairment and required extensive assistance with activities of daily living (ADL's) of bed mobility, transfers and toileting. The MDS indicated R16 had disorganized thinking, inattention, altered levels of consciousness and delirium. The MDS identified R16 was unable to maintain her balance during transition without physical assistance and had one fall since the last MDS assessment.

On 8/23/21, from 2:35 p.m. to 2:54 p.m. R16 was observed lying on her back in a low bed, eyes were closed and her mouth was opened. R16 had several flies in her room, of which a few would repeatedly land on her face towards her mouth and fly away.

-at 5:55 p.m. R16 was observed lying in bed, on her back, moved her legs and bare feet out of bed towards the floor, took hold of the grab bar with her left hand and attempted to sit up. R16 was unable to sit up, let go of the bar and shut her eyes. At that time, NA-G entered R16's room, picked up the yellow gripper socks from the floor,

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indicated R16 was restless and stated she had told the nurse about R16's restlessness. NA-G left the room and R16's legs remained out of bed. Several flies remained flying around R16's room and on her body. NA-G made no attempt to remove the flies.

-at 6:37 p.m. R16 was observed lying in a low bed on her back, eyes were closed, her body was covered with a sheet, a pink blanket covered her lower body. Several flies were observed flying in her room and on R16's body, periodically landing and flying away.

On 8/24/21, at 8:35 a.m. R16 was observed lying in a low bed, on her back, pillows were positioned on her right side, she had a blanket covering her legs and body up to her mid chest. Several flies were observed in R16's room, periodically landing on her face and body.

On 8/25/21, at 7:06 a.m. R16 was observed lying in bed on her back, covered with a sheet, eyes were closed, she had pillows placed on both her right and left sides and underneath her legs. R16 made no attempt to move her legs out of bed or to try to sit up.

During observations on 8/23/21, at 6:01 p.m. dietary cook (DC)-A was serving the supper meal from the steam table in the main dining room area. DC-A had her hands gloved, she grabbed a plate, placed a scoop of turkey, a scoop of gravy on the turkey and a scoop of baked beans on the plate. DC-A grabbed a handful of raw carrots with her gloved hand, placed them on the plate and set the plate on the steam table to be delivered. During this time multiple flies were flying around the steam table landing on the steam table and on food at times.

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21730	Continued From page 101 R11 R11's annual MDS dated 6/11/21, indicated R11 had severe cognitive impairment and had diagnoses which included: seizure disorder, depression and muscle weakness. The MDS identified R11 was independent with bed mobility, transfers, dressing, toileting, eating and personal hygiene. During observations on 8/23/21, at 5:08 p.m. R11 walked independently in the hallway and back to her room. R11 was wearing a light blue pair of denim jeans and the inside of her legs, half way to her knees and her entire buttocks area had light brown colored stain. R11 sat down in her chair in her room independently and she had multiple flies buzzing around and landing on her and her clothing. R14 R14's quarterly MDS dated 7/13/21, indicated R14 had severe cognitive impairment and had diagnoses which included: depression, poly-arthritis and lymphedema. The MDS identified R14 required two staff assistance with bed mobility, transfers, dressing, toileting, one staff for personal hygiene and supervision with eating. During observations on 8/25/21, at 8:26 a.m. NA-B approached R14 while she was laying in bed, removed R14's covers and there were multiple flies buzzing around and landing on R14 while NA-B collected her supplies. While NA-B provided cares to R14, the flies continued to fly around and NA-B made several attempts to swat at them. NA-B walked to the closet, picked out	21730		

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clothes for R14 and multiple flies continued to fly around R14 and land on her.
- at 8:39 a.m. NA-B brought over some clothes and R14 chose what she wanted to wear. NA-B grabbed R14's pants, donned the pants and applied ace wraps to her lower legs while she tried to swat away several flies that landed or attempted to land on R14.

R6:

R6's quarterly MDS dated 5/27/21, indicated R6 was cognitively intact and had diagnoses which included: diabetes mellitus, anxiety and schizophrenia. The MDS identified R6 required extensive assistance of one staff with bed mobility, toileting, personal hygiene, limited assistance with dressing and supervision with transfers. The MDS identified R6 was always incontinent of bowel and frequently incontinent of bladder, and was not on a bowel or bladder toileting program.

During observations on 8/23/21, at 5:20 p.m. R6 was seated in her wheelchair in the dining room area and her shirt continued to be wet with several soiled white spots. R6 had several flies buzzing around her and landing on the chest of her shirt.

During observations on 8/24/21, at 1:49 p.m. R6 was seated in her wheelchair in her room and had several flies buzzing around her and landing on her pants and shirt. R6 was trying to swat them away with her hands and had no success attempting to get rid of the flies.

During observations on 8/25/21, at 9:52 a.m. R6 was seated in her wheelchair in the dining room at a table and eating a fig bar. While R6 ate her

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21730	Continued From page 103	21730		

fig bar there were several flies buzzing around and landing on her while she ate.
- at 12:21 p.m. R6 was laying in bed resting, with her wheelchair at the side of the bed and several flies were buzzing around her and landing on her while she tried to sleep.

On 8/24/21, at 2:45 p.m. the facility's contracted exterminator technician was observed at the facility. The technician indicated he was there for a routine visit to spray for spiders. He confirmed the facility had several dozen flies throughout both wings, resident rooms and in the common area of the facility. The technician stated he felt the facility would have benefited from spraying outside by the entrances for fly control. He stated he felt the flies were more prominent and bothersome this year versus previous years. The technician indicated the facility had a black light fly trap by the kitchen entrance and indicated he felt it would be beneficial to place one in each hallway to control the flies that could enter through those doorways. The technician stated he was not aware of the facility reaching out to the company regarding pest control for flies.

On 8/27/21, at 12:47 p.m. during an environmental tour with the facility maintenance manager he confirmed there were flies present in the facility, though indicated he felt the number flies were not abnormal and would not qualify as an "infestation." The maintenance manager stated he did not feel the flies in the facility were a problem and residents had access to fly swatters. He stated the facility had routine pest control, which had been there on Tuesday of this week. He indicated he had not spoken to the technician about the flies as he was unaware there was a concern. The maintenance manager stated no staff or residents had voiced any concerns to him

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21730	Continued From page 104 regarding the flies. A policy was requested on pest control and was not provided. SUGGESTED METHOD OF CORRECTION: The administrator, maintenance supervisor, or designee could ensure a preventative pest control program was developed and implemented. The facility could educate staff on these policies and perform routine environmental rounds/audits to ensure adequate pest control. The facility could report these findings to the quality assurance performance improvement (QAPI) committee for further recommendations to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21730		
21805	MN St. Statute 144.651 Subd. 5 Patients & Residents of HC Fac.Bill of Rights Subd. 5. Courteous treatment. Patients and residents have the right to be treated with courtesy and respect for their individuality by employees of or persons providing service in a health care facility. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to promote dignity while utilizing a mechanical lift sling for extended periods of time for 3 of 3 residents (R14, R1 and R21) who were dependent on staff for activities of daily living and required the use of a mechanical lift for transfers.	21805	"corrected"	10/11/21

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21805	Continued From page 105 Findings include: R14 R14's quarterly MDS dated 7/13/21, indicated R14 had severe cognitive impairment and diagnoses which included: depression, poly-arthritis and lymphedema. The MDS indicated R14 required two staff assistance with bed mobility, transfers, dressing, toileting, and one staff for personal hygiene. R14's care plan revised on 2/9/21, indicated R14 had physical functioning deficit related to mobility impairment. The care plan indicated R14 required staff assistance with using a full body lift (hoyer) for transfers and utilized a wheel chair for mobility. During observations on 8/23/21, at 5:08 p.m. R14 was seated in her wheel chair in her room with the door open. R14's mechanical lift sling was visibly draped over the sides and back of her wheelchair and was not tucked in around her or removed while she sat in her wheel chair. During observations on 8/24/21, at 10:02 a.m. R14 was seated in her wheel chair in her room with the door open. R14's mechanical lift sling remained visibly draped over the sides and back of her wheelchair and was not tucked in around her or removed while she sat in her wheel chair. - at 11:29 a.m. R14 was out in the activity room seated in her wheel chair with other residents present and they were playing family feud. R14's mechanical lift sling remained the same. - at 1:07 p.m. R14 was out in the activity room seated in her wheel chair with other residents present and they were playing bingo. R14's	21805		

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21805	Continued From page 106 mechanical lift sling remained the same. During observations on 8/25/21, at 8:52 a.m. nursing assistant (NA-B) went out into the hallway to ask for assistance and returned to R14's room, positioned the mechanical lift over R14, hooked the lift to the sling while trained medication aid (TMA-A) entered the room. NA-B and TMA-A transferred R14 via mechanical lift from her bed to her wheel chair, unhooked the lift from the sling and TMA-A washed her hands and immediately left R14's room. NA-B applied foot peddles to R14's wheelchair, placed her feet on the peddles, grabbed a blanket and covered R14's legs with it. - at 9:03 a.m. NA-B wheeled R14 out of her room, down the hallway towards the dining room area, set her up to the table with other residents in the area and immediately left. R14's mechanical lift sling was visibly draped over the sides and the back of her wheelchair and was not tucked in around her or removed while she sat in her wheel chair. - at 9:36 a.m. R14 remained seated in the dining room area with other residents and continued to have her mechanical lift sling visibly draped over the sides and back of her wheelchair. NA-B was not observed to offer or attempt to tuck the mechanical lift sling out of other's view or remove it while R14 sat in her wheel chair. On 8/25/21, at 9:14 a.m. NA-B confirmed the above findings and indicated R14 utilized the sling with a mechanical lift for all of her transfers. NA-B indicated the sling should have been tucked in out of site or removed to maintain R14's dignity. On 8/27/21, at 9:36 a.m. attempted to call family member about dignity with use of sling and family member did not answer.	21805		

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21805	Continued From page 107 R1 Findings include: R1's quarterly Minimum Data Set (MDS) dated 8/17/21, identified R1 had diagnoses of dementia, depression weakness and peripheral neuropathy (numbness/tingle in extremities.) The MDS identified R1 had severe cognitive impairment and required extensive assistance with activities of daily living (ADL's) of bed mobility, transfers, toileting and locomotion. The MDS identified R1 used assistive devices of a wheelchair. R1's care plan revised 7/12/21, revealed R1 had impaired cognition, function, thought process and required the use of a full body mechanical lift for transfers. The care plan revealed R1 used a wheelchair and required extensive assistance with locomotion. R1's care plan lacked direction for placement of the sling used to transfer R1 with the full body mechanical lift. R1's nursing assistant care guide dated 8/26/21, revealed R1 required extensive assistance of two staff and the use of a full body mechanical lift to transfer. The care guide lacked direction for placement of the sling used to transfer R1 with the full body mechanical lift. On 8/23/21, at 6:08 p.m. R1 was observed seated in a wheelchair in the hallway, wheeled down the hall by nursing assistant (NA)-H towards the dining room, a blue mechanical lift transfer sling hung over the back and sides of R1's wheelchair approximately five to six inches. R1 was wheeled to the dining room which held several residents, to a squared table next to another resident and NA-H walked away.	21805		

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21805	Continued From page 108 On 8/24/21, at 8:50 a.m. R1 was observed seated in a wheelchair in the dining room at a squared table next to another resident. R1 was observed seated on a blue mechanical lift transfer sling which hung over the back and sides of R1's wheelchair approximately five to six inches. - at 11:32 a.m. R1 was observed seated in a wheelchair in the facility activity room with several other residents, a blue mechanical lift transfer lift sling hung over the back and the sides of R1's wheelchair approximately five to six inches. - at 11:36 a.m. R1 was observed seated in a wheelchair, with a blue mechanical lift sling hanging over the back and sides of her wheelchair and NA-D wheeled R1 to her room from the activity room. NA-C entered R1's room with a full body mechanical lift. NA-D and NA-C placed the mechanical lift in front of R1, took hold of the blue sling strap which R1 was seated on, attached the sling straps to the mechanical lift and transferred R1 to bed. NA-C and NA-D removed the blue mechanical lift sling from underneath R1 and placed it in the wheelchair. On 8/25/21, at 8:24 a.m. R1 was observed seated in a wheelchair in her room, her eyes were closed, head was tilted back and her mouth was open. R1 was seated on a blue full body mechanical lift transfer sling, which hung over the sides and the back of the wheelchair. - at 10:17 a.m. R1 was observed seated in a wheelchair and was wheeled by trained medication aid (TMA)-A towards her room. TMA-A wheeled R1 into her room, obtained a full body mechanical lift and the occupational therapy assistant, they proceeded to gather the straps	21805		

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from the sling underneath R1, attached the straps to the lift and assisted R1 to transfer from her wheelchair to bed. TMA-A removed the sling from underneath R1 and placed it into the wheelchair.

On 8/24/21, at 11:48 a.m. NA-C indicated R1 was totally dependent on staff for all ADL's and was not able to tell staff of her needs. NA-C stated R1's blue lift sling was kept underneath R1 when she was seated in the wheelchair for ease of use.

On 8/25/21, at 8:30 a.m. NA-E stated R1 was dependent on staff for transfers and required the use of a full body mechanical lift. NA-E indicated R1's sling was kept underneath her in the wheelchair as it was easier on R1 to leave the sling underneath her. NA-E indicated R1's sling and straps were usually visible when she was in her wheelchair.

On 8/25/21, at 10:21 a.m. TMA-A indicated R1 was dependent on staff for all of her ADL's and required the use of a full body mechanical lift for transfers into bed. TMA-A stated the sling used to transfer R1 was left underneath her when she was in her chair and it was easier to transfer. TMA-A indicated the blue sling used to transfer R1 was usually visible when she was seated in her wheelchair.

On 8/26/21, at 10:44 a.m. a telephone call was placed to R1's family member and a message was left.

R21

R21's significant change Minimum Data Set (MDS) dated 8/4/21, identified R21 had significant cognitive impairment and diagnoses which included Alzheimer's disease, muscle weakness

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and thyroid disorder. R21's MDS further identified R21 required total assistance with transfers, and extensive assistance with bed mobility, dressing and personal hygiene.

R21's significant change Care Area Assessment (CAA) dated 8/5/21, identified R21 had advanced dementia and was not able to communicate her wants or needs. The CAA indicated R21 was dependent on staff for all transfers and locomotion. R21's CAA identified R21 required extensive assistance with bed mobility and activities of daily living (ADLs).

R21's care plan revised 7/12/21, identified R21 required extensive assistance with full body lift for all transfers and had impaired thought processes related to Alzheimer's disease.

On 8/23/21, at 5:11 p.m. R21 was in her wheelchair in her room with the door open and visible from the hallway. R21's mechanical lift sling was visibly draped over the sides and back of her wheelchair by 3-4 inches. At 5:57 p.m. R21 was in the dining room in her wheelchair while the mechanical lift sling remained visibly draped over the sides and back of her wheelchair.

On 8/24/21, at 11:56 a.m. R21 was sitting in her wheelchair in her room with the door open and was visible from the hallway. R21's mechanical lift sling was visibly draped over the sides and back of her wheelchair.

On 8/24/21, at 1:13 p.m. licensed practical nurse (LPN)-A was transporting R21 down the hallway to her room. R21's mechanical lift sling remained visibly draped over the sides and the back of the wheelchair by 3-4 inches. At 1:36 p.m. nursing assistant (NA)-F and NA-G were in R21's room

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assisting R21 with a mechanical lift from her wheelchair to her bed. R21's sling had remained draped around R21's wheelchair sides and back until they completed R21's transfer from her wheelchair to her bed.

On 8/25/21, at 11:45 a.m. R21 was in her wheelchair and the mechanical lift sling was visibly draped on both sides and above her back and shoulders. R21 was in the activity room with other residents and staff members.

On 8/25/21, at 12:09 p.m. NA-E indicated her usual process for mechanical lift slings was to leave them in the wheelchair of the residents. NA-E said she tried to tuck them in so the slings were not visible to others.

On 8/27/21, at 10:29 a.m. clinical manager (CM)-A confirmed mechanical lift slings should have been removed after each use. CM-A indicated the mechanical lift slings the facility used were designed to be easily removed from the wheelchair or bed after each use. CM-A stated she expected the mechanical lift slings to be removed for all residents and indicated keeping them in the wheelchair increased the residents' risk of developing skin tears or bruises. CM-A confirmed it was a dignity issue as well.

On 8/26/21, at 2:21 p.m. the administrator confirmed the above findings and indicated once the resident was up and in their wheel chair staff should have removed or tucked the sling out of sight so it was not visible to others. The administrator confirmed it was a dignity issue when staff did not remove or tuck the sling out of sight of others.

On 8/27/21, at 9:50 a.m. the director of nursing

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21805	Continued From page 112 (DON) stated she expected residents who used a sling for transfers with a mechanical lift to have the sling hidden or removed in order to maintain dignity. Review of facility policy titled, Quality of Life Dignity dated 3/17/21, indicated each resident should be cared for in a manner that promoted and enhanced his or her sense of well being, level of satisfaction with life, feeling of self worth and self esteem. Residents were to be treated with dignity and respect at all times. SUGGESTED METHOD OF CORRECTION: The director of nursing or her designee could develop policies and procedures to ensure residents are treated with dignity. The director of nursing or her designee could educate all appropriate staff members on the processes. The director of nursing or her designee could develop monitoring systems to ensure ongoing compliance TIME PERIOD FOR CORRECTION: Twenty-One (21) Days	21805		

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E 000	Initial Comments On 8/23/21, to 8/27/21, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) was conducted during a standard recertification survey. The facility was 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 024 SS=C	Policies/Procedures-Volunteers and Staffing CFR(s): 483.73(b)(6) §403.748(b)(6), §416.54(b)(5), §418.113(b)(4), §441.184(b)(6), §460.84(b)(7), §482.15(b)(6), §483.73(b)(6), §483.475(b)(6), §484.102(b)(5), §485.68(b)(4), §485.625(b)(6), §485.727(b)(4), §485.920(b)(5), §491.12(b)(4), §494.62(b)(5). [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:]	E 024		10/11/21

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

Electronically Signed | 10/01/2021

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E 024	Continued From page 1 (6) [or (4), (5), or (7) as noted above] The use of volunteers in an emergency or other emergency staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency. *[For RNHCIs at §403.748(b):] Policies and procedures. (6) The use of volunteers in an emergency and other emergency staffing strategies to address surge needs during an emergency. *[For Hospice at §418.113(b):] Policies and procedures. (4) The use of hospice employees in an emergency and other emergency staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to develop policies and procedures for volunteer support during an emergency as part of the facility's emergency preparedness plan. This deficient practice had the potential to affect all 25 residents who currently resided in the facility. Findings include: A review of the facility's Meadow Lane Restorative Care Center Disaster manual, updated August 2020, was conducted with the administrator present and she confirmed the findings. The manual included various topics which included bomb threat, fires, active shooter	E 024	1. It is the expectation of the facility to have policies and procedures for volunteer support during an emergency as part of the facility□s emergency preparedness plan. The facility emergency policies and procedures were requested on August 27th were reviewed and provided via email on August 31st, 2021. 2. All residents have the potential to be affected by failure to have policies and procedures on volunteer support as part of the emergency preparedness plan. The facility had last reviewed and revised the orientation for newly hired employees, transfers, volunteers last on March 17th,	

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E 024	Continued From page 2 and natural disasters. However, the manual lacked documentation of a policy for the use of volunteer support during an emergency. Additional facility volunteer support during emergencies documentation was requested and not received.	E 024	2021 and has since re-reviewed the policies and procedures. 3. The facility has assigned routine reviewing of annual requirements through monthly QAPI to ensure that the facility has at a minimum annually reviewed and revised policies and procedures to ensure compliance with regulatory requirements. All staff in-service education is planned for 10/4/2021 to include volunteer support during emergency. The expectation of the facility is to educate and train new volunteers and new employees upon hire and annually. 4. Under the direction of the Administrator, the facility will review current policy and update as indicated. Audits for new employee□s emergency preparedness policies and procedures for volunteers and staff weekly for 6 weeks and monthly for 3 months. All findings will be brought to and monitoring through the monthly quality assurance committee.	
E 037 SS=C	EP Training Program CFR(s): 483.73(d)(1) §403.748(d)(1), §416.54(d)(1), §418.113(d)(1), §441.184(d)(1), §460.84(d)(1), §482.15(d)(1), §483.73(d)(1), §483.475(d)(1), §484.102(d)(1), §485.68(d)(1), §485.625(d)(1), §485.727(d)(1), §485.920(d)(1), §486.360(d)(1), §491.12(d)(1). *[For RNCHIs at §403.748, ASCs at §416.54, Hospitals at §482.15, ICF/IIDs at §483.475, HHAs at §484.102, "Organizations" under §485.727, OPOs at §486.360, RHC/FQHCs at §491.12:] (1) Training program. The [facility] must do all of the following:	E 037		10/11/21

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E 037	Continued From page 3 (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the [facility] must conduct training on the updated policies and procedures. *[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles. (ii) Demonstrate staff knowledge of emergency procedures. (iii) Provide emergency preparedness training at least every 2 years. (iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others. (v) Maintain documentation of all emergency preparedness training. (vi) If the emergency preparedness policies and procedures are significantly updated, the hospice must conduct training on the updated policies and	E 037		

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E 037	Continued From page 4 procedures. *[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) After initial training, provide emergency preparedness training every 2 years. (iii) Demonstrate staff knowledge of emergency procedures. (iv) Maintain documentation of all emergency preparedness training. (v) If the emergency preparedness policies and procedures are significantly updated, the PRTF must conduct training on the updated policies and procedures. *[For PACE at §460.84(d):] (1) The PACE organization must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, contractors, participants, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Demonstrate staff knowledge of emergency procedures, including informing participants of what to do, where to go, and whom to contact in case of an emergency. (iv) Maintain documentation of all training. (v) If the emergency preparedness policies and procedures are significantly updated, the PACE must conduct training on the updated policies and procedures.	E 037		

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E 037	Continued From page 5 *[For LTC Facilities at §483.73(d):] (1) Training Program. The LTC facility must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. *[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following: (i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment. (v) If the emergency preparedness policies and procedures are significantly updated, the CORF must conduct training on the updated policies and procedures.	E 037		

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E 037	Continued From page 6 *[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following: (i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the CAH must conduct training on the updated policies and procedures. *[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least every 2 years. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to develop a system to provide new employee education on the policies and	E 037	1. It is the expectation of the facility to develop a system to provide new employee education on the policies and	

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E 037	Continued From page 7 procedures for the facility's emergency preparedness plan for 2 out of 3 employees. This deficient practice had the potential to affect all 25 residents who currently resided in the facility. Findings include: A review of the facility Meadow Lane Restorative Care Center manual, updated October 2020, conducted with the administrator present and she confirmed the findings. The manual included various topics which included bomb threat, fires, active shooter and natural disasters. However, the manual lacked documentation of a system to provide new employee education on the policies and procedures for the facility's emergency preparedness plan. On 8/31/21, emergency preparedness certificates were provided by the administrator and identified the following: -Director of Nursing (DON) completed the new employee emergency preparedness education on 8/30/21. -Registered nurse (RN)-A completed the new employee emergency preparedness education on 8/31/21. During an interview on 8/27/21, at 9:53 a.m. RN-A stated she had been working at this facility for approximately a few months. Review of a facility staff record on 08/27/21, at 10:37 a.m. identified DON date of hire had been 3/30/21. A facility policy titled Orientation program for	E 037	procedures for the facility's emergency preparedness plan. It was identified that the facility lacked providing new hire education timely for 2 out of 3 employees who were reviewed for emergency preparedness training. RN-A was at the facility for a few months before completing her training on 8/21/2021. DON hire date was 3/30/2021, however she did not begin employment at the facility until 5/5/2021, and her training completed on 8/30/21. Both had not completed their orientation within the expected 5 days of starting employment at facility, but since have completed. 2. All employees are expected to have completed emergency preparedness training timely. All new hires were reviewed to ensure compliance with emergency preparedness training requirements. No further employees were found to be out of compliance. 3.To enhance currently compliant operations and under the direction of the Administrator, an all-staff training is being provided on 10/4/21 which includes re-education and review of the training of EP policies and procedures. 4. Effective 10/1/2021, a quality assurance program was implemented under the supervision of the Administrator to monitor supervision to ensure ongoing compliance with new hire orientation and training. The Director of Clinical Education will audit current employees and all new hires since last audit weekly for 6 weeks and monthly for 3 months. Any identified deficiencies will be corrected; all findings will be brought to	

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E 037	Continued From page 8 newly hired employees, transfers, volunteers, last revised 5/2019, identified an orientation program shall be conducted for all newly employees, transfers from other departments, those providing services under contractual agreements, and volunteers. All newly hired personnel/volunteers/transfers, contractors must attend a 10 hour orientation program within their first 5 days of hire.	E 037	the monthly quality assurance committee for further review and ongoing monitoring.	
F 000	INITIAL COMMENTS On 8/23/21, to 8/27/21, 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. The following complaints were found to be SUBSTANTIATED: H5313059C (MN00055846), with a deficiency cited at F677. H5313061C (MN00073747), with a deficiency cited at F677, and F689. AND The following complaint was found to be UNSUBSTANTIATED: H5313060C (MN00055887). 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.	F 000		

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F 000	Continued From page 9 Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal	F 550		10/11/21

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F 550	Continued From page 10 from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to promote dignity while utilizing a mechanical lift sling for extended periods of time for 3 of 3 residents (R14, R1 and R21) who were dependent on staff for activities of daily living and required the use of a mechanical lift for transfers. Findings include: R14 R14's quarterly MDS dated 7/13/21, indicated R14 had severe cognitive impairment and diagnoses which included: depression, poly-arthritis and lymphedema. The MDS indicated R14 required two staff assistance with bed mobility, transfers, dressing, toileting, and one staff for personal hygiene. R14's care plan revised on 2/9/21, indicated R14 had physical functioning deficit related to mobility impairment. The care plan indicated R14 required staff assistance with using a full body lift (hoyer) for transfers and utilized a wheel chair for mobility. During observations on 8/23/21, at 5:08 p.m. R14 was seated in her wheel chair in her room with	F 550	1. It is the expectation of the facility to promote dignity while utilizing a mechanical lift sling for residents who were dependent on staff for activities of daily living and required the use of a mechanical lift for transfers. R14, R1 and R21 were observed and reviewed to ensure that their slings were not visible in their room or wheelchair, regardless of if they we or weren□t in either; corrective actions were reviewed and in place. 2. To promote dignity, all residents who require the use of a mechanical lift should not have their sling left visible in their room or wheelchair. All residents who use a mechanical lift for transfers were reviewed and appropriate interventions in place. No other residents were adversely affected. 3. To enhance currently compliant operations and under the direction of the Director of Nurses, a nursing in-service training is planned on 10/4/21 which includes re-education and honoring dignity with residents including those who use slings. Education provided includes resident bill of rights, dignity and how it	

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F 550	Continued From page 11 the door open. R14's mechanical lift sling was visibly draped over the sides and back of her wheelchair and was not tucked in around her or removed while she sat in her wheel chair. During observations on 8/24/21, at 10:02 a.m. R14 was seated in her wheel chair in her room with the door open. R14's mechanical lift sling remained visibly draped over the sides and back of her wheelchair and was not tucked in around her or removed while she sat in her wheel chair. - at 11:29 a.m. R14 was out in the activity room seated in her wheel chair with other residents present and they were playing family feud. R14's mechanical lift sling remained the same. - at 1:07 p.m. R14 was out in the activity room seated in her wheel chair with other residents present and they were playing bingo. R14's mechanical lift sling remained the same. During observations on 8/25/21, at 8:52 a.m. nursing assistant (NA-B) went out into the hallway to ask for assistance and returned to R14's room, positioned the mechanical lift over R14, hooked the lift to the sling while trained medication aid (TMA-A) entered the room. NA-B and TMA-A transferred R14 via mechanical lift from her bed to her wheel chair, unhooked the lift from the sling and TMA-A washed her hands and immediately left R14's room. NA-B applied foot peddles to R14's wheelchair, placed her feet on the peddles, grabbed a blanket and covered R14's legs with it. - at 9:03 a.m. NA-B wheeled R14 out of her room, down the hallway towards the dining room area, set her up to the table with other residents in the area and immediately left. R14's mechanical lift sling was visibly draped over the sides and the back of her wheelchair and was not tucked in around her or removed while she sat in her wheel	F 550	pertains to residents, their rooms/home, and audits implemented. Policies reviewed include Quality of Life: Dignity dated 3-17-21. 4. Effective 10/1/2021, a quality assurance program was implemented under the supervision of the Director of Nursing to monitor supervision to ensure ongoing compliance with promoting dignity. The Director of Nursing/Designee will audit residents 2 times a week for 6 weeks and then once a week for 6 weeks. Any identified deficiencies will be corrected, and all findings brought to the monthly quality assurance committee for further review and ongoing monitoring.	

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chair.
- at 9:36 a.m. R14 remained seated in the dining room area with other residents and continued to have her mechanical lift sling visibly draped over the sides and back of her wheelchair. NA-B was not observed to offer or attempt to tuck the mechanical lift sling out of other's view or remove it while R14 sat in her wheel chair.

On 8/25/21, at 9:14 a.m. NA-B confirmed the above findings and indicated R14 utilized the sling with a mechanical lift for all of her transfers. NA-B indicated the sling should have been tucked in out of site or removed to maintain R14's dignity.

On 8/27/21, at 9:36 a.m. attempted to call family member about dignity with use of sling and family member did not answer.

R1

Findings include:

R1's quarterly Minimum Data Set (MDS) dated 8/17/21, identified R1 had diagnoses of dementia, depression weakness and peripheral neuropathy (numbness/tingle in extremities.) The MDS identified R1 had severe cognitive impairment and required extensive assistance with activities of daily living (ADL's) of bed mobility, transfers, toileting and locomotion. The MDS identified R1 used assistive devices of a wheelchair.

R1's care plan revised 7/12/21, revealed R1 had impaired cognition, function, thought process and required the use of a full body mechanical lift for transfers. The care plan revealed R1 used a

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wheelchair and required extensive assistance with locomotion. R1's care plan lacked direction for placement of the sling used to transfer R1 with the full body mechanical lift.

R1's nursing assistant care guide dated 8/26/21, revealed R1 required extensive assistance of two staff and the use of a full body mechanical lift to transfer. The care guide lacked direction for placement of the sling used to transfer R1 with the full body mechanical lift.

On 8/23/21, at 6:08 p.m. R1 was observed seated in a wheelchair in the hallway, wheeled down the hall by nursing assistant (NA)-H towards the dining room, a blue mechanical lift transfer sling hung over the back and sides of R1's wheelchair approximately five to six inches. R1 was wheeled to the dining room which held several residents, to a squared table next to another resident and NA-H walked away.

On 8/24/21, at 8:50 a.m. R1 was observed seated in a wheelchair in the dining room at a squared table next to another resident. R1 was observed seated on a blue mechanical lift transfer sling which hung over the back and sides of R1's wheelchair approximately five to six inches.

- at 11:32 a.m. R1 was observed seated in a wheelchair in the facility activity room with several other residents, a blue mechanical lift transfer lift sling hung over the back and the sides of R1's wheelchair approximately five to six inches.

- at 11:36 a.m. R1 was observed seated in a wheelchair, with a blue mechanical lift sling hanging over the back and sides of her wheelchair and NA-D wheeled R1 to her room

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from the activity room. NA-C entered R1's room with a full body mechanical lift. NA-D and NA-C placed the mechanical lift in front of R1, took hold of the blue sling strap which R1 was seated on, attached the sling straps to the mechanical lift and transferred R1 to bed. NA-C and NA-D removed the blue mechanical lift sling from underneath R1 and placed it in the wheelchair.

On 8/25/21, at 8:24 a.m. R1 was observed seated in a wheelchair in her room, her eyes were closed, head was tilted back and her mouth was open. R1 was seated on a blue full body mechanical lift transfer sling, which hung over the sides and the back of the wheelchair.

- at 10:17 a.m. R1 was observed seated in a wheelchair and was wheeled by trained medication aid (TMA)-A towards her room. TMA-A wheeled R1 into her room, obtained a full body mechanical lift and the occupational therapy assistant, they proceeded to gather the straps from the sling underneath R1, attached the straps to the lift and assisted R1 to transfer from her wheelchair to bed. TMA-A removed the sling from underneath R1 and placed it into the wheelchair.

On 8/24/21, at 11:48 a.m. NA-C indicated R1 was totally dependent on staff for all ADL's and was not able to tell staff of her needs. NA-C stated R1's blue lift sling was kept underneath R1 when she was seated in the wheelchair for ease of use.

On 8/25/21, at 8:30 a.m. NA-E stated R1 was dependent on staff for transfers and required the use of a full body mechanical lift. NA-E indicated R1's sling was kept underneath her in the wheelchair as it was easier on R1 to leave the sling underneath her. NA-E indicated R1's sling

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and straps were usually visible when she was in her wheelchair.

On 8/25/21, at 10:21 a.m. TMA-A indicated R1 was dependent on staff for all of her ADL's and required the use of a full body mechanical lift for transfers into bed. TMA-A stated the sling used to transfer R1 was left underneath her when she was in her chair and it was easier to transfer. TMA-A indicated the blue sling used to transfer R1 was usually visible when she was seated in her wheelchair.

On 8/26/21, at 10:44 a.m. a telephone call was placed to R1's family member and a message was left.

R21

R21's significant change Minimum Data Set (MDS) dated 8/4/21, identified R21 had significant cognitive impairment and diagnoses which included Alzheimer's disease, muscle weakness and thyroid disorder. R21's MDS further identified R21 required total assistance with transfers, and extensive assistance with bed mobility, dressing and personal hygiene.

R21's significant change Care Area Assessment (CAA) dated 8/5/21, identified R21 had advanced dementia and was not able to communicate her wants or needs. The CAA indicated R21 was dependent on staff for all transfers and locomotion. R21's CAA identified R21 required extensive assistance with bed mobility and activities of daily living (ADLs).

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R21's care plan revised 7/12/21, identified R21 required extensive assistance with full body lift for all transfers and had impaired thought processes related to Alzheimer's disease.

On 8/23/21, at 5:11 p.m. R21 was in her wheelchair in her room with the door open and visible from the hallway. R21's mechanical lift sling was visibly draped over the sides and back of her wheelchair by 3-4 inches. At 5:57 p.m. R21 was in the dining room in her wheelchair while the mechanical lift sling remained visibly draped over the sides and back of her wheelchair.

On 8/24/21, at 11:56 a.m. R21 was sitting in her wheelchair in her room with the door open and was visible from the hallway. R21's mechanical lift sling was visibly draped over the sides and back of her wheelchair.

On 8/24/21, at 1:13 p.m. licensed practical nurse (LPN)-A was transporting R21 down the hallway to her room. R21's mechanical lift sling remained visibly draped over the sides and the back of the wheelchair by 3-4 inches. At 1:36 p.m. nursing assistant (NA)-F and NA-G were in R21's room assisting R21 with a mechanical lift from her wheelchair to her bed. R21's sling had remained draped around R21's wheelchair sides and back until they completed R21's transfer from her wheelchair to her bed.

On 8/25/21, at 11:45 a.m. R21 was in her wheelchair and the mechanical lift sling was visibly draped on both sides and above her back and shoulders. R21 was in the activity room with other residents and staff members.

On 8/25/21, at 12:09 p.m. NA-E indicated her

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usual process for mechanical lift slings was to leave them in the wheelchair of the residents. NA-E said she tried to tuck them in so the slings were not visible to others.

On 8/27/21, at 10:29 a.m. clinical manager (CM)-A confirmed mechanical lift slings should have been removed after each use. CM-A indicated the mechanical lift slings the facility used were designed to be easily removed from the wheelchair or bed after each use. CM-A stated she expected the mechanical lift slings to be removed for all residents and indicated keeping them in the wheelchair increased the residents' risk of developing skin tears or bruises. CM-A confirmed it was a dignity issue as well.

On 8/26/21, at 2:21 p.m. the administrator confirmed the above findings and indicated once the resident was up and in their wheel chair staff should have removed or tucked the sling out of sight so it was not visible to others. The administrator confirmed it was a dignity issue when staff did not remove or tuck the sling out of sight of others.

On 8/27/21, at 9:50 a.m. the director of nursing (DON) stated she expected residents who used a sling for transfers with a mechanical lift to have the sling hidden or removed in order to maintain dignity.

Review of facility policy titled, Quality of Life Dignity dated 3/17/21, indicated each resident should be cared for in a manner that promoted and enhanced his or her sense of well being, level of satisfaction with life, feeling of self worth and self esteem. Residents were to be treated with dignity and respect at all times.

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F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide privacy during	F 583	1. It is the expectation of the facility to provide privacy to residents during	10/11/21

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F 583	Continued From page 19 personal cares for 3 of 7 residents (R2, R22, R21) observed during personal cares. R2 R2's quarterly Minimum Data Set (MDS) dated 8/18/21, identified R2 was cognitively intact and had diagnoses which included: cerebrovascular accident (CVA) (stroke), hemiplegia (paralysis on one side of the body) and hemiparesis (weakness on one side of the body). R2's MDS indicated R2 required extensive assistance with dressing and transfers. R2's care plan revised 7/12/21, identified R2 had a physical functioning deficit and required assistance of one staff with dressing, personal hygiene and transferring while using a standing lift. On 8/25/21, at 8:48 a.m. clinical manager (CM)-A and nursing assistant (NA)-E assisted R2 to a sitting position with the use of the sit to stand mechanical lift out of the right side of the bed which was near R2's roommate's side of the room. The privacy curtain was pulled back against the wall while R2's roommate sat in her wheelchair facing R2 and R2's side of the room. R2's pants were pulled down to her thighs and her brief was visible. CM-A assisted R2 to place her feet onto the lift, applied the strap around her legs and NA-E applied the harness around her waist. CM-A raised R2 up in the lift while R2's pants remained down, continued to expose her bare thighs and brief and R2's roommate was facing R2 . CM-A and NA-E asked R2 questions and R2's roommate responded by saying yeah repeatedly. CM-A and NA-E moved R2 towards her wheelchair with the lift while her pants	F 583	personal cares. R2, R22, R21 were reviewed, and staff educated to ensure compliance with providing privacy to residents during personal cares. 2. All residents are expected to be provided privacy and can be affected by the deficient practice. All residents were reviewed an no other incidents were identified. 3. To enhance currently compliant operations and under the direction of the director of nurses, a nursing in-service training is planned on 10/4/21 which includes re-education and review of facility policies and providing privacy reviewed. 4. Effective 10/1/2021, a quality assurance program was implemented under the supervision of the Director of Nursing to monitor supervision to ensure ongoing compliance with providing privacy. The Director of Nursing/Designee will audit weekly for 6 weeks and then monthly for 3 months. Any identified deficiencies will be corrected, and all findings brought to the monthly quality assurance committee for further review and ongoing monitoring.	

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remained down and her thighs and brief were exposed and the feet of the lift were only a few inches away from R2's roommate. NA-E pulled up R2's pants and CM-A lowered R2 to the wheelchair with the use of the lift. NA-E assisted R2 to put a sweat shirt on and assisted R2 out of the room in her wheelchair.

On 8/26/21, at 1:54 a.m. NA-E indicated R2's roommate had been in the room during R2's transfer and they had pulled up R2's pants in front of R2's roommate. NA-E indicated they always assisted R2 to transfer out of bed on her right side which faced R2's roommate's side of the room. NA-E stated her usual practice was to transfer R2 when her roommate was not in the room or to pull the privacy curtain between them. NA-E indicated R2 had been hollering at her to get her up and NA-E was in a hurry, so she did not pull the privacy curtain.

On 8/27/21, at 10:41 a.m. during a phone interview CM-A confirmed they had not provided privacy for R2 during her transfer out of bed. CM-A stated the privacy curtain should have been pulled between R2 and R2's roommate during R2's transfer out of bed. CM-A indicated her normal practice was to pull the privacy curtain between residents during cares and indicated she was aware of the normal practice.

On 8/27/21, at 1:38 p.m. director of nursing (DON) stated her expectation was for resident's privacy to be assured by closing window curtains, privacy curtains and doors during all cares. DON stated when a resident's roommate was in the room, the privacy curtain must be pulled to assure privacy.

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R22

R22's significant change Minimum Data Set (MDS) dated 8/6/21, identified R22 had significant cognitive impairment and diagnoses which included: dementia, arthritis and hypertension (high blood pressure). R22's MDS indicated R22 required extensive assistance with bed mobility, dressing, and personal hygiene.

R22's care plan, revised 8/13/21, identified R22 had an activities of daily living (ADL) self-care performance deficit related to advanced dementia and limited mobility. R22's care plan interventions included extensive assistance of one staff for dressing, personal hygiene, and bed mobility.

On 8/25/21, at 7:37 a.m. NA-B raised up R22's bed and informed R22 she would be assisting her with her cares. NA-B asked R22 to let go of the sheet, which R22 did and NA-B pulled down R22's sheet and proceeded to remove R22's gown, while R22 repeatedly grabbed at NA-B's right arm and hand. After NA-B pulled down the sheet, R22 laid exposed in her bed from her neck down to her feet; with only a brief on and her sheet and blanket bunched down by her feet. Additionally, the privacy curtain was not pulled to provide privacy. NA-B unfastened the tabs of R22's brief, checked R22's brief and lowered R22's bed to the low position. NA-B went to the sink and obtained R22's basin of water, soap, wash cloth and towel and placed it beside R22 on her bed side table. NA-B instructed R22 to wash her face and provided assistance. R22 remained in the bed, uncovered and exposed from her neck down to her feet with only her brief on, while the sheet and blanket laid bunched up at the foot of

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her bed. At 7:45 a.m. housekeeper (HK)-A knocked on the door, opened the door slightly then said "laundry, I will come back". At 7:46 a.m. NA-B assisted R22 by washing her hands and arms, while R22 sat up on the edge of the bed. NA-B informed R22 she would assist her with the brief and assisted R22 to lay back down, still uncovered and exposed from her neck down to her feet. NA-B pulled R22's brief down, cleansed her perineal area in the front, dried her, went to the closet to obtain a new brief while R22 was fully exposed from her neck down to her feet. NA-B returned to R22's bed, removed the brief from under her, washed her buttocks and applied a new brief. At 7:49 p.m. HK-A knocked on the door, began to open the door and asked if laundry now could be delivered. NA-B did not answer HK-A, surveyor blocked view by moving body in front of door opening, answered no and HK-A closed the door. At 7:55 a.m. NA-B applied R22's shirt and at 8:00 a.m. NA-B applied R22's socks and pants.

On 8/25/21, at 10:06 a.m. NA-B confirmed she had not provided R22 privacy by leaving her exposed from her neck down to her feet during cares. NA-B stated it was expected staff provide privacy and provide a dignified experience for residents.

On 8/27/21, at 11:42 a.m. during a phone interview family member (FM)-A stated R22 was a very modest person and she would not like it if she was exposed during cares. FM-A indicated R22's bed was right by the door and if someone opened the door during cares while she was exposed that would be an undignified experience for R22. FM-A indicated she expected the facility to provide privacy during cares for R22.

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R21

R21's significant change Minimum Data Set (MDS) dated 8/4/21, identified R21 had significant cognitive impairment and diagnoses which included: Alzheimer's disease, muscle weakness and thyroid disorder. R21's MDS further indicated R21 required total assistance with transfers, extensive assistance with bed mobility, dressing and personal hygiene.

R21's care plan revised 7/12/21, identified R21 required extensive assistance with dressing, personal hygiene and R22 did not use the toilet and was to be checked and changed periodically. R21's care plan identified R21 had impaired thought processes related to Alzheimer's disease.

On 8/23/21, at 2:41 p.m. NA-H entered R21's room. R21's door was open while R21 was lying on her bed, with her feet out touching the mat next to her bed. NA-H repositioned R21 back into bed, pulled down R21's sheet, which then exposed her brief and bare thighs, while her pants had been pulled down to her thighs. NA-H checked her brief, then pulled the sheet back over her to cover her, while R2's pants remained down around her thighs. NA-H did not pull the privacy curtain or shut the door while checking R21's brief for incontinence and R21 was visibly exposed from the hallway.

On 8/27/21, at 10:19 a.m. during a phone interview CM-A confirmed she expected staff to provide as much privacy as possible for residents during cares as possible.

On 8/27/21, at 12:54 p.m. NA-H stated he had

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F 583	Continued From page 24 checked R21 for incontinence on 8/23/21, in the afternoon. NA-H indicated he had forgotten to close R21's door when he checked her for incontinence. NA-H indicated indicated the usual practice was to close resident's doors when providing cares to provide privacy. On 8/27/21, at 1:19 p.m. director of nursing (DON) confirmed she expected staff to provide privacy and promote dignity during cares for all residents, which included covering areas not being bathed, etc. The facility policy titled Dressing And Undressing, Assisting the Resident With Level II dated 3/17/21, instructed staff to allow the resident as much privacy as possible while he or she was dressing or undressing. The facility policy titled Confidentiality of Information And Personal Privacy, dated 3/17/21, identified the facility would strive to protect the resident's privacy regarding his or her personal care.	F 583		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission.	F 655		10/11/21

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F 655	Continued From page 25 (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide a summary of the baseline care plan to the resident or resident representative for 1 of 1 residents (R26) recently admitted.	F 655	1. It is the expectation of the facility to ensure compliance with providing the baseline care plan to the resident or resident representative after they have admitted. R26 no longer resides at the facility.	

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F 655	Continued From page 26 Findings include: R26's admission Minimum Data Set (MDS) dated 6/19/21, identified R26 was admitted to the facility on 5/28/21. The MDS indicated R26 was cognitively intact and had diagnoses which included: hypertension, diabetes mellitus and respiratory failure. The MDS indicated R26 required extensive assistance of two staff for bed mobility, transfers, dressing, toileting, personal hygiene and bathing. Review of the undated form titled Individual Resident Baseline Care Plan identified the form was completed by nursing staff. The form lacked any documentation R26 or R26's representative had received a copy of the care plan. Additionally, the form lacked a signature from R26 or R26's representative. On 8/27/21, at 11:09 a.m. clinical manager (CM)-A was interviewed via telephone. CM-A indicated the 24 hour care plan was to be completed right away upon admission and staff were to review it with the resident. CM-A indicated after reviewing it, staff were expected to have the resident sign it when completed and to provide them a copy of the baseline care plan. On 8/27/21, at 11:27 a.m. the director of nursing (DON) confirmed the above finding and indicated she expected staff to complete the baseline care plan within 48 hours, review it with the resident or resident representative and provide them with a copy. On 8/27/21, requested a policy regarding baseline care plans and one was not provided.	F 655	2. All residents could be affected by the deficient practice, and other recent admissions were reviewed and no other residents were adversely affected. 3. To enhance currently compliant operations and under the direction of the director of nurses, a nursing in-service training is planned on 10/4/21 which includes re-education of the facility policies and procedures for baseline care plans to ensure ongoing compliance. 4. Effective 10/1/2021, a quality assurance program was implemented under the supervision of the Director of Nursing to ensure compliance with providing baseline care plans for residents recently admitted. The Director of Nursing/Designee will audit weekly for 6 weeks and then monthly for 3 months. Any identified deficiencies will be corrected, and all findings brought to the monthly quality assurance committee for further review and ongoing monitoring.	

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F 657	Continued From page 27	F 657		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on interview, and document review, the facility failed to ensure residents/resident representatives were allowed to participate in care planning for 1 of 1 residents (R23) reviewed for care plan. Findings include:	F 657	1. It is the expectation of the facility to ensure residents/resident representatives are allowed to participate in the planning of care. R23 had not had an initial care conference held within 72 hours of admission, but since has had a care conference and has participated in the	10/11/21

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F 657	Continued From page 28 R23's quarterly Minimum Data Set (MDS) dated 9/8/21, indicated R23 was cognitively intact and had diagnoses which included: diabetes mellitus, stroke, and hemiplegia or hemiparesis. The MDS indicated R23 was independent with all activities of daily living. On 8/23/21, at 3:00 p.m R23 indicated he had not attended any care conference that he was aware of and could not recall anyone going over his plan of care with him during a care conference meeting. Review of R23's Care Conference Summary Sheets from 2/1/21, to 8/27/21, revealed the following: - on 5/18/21, the care conference summary sheets were completed and care conference was held. Review of R23's Progress Notes from 2/1/21, to 8/27/21, revealed the following: - R23's progress notes lacked any documentation that care conferences were held on a regular basis. Review of R23's medical record lacked further documentation of care conference being held, who attended and what concerns were discussed. On 8/26/21, at 10:51 a.m. the social worker (SW) confirmed the above findings and indicated the facility held care conferences within 72 hours of admission, within two weeks and quarterly. The SW indicated she was not in the building when R23 was admitted to the facility and confirmed there had been a lapse in his care conferences.	F 657	planning of his care. 2. All residents and their representatives are allowed to participate in the planning of their care. All other residents were reviewed, no deficient practices found. 3. To enhance currently compliant operations and under the direction of the director of nurses, a nursing in-service training is planned on 10/4/21 which includes re-education of the facility expectations to ensure residents and their representatives are allowed to participate in the planning of care. 4. Effective 10/1/2021, a quality assurance program was implemented under the supervision of the Director of Nursing to ensure compliance with providing participation of care planning for residents and their representatives. The Director of Nursing/Designee will audit weekly for 6 weeks and then monthly for 3 months. Any identified deficiencies will be corrected, and all findings brought to the monthly quality assurance committee for further review and ongoing monitoring.	

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F 657	Continued From page 29 The SW stated she expected staff to hold the care conferences on a regular basis and to ensure everyone attended the care conferences including the resident and his representative. On 8/26/21, at 2:07 p.m. the director of nursing (DON) confirmed the above finding and indicated care conferences were to be held upon admission and quarterly. The DON indicated she expected staff to hold the care conferences as required. On 8/27/21, requested a policy regarding care conferences and one was not provided.	F 657		
F 677 SS=E	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to provide assistance with routine grooming which included facial hair removal and oral cares for 7 of 7 residents (R18, R11, R14, R6, R1, R21, R22) who were dependent on facility staff for activities of daily living (ADL's). Further, the facility failed to provide routine incontinence cares and changing of soiled clothing for 1 of 1 resident (R6) reviewed for routine checking and changing cares. Findings include: R18	F 677	1. It is the expectation of the facility to aid with routine grooming which included facial hair removal and oral cares for residents that were dependent of staff for activities of daily living. It is also an expectation that routine incontinence cares are provided, and soiled clothing changed appropriately. Upon identification, R18, R11, R14, R6, R1, R21 and R22 were reviewed and observed to ensure compliance with facial hair removal and oral cares. R6 was reviewed to ensure clothing wasn□t soiled and to observe compliance with routine check and changing for cares.	10/11/21

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F 677	Continued From page 30 R18's quarterly Minimum Data Set (MDS) dated 7/21/21, identified R18 had severe cognitive impairment and had diagnoses which included: chronic obstructive pulmonary disease, arthritis and anxiety. The MDS indicated R18 was independent with bed mobility, transfers, dressing, toileting, eating and personal hygiene. R18's care plan revised on 3/23/20, indicated R18 had physical functioning deficit related to self care impairment and mobility impairment. The care plan indicated R18 required assistance from staff for set up, assist as needed and assist of one for shower and personal hygiene. During observations on 8/23/21, at 2:38 p.m. R18 was walking around the nursing home independently with her walker. R18's hair was noted to be uncombed and her hair was pasted to the back of her head and to the right side of her head. R18's hair was also sticking straight up on the back side of her head and the right side of her head. - at 4:32 p.m. R18 was seated on the edge of her bed and her hair continued to be uncombed. - at 4:34 p.m. R18 walked out of her room independently with her walker and her hair continued to be uncombed. - 5:26 p.m. R18 walked into the dining room area independently with her walker and her hair continued to be uncombed. During observations on 8/24/21, at 9:41 a.m. R18 was standing up at the nurses station with her walker talking to the trained medication aid (TMA)-A and her hair was uncombed, pasted to the back and left side of her head. R18's hair was sticking straight up on the left and back of her head.	F 677	2. All resident□s needing assistance with routine grooming and routine incontinence cares have the potential to be affected by the deficient practice. All residents were reviewed and observed to ensure compliance; no other deficient practices were identified. The facility did review the body/facial hair trimming equipment to ensure that it is available and functions properly. Processes were reviewed for new admissions to ensure further compliance with ADL cares. Ongoing review of resident□s grooming, facial hair, skin, incontinence, and ADLs are reviewed during care conferences and more frequently as needed. 3. To enhance currently compliant operations and under the direction of the director of nurses, a nursing in-service training is planned on 10/4/21 which includes re-education of the facility policies to aid with assisting resident with their activities of daily living. 4. Effective 10/1/2021, a quality assurance program was implemented under the supervision of the Director of Nursing to ensure there is compliance with ADLs per facility policy. Audits implemented including but not limited to include facial care, clothing, hair, fingernails, body, skin, teeth and incontinence cares for resident□s dependent on staff for activities of daily living. The Director of Nursing/Designee will audit weekly for 6 weeks and then monthly for 3 months. Any identified	

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F 677	Continued From page 31 During observations on 8/25/21, at 10:38 a.m. R18 walked down the hallway independently with her walker and sat down in a chair in the main entrance area. R18's hair was uncombed, pasted to the back and left side of her head. R18's hair was sticking straight up on the left and the back of her head. - 11:39 a.m. R18 was seated in the dining room area drinking pop and her hair continued to be uncombed. During observations on 8/26/21, at 11:13 a.m. R18 walked down the hallway independently with her walker and her hair was uncombed and sticking straight up all over. On 8/26/21, at 11:11 a.m. nursing assistant (NA)-A confirmed R18 needed staff assistance and verbal reminders to complete ADL's and personal hygiene tasks. NA-A indicated staff should have followed R18's care plan and should have ensured her personal hygiene tasks had been completed and her hair was combed. On 8/26/21, at 2:07 p.m. the director of nursing (DON) confirmed the above findings and indicated staff should have been following the care plan. The DON indicated her expectations were for staff to ensure the residents were properly groomed and hair combed. R11 R11's annual MDS dated 6/11/21, identified R11 had severe cognitive impairment and had diagnoses which included: seizure disorder, depression and muscle weakness. The MDS	F 677	deficiencies will be corrected, and all findings brought to the monthly quality assurance committee for further review and ongoing monitoring.	

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indicated R11 was independent with bed mobility, transfers, dressing, toileting, eating and personal hygiene.

R11's care plan revised on 2/10/21, indicated R11 had ADL self care performance deficit related to confusion and impaired balance. The care plan identified R11 required limited assistance from staff for dressing and personal hygiene.

During observations on 8/23/21, at 4:53 p.m. R11 was seated in the chair in her room. R11 was noted to be wearing a white turtle neck shirt with blue snow flakes and a pair of blue shoes. R11's shirt had several soiled white/brown spots on the chest area and her shoes had several soiled white spots on the top of the shoes.
- at 5:08 p.m. R11 walked independently in the hallway with her walker and back to her room. R11 wore a light blue pair of denim jeans and the inside of her legs, half way to her knees and her entire buttocks area had a light brown colored stain. The outer ring of the stain was darker brown in color and no odor was noted. R11 sat down in her chair in her room independently. Multiple flies flew around R11 and landed on her and her clothing. R11 had several white long hairs on her chin and neck area measuring approximately 1/4 to 1/2 inch long.
- at 6:42 p.m. R11 walked down the hallway independently with her walker and continued to be wearing the same soiled shirt, pants and R11's facial hair remained unchanged.

During observations on 8/24/21, at 1:09 p.m. R11 was seated in the activity room playing bingo with several other residents. R11 was noted to be wearing the same clothing from yesterday. R11's shirt had several soiled red/brown spots on her

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chest and belly area and facial hair remained the same.
-at 1:34 p.m. R11 stood up up independently with her walker and walked around the nursing home. R11 continued to wear the same light blue pair of denim jeans and on the inside of her legs, half way to her knees and her entire buttocks area a light brown colored stain remained. The outer ring of the stain was darker brown in color and no odor was noted.
- at 1:56 p.m. R11 was seated out in the activity area and her clothing remained unchanged.

During observations on 8/25/21, at 11:59 a.m. R11 was seated in the dining room and continued to wear the same shirt from Monday and had a pair of yellow pants on. R11's shirt continued to be soiled and stained with red/brown spots on her chest and belly area and R11's facial hair remained unchanged.

During observations on 8/26/21, at 12:20 p.m. R11 walked independently with her walker to the dining room area. R11 continued to wear the same shirt from 8/23/21, and the same pair of yellow pants from 8/25/21. R11's shirt continued to be soiled and stained with red/brown spots on her chest and belly area and R11's facial hair remained. R11 continued to wear the same soiled shirt for four days and the same soiled pants for two days and had not been shaved in four days.

On 8/26/21, at 11:21 a.m. NA-A confirmed R11 required staff assistance with ADL's, shaving and personal hygiene. NA-A indicated R11 needed verbal reminders to change her clothes and staff should have supervised her to ensure her clothes were neat and clean. NA-A indicated R11 had not refused cares and staff should have followed her

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care plan.

On 8/26/21, at 2:07 p.m. DON confirmed the above findings and indicated R11 needed staff assistance with her ADL's. The DON indicated she expected staff to assist residents with shaving, grooming, personal hygiene, changing of their clothes and staff should have followed the care plan.
R14

R14's quarterly MDS dated 7/13/21, indicated R14 had severe cognitive impairment had diagnoses which included: depression, poly-arthritis, lymphedema. The MDS indicated R14 required two staff assistance with bed mobility, transfers, dressing, toileting and one staff assistance with personal hygiene and supervision with eating.

R14's care plan revised on 2/9/21, indicated R14 had physical functioning deficit related to mobility impairment. The care plan indicated R14 required one staff to assist with oral care and personal hygiene.

During observations on 8/23/21, at 5:05 p.m. R14's hair uncombed, matted to the back of her head and sticking straight up on the back of her head. R14 had several long white chin hairs approximately 1/4 inch long or longer.
- at 5:45 p.m. R14 was seated in her wheel chair in the dining room area with several other residents. R14 hair remain uncombed and her facial hair remained the same.

During observations on 8/24/21, at 8:18 a.m. R14 was seated in her wheelchair in her room and continued to have several long white chin hairs

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approximately 1/4 inch long or longer.
- at 11:29 a.m. R14 was seated in her wheel chair in the activity room with several other resident and her hair continued to be matted to the back of her head and sticking straight up.
- at 1:07 p.m. R14 was seated in her wheel chair in the activity room with several other residents and her hair continued to be the same.
- at 2:22 p.m. R14 was in bed resting and R14 continued to have several long white chin hairs approximately 1/4 inch long.

During observations on 8/25/21, at 8:17 a.m. R14 was in bed on her back and NA-B entered her room and said good morning. NA-B removed R14's covers and unhooked R14's incontinent brief. NA-B washed R14's hands and face, tucked R14's brief on the left side and began to wash R14's peri area. NA-B asked R14 to roll to the right while she washed her buttocks area, removed the wet soiled brief and threw it in the garbage. NA-B placed a clean incontinent brief under R14, assisted her to roll to the left and applied the incontinent brief. NA-B walked to the closet and picked out clothes for R14.
- at 8:39 a.m. NA-B brought over the clothes and R14 chose what she wanted to wear. NA-B obtained R14's pants, donned the pants and applied ace wraps to her lower legs. NA-B placed slippers on R14's feet, removed her gown, applied deodorant and donned her shirt over her head. NA-B assisted R14 to roll to the left and to the right while straightening her clothes and placing the lift sling under her.
- at 8:52 a.m. NA-B went out into the hallway to ask for assistance and returned to the room. NA-B positioned the mechanical lift over R14 and hooked the sling to the lift while TMA-A entered the room. NA-B and TMA-A transferred R14 via

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mechanical lift from her bed to her wheel chair, unhooked the lift from the sling and TMA-A washed her hands and immediately left R14's room. NA-B applied peddles to R14's wheelchair, placed her feet on the peddles, combed her hair and placed her glasses on her face. NA-B collected the soiled linen, washed her hands, put R14's supplies away and washed her hands again at the sink. NA-B grabbed a blanket and covered R14's legs with it.
- at 9:03 a.m. NA-B wheeled R14 out of her room area, down the hallway towards the dining room. Several residents were seated in the dining room area. R14 continued to have several long white chin hairs approximately 1/4 inch long. NA-B was not observed to offer or attempt to provide R14 oral cares or assist her with shaving.
- at 9:36 a.m. R14 remained seated in the dining room area and continued to have several long white chin hairs approximately 1/4 inch long.

On 8/25/21, at 9:14 a.m., NA-B confirmed the above findings and indicated R14 required assistance with all ADL's. NA-B confirmed she had not offered or provided R14 oral cares or facial hair removal.

On 8/26/21, at 2:07 p.m. DON confirmed the above findings and indicated R14 required staff assistance with her ADL's. The DON indicated she expected staff to assist residents with shaving, oral care, personal hygiene, grooming and staff should have followed the care plan.

R6

R6's quarterly MDS dated 5/27/21, indicated R6 was cognitively intact and had diagnoses which

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included: diabetes mellitus, anxiety and schizophrenia. The MDS identified R6 required extensive assistance of one staff with bed mobility, toileting, personal hygiene, limited assistance with dressing and supervision with transfers. Further, the MDS identified R6 was always incontinent of bowel and frequently incontinent of bladder, and was not on a bowel or bladder toileting program.

R6's care plan revised on 8/25/21, indicated R6 had ADL self care performance deficit related to aggressive behavior, confusion, impaired balance and pain. The care plan identified R14 required one to two staff assistance with dressing, personal hygiene and toileting.

During observations on 8/23/21, at 2:12 p.m. R6 was in bed and NA-D assisted R6 into her wheelchair using a gait belt. NA-C entered the room with a cup of coffee and asked R6 if she wanted to go to the dining room and R6 agreed. NA-D wheeled R6 down to the dining room area in her wheelchair and gave her the cup of coffee to drink. R6 was wearing a purple sweat shirt with flowers on it and the shirt was wet and had several soiled white spots on R6's chest area .
- at 2:28 p.m. R6 wheeled herself around the nursing home using her feet to peddle herself and her shirt remained the same.
- at 4:25 p.m. R6 was seated in her wheelchair out in the front lobby area and was asking for a piece of pizza. R6's shirt remained the same.
- at 5:20 p.m. R6 was seated in her wheelchair in the dining room area and her shirt continued to be wet with several soiled white spots. R6 had several flies buzzing around her and landing on the chest of her shirt.
- at 7:14 p.m. R6 wheeled herself around the

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nursing home using her feet to peddle herself and her shirt remained the same. Nursing staff were not observed to offer or provide R6 with assistance to change her soiled shirt.

During observations on 8/25/21, at 7:03 a.m. R6 was awake lying in bed, covered up with blankets, her call light was within reach and she said good morning.
- at 7:24 a.m. R6 remained in bed.
- at 7:25 a.m. R6 turned her call light on and proceeded to transfer herself to her wheelchair. R6 was wearing a gown and a sweater over it.
- at 7:27 a.m. clinical manager (CM)-A entered R6's room, asked R6 if she needed assistance and R6 was noted to have a very strong pungent odor of urine on her. CM-A washed her hands and informed R6 it was time to get washed up and changed. R6 stated she was last changed at four o'clock. CM-A retrieved a pair of pants out of the closet and placed them on R6 up to he knees while she sat in her wheelchair. CM-A said R6 needed her bedding changed and began to collect the linen. R6's bed and bedding was completely saturated with urine and flies were buzzing around and landing on her bed and bedding. R6's entire room was noted to have a pungent odor of urine.
- at 7:31 a.m. NA-E entered the room to assist CM-A and spoke to R6 about using the bathroom. R6 agreed after staff encouraged her and CM-A placed the gait belt around her waist while she sat in her wheelchair.
- at 7:33 a.m. CM-A wheeled R6 into the bathroom, CM-A and NA-E placed gloves on their hands and assisted R6 to stand while using the gait belt. CM-A and NA-E removed R6's incontinent brief which was completely saturated with urine and had a streak of bowel in it as well.

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R6's buttocks were wrinkled, pink in color and no skin breakdown was noted. R6's plastic wheelchair cushion was noted to have urine present on it. CM-A proceeded to cleanse R6's buttocks and peri area with wipes while NA-E wiped R6's plastic wheelchair cushion off with wipes and dried it with a paper towel. NA-E and CM-A placed a clean incontinent brief on R6, pulled up her pants and assisted her to sit in her wheelchair. R6 refused the rest of her morning cares and peddled herself out of her room. NA-E indicated she had not received report that morning from the night shift. NA-E and CM-A stated they were not aware when the last time R6 had been checked, changed or offered assistance with toileting.
- at 7:41 a.m. CM-A reviewed R6's medical record (MR) to review the last time R6 had been checked and changed and indicated R6 had last been checked and changed at 3:40 a.m. and was incontinent of urine at that time.

R6's MR lacked any documentation of R6 being checked and changed by staff or offered toileting from 3:40 a.m. to 7:33 a.m. for a total of 3 hours and 53 minutes.

On 8/25/21, at 9:24 a.m. NA-B confirmed R6 was routinely incontinent of bowel and bladder and needed to be checked/changed every two hours. NA-B indicated he thought she had last checked and changed R6 around 4:15 a.m. and thought she was dry at the time but could not remember.

On 8/26/21, at 1:57 p.m. CM-A confirmed the above finding and indicated R6 was incontinent of bowel and bladder and required staff assistance with toileting. CM-A stated staff were to check and change R6 every two hours and indicated

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she expected staff to follow her care plan.

On 8/26/21, at 2:07 p.m. DON confirmed the above findings and indicated R6 needed staff assistance with her ADL's. The DON indicated she expected staff to assist R6 with personal hygiene, grooming and incontinence cares. The DON indicated staff should have been checking and changing R6 per her care plan and if she refused to re-approach her at a later time.

R1

Findings include:

R1's quarterly Minimum Data Set (MDS) dated 8/17/21, identified R1 had diagnoses of dementia, depression weakness and peripheral neuropathy (numbness/tingle in extremities.) The MDS identified R1 had severe cognitive impairment and required extensive assistance with activities of daily living (ADL's) of dressing, personal hygiene, and bathing. The MDS identified R1 had no rejection of cares during the assessment period.

R1's care plan revised 7/12/21, revealed R1 had impaired cognition, function, thought process and required extensive assistance with personal hygiene, dressing and bathing. R1's care plan lacked direction for facial hair removal.

R1's nursing assistant care guide dated 8/26/21, revealed R1 required extensive assistance with personal hygiene.

On 8/23/21, at 1:43 p.m. R1 was observed lying in bed, eyes closed, covered with a blanket from her feet to mid chest. R1's hands were rested on

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her abdomen above the blanket. R1 had several dozen four (4) to five (5) millimeters (mm) long, thick black coarse facial hairs along her upper lip, chin and jaw line. R1 had several six (6) to ten (10) mm long white wispy facial hairs along both corners of her mouth and chin.

- at 6:08 p.m. R1 was observed seated in a wheelchair, wheeled down the hall by nursing assistant (NA)-H towards the dining room. R1's hair was sticking up on the back of her head and along the sides. R1 continued to have several dozen 4 to 5 mm long, thick black coarse facial hairs along her upper lip, chin and jaw line. R1 had several 6- 10 mm long white wispy facial hairs along both corners of her mouth and chin.

On 8/24/21, at 8:50 a.m. R1 was observed seated in a wheelchair in the dining room at a squared table next to another resident. R1's hair was combed straight to her head and she continued to have several dozen 4 to 5 mm long, thick black coarse facial hairs along her upper lip, chin and jaw line. R1 had several 6- 10 mm long white wispy facial hairs along both corners of her mouth and chin.

- at 11:32 a.m. R1 was observed seated in a wheelchair in the facility activity room with several other residents. R1 continued to have several dozen 4 to 5 mm long, thick black coarse facial hairs along her upper lip, chin and jaw line. R1 had several 6- 10 mm long white wispy facial hairs along both corners of her mouth and chin.

- at 11:36 a.m. R1 was observed seated in a wheelchair, was wheeled out of the activity room towards her bedroom by NA-D. At that time, NA-D indicated another NA would need to assist

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to transfer R1 into bed. NA-C entered R1's room, provided R1 with her call light and indicated she needed to go find the other NA to assist R1 to bed and NA-D exited R1's room. At 11:43 a.m. R1 had remained seated in her wheelchair in her room, at that time NA-D and NA-C entered R1's room and proceeded to assist R1 to bed and with her cares. R1 was covered with a blanket, provided her call light and both NA-D and NA-C left R1's room. R1 continued to have several dozen 4 to 5 mm long, thick black coarse facial hairs along her upper lip, chin and jaw line. R1 had several 6- 10 mm long white wispy facial hairs along both corners of her mouth and chin.

On 8/25/21, at 8:24 a.m. R1 was observed seated in a wheelchair in her room, her eyes were closed, head was tilted back and her mouth was open. R1 continued to have several dozen 4 to 5 mm long, thick black coarse facial hairs along her upper lip, chin and jaw line. R1 had several 6- 10 mm long white wispy facial hairs along both corners of her mouth and chin. At that time, NA-E confirmed R1's facial hair and indicated she did not have a razor to remove her facial hair.

- at 10:17 a.m. R1 was observed seated in a wheelchair, wheeled by trained medication aid (TMA)-A towards her room. TMA- A proceeded to assist R1 to transfer from her wheelchair to bed with a full mechanical lift. R1 continued to have several dozen 4 to 5 mm long, thick black coarse facial hairs along her upper lip, chin and jaw line. R1 had several 6- 10 mm long white wispy facial hairs along both corners of her mouth and chin.

On 8/24/21, at 11:48 a.m. NA-C indicated R1 was totally dependent on staff for all ADL's and was not able to tell staff of her needs.

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On 8/25/21, at 8:30 a.m. NA-E stated she had assisted R1 with morning cares and had not removed R1's facial hair. NA-E indicated R1 did not have a razor to remove the facial hair and further indicated she would not have had time that morning to shave R1 since they were short staffed that morning. NA-E indicated she felt she was not able to provide R1 with standard cares due to insufficient staffing. NA-E indicated that morning an NA did not show up for the day shift and a night aid had stayed over that was not familiar with morning cares.

On 8/25/21, at 10:21 a.m. TMA-A indicated R1 was dependent on staff for all of her ADL's and felt R1 was not able to verbalized her needs. TMA-A indicated R1's facial hair should have been removed as needed and was not aware if R1 had a razor. TMA-A indicated she felt the NA's did not have time for routine cares, such as shaving, routinely due to lack of sufficient staff.

On 8/26/21, at 10:44 a.m. a telephone call was placed to R1's family member and a message was left.

On 8/26/21, at 2:32 p.m. NA-F indicated R1 was dependent on staff for all of her ADL's, which included personal hygiene and grooming. NA-F indicated she oftentimes would see residents unshaved and felt there was not enough direct care staff available on a routine basis to ensure standard cares, such as facial hair removal, were provided to residents, which included R1.

On 8/27/21, at 9:50 a.m. the director of nursing (DON) stated she expected R1's facial hair to be removed on a routine basis. The DON stated she

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was not aware R1 or any other residents were in need of shavers.

R21

R21's significant change Minimum Data Set (MDS) dated 8/4/21, identified R21 had significant cognitive impairment and diagnoses which included Alzheimer's disease, muscle weakness and thyroid disorder. R21's MDS indicated R21 required total assistance with transfers, extensive assistance with bed mobility, dressing and personal hygiene.

R21's care plan revised 7/12/21, identified R21 required extensive assistance with dressing, personal hygiene and R22 did not use the toilet, but was to be checked and changed periodically. R21's care plan identified R21 had impaired thought processes related to Alzheimer's disease. R21's care plan did not include specific instructions for facial hair removal.

On 8/23/21, at 2:31 p.m. R21 was sitting in her wheelchair in her room. R21 had multiple long wispy white hairs on her chin and neck ranging from 1/8 inch with 4-5 hairs up to 3/4 inches long.

On 8/24/21, at 8:13 a.m. R21 was sitting in her wheelchair in her room. R21 continued to have multiple facial hairs, white in color on her chin and neck, ranging from 1/8 inch long to 3/4 inch long.

On 8/25/21, at 11:45 a.m. R21 was in her wheelchair in the activity room with multiple other residents and staff members present. R21 continued to have facial hairs present as before, with multiple white wispy hairs up to 3/4 inch long

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on her chin and neck.

On 8/25/21, at 12:09 a.m. nursing assistant (NA)-E indicated she had assisted another staff member with R21's cares earlier that morning. NA-E stated she had noticed R21's facial hair that morning and indicated the facility needed to provide a razor for R21. NA-E indicated none of the female residents in the facility had any razors and thus staff were unable to shave them. NA-E stated she had informed clinical educator (CE)-A that morning of the need to purchase razors and was told the facility would obtain some razors for the female residents. NA-E indicated all the male residents had their own razors.

On 8/27/21, at 11:16 a.m. CE-A confirmed she had been informed by staff the female residents did not have any razors. CE-A stated the administrator would be obtaining razors and the facility would discuss the need to purchase razors with family members at care conferences.

On 8/27/21, at 11:33 a.m. during a phone interview family member (FM)-B stated she used to remove R21's facial hair for her. FM-B stated removing R21's facial hair was important to her.

ON 8/27/21, at 10:29 a.m. during a phone interview, clinical manager (CM)-A confirmed she expected all female residents to have their facial hair removed. CM-A indicated they would work on obtaining razors for the female residents so their facial hair would be removed.

On 8/27/21, at 1:29 p.m. director of nursing (DON) confirmed she expected staff to remove the residents' facial hair to maintain their dignity and for personal hygiene purposes.

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R22

R22's significant change Minimum Data Set (MDS) dated 8/6/21, identified R22 had significant cognitive impairment and diagnoses which included: dementia, arthritis and hypertension (high blood pressure). R22's MDS indicated R22 required extensive assistance with bed mobility, dressing, and personal hygiene.

R22's care plan revised 8/13/21, identified R22 had an activities of daily living (ADL's) self-care performance deficit related to advanced dementia and limited mobility. The care plan interventions indicated R22 required extensive assistance of one staff with dressing, personal hygiene and oral cares.

On 8/25/21, at 7:36 a.m. to 8:16 a.m. NA-B assisted R22 with morning cares and wheeled her in her wheelchair into the hallway after the cares were completed. At 8:09 a.m. trained medication aide (TMA)-A entered the room, washed her hands and assisted NA-B to transfer R22 out of the bed into her wheelchair using a gait belt. TMA-A exited the room and NA-B combed R22's hair. NA-B was not observed to complete oral cares for R22. At 8:16 a.m. NA-B wheeled R22 in her wheelchair out of her room into the hallway. From 8:16 a.m. to 8:40 a.m. R22 was observed propelling herself up and down the hallways and no oral cares were observed to be provided during that time. At 9:06 a.m. R22 was observed in the dining room with CE-A feeding her. At 9:19 a.m. CE-A assisted R22 to the hallway near the nursing desk, where R22 began to self propel herself in her wheelchair down the hallway.

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On 8/25/21, at 10:06 a.m. NA-B stated she typically did not perform R22's morning cares and usually worked the night shift. NA-B confirmed she had not completed oral cares for R22 that morning.

On 8/26/21, at 10:44 a.m. NA-E confirmed she had not completed oral cares for R22.

On 8/27/21, at 10:19 a.m. during a phone interview, CM-A stated she expected staff to perform oral cares on R22 which should have been completed by swabbing R22's mouth with toothettes. CM-A indicated oral cares were especially important for R22 as she had the tendency to pocket food.

On 8/27/21, at 12:24 p.m. DON confirmed she expected staff would complete oral cares on R22. DON indicated oral cares were important to keep the mouth clean, prevent infections or sores, and remove food.

The facility policy titled Activities Of Daily Living (ADLs), Supporting dated 3/17/21, identified residents would be provided with care, treatment and services to ensure that their ADLs did not diminish unless the circumstances for their clinical condition(s) demonstrate that diminishing ADLs are unavoidable. The policy also identified that appropriate care and services would be provided for residents who were unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care, which included: hygiene (bathing, dressing, grooming, and oral care), mobility, elimination, dining and communication.

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F 677	Continued From page 48 The facility policy titled Shaving The Resident, dated 3/17/21, identified the purpose was to promote cleanliness and to provide skin care. The policy instructed staff to review the resident's care plan to assess for any special needs of the resident. The policy further instructed staff to notify the supervisor if the resident refused the procedure or other information in accordance with the facility policy and professional standards of practice. The facility policy titled Dressing And Undressing, Assisting The Resident With Level II dated 3/17/21, identified the purpose of this procedure was to assist the resident as necessary with dressing and undressing to promote cleanliness. The policy further instructed staff to notify the supervisor if the resident refused the procedure or other information in accordance with the facility policy and professional standards of practice. The facility policy titled Mouth Care dated 3/17/21, identified the purpose of the procedure was to keep the resident's lips and oral tissues moist, to cleanse and freshen the resident's mouth, and to prevent oral infection. The equipment and supplies listed that would be necessary included: toothbrush, toothpaste, emesis basin, and applicators or gauze sponges. The policy further instructed staff to notify the supervisor if the resident refused the mouth care or other information in accordance with the facility policy and professional standards of practice.	F 677		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that -	F 689		10/11/21

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F 689	Continued From page 49 §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to conduct comprehensive fall assessments to determine root cause, identify patterns of falls and effective interventions for 1 of 1 resident (R16) who had repeated falls. Further, the facility failed to routinely implement interventions to prevent further falls for 2 of 3 residents (R16 and R21) who had repeated falls in the facility and remained at high risk for falls. Findings include: R16's significant change of status (SCSA) Minimum Data Set (MDS) dated 7/15/21, identified R16 had diagnoses which included dementia, polymyalgia rheumatica (inflammatory disorder causing muscle pain and stiffness around the shoulders and hips) and psychosis. The MDS identified R1 had severe cognitive impairment and required extensive assistance with activities of daily living (ADL's) of bed mobility, transfers and toileting. The MDS indicated R16 had disorganized thinking, inattention, altered levels of consciousness and delirium. The MDS identified R16 was unable to maintain her balance during transition without physical assistance and had one fall since the last MDS assessment. R16's SCSA Care Area Assessment (CAA) dated	F 689	1. It is the expectation of the facility to conduct comprehensive fall assessments to determine root cause, identify patterns of falls and effective interventions for residents who had repeated falls. The facility also is expected to routinely implement interventions to prevent further falls for residents who have had repeated falls. Comprehensive assessments and interventions were reviewed and revised to ensure compliance residents R16 and R21. 2. All residents at risk for or who have fallen have the potential to be affected by the deficient practice. All residents with falls or at risk for falls were reviewed to ensure that they are receiving the necessary treatment/services. 3. To enhance currently complaint operations and under the direction of the Director of Nurses, policies were reviewed, and assessments were revised to further ensure compliance with comprehensive assessments and fall interventions to prevent further falls, identify patterns and to determine root cause. Procedures were revised to ensure compliance with deficient practice. A nursing in-service training is scheduled on 10/4/21 which includes education of revised nursing assessments, appropriate	

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F 689	Continued From page 50 7/15/21, identified R16 had a significant change in her ability to perform her ADL's independently and required extensive assistance, had been referred to both occupational and physical therapies though R16 refused services. The CAA's revealed R16 had one in the last quarter, remained at risk for falls due to incontinence, impaired mobility and need for assistance with ADL's. The CAA listed fall interventions which included, gripper socks, keeping environment free of clutter and her call light was to be within reach. Review of R16's resident fall risk assessment form dated 8/21/21, identified a check list type form that listed several headings and subsets of conditions/factors which had the potential to affect R16's fall risk. The checklist assessment form identified R16 had the following conditions/risk factors present: intermittent confusion, 1-2 falls in the last three months, 1-2 medications that had possible side effects which could increase risk for falls, and three or more predisposing diseases, circulatory, cognitive condition, etc. The form identified R16 had a score of 17, however the form did not identify or define what the score meant in relation to R16's fall risk. R16's care plan revised 7/12/21, revealed R16 had cognitive impairment, was at risk for falls, required extensive assistance with ADL's and used a full body mechanical lift for transfer. The care plan listed various interventions for fall prevention which included: mat on the floor by R16's bed, gripper socks to be worn or non-skid footwear and directed staff to keep her room free of clutter and ensure her call light was within reach.	F 689	fall interventions, appropriate review and documentation to ensure compliance. 4. Effective 10/1/21, a quality assurance program was implemented under the supervision of the director of nursing to monitor the delivery of care, to ensure appropriate care and services are implemented and to better ensure implementation of treatment. The Director of Nursing/Designee will audit weekly for 6 weeks and then monthly for 3 months. Any identified deficiencies will be corrected, and all findings brought to the monthly quality assurance committee for further review and ongoing monitoring.	

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On 8/24/21, 9:07 a.m. during a telephone interview with R16's family member (FM)-C, he stated R16 had been declining overall in the last few months, had fallen a few days ago and had sustained a bump on her forehead. FM-C stated R16 had severe dementia, was not able to voice her needs or concerns and felt she was not able to remember to call for help when she needed to get out of bed. FM-C stated he had visited R16 the evening of 8/23/21, at approximately 8:00 p.m. During the half hour long visit, R16 had attempted to get out of bed by placing her legs/feet towards the floor and attempting to pull herself up with the grab bar. He indicated R16 was barefooted and he had notified staff of R16's attempts to get out of bed. FM-C stated staff was responsive to his request for help, had come into R16's room, placed her legs back into bed and reminded her to stay laying down. FM-C indicated he felt R16 would have fallen if she had been able to sit up on her own and stated he was not aware of what the facility was currently doing to decrease R16's risk for falls.

Review of R16's falls incident reports from 1/27/21, to 8/21/21, revealed the following:

- on 1/27/21, at 7:15 p.m. the incident report identified R16 had called for help and had been lowered to the ground by a trained medication aid (TMA) while transferring from toilet to the wheelchair. The report revealed R16 had indicated her legs had given out and she couldn't stand. The incident report revealed a check list type assessment with several areas to assess which included; injuries, pain, mental status at the time of the incident, post incident, predisposing environmental, physiological, and

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situational factors. The report revealed R16 was confused, had a gait imbalance, impaired memory and had been incontinent.

- on 1/29/21, a follow up note revealed therapy would screen resident to see if she would be a candidate and staff would offer to assist resident with laying down in the afternoon. The report lacked any analysis of the fall, current fall interventions, potential patterns and newly implemented interventions.

R16's medical record lacked any therapy evaluation following the fall on 1/27/21.

- on 6/25/21, at 11:34 p.m. the incident report identified R16 had been heard calling for help from her room and had been found on the floor near her bed. The note revealed R16 was independent with transfers at the time of the fall, had indicated she had tried to transfer herself from her bed to the wheelchair and fell. The note revealed R16 had one gripper stocking on and one bare foot. The report listed R16 was oriented to person, place, time, situation and revealed R16 was not able to walk, but was able to transfer to and from the toilet without assistance. The incident report revealed R16 likely slid out of bed, however the report lacked any analysis of R16's fall interventions, potential patterns or newly implemented interventions.

Review of R16's fall follow up note dated 6/27/21, identified R16 was alert, oriented, was able to make her needs known and had no complications from the fall in her room on 6/25/21.

R16's medical record lacked a therapy evaluation following the fall on 6/25/21.

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-on 8/21/21, at 7:20 p.m. the incident report identified R16 had been found on the floor of her room lying on her right side by the doorway. The incident report revealed R16 was last seen at approximately 6:30 p.m. when she wheeled herself out of the dining room following the evening meal, to her and had been waiting for staff to help her get ready for bed. The report identified R16 was alert, confused and was not able to identify what had happened. The report revealed R16 had a bump on her forehead, ice was applied and neurological checks were started (assessment of neurological status to help determine possible brain impact from a head injury.) The report identified R16 was recently started on a new medication of Ativan (anti-anxiety) and had received a dose at 7:00 p.m. that day. The incident report lacked any analysis of R16's fall, interventions, potential patterns or newly implemented interventions.

Review of R16's progress notes from 5/30/21, to 8/27/21, revealed the following:

- on 6/26/21, a follow up fall note revealed R16 was alert, oriented and had no new injuries or complications from the fall on 6/25/21. The note revealed R16 had difficulties with moving from a lying to sitting position, with transfers and had been using her call light for assistance. The note revealed R16 needed a therapy evaluation.

- on 6/28/21, a progress note revealed R16 was alert, oriented, had episodes of hallucinations and had not needed to call for help with transfers.

-on 6/29/21, a progress note revealed R16 had troubles transferring, could not pick her bottom

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more than a couple of inches from the chair. The note revealed a fax communication was sent to R16's primary provider for therapy evaluation.

-on 7/1/21, a progress note revealed R16's primary physician had ordered a therapy evaluation for R16's difficulties with bed mobility and transfers.

-on 7/2/21, a progress note revealed R16 continued having difficulty performing ADL's and needed assistance with transferring from her wheelchair to the toilet.

-on 7/5/21, a progress note revealed R16 moved from the facility board and care to the skilled nursing side of the facility due to increased confusion and needing more assistance.

-on 7/14/21, a social service note revealed R16's BIMS (test to assess cognition) had significantly declined from cognitively intact, to severe cognitive impairment.

-on 7/15/21, a progress note revealed R16 was seen on a routine visit by her primary doctor for increased confusion and diarrhea.

-on 7/28/21, a progress note revealed R16 was sent to the local emergency room for change of condition of lethargy, not able to transfer and was not answering questions. A later note revealed R16 was returned to the facility from the emergency room with a diagnosis of congestive heart failure and was ordered diuretic medication (medication used to help released excess fluid from the body)

-on 8/8/21, a progress note revealed R16 was

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sent to the local emergency room for lethargy and difficulty breathing.

-on 8/9/21, a progress note revealed R16 returned to the facility and was expected to receive hospice services.

-on 8/10/21, a progress note revealed R16 required total assistance of 1-2 staff for all cares.

-on 8/19/21, a progress note revealed R16 was anxious, exit seeking, was seen by hospice and an anti-anxiety medication (Ativan) was ordered for twice daily and as needed for anxiety.

-on 8/22/21, a progress note revealed R16 had a fall in her room on 8/21/21, at 7:20 p.m., R16 had a painful bump on her forehead and had required the use of oxygen. The note revealed R16 was checked on frequently.

-on 8/23/21, a progress note revealed R16 had been calm, the bump to her forehead had resolved and she had no changes in her range of motion. A later note revealed R16 had been calm and was repositioned every two hours.

R16's progress notes lacked any documentation R16 had been assessed by therapy or any recommendations by therapy following her fall on 1/27/21, and 6/25/21.

On 8/23/21, at 2:35 p.m. R16 was observed lying on her back in a low bed, she had a grab bar affixed to the left side of her bed (faced the doorway,) her bare feet hung off of the lower end of the bed, towards the floor. R16 had a rug on the floor next to her bed towards the head of her bed. R16's bare feet hovered over laminate

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flooring. At 2:36 p.m. R16 reached towards the grab bar with both her right and left hands and attempted to pull herself upwards while moving her bare feet towards the laminate flooring. R16 was unable to pull herself up, she began to rock back and forth in a momentum type motion and attempted to pull herself up with the assist bar. R16 was not able to pull herself up, she let go of the bar and moved her legs in and out of the bed again.

-at 2:38 p.m. R16 was observed lying in bed on her back in a low bed, at that time nursing assistant (NA)-G entered the room, lifted R16's barefooted feet into the bed, raised the head of her bed and left the room. R16 remained barefooted.

-at 2:46 p.m. R16 was observed lying in bed on her back, R16 then reached her left arm up and grabbed onto the grab bar, moved her legs over the side of the bed and attempted to sit up. R16 rocked back and forth several times. R16 moved her legs back into bed and let go of the grab bar.

-at 2:54 p.m. R16 was observed lying on her back, eyes were closed, blanket was off of her feet and remained around her waist. R16 moved her legs and bare feet off the bed, towards the flooring. She made no attempt to grab the bar on the side of her bed. R16 had a call light button on the right side of her upper body. She moved her feet back into bed.

-at 4:29 p.m. R16 was observed lying on her back in a low bed, her eyes were closed and call light was on. At that time, NA-G entered R16's room, picked up yellow gripper socks from the floor and placed on her bare feet. R16's eyes remained

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closed, though she moved her left arm towards the grab bar, swung her legs out of the bed, NA-G told R16, "you gotta stay in bed, it's okay." NA-G indicated R16 had remained in bed following a fall over the weekend and was on "comfort cares." NA-G indicated R16 had been up and about on her own a few weeks ago, and had recently moved to the skilled living side of the facility. NA-G proceeded to assist R16 with incontinent cares, placed R16's flat call light on her chest and left her room.

-at 5:55 p.m. R16 was observed lying in bed, on her back, moved her legs and bare feet out of bed towards the floor, took hold of the grab bar with her left hand and attempted to sit up. R16 was unable to sit up, let go of the bar and shut her eyes. At that time, NA-G entered R16's room, picked up the yellow gripper socks from the floor, indicated R16 was restless and stated she had told the nurse about R16's restlessness. NA-G left the room and R16's legs remained out of bed.

-at 5:59 p.m. R16 was observed lying in bed, reached her left arm up and her right arm over her chest, took hold of the grab bar and attempted to sit up, R16 fell back against the pillows and closed he eyes. Her legs/bare feet remained hanging off the side of her bed.

-at 6:05 p.m. R16 was observed lying in a low bed on her back, eyes were closed, and her legs hung over the side of the bed with her bare feet visible. At that time, NA-H entered R16's room, picked up her legs and placed them in bed and covered R16 with a pink blanket. R16 remained without gripper socks on.

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-at 6:37 p.m. R16 was observed lying in a low bed on her back, eyes were closed, her body was covered with a sheet, a pink blanket covered her lower body.

-at 7:10 p.m. R16 was observed lying in bed, she had a pillow tucked between her body and the grab bar, her bare feet were visible, call light was within reach.

On 8/24/21, at 8:35 a.m. R16 was observed lying in a low bed, on her back, pillows were positioned on her right side, she had a blanket covering her legs and body up to her mid chest. R16's feet were exposed, no gripper socks were observed.

-at 11:26 a.m. R16 was observed lying in bed on her back, pillows were positioned on the right and left sides of R16. Her eyes were closed, she was covered from her feet to her mid chest.

-at 1:27 p.m. R6 was observed lying in bed on her back, her eyes were closed, covered from her feet to her mid chest, at that time NA-C entered her room, asked if she was alright, lifted up her blanket, looked at her feet which revealed yellow gripper socks and covered R16 back up. NA-C left R16's room.

On 8/25/21, at 7:06 a.m. R16 was observed lying in bed on her back, covered with a sheet, eyes were closed, she had pillows placed on both her right and left sides and underneath her legs. R16 made no attempt to move her legs out of bed or to try to sit up.

-at 9:05 a.m. R16 was observed lying in bed on her back, eyes were closed, pillows were placed on either side of her upper body, at that time

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trained medication aid (TMA)-A and hospice nurse entered R16's room. TMA-A and the hospice nurse removed the blanket from R16 and proceeded to assist R16 with morning cares, positioned R16 on her right side with pillows. At that time, the hospice nurse indicated R16 had been kept in bed since her fall on 8/21/21, for comfort per facility report.

On 8/23/21, at 5:55 p.m. during an interview with NA-G, she stated R16 was totally dependent on staff for all of her ADL's and had been rapidly declining over the past couple of weeks. NA-G indicated R16 had a fall over the past weekend and had remained in bed since the fall. She indicated she was not aware if R16 had any injuries or if there were any changes with her plan of care other than keeping her in bed.

On 8/24/21, at 1:32 p.m. during an interview with NA-C, indicated R16 was totally dependent on staff for all of her needs. NA-C indicated R16 had recently fallen and had been in bed since then for her comfort. NA-C indicated R16 was not able to tell staff of her needs and indicated she needed routine cares of repositioning and checking and changing. NA-C indicated R16 would attempt to get out of bed at times, though felt she did not have the strength to get out of bed on her own anymore. NA-C further stated R16 had fall prevention interventions of a low bed, gripper socks and making sure her call light was by her.

On 8/25/21, at 7:47 a.m. during an interview the hospice nurse indicated she felt R16 remained at risk for falls and should have fall interventions in place, such as gripper socks should R16 try to get out of bed. However, the hospice nurse stated she did not feel R16 had the strength to get out of

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bed on her own in her current state.

On 8/25/21, at 11:45 a.m. the certified occupational therapy assistant (COTA) stated R16 was currently not receiving therapy and had not within the last few months. COTA stated R16 had been referred in the past, however she refused any treatment and likely evaluation. She stated she could not recall the last time R16 had been seen by therapies.

On 8/26/21, at 10:21 a.m. during an interview with licensed practical nurse (LPN)-A, indicated R16 had been declining within the last couple weeks and had recently fallen in her room. LPN-A stated R16 had been in bed since the fall on the 8/21/21, did not appear to be in pain, but was lethargic and overall was not eating well. LPN-A indicated the night R16 had fallen, he was not able to recall what footwear R16 was wearing or if she had her call light within reach. LPN-A stated at the time of R16's fall, she was independent with transfers and mobility, though had been having weakness and was unable at times to transfer herself. LPN-A indicated following R16's fall on 8/21/21, frequent checks were done for the remainder of the shift. LPN-A was not sure what other interventions had been implemented following the fall.

On 8/26/21, at 2:01 p.m. during an interview with NA-E, indicated R16 was totally dependent on staff for all of her ADL's. NA-E stated R16 had been independent approximately a month ago and had moved over from the board and care as she needed increased help with her cares. NA-E stated R16 had been in bed since her fall on 8/21/21, was not sure if it was for her comfort or because R16 could no longer hold herself up.

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NA-E indicated R16 had been observed trying to get out of bed that morning and was redirected to lay back down. NA-E stated she had told the nurse and the nurse had given something to R16 to help her relax and since she had not attempted to get out of bed. NA-E stated R16 was supposed to wear gripper socks, have her bed in the low position and have a mat on the floor by her bed for fall prevention.

On 8/26/21, at 2:34 during an interview with NA-F, indicated R16 was totally dependent on staff for all ADL's and had been rapidly declining in her overall condition in the last few weeks. NA-F stated R16 had fallen the past weekend and no longer was helped out of bed. NA-F indicated she had thought R16 was in bed for her comfort and overall she was not able to hold herself up anymore. She stated R16 still attempted to get out of bed, which occurred that morning, though was not able to get herself into a sitting position. NA-F indicated she did not feel R16 had the strength to make it out of bed. NA-F indicated R16 had fall interventions in place of gripper socks, low bed, mat on the floor by her bed and call light within reach.

On 8/27/21, at 9:43 during an telephone interview clinical manager (CM)-A stated she had been back to work at the facility for several weeks off and on, and had not completed R16's post fall assessment. CM-A stated she would expect R16's fall to have been assessed for causative factors, review all falls to see if a pattern and to review current interventions and implement an immediate and longer term intervention with the interdisciplinary team (IDT) as appropriate. CM-A stated R16 had been in bed since her fall for comfort and her weakness. CM-A indicated she

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would expect R16 to wear gripper socks when in bed for safety, in case R16 was able to get herself into a sitting position.

On 8/27/21, at 10:07 a.m. during a telephone interview with R16's primary physician, medical doctor (MD)-A, she indicated R16 had been rapidly declining within the last few weeks and had been notified of R16's two falls since June. She indicated she had ordered a therapy evaluation following the fall in June, but did not feel R16 would be compliant with therapy based on previous attempts from therapy to work with R16. She indicated she would expect the facility to look at other interventions that R16 would have been complaints with, and felt R16 should have footwear in place that prevents slipping. She further stated she would expect the facility to complete a comprehensive assessment following R16's falls to help determine causative factors, evaluate current interventions and implemented appropriate fall interventions post fall.

R21

R21's significant change Minimum Data Set (MDS) dated 8/4/21, identified R21 had significant cognitive impairment and diagnoses which included Alzheimer's disease, muscle weakness and thyroid disorder. R21's MDS further identified R21 required total assistance with transfers, and extensive assistance with bed mobility, dressing and personal hygiene. R21's MDS identified R21's balance during surface to surface transfer was not steady, and unable to

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stabilize without human assistance. R21's MDS identified R21 had no falls since prior assessment.

R21's Care Area Assessment (CAA) dated 8/5/21, identified R21 was at risk for falls and had a history of falls since admission and was dependent on staff for all transfers with a full body lift for all transfers. R21's CAA identified R21 required extensive assistance from staff for all repositioning. R21's CAA indicated interventions included gripper socks and to proceed to R21's care plan.

R21's care plan revised 7/12/21, identified R21 required extensive assistance with dressing, personal hygiene and required extensive assistance with transfers using a full body lift for all transfers. R21's care plan identified R21 had impaired thought processes related to Alzheimer's disease. R21's care plan indicated R21 was at high risk for falls and the following interventions included: bedside mat during naps, ensuring R21 wore appropriate footwear no skid footwear when transferring or mobilizing in wheelchair and R21 was to be up in wheelchair during periods of wakefulness.

R21's kardex dated 8/27/21, identified interventions for safety included: ensure R21 wore appropriate footwear no skid footwear when transferring or mobilizing in wheelchair and R21 to be up in wheelchair during periods of wakefulness.

R21's Resident Fall Risk assessment dated 8/4/21, identified R21 was disorientated X 3 at all times, had 3 or more falls in the past 3 months and was wheelchair bound. R21's assessment

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score was 19, which was high risk for falls.

On 8/23/21, at 2:19 p.m. R21 was observed lying on her back, slightly onto her right side, covered with a sheet and blanket, with her feet hanging over the edge of he bed, trained medication aide (TMA)-B entered R21's room, with a glass of ice water, and assisted R21 to put her feet back onto the bed. R21's bed was in low position, had a concave mattress with a mat on the floor next to the bed. At 2:25 p.m. R21's feet were again out of the bed, eyes open, alert, informed TMA-B who was outside of R21's room. TMA-B asked R21 if she wanted to get up, or was uncomfortable and assisted R21 to put her feet back into bed. R21's response to TMA-B could not be heard. At 2:26 p.m. R21's eyes were open and her feet were touching the mat next to her bed and the head of her bed was slightly elevated. At 2:30 p.m. R21 was lying on her right side, her head resting on the pillow, covered with blanket and sheet and R21's feet were again noted to be out of the bed. R21 moved her left arm to her mouth and back in front of her face. At 2:34 p.m. nursing assistant (NA)-G entered R21's room, told her she was going to put her feet up, then quickly moved R21's feet to her bed, while R21 said "ow" and NA-G exited R21's room. At 2:41 p.m. R21's feet were on the floor and she was in a partial sitting position. NA-H entered the room and told R21 it was not time to get up. NA-H raised R21's bed up, told R21 he would come to get her when it was time to get up, pulled R21's sheet down, checked her brief, placed R21's bed back in place, raised up her head of bed slightly and lowered her bed back down. NA-H told R21 he would come back to check on her and instructed R21 to not attempt to get up on her own. At 2:54 p.m. R21's feet were wrapped up tightly in her

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blanket and sheet and were hanging from the side of the bed. R21's eyes were noted to be open and she was lying on her right side. NA-H exited a room across the hallway however did not look into R21's room. At 2:55 p.m. NA-G entered R21's room, asked if she could turn her again and put her feet back into the bed. R21 made a noise, NA-G told her to keep her feet up, asked her if it hurt and R21 said my legs. NA-G raised R21's head of bed up, the bottom of her bed slightly and exited the room. NA-G was not observed reporting R21's complaint of pain to nurse or wakefulness and feet out of bed after incident. At 3:03 p.m. R21 moved her feet off of the bed, NA-H walked by R21's room twice and did not look into the room. NA-H was observed looking into R21's room again, said Oh, getting down again. At 3:05 p.m. NA-H entered R21's room and NA-H told R21 he was going to put her feet back into bed, assisted her to put feet back into bed, then he untangled her sheets from around her feet and legs. At 3:08 p.m. NA-H told R21 he would come check on her again then left the room. At 4:34 p.m. NA-H entered R21's room, with the mechanical lift and TMA-B. NA-H told surveyor they were getting R21 up for supper, then closed the door. At 4:39 p.m. R21 was sitting up in her wheelchair with her feet on the foot pedals, sitting in her room. R21 had no socks or shoes on, her feet had leg ace wraps, (elastic strips of cloth used for dressings and swelling of he legs) with her toes exposed.

ON 8/25/21, at 11:45 a.m. R21 was in the activity room, sitting in her wheelchair, no slipper socks or shoes on, with toes exposed and feet wrapped with ace wrap.

On 8/25/21, at 12:09 a.m. NA-E indicated she

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usually did not take care of R21 and was not aware if she had any falls. NA-E stated R21 had a mat by her bed, but did not wear any socks, just her leg wraps.

On 8/26/21, at 10:37 a.m. NA-F stated she did not usually work with R21, but stated she does put her feet out, and NA-F said she would check to make sure she was dry. NA-F stated if R21 kept putting her feet out of he bed, she would get her up at that time.

On 8/26/21, at 12:54 p.m. during a phone interview, NA-H stated yes, R21 kept getting out of bed on 8/23/21. NA-H said he kept putting her feet back into bed, and no, he did not get her up at that time. NA-H indicated he usually worked the night shift, and he would just straighten R21 out in bed, and his usual intervention did not include getting her up from her bed when she was awake. NA-H said R21 was to have gripper socks on, before he got her out of bed. NA-H stated on 8/23/21, R21's socks would fall off her feet while she was in bed and was the reason they were not on after she was up in her wheelchair. NA-H stated he had checked R21 for incontinence at one time 8/23/21, when R21 had her feet out of the bed but had not gotten her up at that time.

On 8/27/21, at 11:47 a.m. NA-G stated she remembered R21 attempted to get out of bed on 8/23/21. NA-G said R21 kept getting up, so they would readjust her and check on her more often. NA-G indicated she was not aware that one of R21's interventions included to get her up when she was awake. NA-G said she was aware R21 was to have gripper socks on over her wraps, but did not realize R21 did not have them on.

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On 8/26/21, at 2:42 p.m. licensed practical nurse (LPN)-A stated R21's interventions for falls included her bed always low, check on her often and keep her door open. LPN-A sated R21 was also to have slipper socks on, but R21 did not walk. LPN-A stated if R21 kept trying to get up out of bed, they should get R21 up, and if she kept putting her feet out of the bed, R21 should be checked for pain, discomfort or incontinence and should be repositioned. LPN-A stated for safety reasons following R21's care plan he would get R21 up, no leave her in bed, because she could roll out of the bed.

On 8/27/21, at 10:29 a.m. during a phone interview, clinical manager (CM)-A indicated R21 often would hang her feet over the bed, floating in air. CM-A confirmed if R21 was awake, and attempted to get up, they should address R21's needs, get her up and not tell R21 to stay in bed. CM-A confirmed she would expect R21 to have slipper socks when she was up in the wheelchair also.

On 8/27/21, at 1:29 p.m. director of nursing (DON) reviewed R21's care plan in her electronic medical record. DON confirmed R21's care plan stated R21 was to be up in wheelchair during periods of wakefulness and R21 was to have gripper socks on when she was up in her wheelchair. DON stated she expected staff to follow R21's care plan. DON stated she was unaware if R21 had a history of falls, but indicated she believed R21 has had no falls since she began at the facility.

R21's facility incident report identified R21 was observed lying on the floor next to her bed in low

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position on 3/27/21, at 11:00 a.m., no injuries noted at time of incident. Interdisciplinary team (IDT) reviewed the fall dated 3/30/21, and included a new intervention for a fall mat next to bed while occupied.

R21's facility incident report identified R21 was found by staff lying on the fall protection mattress on 3/30/21, at 3:32 p.m. , no injuries noted at time of incident. IDT review of fall dated 3/31/21, included an intervention of a concave mattress to assist with fall risk, with plan to get R21 twice a day for activities. Also the incident report intervention implemented a wake/sleep schedule.

R21's facility incident report identified R21 was found by staff sitting on floor in front of bed on 4/7/21, at 9:44 p.m. , no injuries noted at time of incident. Notes on report dated 4/26/21, identified intervention for 3 day trial of Tylenol (pain medication) to assess for neuropathy pain. Noted resident likes to have feet hanging over bed.

R21's primary physician's progress note dated 4/1/21, identified R21 continued to have frequent falls out of bed, and had been switched to a concave mattress to try to help with that.

R21's primary physician's progress note dated 4/15/21, identified R21 had 5 falls in the past 30 days. R21's falls were at different times with no apparent pattern. R21's physician note further identified the facility had tried multiple prevention methods and were trying a concave mattress as multiple falls occurred when R21 rolled out of bed.

On 8/27/21, at 10:34 a.m. during an interview, the

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F 689	Continued From page 69 director of nursing (DON) confirmed R16's care plan, fall prevention interventions included mat to the floor, call light within reach, keep environment free of clutter and directed staff to ensure gripper socks/non-skid footwear was worn. The DON stated since R16 was no longer getting out of bed, she would expect gripper socks to be worn. She indicated with R16's current state, she did not feel R16 had the strength to get out of bed on her own and felt R16 may have been uncomfortable vs wanting to get up and out of bed. The DON stated she would have expected staff to ask R16 what she was trying to do when she attempted to get out of bed. R16's fall incidents were reviewed with the DON, she confirmed R16's medical record lacked a comprehensive analysis of R16's falls on 1/27/21, 6/25//21, and 8/21/21, further R16's medical record lacked any documentation R16 was followed up by therapy after her fall on 6/25/21. The facility's physical therapist was not available for interview. A facility policy titled, Falls and Fall Risk Managing, dated 3/17/21, identified the facility staff would identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling. The policy directed facility staff to implement resident centered fall prevention plan and monitoring for subsequent falls and fall risk. The policy lacked information on a comprehensive fall assessment.	F 689		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration.	F 692		10/11/21

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F 692	Continued From page 70 (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a comprehensive nutritional assessment and interventions were implemented to prevent significant weight loss for 1 of 1 residents (R6) reviewed for significant weight loss. Findings include: R6's admission Minimum Data Set (MDS) dated 2/24/21, indicated R6 had severe cognitive impairment and had diagnoses which included: diabetes mellitus, anxiety and schizophrenia. The MDS indicated R6 required extensive assistance of one staff with transfers, dressing, toileting, personal hygiene, limited assistance with bed mobility and supervision with eating. The MDS	F 692	1. It is the expectation of the facility to ensure that comprehensive nutritional assessment and interventions were implemented to prevent significant weight loss for residents reviewed for weight loss. R6 was reviewed and staff educated to ensure compliance with assessments and interventions in place were appropriate. 2. All residents have the potential to be affected by the deficient practice; resident□s assessments and weights were reviewed, and no other residents were identified to have been affected. Clinical morning meetings have been updated to include review of weight loss,	

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F 692	Continued From page 71 identified R6's most recent weight was 168 pounds (lbs) and her height was 66 inches. The MDS further indicated R6 had no signs or symptoms of a swallowing disorder and had not had a five (5) percent or more weight loss in the last month and/or had 10% weight loss in the last six months. R6's admission Care Area Assessment (CAA) dated 2/24/21, identified R6 had severe cognitive impairment and had diagnoses which included: anemia, diabetes mellitus and schizophrenia. The CAA indicated R6 required extensive assistance of staff for transfers, dressing, toilet use, personal hygiene, limited assistance with bed mobility and supervision with eating. The CAA indicated R6 had no swallowing disorders, weight was 168 lbs, height was 66 inches and R6 had not had a five (5) percent or more weight loss in the last month and/or had 10% weight loss in the last six months. The CAA identified R6 was not receiving any nutritional approaches. The CAA indicated the nutritional status care area was triggered related to R6's body mass index (BMI) (a person's weight in kilograms divided by the square of height in meters). BMI can be used to screen for weight categories that may lead to health problems but it is not diagnostic of the body fatness or health of an individual. The CAA identified R6's BMI was 27.1 which identified RR in an overweight range, however, indicated with R6's advanced age, she was at a "healthy weight." The CAA indicated R6 received a consistent carbohydrate diet, consumed 75 plus % of daily meals and occasional snacks through out the day, required set up help with meals and R6 was able to feed self. R6's quarterly MDS dated 5/27/21, indicated R6	F 692	decrease in appetite, change of condition and ensuring proper notifications to dietician and MD as needed and as required for ongoing assessment/interventions. 3. To currently enhance complaint operations and under the direction of the Director of Nurses, a nursing in-service training is scheduled on 10/4/21 which includes education of the policies and procedures to ensure nutritional assessments are completed and appropriate interventions are in place to prevent significant weight loss. 4. Effective 10/1/21, a quality assurance program was implemented under the supervision of the director of nursing to ensure compliance with the expectations of completing comprehensive nutritional assessments and completing appropriate interventions to maintain nutrition as determined necessary by their individualized assessment. The Director of Nursing/Designee will audit weekly for 6 weeks and then monthly for 3 months. Any identified deficiencies will be corrected, and all findings brought to the monthly quality assurance committee for further review and ongoing monitoring.	

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F 692	Continued From page 72	F 692		

was cognitively intact and had diagnoses which included: diabetes mellitus, anxiety and schizophrenia. The MDS indicated R6 required extensive assistance of one staff with bed mobility, toileting, personal hygiene, limited assistance with dressing and supervision with transfers. The MDS identified R6 was independent with eating and required set up help only from staff. The MDS indicated R6's most recent weight was 168 lbs and her height was 66 inches. The MDS identified R6 had no signs or symptoms of a swallowing disorder and was unknown if R6 had a five (5) percent or more weight loss in the last month and/or had 10% weight loss in the last six months.

Review of R6's admission Nutritional Data form dated 1/26/21, identified R6's admission weight was 170 lbs and her weight at the time of the completion of the form was 170 lbs. The assessment revealed R6 had no change in her weight, did not use adaptive equipment and averaged 65 plus % of her meal intakes per day. R6's nutritional assessment revealed her estimated nutrition needs as 1500 to 1600 kcal (kilocalorie (Cal or kcal) per day, estimated protein 90-95 grams per day and estimated fluid needs were 2000 milliliters (ml) per day.

R6's medical record (MR) lacked any further nutritional assessments.

Review of R6's signed physician order revealed an order dated 8/4/21, Doxycycline (antibiotic) 100 milligrams (mg) one tablet by mouth twice a day for urinary tract infection and start 2 Cal supplement 120 milliliters (ml) twice a day for weight loss. Which had been started on 8/4/21.

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Review of R6's signed Order Summary Report dated 8/5/21, revealed an order was received to discontinue R6's Metformin, Fosamax, Simvastatin, Sitagliptin and to consult hospice if not improving due to diagnoses of dementia with weight loss and hypoalbumenia.

Review of R6's Problem Sheet dated 8/7/21, revealed staff had notified R6's primary doctor requesting an order for adaptive dining utensils to assist R6 with eating. R6's primary doctor gave order on 8/9/21, for R6 to be evaluated and treated by occupational therapy (OT) for adaptive equipment.

The MR lacked any documentation of an OT evaluation being completed.

Review of R6's medication administration record (MAR) from 8/1/21, to 8/25/21, revealed the following:
- R6 had received her 120 ml of 2 Cal supplement everyday and had refused it twice during this time.

R6's care plan revised on 8/25/21, indicated R6 had a nutritional problem or potential nutritional problem and was at risk for dehydration with an altered state of mind, age and decrease mobility. The care plan indicated staff were to follow diet as ordered by medical doctor, monitor fluid intake, monitor for signs and symptoms of dehydration, record daily intake, weights per facility protocol and snacks per R6's preference. The care plan identified R6 required set up help from staff for eating.

Review of R6's weights from 2/17/21, to 8/23/21, revealed the following:

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- 2/17/21, - 168 lbs
- 5/3/21, - 168 lbs
- 8/4/21, - 140.8 lbs
- 8/16/21, - 141.6 lbs
- 8/23/21, - 142 lbs

R6's MR lacked any weights from 5/3/21, to 8/4/21.

Review of R40's progress notes from 8/4/21, to 8/10/21, revealed the following:
- 8/4/21, medical doctor noted having increased lethargy and very poor appetite. R6 was weighed today and had lost 28 lbs in the last 2 months. Nursing reports she had refused nourishments saying she just ate and was increasingly confused. R6 had a strong odor to her urine and severe protein calorie malnutrition. Difficult to obtain labs due to behaviors, start Doxyclycline 100 mg twice a day to cover pulmonary and urinary symptoms and start 2 Cal supplement 120 ml by mouth twice a day.

- 8/4/21, R6 seen by nurse practitioner for rounds due to change in condition, more tired, confused, agitated and not eating as well. Suspected urinary tract infection, R6 had lost 30 lbs since January when she admitted. New orders received for Doxyclycline 100 mg twice a day for 7 days for UTI and 2 Cal supplement 120 ml by mouth twice a day for weight loss.

- 8/7/21, R6 had trouble feeding herself and spilled a lot of her meals. Tried lipped plate with sippy cup and worked well. Faxed medical doctor for orders for OT to evaluate and treat for adaptive dining utensils.

- 8/10/21, R6 refused to eat.

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R6's MR lacked any other documentation of R6's unplanned significant weight loss of 28 lbs from her admission, 16.47% of her body weight within the last 6 months.

During observations on 8/26/21, at 12:09 p.m. R6 was seated at the dining room table waiting for lunch. Dietary staff brought R6 a plate of food, set it down in front of her, asked her if she needed any help, R6 declined and said she was ok. R6 had beans, diced potatoes, country fried steak with gravy on her plate, a cup of coffee and a cup of tea. R6 began to eat her potatoes independently with a silver spoon.
- at 12:22 p.m. R6 continued to eat her fried steak with gravy independently.
- at 12:25 p.m. licensed practical nurse (LPN)-A came over and asked R6 how she was doing and R6 responded ok. LPN-A asked R6 if she wanted him to cut up her steak, R6 agreed and LPN-A cut up her fried steak for her. R6 indicated she wanted a cola, LPN-A went to the kitchen and brought R6 a can of cola back while R6 continued to eat and drink her food independently.
- at 12:28 p.m. dietary staff asked R6 if she would like a piece of cake or pudding for dessert and R6 said she wanted cake. Dietary staff brought R6 a piece of chocolate cake and she began to eat her cake independently. R6 ate all of her potatoes, 75% of her beans and approximately 75% of her country fried steak with gravy.

On 8/24/21, at 2:47 p.m., dietary manager (DM)-A indicated nutritional assessments were to be completed on admission, quarterly and with a significant change. DM-A stated weights were reviewed daily in the MR and the reports would trigger out a 5% weight loss in one month or 10%

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in 6 months. DM-A indicated he believed registered dietician (RD)-A was covering the facility until recently when the facility hired RD-B. DM-A stated when a significant weight change was identified, the expectation was for staff to contact the RD.

On 8/25/21, at 12:37 p.m. in a follow up interview via phone R6's MR was reviewed with DM-A. DM-A verified R6 received a diabetic diet, received 120 ml of 2 Cal supplement twice a day and started the supplement on 8/4/21, due to weight loss. DM-A confirmed R6 had a significant weight loss from May 2021, to August 2021. DM-A reported the MR had revealed R6 had lost 24 lbs from February 2021, to August 2021, which was a 15% weight loss in 6 months. DM-A confirmed the last nutritional assessment was completed in January 2021, when R6 was admitted and verified no other nutritional assessments had been completed since that time. DM-A stated nutritional assessments should have been completed on R6 upon admission, quarterly and with any significant change of condition. DM-A stated he believed R6's weight loss would have been identified sooner if the assessments and R6's weights had been completed as indicated. DM-A indicated the normal process was to notify the RD and the doctor of any changes in weight loss and to start the residents on a supplement. DM-A confirmed the above findings and indicated he expected staff to complete R6's weights weekly on her bath day and to notify the nurses, DM whenever a weight loss is identified.

On 8/25/21, at 11:44 a.m. NA-E indicated R6 required one to two staff assistance with activities of daily living (ADL's) for dressing, personal

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hygiene and toileting. NA-E stated R6 was able to feed herself after staff set up her tray and they supervised her. NA-E indicated she believed R6 had good intake and was not aware if she received snacks during the day. NA-E stated she was not aware if R6 received nutritional supplements.

On 8/25/21, at 12:09 p.m. LPN-A indicated R6 required extensive assistance of one staff for her ADL's and sometimes needed two staff during times when she was weaker. LPN-A stated R6 was independent with eating however staff were to supervise and encourage her to eat. LPN-A indicated R6 received snacks through out the day and additionally received 2 Cal supplement 120 ml twice a day. LPN-A stated R6 consumed the supplement the majority of the time however did refuse at times. LPN-A indicated when R6 refused the supplement staff were expected to re-approach her or offer an alternative. LPN-A stated staff were expected to weigh the residents on their weekly bath day, if a significant weight loss is identified or when dietary staff request the weight.

On 8/25/21, at 1:56 p.m. in an interview via the phone RD-A indicated she had resigned from the facility.

On 8/25/21, at 2:01 p.m. in an interview RD-B indicated she was asked by the facility to provide a little input, worked full time at another facility and as a result did not have the ability to be the facility's RD or consultant. RD-B stated she had not been informed R6 had a significant weight loss. RD stated she expected staff to contact the RD for recommendations, provide supplements and review again in a week when a weight loss

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had been identified. RD-B indicated she expected staff would be completing weekly weights, monitoring intakes daily and to document the findings. RD-B stated if a resident had refused meals, it was expected staff would start nutritional supplement. The RD-B indicated nutritional assessments should have been completed on admission by the DM and quarterly after thereafter. RD-B stated the DM should have notified RD of R6's weight loss and put interventions in place to stabilize the weight loss which would include completing weekly weights for four weeks. In a follow up interview on 8/27/21, at 11:03 a.m. RD-B confirmed she had no written contract with the facility to provide dietician services.

On 8/25/21, at 2:15 p.m. OT assistant (OTA)-A confirmed R6 had not been receiving OT services and stated she had not received any orders to evaluate R6. OTA-A indicated Physical therapist assistant (PTA)-A received the orders from nursing staff and PTA-A then communicated the need to evaluate and treat residents.

On 8/26/21, at 10:27 a.m., MDS consultant (MDSC) spoke with PTA-A via the phone and confirmed PT-A was not aware of the order to evaluate and treat R6. MDSC indicated PTA-A stated OT would evaluate R6 on 8/30/21.

On 8/26/21, at 10:27 a.m., during an interview via phone PTA-A confirmed OT had not evaluated or treated R6 yet for use of adaptive eating equipment and had scheduled the evaluation to be completed on 8/30/21.

On 8/26/21, at 1:57 during an interview via phone clinical manager (CM)-A stated R6 needed staff

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assistance with all of her activities of daily living. CM-A indicated R6 would miss the spoon and would spill her food on herself due to having issues with her plate. CM-A stated when orders were obtained for therapy, nursing staff placed the order in the computer and would email therapy staff the new order. CM-A indicated staff were expected to process orders immediately and OT should have evaluated R6 soon after to ensure R6 received the adaptive equipment she needed to eat her meals.

On 8/27/21, at approximately 9:50 a.m. via phone call medical doctor (MD)-A indicated she recently assumed the role of R6's primary physician and confirmed R6 had recently experienced weight loss. MD-A stated R6 had diagnoses of advanced dementia with schizophrenia and the combination caused her weight loss. MD-A indicated lately R6 had a poor appetite, refused labs and R6 had been progressing to later stages of her dementia. MD-A stated she had ordered 2 Cal supplement 120 ml twice a day for R6 and indicated she expected OT to evaluate residents within 2 weeks from the order. MD-A stated she expected staff and the RD to comprehensively assess R6, monitor her weights weekly and update her with any changes.

On 8/27/21, at 12:34 p.m. the director of nursing (DON) confirmed the above findings and indicated she was just made aware of R6's significant weight loss. The DON indicated she expected staff to monitor intakes, to offer snacks ,to report nutritional changes to the nurse, dietary team and MD. The DON stated she expected staff to monitor weights weekly, report changes to the RD and MD and follow up on MD orders. The DON indicated she expected staff to complete a

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F 692	Continued From page 80 comprehensive nutritional assessment, review medications and find out the root cause of the problem. The DON verified R6's OT order to evaluate and treat had not been processed as ordered. The DON indicated the facility did not have RD on staff and RD-B was trying to assist the facility. Review of facility policy titled, Nutritional Assessment dated 3/17/21, identified a nutritional assessment, which included current nutritional status and risk factors for impaired nutrition, should have been conducted for each resident. The policy identified the dietician in conjunction with the nursing staff and healthcare practitioners, were to conduct a nutritional assessment for each resident upon admission, and as indicated a change in condition that placed the resident at risk for impaired nutrition. The policy revealed resident nutritional assessments included at least the following components: usual body weight, current height and weight, usual intake, food preferences, usual meal and intake patterns, general appearance and clinical conditions and resident usual routine. The policy revealed residents current conditions and risk factors were to be assessed, then analyzed and an individual care plan was to be developed to address and minimize further nutritional complications.	F 692		
F 725 SS=F	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial	F 725		10/11/21

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F 725	Continued From page 81 well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure sufficient staffing to provide routine assistance with activities of daily living (ADL's) of grooming, personal hygiene and dressing for 7 of 7 residents (R1, R18, R11, R14, R6, R1, R21 and R22) who required assistance and were dependent on staff for ADL's. This deficient practice had the potential to affect all 25 residents who resided in the facility. Findings include: R1 R1's quarterly Minimum Data Set (MDS) dated	F 725	1. It is the expectation of the facility to ensure sufficient staffing is in place to provide routine assistance with resident□s ADL□s who required assistance and who were dependent on staff for ADLs. R1, R18, R11, R14, R6, R1, R21 and R22 were reviewed, and input provided to further make adjustments with staff patterns in order to meet all resident needs in a timely manner. 2. All residents have the potential to be affected by staffing. Facility policies for staff were reviewed, staff and resident input gathered; changes were implemented to ensure compliance with sufficient staffing. Clinical managers were	

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F 725	Continued From page 82 8/17/21, identified R1 had diagnoses of dementia, depression weakness and peripheral neuropathy (numbness/tingle in extremities.) The MDS identified R1 had severe cognitive impairment and required extensive assistance with activities of daily living (ADL's) of dressing, personal hygiene, and bathing. R1's care plan revised 7/12/21, revealed R1 had impaired cognition, function, thought process and required extensive assistance with personal hygiene, dressing and bathing. R1's care plan lacked direction for facial hair removal. On 8/23/21, at 1:43 p.m. R1 was observed lying in bed, eyes closed, covered with a blanket from her feet to mid chest. R1's hands were rested on her abdomen above the blanket. R1 had several dozen four (4) to five (5) millimeters (mm) long, thick black coarse facial hairs along her upper lip, chin and jaw line. R1 had several six (6) to ten (10) mm long white wispy facial hairs along both corners of her mouth and chin. On 8/24/21, at 8:50 a.m. R1 was observed seated in a wheelchair in the dining room at a squared table next to another resident. R1's hair was combed straight to her head and she continued to have several dozen 4 to 5 mm long, thick black coarse facial hairs along her upper lip, chin and jaw line. R1 had several 6- 10 mm long white wispy facial hairs along both corners of her mouth and chin. On 8/25/21, at 8:24 a.m. R1 was observed seated in a wheelchair in her room, her eyes were closed, head was tilted back and her mouth was open. R1 continued to have several dozen 4 to 5 mm long, thick black coarse facial hairs along her	F 725	retrained on additional duties to oversee ongoing the day to day staff patterns, and reporting and processes were enhanced to more closely monitor staffing patterns. Clinical managers were also assigned additional rotating oversight on coverage to ensure that there was further observation and evaluation of floor staff based on resident input, staff and family. 3. An all staff in-service training is planned for 10/4/2021 which includes evaluating and reviewing ongoing staffing patterns and input in order to meet resident needs in a timely manner, including reviewing policies and procedures for staffing. 4. Effective 10/1/2021, a quality assurance program was initiated under the direction of the Director of Nursing for ensuring sufficient staffing to provide routine assistance with activities of daily living. Audits are being conducted to observe for timely and complete care and meeting needs of residents based on their individualized plan of care. Audits completed weekly for 6 weeks and monthly for 3 months to ensure compliance in this area. Any deficiencies will be corrected immediately; results brought to, and recommendations provided through to the monthly quality assurance committee team for further review and ongoing monitoring.	

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upper lip, chin and jaw line. R1 had several 6- 10 mm long white wispy facial hairs along both corners of her mouth and chin. At that time, nursing assistant (NA)-E confirmed R1's facial hair and indicated she did not have a razor to remove her facial hair.

On 8/25/21, at 8:30 a.m. NA-E stated she had assisted R1 with morning cares and had not removed R1's facial hair. NA-E indicated R1 did not have a razor to remove the facial hair and further indicated she would not have had time that morning to shave R1 since they were short staffed that morning. NA-E indicated she felt she was not able to provide R1 with standard cares due to insufficient staffing. NA-E indicated that morning an NA did not show up for the day shift and a NA from the night shift had stayed over that was not familiar with morning cares.

On 8/25/21, at 10:21 a.m. trained medication aid (TMA)-A indicated R1 was dependent on staff for all of her ADL's and felt R1 was not able to verbalized her needs. TMA-A stated R1's facial hair should have been removed as needed and was not aware if R1 had a razor. TMA-A indicated she felt the NA's did not have time for routine cares, such as shaving, routinely due to lack of sufficient staff. TMA-A stated she would help on the floor as she was able between medication pass and when there were call ins. She indicated the facility had been using pool staff for the past few months which had been helpful. TMA-A stated this past week, they had a call in approximately daily and had not been able to find replacements.

R18

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R18's quarterly Minimum Data Set (MDS) dated 7/21/21, indicated R18 had diagnoses of chronic obstructive pulmonary disease, arthritis, anxiety and was severely cognitively impaired. The MDS indicated R18 was independent with bed mobility, transfers, dressing, toileting, eating and personal hygiene.

R18's care plan revised on 3/23/20, indicated R18 had a physical functioning deficit related to self care impairment and mobility impairment. The care plan indicated R18 required assistance from staff for set up, assist as needed and assist of one for shower for personal hygiene.

During observations on 8/23/21, at 2:38 p.m. R18 was walking around the nursing home independently with her walker. R18's hair was noted to be uncombed, and her hair was pasted to the back of her head and to the right side of her head. R18's hair was also sticking straight up on the back side of her head and the right side of her head.

During observations on 8/24/2,1 at 9:41 a.m. R18 was standing up at the nurses station with her walker talking to the trained medication aid (TMA)-A and hair was uncombed, pasted to the back and left side of her head. R18's hair was sticking straight up on the left and back of her head.

During observations on 8/25/21, at 10:38 a.m., R18 walked down the hallway independently with her walker and sat down in a chair in the main entrance area. R18's hair was uncombed, pasted to the back and left side of her head. R18's hair was sticking straight up on the left and back of her head.

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During observations on 8/26/21, at 11:13 a.m. R18 walked down the hallway independently with her walker and R18's hair was uncombed and hair sticking straight up all over.

On 8/26/21, at 11:11 a.m. nursing assistant (NA)-A indicated she worked as a casual NA-A and was not familiar with R18's needs. She stated she had access to resident care guides which were stored at the nurses station in a binder. NA-A attempted to retrieve the binder, and was unable to locate it at the nurses station. NA-A indicated that day she had been pulled from medical records to work on the floor due to a call in. NA-A located R18's plan of care in the facility's electronic medical record (MR) system, and indicated R18 required staff assistance with ADL's. NA-A did not identify why R18 was not assisted with grooming that morning.

R11

R11's annual MDS dated 6/11/21, indicated R11 had diagnoses which included seizure disorder, depression, muscle weakness and was severely cognitively impaired. The MDS indicated R11 was independent with bed mobility, transfers, dressing, toileting, eating and personal hygiene.

R11's care plan revised on 2/10/21, indicated R11 had ADL self care performance deficit related to confusion and impaired balance. The care plan indicated R11 required limited assistance from staff for dressing and personal hygiene.

During observations on 8/23/21, at 4:53 p.m. R11 was seated in the chair in her room, wore a white turtle neck with blue snow flakes and a pair of

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blue shoes. R11's shirt had several soiled white/brown spots on the chest area and her shoes had several soiled white spots on the top of the shoes.

- at 5:08 p.m. R11 walked independently in the hallway with her walker and back to her room. R11 wore a light blue pair of denim jeans with light brown colored stain noted on the inside of her legs, half way to her knees and over her entire buttocks area. The outer ring of the stain was darker brown in color and no odor was noted. R11 sat down in her chair in her room independently, while visiting with her, multiple flies buzzed around and landed on her and her clothing. R11 had several white long hairs on her chin and neck area measuring approximately 1/4 to 1/2 inch long.

- at 6:42 p.m. R11 walked down the hallway independently with her walker, continued to wear the same soiled shirt and pants and R11's facial hair remained the same.

During observations on 8/24/21, at 1:09 p.m. R11 was seated out in the activity room playing bingo with several other residents. R11 wore the same clothing from yesterday, her shirt had several soiled red/brown spots on her chest and belly area and facial hair remained the same.

During observations on 8/25/21, at 11:59 a.m. R11 was seated in the dining room and continued to wear the same shirt from Monday, 8/23/21, with a pair of yellow pants. R11's shirt continued to be soiled and stained with red/brown spots on her chest and belly area and R11's facial hair remained the same.

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During observations on 8/26/21, at 12:20 p.m. R11 walked independently with her walker to the dining room area, continued to wear the same shirt from Monday 8/23/21, with the same pair of yellow pants. R11's shirt continued to be soiled and stained with red/brown spots on her chest and belly area and R11's facial hair remained the same.

R11 was observed to wear the same soiled shirt for four days and the same soiled pants for two days and had not been shaven in four days.

On 8/26/21, at 11:21 a.m. NA-A indicated she worked as an NA on a causal basis and was not familiar with R11's needs. She stated she had access to resident care guides which were stored at the nurses station in a binder. NA-A attempted to retrieve the binder, and was unable to locate it at the nurses station. NA-A indicated that day she had been pulled from medical records to work on the floor due to a call in. NA-A located R11's plan of care in the facility's electronic MR system, and indicated R11 required staff assistance with ADL's. NA-A did not identify why R11 was not assisted with grooming that morning.

R14

R14's quarterly MDS dated 7/13/21, indicated R14 had diagnoses which included depression, poly-arthritis, lymphedema (swelling of the legs) and was severely cognitively impaired. The MDS indicated R14 required two staff assistance with bed mobility, transfers, dressing, toileting, one staff for personal hygiene and supervision with eating.

R14's care plan revised on 2/9/21, indicated R14

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had physical functioning deficit related to mobility impairment. The care plan indicated R14 required one staff to assist with oral care and personal hygiene.

During observations on 8/23/21, at 5:05 p.m. R14 was noted to have her hair uncombed, matted to the back of her head and sticking straight up on the back of her head. R14 had several long white chin hairs approximately 1/4 inch long.

During observations on 8/24/21, at 8:18 a.m. R14 was seated in her wheel chair in her room and R14 continued to have several long white chin hairs approximately 1/4 inch long.

During observations on 8/25/21, at 8:17 a.m. R14 was in bed on her back, NA-B entered her room, began to make R14's room mates bed, straightened up the room, collected the garbage and soiled linen. NA-B left R14's room with the garbage and soiled linen and walked down the hallway on the other end of the nursing home. NA-B entered the utility room, placed the linen and garbage in the proper bins and washed her hands.

During an observation on 8/25/21, at 9:03 a.m. NA-B wheeled R14 out of her room, down the hallway towards the dining room. R14 continued to have several long white chin hairs approximately 1/4 inch long. NA-B was not observed to offer or provide oral cares or shaving to R14.

On 8/25/21, at 9:14 a.m. NA-B stated R14 required assistance with all of her cares. NA-B indicated she forgot to provide R14 with oral cares and shaving that morning, stated she had

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stayed over from the night shift due the facility was short staffed. She stated she was not familiar with morning care routines and indicated she had difficulty finding supplies to provide cares with, such as oral cares and shaving.

R6

R6's quarterly MDS dated 5/27/21, indicated R6 had diagnoses which included diabetes mellitus, anxiety, schizophrenia and was cognitively intact. The MDS indicated R6 required extensive assistance of one staff with bed mobility, toileting, personal hygiene, limited assistance with dressing and supervision with transfers.

R6's care plan revised on 8/25/21, indicated R6 had ADL self care performance deficit related to aggressive behavior, confusion, impaired balance and pain. The care plan identified R14 required one to two staff assistance with dressing, personal hygiene and toileting.

During observations on 8/25/21, 7:33 a.m. R6 was seated in her room in a wheelchair and a strong, pungent, heavy odor of urine was permeating from her room. R6's bed and bedding were completely saturated with urine and a strong odor of urine was noted. Clinical Manager (CM)-A and NA-E removed R6's incontinent brief which was completely saturated with urine and had a streak of bowel in it. R6's buttocks were wet, pink, puckered and wrinkled, with markings noted from the soiled brief. CM-A and NA-E proceeded to assist R6 with peri-cares and transferred R6 back into the wheelchair. R6 refused the rest of her morning cares and wheeled herself out of the room. NA-E indicated she had not received report that morning from the

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night shift and stated she never received report. Both NA-E and CM-A stated they were not aware when the last time R6 had been checked or changed or offered assistance with toileting.

- at 7:41 a.m. CM-A reviewed R6's MR, to see the last time R6 had been checked and changed. CM-A reported R6 had last been checked and changed at 3:40 a.m. and was incontinent at that time of urine.

R6's MR lacked any further documentation when R6 had last been checked and changed since 3:40 a.m..

R21

R21's significant change Minimum Data Set (MDS) dated 8/4/21, identified R21 had significant cognitive impairment and diagnoses which included: Alzheimer's disease, muscle weakness and thyroid disorder. R21's MDS indicated R21 required total assistance with transfers and extensive assistance with bed mobility, dressing and personal hygiene.

R21's care plan revised 7/12/21, identified R21 required extensive assistance with dressing, personal hygiene and R22 did not use the toilet, however was expected to be checked and changed periodically. R21's care plan identified R21 had impaired thought processes related to Alzheimer's disease. R21's care plan did not include specific instructions for facial hair removal.

On 8/23/21, at 2:31 p.m. R21 was observed seated in her wheelchair in her room. R21 had multiple long wispy white hairs on her chin and

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neck ranging from 1/8 inch with 4-5 hairs up to 3/4 inches long.

On 8/24/21, at 8:13 a.m. R21 was observed seated in her wheelchair in her room. R21 continued to have multiple facial hairs, white in color on her chin and neck, ranging from 1/8 inch long to 3/4 inch long.

On 8/25/21, at 11:45 a.m. R21 was observed seated in her wheelchair in the activity room with multiple other residents and staff members present. R21 continued to have facial hairs present as before, with multiple white wispy hairs up to 3/4 inch long on her chin and neck.

On 8/25/21, at 12:09 a.m. nursing assistant (NA)-E indicated she did not usually assist R21 with cares however had helped another staff member with R21's cares that morning.

R22

R22's significant change Minimum Data Set (MDS) dated 8/6/21, identified R22 had significant cognitive impairment and diagnoses which included: dementia, arthritis and hypertension (high blood pressure). R22's MDS further indicated R22 required extensive assistance with bed mobility, dressing, and personal hygiene.

R22's care plan revised 8/13/21, identified R22 had an activities of daily living (ADL) self-care performance deficit related to advanced dementia and limited mobility. R22's care plan interventions included extensive assistance of one staff for dressing, personal hygiene and oral care.

On 8/25/21, at 7:36 a.m. to 8:16 a.m. NA-B

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assisted R22 with morning cares, then assisted in her wheelchair out into the hallway after the cares were completed. During the observation, NA-B had not completed oral cares for R22.

On 8/25/21, at 9:37 a.m. during an interview, NA-B indicated her typical shift was working the night shift, 10:30 p.m. to 6:00 a.m., however within the last few weeks the facility had direct care staff calling in sick or just not showing up for their morning shifts. NA-B stated upon shift start, several residents were routinely saturated with urine and would require complete bed changes, which included R1, R6 and several other residents. NA-B indicated she felt the facility had been struggling with staffing for several months, had improved some when pool staff came in a couple of months ago and had been worsening again the last several weeks. She indicated when the facility had a call in or a no show for the morning shift, either someone from the night shift would stay or the day shift would work with only one NA. NA-B indicated the usual staffing patterns would include at least two NA's on each shift. She stated there had been several times within the last few months when she had to work alone at night and other NA's had worked alone on the day and evening shifts. NA-B stated this occurred most recently as the week prior and indicated she was the only NA scheduled for that night. NA-B indicated when she worked alone, it was expected she would provide care for residents who were care planned for two assist for repositioning, transfers, or checking and changing which included R16, R4, and R9. NA-B stated some of the nurses would help with resident cares and some would not and felt the only way residents would receive needed cares was for her to complete them herself. NA-B

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indicated she had spoken with facility administration and the director of nursing (DON) as recently as that day regarding concerns with sufficient staffing and had been informed the facility was working on a solution.

On 8/25/21, at 10:06 a.m. during a follow up interview, NA-B stated she typically did not perform R22's morning cares and was unfamiliar with her morning routine. NA-B stated no, she had not completed oral cares for R22 that morning, but indicated her usual practice would be to complete oral cares. NA-B indicated she had stayed over from the night shift that morning due to a no call no show.

On 8/24/21, at 1:32 p.m. during an interview NA-C indicated the facility usually had two NA's and two nurses each shift. NA-C indicated within the last few weeks, there had been call-ins, holes in the schedule and they would end up working short nursing assistants. NA-C stated almost daily, when they started their shift, residents would be soaked with urinary incontinence and felt the prior shift was not able to keep up routine cares with one NA. NA-C stated they would not take a break during their eight hour shift, as there would be no one to answer resident call lights. NA-C indicated they made sure residents were repositioned but when they were short staffed they would not be able to give residents baths and cares and essential cares would be provided, such as repositioning and toileting. NA-C indicated shaving, showering and hair care would not generally be included in essential cares. NA-C indicated the charge nurse and DON were aware of the staffing concerns and as recently as that day, had indicated they were working on it.

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On 8/24/21, at 2:32 p.m. during an interview, NA-G stated the usual staffing was for two NA's on each shift and two nurses. NA-G indicated there were several times an NA had called in and they would be responsible for working the floor alone. NA-G stated the nurses would help as they were able, but oftentimes they were responsible for getting residents up for meals and all routine cares. NA-G indicated this occurred as recently as that week and the week prior. NA-G stated she felt residents did not receive quality of care during times when they were short staffed, however felt they did they best they could. NA-G stated the facility had pool staff come in several months ago, which had helped though call-ins still occurred, usually with the NA's. NA-G indicated they had reported to the DON and charge nurse concerns with staffing as recently as that day and had been told the facility was working on it.

On 8/25/21, at 12:39 p.m. the facility administrator stated the facility schedule was developed by herself and the DON and stated they were working through significant process changes with staffing currently. The administrator indicated the facility had a high staff turnover within the last few months, with several long term staff having been let go and shifts in management/leadership. She indicated the facility was currently using pool agency staff and had been using the service for the past few months. The administrator stated they had moved all of their board and care residents up to one wing of the skilled nursing side while renovations took place in the board and care, which also helped to consolidate the staff. She indicated within the last week or so, the facility has had an increase in staff not coming in for their shifts and call ins. She stated the facility had recently implemented a

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staffing coordinator who was responsible for data entry and posting/staff notification of open shifts. The administrator indicated she was aware of the current weeks staffing shortages and had replaced the open shifts with licensed staff and NA's from other shifts.

On 8/26/21, at 10:21 a.m. during an interview, licensed practical nurse (LPN)-A indicated that day an NA had called in for the day shift, therefore the clinical manager had helped on the floor in the morning until one of the evening NA's arrived early. LPN-A stated this occurred almost daily, the prior day the facility had a no call no show NA and that had been a problem off and on the last few months. LPN-A indicated most of the time, the facility was able to mandate an NA to stay from the previous shift when there was a call in, though there were occurrences when there was only one NA from nights and that NA had also worked the evening shift. He indicated on those days, he felt residents would not receive the quality of care they would like and may not have received cares or medications timely. LPN-A stated he had received no complaints from residents or family members regarding lack of sufficient staffing however staff had voiced concerns about resident care due to lack of staff, as recently as that day. LPN-A indicated he was able to help answer call lights and assist with cares at times however he was expected to administer medications in a timely manner as well. LPN-A stated he had voiced concerns to the facility DON and assistant director of nursing (ADON) as recently as the day prior regarding lack of sufficient staff on the day shift and indicated they had promised to resolve the issue.

On 8/26/21, at 1:37 p.m. during an interview NA-F

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indicated the facility's usual staffing pattern for NA's was two per shift and that day one of the NA's had not shown up for her shift. NA-F stated that occurred weekly and the facility routinely scrambled to find staff to piece a shift together. NA-F indicated there had been several occasions where upon starting her shift there had been only one NA on the prior shift and several residents had appeared to have not gotten out of bed at all including R1. NA-F stated it had occurred as recently as the day prior. NA-F stated she felt within the last few months the facility routinely did not have sufficient staff to provide resident cares in a timely manner. NA-F indicated as recently as that day, they had spoken with the facility administrator and DON regarding staff routinely calling in for shifts and/or not showing up at all. NA-F indicated the facility management had indicated they were aware of the issue and were working to resolve it.

On 8/26/21, at 2:01 p.m. during an interview, NA-E indicated the NA that was scheduled to work with her that day during the day shift had not shown up for work and the night NA had stayed to help. NA-E indicated this occurred weekly, almost every time she worked. NA-E stated there were times when an NA did not come in for the day shift, the facility was unable to replace the NA then the facility had one of the charge nurses work the floor. NA-E indicated when she arrived for work in the morning, several residents including R6, R9, R16 and R1 were routinely wet and required complete bed changes. NA-E stated she felt it occurred when there was only one NA on the night shift. She indicated the usual staffing patterns for NA's was two per shift, however she stated more frequently they only had one NA during the nights. NA-E stated she spoke to the

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DON and administration regarding staffing as recently as that day and had been told "things will start looking up soon."

On 8/26/21, at 3:15 p.m. the facility activity director (AD) stated she had been asked to work the floor that day and on prior days when the facility was short staffed. She indicated she was not routinely scheduled on the floor, though had maintained her NA certification so she was able to help when needed.

On 8/27/21, at 9:53 a.m. the clinical manager (CM)-A indicated the facility had frequent ill calls/ no shows for direct care staff or NA's routinely and was responsible for filling the shift and assisting with cares on the floor. CM-A stated she worked the floor at a minimum of weekly and was concerned for the scheduled NA's who were required to work alone. CM-A indicated she had not received any complaints from residents or family members regarding staffing however several staff members voiced concerns that residents cares were not being routinely provided such as incontinence cares, grooming, oral cares and bathing. She stated oftentimes the facility would piece shifts, for example if a day NA did not show up for work, such as the day prior, the night aid would stay and they would try to get an evening NA to come in early, or find one to pick up the whole shift. CM-A stated at times there was only one NA on nights who had already worked the evening shift and would not be able to stay for the day shift, then the CM was expected to help on the floor. CM-A indicated she spoke to the facility DON as recently as the day prior regarding lack of sufficient staffing and had been told they were working on it.

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On 8/27/21, at 10:13 a.m. during a follow up interview, the AD stated she helped out on the floor approximately a few times a week at varying times due to lack of direct care staff. She indicated she felt the facility administrator and DON had been doing all they could to hire new staff and they continued to use agency pool staff to help meet resident needs.

On 8/27/21, at 11:46 a.m. during a joint interview with the facility administrator and DON, the administrator stated they were aware of the facility staffing concerns and were currently in the process of hiring direct care staff. The DON indicated she felt the facility's staffing had overall improved within the last few months, though indicated this past week staffing had ben a challenge with call ins and unfilled holes in the schedule. The administrator indicated the facility had implemented daily charge nurses who were responsible for the daily work flow which included staffing and were responsible to help on the floor in the event of a call in or no show. The administrator stated at those times, the charge nurse was also responsible for attempting to fill the shift. The administrator indicated in the last several months the facility had several direct care staff hired, they went through some orientation and then never came back. She indicated the facility was currently hiring for several NA's positions and had hiring bonuses and incentives in place for for staff who picked up extra shifts. The DON stated she felt now that the facility had a management/leadership team established with clinical managers, charge nurses, ADON the overall workflow would improve. She indicated she planned to have nursing leadership on the floor to ensure resident cares were completed routinely. The current staffing pattern was

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identified:

- day shift; one licensed staff were scheduled for 12 hour shifts 5:00 a.m. to 5:00 p.m., a TMA from 6:00 a.m. to 2:00 p.m. and two NA's from 5:30 a.m. to 2:00 p.m., goal with full census would be three NA's.

- evening; TMA 2:00 p.m. to 10:30 p.m. (or licensed nurse) and two NA's from 1:30 p.m. to 10:00 p.m., goal with full census would be three NA's.

- nights; licensed nurse 5:00 p.m. to 5:00 a.m. and two NA's from 10:00 p.m. to 6:30 a.m.

Both the facility administrator and the DON confirmed the facility did not routinely have the identified required staff on each shift available for resident cares during the week of survey, though both stated they felt it was a fluke and staffing had been improving within the last few months.

On 8/27/21, at 1:55 p.m. the staffing coordinator stated he had just started the role of staffing coordinator, was provided the staffing data from the facility administrator and DON, such as staffing pattern and developed the schedule for the month. The staffing coordinator indicated he posted the openings for the month for staff to pick up. He indicated he was not responsible for filling open shifts caused by a call in or a no show, and indicated it was the charge nurses responsibility to find a replacement in those situations.

Review of the facility staffing schedule from 8/17/21, to 8/27/21, identified the following unfilled shifts:

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F 725	Continued From page 100 -8/22/21, revealed unfilled 5:30 a.m. to 2:00 p.m. NA shift. -8/25/21, revealed unfilled 1:30 p.m. to 10:00 p.m. NA shift. Review of the facility daily schedule for the week of survey 8/17/21, to 8/27/21, identified the following unfilled shifts/open shifts: -8/17/21, revealed unfilled 10:00 p.m. to 6:30 a.m. NA shift -8/20/21, revealed unfilled 10:00 p.m. to 6:30 a.m. NA shift -8/21/21, revealed unfilled 6:00 a.m. to 2:00 p.m. TMA shift -8/22/21, revealed unfilled 6:00 a.m. to 2:00 p.m. TMA shift -8/23/21, revealed unfilled 10:00 p.m. to 6:30 a.m. NA shift -8/24/21, revealed unfilled 10:00 p.m. to 6:30 a.m. NA shift -8/25.21, revealed call in NA on 5:30 a.m. to 2:00 p.m., one night NA stayed from previous shift, unfilled 1:30 p.m. to 10:00 p.m. NA shift and a 10:00 p.m. to 6:30 a.m. NA shift. -8/26/21, revealed call in NA on 5:30 a.m. to 2:00 p.m., CM was pulled to the floor, and evening NA in at 10:00 a.m., unfilled 10:00 p.m. to 6:30 a.m. NA shift. -8/27/21, revealed unfilled 5:30 a.m. to 2:00 p.m.	F 725		

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F 725	Continued From page 101 NA shift, one night NA stayed from previous shift. Review of Meadow Lane Restorative Care Center facility assessment updated 7/25/21, identified the facility was licensed for 37 skilled nursing beds, 19 board and care beds, for a total of 56 beds, had an average daily census of 34. The facility assessment identified the following staffing plan: -day shift, two licensed nurses, one for eight hours and one for six and a half hours, TMA for eight hours and three NA's for eight hours each. -evening shift, two licensed nurses for four hours each and one for eight hours, TMA for eight hours and three NA's for eight hours each. -night shift, one licensed nurse for eight hours and two NA's for eight hours each.	F 725		
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug.	F 756		10/11/21

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F 756	Continued From page 102 (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the pharmacy consultant (PC) identified and reported an irregularity related to the lack of a rational for gradual dose reduction (GDR) for a psychotropic medication for 2 of 5 residents (R10 and R22,) and physician ordered laboratory for 1 of 5 residents (R10) reviewed for unnecessary medications. Findings include: R10's quarterly Minimum Data Set (MDS) dated 6/11/21, identified R10 had diagnoses which included cerebral vascular disease, depression, chronic pain, arthritis and depression. The MDS	F 756	1. It is the expectation of the facility to ensure the pharmacy consultant (PC) identified and reported an irregularity related to the lack of a rational for gradual dose reduction (GDR) psychotropic medication, and physician ordered laboratory reviewed for unnecessary medications. R10 and R22□s drug regime was reviewed to ensure compliance with monitoring of recommendations. 2. All residents have the potential to be adversely affected by the deficient practice. Facility policies and procedures were reviewed and revised to ensure	

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F 756	Continued From page 103 identified R10 had severe cognitive impairment and required extensive assistance with activities of daily living (ADL's.) The MDS revealed R10 received daily antipsychotic and antidepressant medications and identified a gradual dose reduction had not been attempted in the last quarter. R10's care plan revised 7/12/21, revealed R10 had behavior problems (alcohol abuse) related to depression and chronic pain. The care plan listed various interventions which included: administering medications as ordered, monitor/document side effects and effectiveness. R6's care plan revealed R6 received antidepressants, psychotropic medications and listed several interventions which included pharmacy review monthly or per protocol. R10's Consultant Pharmacist's Medication Review dated 6/9/21, identified R10 had been taking a current dose of Trazodone 50 milligrams (mg) at bedtime since 12-2019. CMS guidelines require at least quarterly assessment of sedatives/hypnotics for continued need and trial dose reduction consideration. The form's suggested course of action included to assess R10 for continued use of Trazodone 50 mg at bedtime for sleep. If a dose reduction was not appropriate at the time, provide clinical rational for continuing current dose. The physician signed the form on 7/15/21, with a handwritten "ok", and underline of "continuing current dose" in message above. The form lacked a rationale for continuing current dose. The form was signed by director of nursing (DON) on 7/20/21. R10's signed Order Summary dated 6/3/21, identified the following orders:	F 756	proper monitoring of pharmacy consultant recommendations. Recommendations were reviewed to ensure compliance with medication reviews. 3. A nursing in-service training is planned for 10/4/2021 which includes education of the importance of the pharmacist□s review. 4. Effective 10/1/2021, a quality assurance program was initiated under the direction of the director of nursing to audit medication reviews on a regular basis to ensure compliance. Audits completed weekly for 6 weeks and monthly for 3 months to ensure compliance with recommendations. Any deficiencies will be corrected immediately, and findings brought to and monitored through the quality assurance committee for further review and ongoing monitoring.	

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-Trazodone (antidepressant medication) 50 mg by mouth at bedtime related to insomnia, start date 12/12/19.

R10's Medication Administration Record (MAR) for August of 2021, revealed R10 had received the following medications:

-Trazodone 50 mg by mouth one time daily at bedtime for insomnia, started 12/12/19.

R10's progress note dated 5/26/21, revealed R10 had received orders for comprehensive metabolic panel (CMP) and complete blood count (CBC) lab draws to check patients liver and heart function due to increased in abdominal girth and pain.

On 8/26/21, at 11:25 a.m. the DON confirmed a fax communication had been sent to R10's primary physician, in response an order had been received for labs of a CBC and CMP to be drawn. The DON stated she would have expected the labs to be done at the next available visit, which would have been the following day. The DON confirmed the pharmacy consultants request to have R10's Trazodone reviewed for a GDR had not been sufficiently addressed by R10's primary physician.

On 8/26/21, at 11:31 a.m. the regional MDS coordinator, confirmed R10's GDR for Trazodone had not been addressed by R10's primary physician, and indicated an "ok" was not sufficient rationale for continued use.

On 8/27/21, at 10:04 a.m. during a telephone interview R10's primary physician stated she had not ordered the labs on 5/24/21, and would have

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remembered to check on them, however would have expected R10's labs to have been drawn during the next available visit. R10's physician stated she had not felt R10 was a candidate for a gradual dose reduction for his Trazodone.

On 8/27/21, at 1:37 p.m. during a telephone interview, the PC stated she expected her recommendations to be addressed within 30 to 60 days after being written. She stated R10 had been seen by psychiatry within the last few months and she had reminded the facility to have one of R10's providers address his Trazodone GDR. The PC stated she did not feel an "ok" in response to a GDR was a sufficient rationale and had voiced this to the facility nursing management in the past. The PC stated she was not aware of R10's lab order on 5/25/21, for a CBC and CMP. The PC confirmed had she been aware of the lab orders and she would have recommended the facility obtain them.

R22

R22's significant change Minimum Data Set (MDS) dated 8/6/21, identified R22 had significant cognitive impairment and diagnoses which included: dementia, arthritis and hypertension (high blood pressure). R22's MDS further indicated R22 required extensive assistance with bed mobility, dressing, and personal hygiene. R22's MDS identified R22 received antipsychotic

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and antidepressant medications 7 of the last 7 days.

R22's care plan revised 8/13/21, identified R22 had an activities of daily living (ADL) self-care performance deficit related to advanced dementia and limited mobility. R22's care plan interventions included: extensive assistance of one staff for dressing, personal hygiene, and bed mobility. R22's care plan identified R22 received antidepressant medication, Trazodone (antidepressant) related to dementia with behavioral disturbance and an aid to sleep. R22's care plan indicated R22 received psychotropic medications, risperidone (antipsychotic) related to behavior management.

R22's Consultant Pharmacist's Medication Review dated 6/9/21, identified R22 had been taking current dose of Trazodone 25 mg at bedtime since 2/2021. CMS guidelines required at least quarterly assessment of sedatives/hypnotics for continued need and trial dose reduction consideration. The form's suggested course of action included to assess R22 for continued use of Trazodone 25 mg at bedtime for sleep. If a dose reduction was not appropriate at the time, provide clinical rational for continuing current dose. The physician signed the form on 7/15/21, with a handwritten "ok", and underline of "continuing current dose" in message above. The form lacked a rationale for continuing current dose. The form was signed by director of nursing (DON) on 7/21/21.

R22's Order Summary Report signed 4/15/21, included the following:

-lorazepam (antianxiety medication) tablet 0.5

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mg (milligram). Give 0.5 mg by mouth every 6 hours as needed for anxiety and agitation, start date of 8/23/21.

-risperidone (antipsychotic medication) tablet 1 mg. Give 1 mg by mouth every morning and at bedtime related to unspecified dementia with behavioral disturbance, start date of 2/18/21.

-Trazodone hydrochloride (HCl) tablet. Give 25 mg by mouth at bedtime related to unspecified dementia with behavioral disturbance, start date of 12/4/20.

R22's physician progress note dated 4/15/21, identified R22 was currently on Trazodone 25 mg at bedtime, and if R22 appeared fatigued the next day it would be discontinued. No rationale for continued use of Trazodone was included and no orders to discontinue Trazodone were found.

On 8/27/21, at 1:19 p.m. DON indicated she expected the PC to review medications and gradual dose reductions. DON reviewed R22's recommendations from 6/9/21, and the response by her primary physician of "Ok" and said nursing should have gotten clarification from the doctor. DON stated R22's primary physician was not very specific on pharmacy recommendation follow ups and indicated the facility needed to have a conversation with R22's primary physician. DON identified the facility was inconsistent with their follow-up of pharmacy recommendations prior to June. DON confirmed she expected the PC's recommendations to be followed up on and if the physician's response was unclear, nursing were to contact the physician to clarify.

On 8/27/21, at 1:45 p.m. during a phone

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F 756	Continued From page 108 interview PC-A confirmed her expectation was for the facility to follow up on her recommendations within 30-60 days. PC-A indicated she was reviewing her documentation and had noted on 7/15/21, the facility identified they would have had R22's primary care physician document about the recommendation on 8/13/21, however could not locate the documentation. PC-A stated she planned to add the required rationale for continuing R22's Trazodone during her next visit in September. PC-A stated a response from R22's primary care physician of "ok" was not an acceptable rationale for continued use.	F 756		
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	F 758		10/11/21

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F 758	Continued From page 109 drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure a gradual dose reduction (GDR) was attempted, or a provider rationale which clinically contraindicated a GDR, for a psychotropic medication was completed for 1 of 5 residents (R10) reviewed for unnecessary medications. R10's quarterly Minimum Data Set (MDS) dated 6/11/21, identified R10 had diagnoses which included: cerebral vascular disease, depression, chronic pain, arthritis and depression. The MDS	F 758	1. It is the expectation of the facility to ensure a gradual dose reduction (GDR) was attempted, or provider rationale which clinically contraindicated a GDR, for a psychotropic medication was completed. R10□s drug regime was reviewed to ensure compliance with unnecessary psychotropic medications/PRN use. 2. All residents on psychotropic meds have the potential to be affected by the deficient practice. Facility policies and procedures were reviewed and residents	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOW LANE RESTORATIVE CARE CENTER	2209 UTAH AVENUE BENSON, MN 56215

(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 758	Continued From page 110 identified R10 had severe cognitive impairment and required extensive assistance with activities of daily living (ADL's.) The MDS revealed R10 received daily antipsychotic and antidepressant medications and identified a gradual dose reduction had not been attempted in the last quarter. R10's care plan revised 7/12/21, revealed R10 had behavior problems (alcohol abuse) related to depression and chronic pain. The care plan listed various interventions which included: administering medications as ordered, monitor/document side effects and effectiveness. R6's care plan revealed R6 received antidepressants, psychotropic medications and listed several interventions which included: pharmacy review monthly or per protocol. R10's Consultant Pharmacist's Medication Review dated 6/9/21, identified R10 had been taking a current dose of Trazodone 50 milligrams (mg) at bedtime since 12-2019. CMS guidelines required at least quarterly assessment of sedatives/hypnotics for continued need and trial dose reduction consideration. The form's suggested course of action included to assess R10 for continued use of Trazodone 50 mg at bedtime for sleep. If a dose reduction was not appropriate at the time, provide clinical rational for continuing current dose. The physician signed the form on 7/15/21, with a handwritten "ok", and underline of "continuing current dose" in message above. The form lacked a rationale for continuing current dose. The form was signed by director of nursing (DON) on 7/20/21. R10's signed Order Summary dated 6/3/21, identified the following orders:	F 758	on psychotropics were reviewed to ensure that compliance with GDRs was completed; no further concerns were identified. 3. A nursing in-service training is planned for 10/4/2021 which includes education of the facilities policies and procedures for unnecessary psychotropic medications/PRN use. 4. Effective 10/1/2021, a quality assurance program was initiated under the direction of the director of nursing to audit residents on psychotropic medications/PRN use and review of GDR compliance. Audits completed weekly for 6 weeks and monthly for 3 months to ensure compliance with recommendations. Any deficiencies will be corrected immediately, findings brought to and monitored through the quality assurance committee for further review and ongoing monitoring.	

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F 758	Continued From page 111	F 758		

-Trazodone (antidepressant medication) 50 mg by mouth at bedtime related to insomnia, start date 12/12/19

R10's Medication Administration Record (MAR) for August of 2021, revealed R10 had received the following medications;

-Trazodone 50 mg by mouth one time daily at bedtime for insomnia, started 12/12/19.

On 8/26/21, at 11:25 a.m. the DON confirmed the pharmacy consultants request to have R10's Trazodone reviewed for a GDR had not been sufficiently addressed by R10's primary physician.

On 8/27/21, at 10:04 a.m. during a telephone interview, R10's physician stated she had not felt R10 was a candidate for a gradual dose reduction for his Trazodone.

On 8/27/21, at 1:37 p.m. during a telephone interview, the pharmacy consultant (PC) stated she expected her recommendations to be addressed within 30 to 60 days after being written. She stated R10 had been seen by psychiatry within the last few months and she had reminded the facility to have one of R10's providers address his Trazodone GDR. The PC stated she did not feel an "ok" in response to a GDR was a sufficient rationale and had voiced this to the facility nursing management in the past.

A facility policy was requested for psychotropic gradual dose reductions and one was not provided.

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F 770	Continued From page 112	F 770		
F 770 SS=D	Laboratory Services CFR(s): 483.50(a)(1)(i) §483.50(a) Laboratory Services. §483.50(a)(1) The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. (i) If the facility provides its own laboratory services, the services must meet the applicable requirements for laboratories specified in part 493 of this chapter. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure physician ordered laboratory monitoring was completed for 1 of 5 residents (R10) reviewed for unnecessary medication use. Findings include: R10's quarterly Minimum Data Set (MDS) dated 6/11/21, identified R10 had diagnoses which included: cerebral vascular disease, depression, chronic pain, arthritis and depression. The MDS identified R10 had severe cognitive impairment and required extensive assistance with activities of daily living (ADL's). Review of R10's physician fax communication dated 5/25/21, identified a request to draw labs due to abdominal bloat and to rule out heart/liver problems. The fax communication revealed a hand written order for a complete blood count (CBC) and comprehensive metabolic panel (CMP) for a diagnosis of abdominal pain. The form had a handwritten signature and date noted of 5/26/21.	F 770	1. It is the expectation of the facility to ensure compliance with physician ordered laboratory monitoring. R10 has since been reviewed to ensure compliance with physician ordered labs. 2. All residents have the potential to be affected by the deficient practice. Policies and procedures were reviewed and other residents with lab orders to ensure compliance with laboratory services. 3. A nursing in-service training is planned for 10/4/2021 which includes education of the policies and procedures for ensuring compliance with physician ordered laboratory services. 4. Effective 10/1/2021, a quality assurance program was initiated under the direction of the director of nursing to audit residents who have routine and new physician ordered laboratory orders. The Director of Nursing/Designee will audit weekly for 6 weeks and then monthly for 3 months. Any identified deficiencies will be corrected, and all findings brought to the monthly quality assurance committee for	10/11/21

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F 770	Continued From page 113 R10's progress note dated 5/26/21, indicated R10 had received orders for CMP and CBC lab draws to check patients liver and heart function due to increased in abdominal girth and pain. On 8/26/21, at 11:25 a.m. the director of nursing (DON) confirmed a fax communication had been sent to R10's primary physician and in response an order had been received for labs of a CBC and CMP to be drawn. The DON stated she would have expected the labs to be done at the next available visit, which would have been the following day. On 8/27/21, at 10:04 a.m. during a telephone interview R10's primary physician stated she had not ordered the labs on 5/24/21, and would have remembered to check on them, however she would have expected R10's labs to have been drawn during the next available visit. On 8/27/21, at 1:37 p.m. during a telephone interview, the pharmacy consultant stated she was not aware of R10's lab order on 5/25/21, for a CBC and CMP. The PC confirmed had she been aware of the lab orders, however she would have recommended the facility obtain them. A facility policy was requested for laboratory services and was not provided.	F 770	further review and ongoing monitoring.	
F 801 SS=F	Qualified Dietary Staff CFR(s): 483.60(a)(1)(2) §483.60(a) Staffing The facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service,	F 801		10/11/21

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F 801	Continued From page 114 taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e) This includes: §483.60(a)(1) A qualified dietitian or other clinically qualified nutrition professional either full-time, part-time, or on a consultant basis. A qualified dietitian or other clinically qualified nutrition professional is one who- (i) Holds a bachelor's or higher degree granted by a regionally accredited college or university in the United States (or an equivalent foreign degree) with completion of the academic requirements of a program in nutrition or dietetics accredited by an appropriate national accreditation organization recognized for this purpose. (ii) Has completed at least 900 hours of supervised dietetics practice under the supervision of a registered dietitian or nutrition professional. (iii) Is licensed or certified as a dietitian or nutrition professional by the State in which the services are performed. In a State that does not provide for licensure or certification, the individual will be deemed to have met this requirement if he or she is recognized as a "registered dietitian" by the Commission on Dietetic Registration or its successor organization, or meets the requirements of paragraphs (a)(1)(i) and (ii) of this section. (iv) For dietitians hired or contracted with prior to November 28, 2016, meets these requirements no later than 5 years after November 28, 2016 or as required by state law.	F 801		

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F 801	Continued From page 115 §483.60(a)(2) If a qualified dietitian or other clinically qualified nutrition professional is not employed full-time, the facility must designate a person to serve as the director of food and nutrition services who- (i) For designations prior to November 28, 2016, meets the following requirements no later than 5 years after November 28, 2016, or no later than 1 year after November 28, 2016 for designations after November 28, 2016, is: (A) A certified dietary manager; or (B) A certified food service manager; or (C) Has similar national certification for food service management and safety from a national certifying body; or D) Has an associate's or higher degree in food service management or in hospitality, if the course study includes food service or restaurant management, from an accredited institution of higher learning; and (ii) In States that have established standards for food service managers or dietary managers, meets State requirements for food service managers or dietary managers, and (iii) Receives frequently scheduled consultations from a qualified dietitian or other clinically qualified nutrition professional. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to designate a qualified person to serve as the director of food service to oversee the dietary department in the absence of a full time dietitian. This had the potential to affect all 25 residents, visitors and staff who consumed food from the kitchen. Findings include:	F 801	1. It is the expectation of the facility to designate a qualified person to serve as the director of food service to oversee the dietary department in the absence of a full-time dietitian. The policies and procedures were reviewed to ensure the Dietary Manager has the proper qualifications for the position. 2. All residents have the potential to be affected by not having a qualified person	

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F 801	Continued From page 116 The facility was unable to provide any documentation to support dietary manager (DM)-A and DM-B were certified to be the manager of the food service position. On 8/23/21, at 12:50 p.m. during the initial tour of the kitchen, DM-A indicated DM-B was being trained in by him to take over the DM position in the kitchen. On 8/24/21, at 2:47 p.m. DM-A confirmed the above findings and indicated registered dietician (RD)-A was covering for the facility until they hired RD. DM-A explained RD-A came to the facility every two weeks to assess the residents and RD-B recently assumed this role to cover for the facility. On 8/25/21, at 12:37 p.m. in a follow up interview DM-A confirmed she was not certified to be a DM. On 8/25/21, at 7:56 a.m. DM-B confirmed she was not certified and was in the midst of new employee training. On 8/25/21, at 1:56 p.m. via phone call RD-A indicated she recently resigned from the facility and was not overseeing the facility. RD-A stated she had offered to fill in until the facility hired a RD however the facility had not followed up with her regarding the offer. On 8/25/21, at 2:01 p.m. via phone call RD-B indicated she was only asked to provide the facility a little input and to help them out. RD-B indicated she worked full time at another facility and did not have the capacity to be their RD or consultant.	F 801	to serve as the director of food service to oversee the dietary department in absence of a full-time dietitian. The current dietary manager has since been enrolled into the Certified Dietary Manager program and has a preceptor assigned with assistance. 3. Under the director of the Administrator, an IDT training was help on 10/1/2021 to review the facility policies and requirements for director of food service to oversee dietary department. 4. Effective 10/1/2021, a quality assurance program was initiated under the direction of the administrator to monitor systems to ensure ongoing compliance with designating a qualified person to oversee the dietary department. The Administrator/Designee will audit weekly for 6 weeks and then monthly for 3 months. Any identified deficiencies will be corrected, and all findings brought to the monthly quality assurance committee for further review and ongoing monitoring.	

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F 801	Continued From page 117 On 8/26/21, at 12:07 p.m. the administrator confirmed the above findings and indicated DM-A and DM-B were not certified. The administrator verified the facility had no written contract with RD-B and that it was only a verbal agreement between the owner and RD-B. On 8/27/21, at 11:30 a.m. in a follow up interview RD-B confirmed there was no written contact between her and the facility. Review of facility policy titled, Director of Food and Nutrition Services Responsibility undated, indicated the director of food and nutritional services would be responsible for providing safe foods to all individuals.	F 801		
F 812 SS=F	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.	F 812		10/11/21

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F 812	Continued From page 118 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to serve food in a safe and sanitary manner to prevent the spread of cross contamination. This deficient practice had the potential to affect all 13 residents who currently resided in the facility and received food from the Blue Horizon kitchenette. Findings include: During observations on 8/23/21, at 6:01 p.m. dietary cook (DC)-A was serving the supper meal from the steam table in the main dining room area. DC-A had her hands gloved, she grabbed a plate, placed a scoop of turkey, a scoop of gravy on the turkey and a scoop of baked beans on the plate. DC-A grabbed a handful of raw carrots with her gloved hand, placed them on the plate and set the plate on the steam table to be delivered. - DC-A proceeded to touch the menu slips with her gloved hands, grabbed a hot dog bun out of the package setting on the back counter and placed it on the plate. DC-A grabbed the tongs, placed a hotdog in the bun, put a scoop of baked beans on the plate and set the plate on top of the steam table to be delivered. - at 6:05 p.m. DC-A touched the menu slips on top of the steam table with both gloved hands, grabbed a plate, grabbed two hot dog buns out of the package, placed them on the plate and used tongs to place hotdog's inside the buns. DC-A poured chips onto the plate, grabbed the hotdog's on the plate and moved them over on the plate, touched the menu slips with her gloved hands, placed a scoop of baked beans on the plate and	F 812	1.It is the expectation of the facility to serve food in a safe and sanitary manner to prevent the spread of cross contamination. This deficient practice had the potential to affect all residents who currently reside and received food from the Blue Horizon kitchenette. 2. All residents have the ability to be affected by this deficient practice; food service policies and procedures were reviewed by the Administrator/Director of Nursing to ensure that food is served in a sanitary manner. 3. Under the direction of the Administrator and Dietician, an Inservice is being held for dietary staff on 10/2/2021 to ensure compliance with the facility policies and procedures of serving food in a safe and sanitary manner. 4. Effective 10/1/2021, a quality assurance program was initiated under the direction of the administrator to monitor systems to ensure ongoing compliance with serving food in a safe and sanitary manner. The Administrator/Designee will audit bi-weekly for 6 weeks and then weekly for 6 weeks, then monthly for 3 months. Any identified deficiencies will be corrected, and all findings brought to the monthly quality assurance committee for further review and ongoing monitoring.	

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F 812	Continued From page 119	F 812		

set the plate on top of the steam table to be served.

- at 6:08 p.m. DC-A removed her gloves, set the dirty gloves on the back counter near her raw carrots, buns and chips. DC-A then grabbed a plastic container of cereal out of the cupboard, gloved her hands, grabbed a bowl and poured cereal into it. DC-A grabbed a plate, placed the bowl of cereal on it, set the plate down on top of the steam table to be served. DC-A grabbed the menu slips off the top of the steam table with her gloved hands and began to review them. DC-A proceeded to grab a plate, place a scoop of pureed turkey on the plate, a scoop of gravy on the turkey, obtained bowls out of cupboard and set them on the counter behind her. DC-A removed her gloves and set the dirty gloves on the back counter near the raw carrots, buns and chips. DC-A gloved her hands, put a scoop of pureed beans in a bowl, set the bowl on a plate, placed a scoop of pureed turkey on the plate with a scoop of gravy and placed it on top of the steam table to be delivered.

- at 6:11 p.m. DC-A grabbed a plate, placed a scoop of pureed turkey, scoop of gravy and a scoop of pureed beans on the plate and set it up on top of the steam table to be delivered. DC-A grabbed a plate, placed a scoop of pureed turkey, gravy and mashed potatoes on the plate and placed it on top of the steam table to be served. DC-A proceeded to grab a plate, grabbed a hot dog bun out of the package, placed it on the plate and used tongs to place a hotdog inside the bun. DC-A continued to serve in this manner until she was done serving at 6:31 p.m.

On 8/24/21, at 4:41 p.m. dietary manager (DM)-A

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F 812	Continued From page 120 confirmed the above findings and indicated staff were expected to change gloves, wash their hands and start over with a clean pair of gloves when contaminated. The DM-A stated the menu slips were completed in the resident rooms and indicated the slips were contaminated. DM-A indicated dietary staff should not have been touching the menu slips while serving food and touching ready to eat foods thereafter. DM-A stated staff were expected to use utensils to serve with and to not use dirty gloved hands. Review of facility policy titled, General Food Preparation and Handling undated, indicated bare hands should never touch ready to eat raw food directly. Food would have been prepared and served with clean tongs, scoops, forks, spoons, spatulas, or other suitable implements to avoid manual contact of prepared foods.	F 812		
F 840 SS=F	Use of Outside Resources CFR(s): 483.70(g)(1)(2) §483.70(g) Use of outside resources. §483.70(g)(1) If the facility does not employ a qualified professional person to furnish a specific service to be provided by the facility, the facility must have that service furnished to residents by a person or agency outside the facility under an arrangement described in section 1861(w) of the Act or an agreement described in paragraph (g)(2) of this section. §483.70(g)(2) Arrangements as described in section 1861(w) of the Act or agreements pertaining to services furnished by outside resources must specify in writing that the facility assumes responsibility for- (i) Obtaining services that meet professional	F 840		10/11/21

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F 840	Continued From page 121 standards and principles that apply to professionals providing services in such a facility; and (ii) The timeliness of the services. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure a written registered dietician agreement had been completed which had the potential to affect all 25 residents currently residing in the facility. Findings include: On 8/24/21, at 2:47 p.m. dietary manager (DM)-A confirmed the above findings and indicated registered dietician (RD)-A was covering the facility until they hired a RD. DM-A indicated RD-A arrived at the facility every two weeks to assess the residents and RD-B recently assumed coverage of the facility. On 8/25/21, at 2:09 p.m. requested a copy of a written contract with RD-B and one was not provided. On 8/25/2,1 at 1:56 p.m. via phone call with RD-A indicated she had not been overseeing the facility and had resigned back in January 2021. RD-A stated she had offered to fill in until the facility hired a RD however had not received any follow-up from the facility regarding coverage. On 8/25/21, at 2:01 p.m. via phone call RD-B indicated she had been asked to provide the facility a little input and to help them out. RD-B stated she worked full time at another facility and was not able to provide coverage as their RD or	F 840	1. It is the expectation of the facility to ensure a written registered dietician agreement is in place. A facility specific written contract was obtained for the from the registered dietician once it was identified that it was not in place. 2. All residents have the potential to be affected by the facility not having a written agreement with a registered dietician. The contract with the dietician was obtained. Policies and procedures were reviewed by the Administrator to ensure compliance with the expectations. 3. An all staff in-service education is planned for 10/4/2021 which includes education regarding the requirements of outside resources; specifically related to a registered dietician. 4. Effective 10/1/2021, a quality assurance program was initiated under the direction of the administrator to ensure monitoring for compliance with written agreements. Audits completed weekly for 6 weeks and monthly for 3 months to ensure monitoring for compliance. Findings will be brought to and monitored through the quality assurance committee for further review and ongoing monitoring.	

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F 840	Continued From page 122 consultant. In a follow up interview on 8/27/21 at 11:03 a.m. RD-B confirmed there was no written contact with the facility for dietician services. On 8/26/21, at 12:07 p.m. the administrator confirmed the above findings and verified the facility had no written contract with RD-B and indicated there was only a verbal agreement between the owner and RD-B.	F 840		
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. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:	F 880		10/7/21

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F 880	Continued From page 123 (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by:	F 880		

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F 880	Continued From page 124 Based on observation, interview and document review, the facility failed to ensure appropriate personal protective equipment (PPE) was worn properly which had the potential to affect all 25 residents who resided in the facility. In addition, the facility failed to assure appropriate hand hygiene and glove use while providing assistance with incontinence cares to prevent the spread of infection for 2 of 5 residents (R22, R14) observed during personal cares. MASK USE On 8/25/21, at 7:19 a.m. housekeeper (HK)-A was in the hallway with his mask worn loosely, which hung below his nose. While HK-A spoke, HK-A's mask would drop down to below. At 7:20 a.m. HK-A entered R21's and R6's room when both R21 and R6 were in the room while his mask continued to hang loosely below his nose. HK-A walked to R6's side of the room and spoke to R6 who was in bed, while he removed garbage from her room. HK-A continued to walk around the room and gathered supplies periodically from the cart outside the doorway. At 7:27 a.m. HK-A stood next to R21 who was in bed in her room, when clinical manager (CM)-A entered the room. HK-A's mask remained below his nose. HK-A spoke to CM-A while his mask remained loosely fitted on his face and falling below his mouth while he spoke. At 7:28 a.m. HK-A walked down the hallway towards the housekeeping closet, put his cart away, walked to the basement door and entered the door. HK-A's mask continued to hang loosely down below his nose. At 11:36 a.m. HK-A entered room 147, while R13 was sitting in his room. HK-A's mask continued to hang loosely under his nose and when he spoke to R13, his mask fell down below his mouth. HK-A cleaned	F 880	DPOC implemented. It is the expectation of the facility to ensure appropriate PPE is worn properly and hand hygiene and glove use while aiding with incontinence cares to prevent the spread of infection for residents observed during cares. Upon identification of deficient practice, R22 and R14 were reviewed and staff observations of providing personal cares to ensure no further infection control deficient practices. Facility policies, procedures and systems were reviewed to ensure system compliance. Infection Preventionist re-educated staff and competencied staff on proper handwashing and PPE use, to assure no other residents were adversely impacted. All residents have the potential to be affected by deficient practices of infection prevention and control, specifically handwashing, gloving and PPE. Staff were competencied and re-educated, observations of the delivery of cares were completed on all applicable employees, orientation packets were reviewed to include completion of competencies for all new hires and annually for all employees. The DON and Infection Preventionist reviewed processes and procedures of handwashing, gloving and PPE to ensure compliance with infection prevention and control practices. A quality assurance program was initiated under the direction of the director of nursing to implement the DPOC. Daily	

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F 880	Continued From page 125 various items in R13's room while R13 remained in his room. On 8/25/21, at 11:50 a.m. during an interview HK-A's mask continued to hang down below his nose. When HK-A spoke his mask fell down below his mouth HK-A positioned his mask up to his nose. HK-A stated he was aware his mask was below his nose and indicated it kept falling and fogging up his glasses. HK-A indicated some residents stated they had a difficult time hearing him when his mask was over his mouth. HK-A said he had received education this week and last week about proper mask use however indicated he pulled it down since it fogged up his glasses. HK-A confirmed he had not received the COVID 19 vaccination yet. On 8/26/21, at 9:29 a.m. housekeeping manager (HM)-A confirmed there had been concerns of improper mask use by staff. HM-A indicated his mask would tend to slip down as well. HM-A stated he had reminded his staff to keep their nose and mouth covered with the mask and indicated it was important due the COVID-19 pandemic concerns. R22 R22's significant change Minimum Data Set (MDS) dated 8/6/21, identified R22 had significant cognitive impairment and diagnoses which included: dementia, arthritis and hypertension (high blood pressure). R22's MDS further indicated R22 required extensive assistance with bed mobility, dressing, and personal hygiene. R22's care plan revised 8/13/21, identified R22 had an activities of daily living (ADL) self-care	F 880	audits on all shifts implemented and 100% compliance must be achieved for 7 days before any changes, any deficiencies will be corrected, findings brought to and monitored through the quality assurance committee for further review and ongoing monitoring.	

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performance deficit related to advanced dementia and limited mobility. R22's care plan interventions included: extensive assistance of one staff for dressing, personal hygiene, and bed mobility.

On 8/25/21, at 7:37 a.m. nursing assistant (NA)-B entered R22's room and informed R22 she would provide R22's morning cares. NA-B was not observed to complete hand hygiene when she entered R22's room. NA-B filled a basin of water in the sink and started to remove R22's gown while R22 sat on the edge of the bed. After R22's gown was removed, NA-B assisted R22 to lie down and unfastened the tabs on R22's brief. NA-B folded the brief down between her legs and placed her bare hand onto the brief to check for wetness. NA-B's goggles were noted to be on the top of her head and not covering her eyes. NA-B was not observed to perform hand hygiene. NA-B lowered R22's bed, walked to the counter and proceeded to open multiple drawers. While NA-B was opening the drawers, NA-B touched the drawer handles and multiple items in the drawers. NA-B located some towels and socks and placed them on the counter top. NA-B put the washcloth into the basin of water, returned to R22's bed and placed the basin of water on the bed side table near R22's bed. NA-B began to wash R22's face and assisted her to wash her hands and arms. NA-B pulled R22's brief back down, touched the inside of her brief with her bare hands and proceeded to complete perineal cares with her bare hands. NA-B walked to the closet, touched the handle of the closet, removed a new brief and returned to R22's bed. NA-B assisted R22 to turn to her side, washed R22's buttock, removed R22's soiled brief and placed the new brief under her. At this point, NA-B placed gloves on, applied skin protective ointment to R22's buttocks and

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perineal area. NA-B pulled up R22's brief and fastened the tabs on the sides. NA-B removed her gloves and was not observed to sanitize her hands. NA-B's goggles remained on the top of her head during the time cares were provided to R22. NA-B walked to the closet, touched the closet door handle, opened the door and removed R22's clothing. At 7:55 a.m. NA-B assisted R22 to sit up, applied R22's shirt, pants, socks and shoes. NA-B went to the counter, opened multiple drawers and the closet and stated she was searching for the gait belt. NA-B located the gait belt on top of R22's chair, attempted to transfer R22 her self and stated she needed assistance. NA-B stopped the transfer attempt, opened R22's door and asked trained medication aid (TMA)-A for assistance. TMA-A entered the room, washed her hands in the sink and assisted NA-B to transfer R22 from her bed to her wheelchair. TMA-A washed her hands in the sink once the task was completed and exited the room. NA-B removed R22's gait belt and rinsed out R22's basin in the sink. NA-B wet R22's comb, combed her hair and placed R22's hair in a bun. At 8:16 a.m. NA-B washed her hands in the sink for the first time. NA-B's goggles remained on top of her head throughout the entire time. NA-B was observed in R22's room for 39 minutes.

On 8/25/21, at 9:32 a.m. during interview NA-B confirmed she had not washed her hands before she began R22's cares. NA-B stated she should have washed her hands however had not thought about it due to the fact staff were running late with cares. NA-B stated she only worked the morning shift when she was mandated to stay or a shift opened up she was available to cover. NA-B indicated she was aware of the importance of

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wearing gloves and stated should have worn gloves when she worked on perineal cares for R22. NA-B d indicated she had been "called on it" in the past when she had not work gloves while providing cares. NA-B stated about 50% of the time she wore gloves when providing incontinence cares at night since the staff she worked with at night worked very quickly. NA-B confirmed she had touched multiple items in R22's rooms without washing her hands after perineal cares and indicated she was aware that action breach in infection control practices. NA-B confirmed she had only washed her hands after she was done with R22's morning cares. NA-B confirmed she had worn her goggles on the top of her head during R22's cares as they kept fogging up.

On 8/27/21, at 10:19 a.m. during a phone interview clinical manager (CM)-A confirmed she expected hand hygiene to be completed when staff entered resident's rooms, gloves were to worn during perineal cares and hands should have been washed or sanitized after gloves were removed. CM-A indicated proper hand hygiene and glove use were important to prevent the spread of infection.

MASK USE

On 8/25/21, at 7:12 a.m. (HK)-A walked down the west hallway towards the end of the hall, facemask was underneath his nose. HK-A walked into resident room 115, which the resident was seated in a wheelchair at a table by the wall. HK-A spoke with the resident, approximately three feet from her, his mask remained underneath his nose. HK-A wiped the floor, then

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F 880	Continued From page 129 left the room. -at 7:12 a.m. HK-A was observed in the west hallway, his mask underneath his chin, nose and mouth exposed. -at 7:49 a.m. HK-A was observed in the west hallway, walked towards the nurses station, his face mask was below his nose and mouth. -at 8:06 a.m. HK-A was observed in the west hallway and walked towards the end of the hallway. HK-A's face mask was below his nose and upper lip. HK-A walked past licensed practical nurse (LPN)-A and trained medication aid (TMA)-A and neither staff member directed him to cover his nose with his mask. R14 R14's quarterly MDS dated 7/13/21, indicated R14 had severe cognitive impairment and had diagnoses which included: depression, poly-arthritis and lymphedema. The MDS identified R14 required two staff assistance with bed mobility, transfers, dressing, toileting, one staff for personal hygiene and supervision with eating.	F 880		

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During observations on 8/25/21, at 8:17 a.m. R14 was in bed on her back when nursing assistant (NA)-B entered her room and her eye protection was noted to be on the top of her head. NA-B proceeded to make R14's room mates bed, straightened up the room, collected the garbage and soiled linen. NA-B exited R14's room with the garbage and soiled linen and walked down the hallway on the other end of the nursing home while her eye protection remained on top of her head. NA-B entered the utility room, placed the linen and garbage in the proper bins and washed her hands.
- at 8:26 a.m. NA-B walked out of the utility room and down the hallway while her eye protection remained on top of her head. NA-B grabbed a tissue at the nurses desks, pulled down her mask with her hand and blew her nose while she walked down the hallway to R14's room. NA-B entered R14's room, threw the tissue in the garbage, grabbed her mask, pulled it back over her nose and mouth area and washed her hands. NA-B approached R14 while she was laying in bed and said good morning. NA-B removed R14's covers while her eye protection remained on top of her head and there were flies buzzing around and landing on R14 while NA-B collected her supplies. NA-B unhooked R14's incontinent brief, touched the soiled surface with her bare hands and indicated R14 was wet. NA-B obtained a wet wash cloth, washed R14's hands and face, tucked R14's brief on the left side and began to wash R14's peri area with her bare hands. NA-B asked R14 to roll to the right while she washed her buttocks area, removed the wet soiled brief with her bare hands and threw it in the garbage. NA-B placed a clean incontinent brief under R14, rolled her to the left and hooked the incontinent brief. NA-B walked over to the closet and picked

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out some clothes for R14.
- at 8:39 a.m. NA-B brought over clothes and R14 chose what she wanted to wear. NA-B grabbed R14's pants, donned the pants and applied ace wraps to her lower legs. NA-B placed slippers on R14's feet, removed her gown, put deodorant under her armpits and donned her shirt over her head. NA-B rolled R14 to the left then to the right straightening her clothes and placing the lift sling under her. NA-B continued to have her eye protection on the top of her head while she provided cares.
- at 8:52 a.m. NA-B went out into the hallway to ask for assistance and continued to have the eye protection on top of her head. NA-B came back into the room, positioned the mechanical lift over R14 and hooked the sling to the lift while trained medication aid (TMA)-A entered the room. NA-B and TMA-A transferred R14 via mechanical lift from her bed to her wheel chair, unhooked the lift from the sling and TMA-A washed her hands and immediately left R14s room. NA-B applied peddles to R14's wheelchair, placed her feet on the peddles, combed her hair and placed her glasses on her face. NA-B collected the soiled linen, washed her hands, put R14's supplies away and washed her hands again at the sink. NA-B grabbed a blanket and covered R14's legs with it.
- at 9:03 a.m. NA-B wheeled R14 out of her room area, down the hallway towards the dining room with her eye protection on top of her head. Several residents were seated in the dining room area.

On 8/25/21, at 9:14 a.m., NA-B confirmed the above findings and indicated R14 required assistance with all of her cares. NA-B verified she wore her eye protection on top of head due to they fogged up and she had difficulty seeing the

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residents. NA-B indicated staff were to wear their eye protection at all times and during cares. NA-B stated she should have worn gloves and washed her hands while providing peri cares to prevent the spread of infection.

R6

R6's quarterly MDS dated 5/27/21, indicated R6 was cognitively intact and had diagnoses which included: diabetes mellitus, anxiety and schizophrenia. The MDS identified R6 required extensive assistance of one staff with bed mobility, toileting, personal hygiene, limited assistance with dressing and supervision with transfers.

During observations on 8/25/21, at 7:25 a.m., R6 was seated in her wheel chair and wheeling herself towards the door. Housekeeper (HK)-A was sweeping R6's room and was wearing a surgical mask. HK-A's surgical mask was down on the top of his chin with his mouth and nose exposed while R6 looked in her closet for clothes. At 7:27 a.m. registered nurse (RN)-A entered R6's room to assist her and HK-A left the room.
- at 7:41 a.m. R6 had soiled her bed and needed it to be cleaned by housekeeping. RN-A left R6's room to inform HK-A.
- at 7:59 a.m. HK-A cleaned R6's bed while R26 was sleeping in bed. HK-A was wearing a surgical mask. HK-A's surgical mask was down on the top of his chin with his mouth and nose exposed.
- at 8:06 a.m. R26 slept while HK-A continued to clean R6's room. HK-A mask continued the same exposing his nose and mouth area.

On 8/27/21, at 1:19 p.m. director of nursing (DON) confirmed she expected gloves to be worn

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MEADOW LANE RESTORATIVE CARE CENTER	**2209 UTAH AVENUE BENSON, MN 56215**

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F 880	Continued From page 133	F 880		

during perineal cares and hand hygiene to be completed between glove changes and when appropriate. DON stated it was important to prevent the spread of infection, prevent cross contamination and for basic hygienic purposes.

On 8/27/21, at 2:47 p.m. during a joint interview with DON and MDS consultant (MDSC)-A DON confirmed staff were expected to wear masks at all times and the masks were to cover the nose and mouth properly. DON stated these practices were important to prevent the spread of infection, respiratory illness and COVID-19. DON confirmed she expected goggles to be worn correctly at all times for the same reasons previously stated.

On 8/27/21, at 3:13 p.m. during a phone interview infection preventionist (IP)-A confirmed staff were expected to wear their masks and goggles at all times. IP-A stated it was important to keep the staff and residents safe and prevent them from being exposed to COVID 19 or any other respiratory illness.

The facility policy titled Perineal Care, dated 3/17/21, identified the purpose was to provide cleanliness and comfort to the resident, and to prevent infection and skin irritation, and to observe the resident's skin condition. The policy instructions to staff included: to wash and dry their hands thoroughly and put on gloves, and once completed to remove gloves and to wash and dry hands thoroughly.

The facility policy titled Handwashing/Hand Hygiene, dated 3/17/21, identified the facility considered hand hygiene the primary means to prevent the spread of infection. The policy identified all personnel would be trained and

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F 880	Continued From page 134 regularly in-serviced on the importance of hand hygiene to prevent the transmission of health care-associated infections and all personnel followed the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents and visitors. The policy instructed alcohol-based hand rub or alternatively soap and water to be used in the following situations which included: before and after direct contact with residents, before moving from a contaminated body site to a clean body site during resident care and after removing gloves. The facility policy titled Personal Protective Equipment-Using Gloves, dated 3/17/21, identified the use of gloves listed, included to prevent the spread of infection. The policy instructed staff to wash hands after removing gloves. The policy identified when gloves were to be worn when touching excretions, secretions, blood, body fluids, mucous membranes, or non-intact skin.	F 880		
F 883 SS=D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been	F 883		10/11/21

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F 883	Continued From page 135	F 883		

immunized during this time period;
(iii) The resident or the resident's representative has the opportunity to refuse immunization; and
(iv)The resident's medical record includes documentation that indicates, at a minimum, the following:
(A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and
(B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal.

§483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that-
(i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization;
(ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;
(iii) The resident or the resident's representative has the opportunity to refuse immunization; and
(iv)The resident's medical record includes documentation that indicates, at a minimum, the following:
(A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and
(B) That the resident either received the pneumococcal immunization or did not receive

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F 883	Continued From page 136 the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure 2 of 5 residents (R23, R10) were offered or received pneumococcal and/or influenza vaccinations in accordance with the Center for Disease Control (CDC) recommendations. Findings include: R23's quarterly Minimum Data Set (MDS) dated 9/8/21, indicated R23 was cognitively intact and had diagnoses which included: diabetes mellitus, stroke and hemiplegia or hemiparesis. The MDS indicated R23 was independent with all activities of daily living and was admitted to the facility on 2/1/21. Review of R23's Immunization Consent or Refusal form signed on 3/1/21, by R23 indicated R23 last received the influenza vaccine on 10/18/19. The form lacked any evidence R23 consented or refused to have a influenza vaccine after he was admitted to the facility. On 8/27/21, at 1:03 p.m. MDS consultant (MDSC) confirmed the above finding and indicated there was no record of R23 receiving his influenza vaccine in Minnesota Immunization Information Connection (MICC) as well. MDSC indicated staff should have reviewed this with R23 on admission and administered it if he had consented to receiving it.	F 883	1. It is the expectation of the facility to ensure residents are offered or received pneumococcal and/or influenza vaccinations in accordance with the Center for Disease Control (CDC) recommendations. R23 R10 have since been offered the vaccinations. 2. All residents have the potential to be affected by not being offered and receiving vaccinations in accordance with the Center for Disease Control recommendations. The facility policies and procedures were reviewed, and recent admissions reviewed to ensure no other individuals were affected by the deficient practice. In addition, vaccination status will be reviewed ongoing at care conferences and administered per consent. 3. A nursing in-service training is planned for 10/4/2021 which includes education from the infection preventionist to review the facility policies and procedures to ensure residents are offered or received if consenting to the pneumococcal and/or influenza vaccinations according to the CDC recommendations. 4. Effective 10/1/2021, a quality assurance program was initiated under the direction of the director of nursing to audit residents on a regular basis to ensure compliance with influenza and	

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F 883	Continued From page 137	F 883	pneumococcal immunizations. Audits completed weekly for 6 weeks and monthly for 3 months to ensure compliance	

R10

R10's quarterly Minimum Data Set (MDS) dated 6/11/21, identified R10 had diagnoses which included cerebral vascular disease, depression, chronic pain, arthritis and depression. The MDS identified R10 had severe cognitive impairment and required extensive assistance with activities of daily living (ADL's.)

Review of R10's Immunization Consent or Refusal form signed 11/3/20, by a facility nurse, lacked any documentation or evidence of R10 consent or refusal to have any of the two pneumococcal vaccines after he was admitted to the facility.

On 8/27/21, at 1:11 p.m. MDS consultant (MDSC) reviewed Minnesota Immunization Information Connection (MIIC,) system and R10's medical record. She confirmed R10 had not received or been offered either of the pneumococcal vaccines. The MDSC stated R10 should have been offered the vaccine upon admission.

A facility policy titled, Pneumococcal Vaccine updated 2/1/18, identified all residents would be offered pneumococcal vaccines to aid in preventing pneumococcal infections (e.g., pneumonia.)

A facility policy titled, Influenza, Prevention and Control of Seasonal updated 2/1/18, identified the facility followed the current guidelines and

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F 883	Continued From page 138 recommendations for the prevention and control of seasonal influenza. The policy revealed the facility Infection Preventionist would promote and administer seasonal influenza vaccine and identified all residents would be offered the vaccine	F 883		
F 886 SS=F	COVID-19 Testing-Residents & Staff CFR(s): 483.80 (h)(1)-(6) §483.80 (h) COVID-19 Testing. The LTC facility must test residents and facility staff, including individuals providing services under arrangement and volunteers, for COVID-19. At a minimum, for all residents and facility staff, including individuals providing services under arrangement and volunteers, the LTC facility must: §483.80 (h)((1) Conduct testing based on parameters set forth by the Secretary, including but not limited to: (i) Testing frequency; (ii) The identification of any individual specified in this paragraph diagnosed with COVID-19 in the facility; (iii) The identification of any individual specified in this paragraph with symptoms consistent with COVID-19 or with known or suspected exposure to COVID-19; (iv) The criteria for conducting testing of asymptomatic individuals specified in this paragraph, such as the positivity rate of COVID-19 in a county; (v) The response time for test results; and (vi) Other factors specified by the Secretary that help identify and prevent the transmission of COVID-19.	F 886		10/11/21

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F 886	Continued From page 139 §483.80 (h)((2) Conduct testing in a manner that is consistent with current standards of practice for conducting COVID-19 tests; §483.80 (h)((3) For each instance of testing: (i) Document that testing was completed and the results of each staff test; and (ii) Document in the resident records that testing was offered, completed (as appropriate to the resident's testing status), and the results of each test. §483.80 (h)((4) Upon the identification of an individual specified in this paragraph with symptoms consistent with COVID-19, or who tests positive for COVID-19, take actions to prevent the transmission of COVID-19. §483.80 (h)((5) Have procedures for addressing residents and staff, including individuals providing services under arrangement and volunteers, who refuse testing or are unable to be tested. §483.80 (h)((6) When necessary, such as in emergencies due to testing supply shortages, contact state and local health departments to assist in testing efforts, such as obtaining testing supplies or processing test results. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to maintain documentation of resident COVID-19 testing results and county positivity rates. This practice had the potential to affect all 25 residents and staff who resided at the facility.	F 886	1. It is the expectation of the facility to maintain documentation of resident COVID-19 testing results and county positivity rates. It was identified that with turnover of IP the facility could not locate POC testing logs for month of June; or one positivity percentage record for a	

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F 886	Continued From page 140 Findings include: Ref: QSO-20-38-NH revised on 04/27/2021, identified an outbreak as any new case that arose in the facility. The memo advised to test all staff and residents, vaccinated and, unvaccinated, that previously tested negative until no new cases had been identified. Upon identification of a single new case of COVID-19 infection in any staff or residents, all staff and residents, regardless of vaccination status, were to be tested immediately, and all staff and residents that tested negative were to be retested every 3 days to 7 days until testing identified no new cases of COVID-19 infection, among staff or residents for a period of at least 14 days since the most recent positive result. The CDC guidance People with Certain Medical Conditions dated 5/13/21, identified older adults were more likely to get seriously ill from COVID-19. More than 80 percent of COVID-19 deaths had occurred in people over the age of 65, and more than 95 percent of COVID-19 deaths had occurred in people older than 45. Further, among adults, the risk for severe illness from COVID-19 increased with age, with older adults at highest risk. Severe illness meant that the person with COVID-19 may require hospitalization, intensive care, or a ventilator to help them breathe, or they may even die. Nursing assistant (NA)-I laboratory report dated 4/23/21, indicated NA-I was positive for COVID-19. Review of MDH (Minnesota Department of Health) COVID-19 Report dated 5/4/21, under "Percent of Tests Positive by County of	F 886	period in April. Since, tracker logs and testing logs are being tracked and documentation reviewed daily in IDT meetings to ensure compliance with testing requirements. 2. All resident's and staff have the potential to be affected by the deficient practice; re-education and review of facility policies and procedures were conducted to ensure that ongoing tracking and documentation reviewed was in compliance with the testing requirements. 3. An all staff in-service training is planned for 10/4/2021 which includes education from the infection preventionist to review the facility policies and procedures to ensure compliance with testing and tracking of covid 19 in residents and staff. 4. Effective 10/1/2021, a quality assurance program was initiated under the direction of the director of nursing to audit testing and tracking logs to ensure continued compliance with maintaining documentation of Covid-19 results. Audits completed weekly for 6 weeks and monthly for 3 months to ensure compliance with recommendations. Any deficiencies will be corrected immediately, and findings brought to and monitored through the quality assurance committee for further review and ongoing monitoring.	

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Residence" revealed Swift County had a "% Positive" of 5.1%.

Review of MDH COVID-19 Report dated 8/3/21, under "Percent of Tests Positive by County of Residence" revealed Swift County had a "% Positive" of 7.7%.

Review of MDH COVID-19 Report dated 8/24/21, under "Percent of Tests Positive by County of Residence" revealed Swift County had a "% Positive" of 5.2%.

Review of the COVID testing logs record provided by facility on 8/27/21 identified:
-No testing log provided on residents April 2021.
-Testing completed on residents May 2021, no results were documented on testing log.
-No testing log provided on residents June 2021.
-No testing log provided on residents July 2021.
-No testing log provided on residents from August 1, 2021, to August 9, 2021.

During a telephone interview on 08/27/21, at 2:35 p.m. assistant director of nursing (ADON) stated the facility checked the country COVID positivity rates every two weeks unless alerted something was going on like the new variant. ADON identified the facility increased the testing policy to weekly which started the beginning of August 2021. ADON stated the facility checked the county positivity rate and it was 4.6%. ADON indicated the facility opted to remain weekly testing for staff and residents. The ADON stated the infection control binder had not been organized yet and during June and July 2021, confirmed the residents had not been tested. ADON indicated the facility had not been aware vaccinated residents could become infected with

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COVID in June and July. ADON stated the facility was in the green county level and was now in the yellow. The ADON stated the facility had no outbreaks and no staff tested positive in June or July 2021.

During an interview on 8/27/21, at 3:08 p.m. Minimum Data Set coordinator (MDSC)-G stated the guidance indicated that if the positivity rate was in the green the facility were not required to test residents and only unvaccinated staff were tested for June and July. MDSC-G stated up until August 2021, the facility tested both vaccinated and unvaccinated residents due to the prevalence of the variant and all residents were negative.

During an interview on 8/27/21, at 3:10 p.m. the administrator stated 3 residents R4, R14, and R23 were fully vaccinated and had not received testing June or July 2021, due to no outbreak and no symptoms.

During an interview on 08/27/21, at 3:15 p.m. director of nursing (DON) and MDSC-G both verified residents had not been tested since back in May 2021, due to county positivity rates. DON confirmed NA-I tested positive for COVID-19 on 4/21/21, nursing assistant (NA)-J and NA-K both tested positive on 8/10/21. DON indicated NA-J and NA-K lived together and both tested positive on a routine testing on Tuesday, 8/24/21. The DON stated neither staff had worked since 8/21/21. DON indicated NA-J and NA-K were asked to leave the facility immediately and had been off work for at least for fourteen days.

On 8/27/21, facility COVID-19 county positivity rates tracker log and staff and resident testing logs with test results for April 2021, through

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F 886	Continued From page 143 August 2021, were requested and not received.	F 886		
F 925 SS=F	Maintains Effective Pest Control Program CFR(s): 483.90(i)(4) §483.90(i)(4) Maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide and maintain a safe, functional, sanitary, and comfortable environment for 2 of 2 residents (R4 and R9) who expressed concern about the pest control of flies, for 4 of 4 residents (R16, R11, R14 and R6) observed to have flies on them while eating, during cares and while sleeping. In addition, the facility failed to ensure a pest free environment related to flies landing on food during meal service. This deficient practice had the potential to affect all 25 residents in the facility. Findings include: R4 R4's quarterly Minimum Data Set (MDS) dated 5/31/21, identified R4 had diagnoses which included multiple sclerosis (progressive neurological condition affecting all bodily systems,) paraplegia, diabetes and depression. The MDS identified R4 was cognitively intact and required extensive assistance with activities of daily living (ADL's) of bed mobility, transfers and toileting. The MDS indicated R4 had limited range of motion to both her bilateral upper and lower extremities.	F 925	. It is the expectation of the facility to provide and maintain a safe, functional, sanitary, and comfortable environment for residents; ensuring a pest free environment. R4 and R9 had expressed concerns, R16, R11, R14 and R6 had been observed to have flies on them while eating, during cares and while sleeping, and there was observation of a fly on food in the dining room. The facility is contracted with Guardian Pest Control who was present for routine monthly inspections during survey on August 24, 2021, which included addressing fly traps. Guardian was again contacted by the Maintenance Supervisor for another onsite visit that occurred on August 31st to address observations of flies still present. 2. All residents have the potential to be adversely affected; maintenance supervisor used temporary repellant measures to keep flies away, staff were re-educated to be mindful of opening/closing exit doors and additional fly traps were placed on the exterior of the facility. Guardian was again contacted by the Maintenance Director for another onsite visit that occurred on August 31st	10/11/21

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F 925	Continued From page 144 On 8/25/21, at 1:16 p.m. during a resident council meeting, R4 stated she was bothered by all of the flies in the facility but was not able to swat at them herself. R4 stated, "I couldn't hit the broad side of a barn," when asked if she had been provided with a fly swatter. R4 indicated she felt the staff should have been aware of all of the flies as they were all over the facility. R4 stated she had not specifically reported to staff the flies had bothered her. R9 R9's quarterly MDS, dated 6/9/21, identified R9 had diagnoses which included, chronic heart failure, diabetes, arthritis and depression. The MDS identified R9 was cognitively intact and required extensive assistance with ADL's of bed mobility, transfers and toileting. The MDS identified R9 had limited range of motion of bilateral lower extremities. On 8/24/21, at 8:38 a.m. during an interview with R9, several dozen flies were observed in his room, flying around, landing on his lower legs, arms, on his table, bed and on his walls. At that time, R9 stated he had a fly swatter, though he was too weak at that time to be able swat at the flies. R9 stated the flies drove him crazy, and he felt there was a higher number of flies than the average at that time of the year. R9 stated one of the nursing assistants (NA) helped him kill the flies when he asked, however the NA could not remain in his rooms killing flies when he had to care for other residents. R9 stated he felt the facility staff should have been aware there were flies in the building as there were so many and indicated he had not "formally" complained to anyone about the flies.	F 925	to address observations of flies still present. 3. An all staff in-service training is planned for 10/4/2021 which includes education from the Maintenance Director in review the facility policies and procedures to ensure proper identification, notification and action to address concerns involving pest control. 4. Effective 10/1/2021, a quality assurance program was initiated under the direction of the Maintenance Director to audit environmental rounds to ensure adequate pest control. Audits completed weekly for 6 weeks and monthly for 3 months to ensure compliance with recommendations. Any deficiencies will be corrected immediately, and findings brought to and monitored through the quality assurance committee for further review and ongoing monitoring.	

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F 925	Continued From page 145	F 925		

R16

R16's significant change of status (SCSA) Minimum Data Set (MDS) dated 7/15/21, identified R16 had diagnoses which included: dementia, polymyalgia rheumatica (inflammatory disorder causing muscle pain and stiffness around the shoulders and hips) and psychosis. The MDS identified R1 had severe cognitive impairment and required extensive assistance with activities of daily living (ADL's) of bed mobility, transfers and toileting. The MDS indicated R16 had disorganized thinking, inattention, altered levels of consciousness and delirium. The MDS identified R16 was unable to maintain her balance during transition without physical assistance and had one fall since the last MDS assessment.

On 8/23/21, from 2:35 p.m. to 2:54 p.m. R16 was observed lying on her back in a low bed, eyes were closed and her mouth was opened. R16 had several flies in her room, of which a few would repeatedly land on her face towards her mouth and fly away.

-at 5:55 p.m. R16 was observed lying in bed, on her back, moved her legs and bare feet out of bed towards the floor, took hold of the grab bar with her left hand and attempted to sit up. R16 was unable to sit up, let go of the bar and shut her eyes. At that time, NA-G entered R16's room, picked up the yellow gripper socks from the floor, indicated R16 was restless and stated she had told the nurse about R16's restlessness. NA-G left the room and R16's legs remained out of bed. Several flies remained flying around R16's room and on her body. NA-G made no attempt to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245313	A. BUILDING _____ B. WING _____	C 08/27/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOW LANE RESTORATIVE CARE CENTER	2209 UTAH AVENUE BENSON, MN 56215

(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 925	Continued From page 146	F 925		

remove the flies.

-at 6:37 p.m. R16 was observed lying in a low bed on her back, eyes were closed, her body was covered with a sheet, a pink blanket covered her lower body. Several flies were observed flying in her room and on R16's body, periodically landing and flying away.

On 8/24/21, at 8:35 a.m. R16 was observed lying in a low bed, on her back, pillows were positioned on her right side, she had a blanket covering her legs and body up to her mid chest. Several flies were observed in R16's room, periodically landing on her face and body.

On 8/25/21, at 7:06 a.m. R16 was observed lying in bed on her back, covered with a sheet, eyes were closed, she had pillows placed on both her right and left sides and underneath her legs. R16 made no attempt to move her legs out of bed or to try to sit up.

During observations on 8/23/21, at 6:01 p.m. dietary cook (DC)-A was serving the supper meal from the steam table in the main dining room area. DC-A had her hands gloved, she grabbed a plate, placed a scoop of turkey, a scoop of gravy on the turkey and a scoop of baked beans on the plate. DC-A grabbed a handful of raw carrots with her gloved hand, placed them on the plate and set the plate on the steam table to be delivered. During this time multiple flies were flying around the steam table landing on the steam table and on food at times.

R11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245313	A. BUILDING _____ B. WING _____	C 08/27/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOW LANE RESTORATIVE CARE CENTER	2209 UTAH AVENUE BENSON, MN 56215

(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 925	Continued From page 147	F 925		

R11's annual MDS dated 6/11/21, indicated R11 had severe cognitive impairment and had diagnoses which included: seizure disorder, depression and muscle weakness. The MDS identified R11 was independent with bed mobility, transfers, dressing, toileting, eating and personal hygiene.

During observations on 8/23/21, at 5:08 p.m. R11 walked independently in the hallway and back to her room. R11 was wearing a light blue pair of denim jeans and the inside of her legs, half way to her knees and her entire buttocks area had light brown colored stain. R11 sat down in her chair in her room independently and she had multiple flies buzzing around and landing on her and her clothing.

R14

R14's quarterly MDS dated 7/13/21, indicated R14 had severe cognitive impairment and had diagnoses which included: depression, poly-arthritis and lymphedema. The MDS identified R14 required two staff assistance with bed mobility, transfers, dressing, toileting, one staff for personal hygiene and supervision with eating.

During observations on 8/25/21, at 8:26 a.m. NA-B approached R14 while she was laying in bed, removed R14's covers and there were multiple flies buzzing around and landing on R14 while NA-B collected her supplies. While NA-B provided cares to R14, the flies continued to fly around and NA-B made several attempts to swat at them. NA-B walked to the closet, picked out clothes for R14 and multiple flies continued to fly

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245313	A. BUILDING _____ B. WING _____	C 08/27/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOW LANE RESTORATIVE CARE CENTER	2209 UTAH AVENUE BENSON, MN 56215

(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 925	Continued From page 148	F 925		

around R14 and land on her.
- at 8:39 a.m. NA-B brought over some clothes and R14 chose what she wanted to wear. NA-B grabbed R14's pants, donned the pants and applied ace wraps to her lower legs while she tried to swat away several flies that landed or attempted to land on R14.

R6:

R6's quarterly MDS dated 5/27/21, indicated R6 was cognitively intact and had diagnoses which included: diabetes mellitus, anxiety and schizophrenia. The MDS identified R6 required extensive assistance of one staff with bed mobility, toileting, personal hygiene, limited assistance with dressing and supervision with transfers. The MDS identified R6 was always incontinent of bowel and frequently incontinent of bladder, and was not on a bowel or bladder toileting program.

During observations on 8/23/21, at 5:20 p.m. R6 was seated in her wheelchair in the dining room area and her shirt continued to be wet with several soiled white spots. R6 had several flies buzzing around her and landing on the chest of her shirt.

During observations on 8/24/21, at 1:49 p.m. R6 was seated in her wheelchair in her room and had several flies buzzing around her and landing on her pants and shirt. R6 was trying to swat them away with her hands and had no success attempting to get rid of the flies.

During observations on 8/25/21, at 9:52 a.m. R6 was seated in her wheelchair in the dining room at a table and eating a fig bar. While R6 ate her

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245313	A. BUILDING _____ B. WING _____	C 08/27/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOW LANE RESTORATIVE CARE CENTER	2209 UTAH AVENUE BENSON, MN 56215

(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 925	Continued From page 149	F 925		

fig bar there were several flies buzzing around and landing on her while she ate.
- at 12:21 p.m. R6 was laying in bed resting, with her wheelchair at the side of the bed and several flies were buzzing around her and landing on her while she tried to sleep.

On 8/24/21, at 2:45 p.m. the facility's contracted exterminator technician was observed at the facility. The technician indicated he was there for a routine visit to spray for spiders. He confirmed the facility had several dozen flies throughout both wings, resident rooms and in the common area of the facility. The technician stated he felt the facility would have benefited from spraying outside by the entrances for fly control. He stated he felt the flies were more prominent and bothersome this year versus previous years. The technician indicated the facility had a black light fly trap by the kitchen entrance and indicated he felt it would be beneficial to place one in each hallway to control the flies that could enter through those doorways. The technician stated he was not aware of the facility reaching out to the company regarding pest control for flies.

On 8/27/21, at 12:47 p.m. during an environmental tour with the facility maintenance manager he confirmed there were flies present in the facility, though indicated he felt the number flies were not abnormal and would not qualify as an "infestation." The maintenance manager stated he did not feel the flies in the facility were a problem and residents had access to fly swatters. He stated the facility had routine pest control, which had been there on Tuesday of this week. He indicated he had not spoken to the technician about the flies as he was unaware there was a concern. The maintenance manager stated no

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	245313	A. BUILDING _____ B. WING _____	C 08/27/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOW LANE RESTORATIVE CARE CENTER	**2209 UTAH AVENUE BENSON, MN 56215**

(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 925	Continued From page 150 staff or residents had voiced any concerns to him regarding the flies. A policy was requested on pest control and was not provided.	F 925		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245313	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/24/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOW LANE RESTORATIVE CARE CENTER	**2209 UTAH AVENUE** **BENSON, MN 56215**

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		10/01/2021

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
	245313	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/24/2021**

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K 000	Continued From page 1 Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. Meadow Lane Restorative Care Center is a one-story building with a partial basement. The building was constructed at three different times. The original building was constructed in 1958; it is an NF2 facility and was determined to be of Type V(000) construction. In 1970, the SNF/NF facility was built that was determined to be of Type II(222) construction. In 1976 an addition was added to connect the SNF/NF building to the NF2 building, which was determined to be of Type II(000) construction. Because the original building	K 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245313	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/24/2021**

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MEADOW LANE RESTORATIVE CARE CENTER	**2209 UTAH AVENUE** **BENSON, MN 56215**

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K 000	Continued From page 2 and the two additions meet the construction types allowed for existing buildings, the facility was surveyed as one building. The building is fully sprinkled throughout, and the facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 56 beds and had a census of 25 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 345 SS=F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to inspect the fire alarm system as required by the NFPA 101 (2012 edition), Life Safety Code, section 9.6.1.5 and NFPA 72 (2010 edition), The National Fire Alarm and Signaling Code, section 14.3.1. This deficient condition could have a widespread impact on the residents within the facility.	K 345	1. It is the expectation of the facility to conduct semi-annual fire alarm inspections as required by the regulatory requirements. The Maintenance Director has since scheduled an inspection and it has been completed. 2. A quality assurance program was initiated by the Maintenance Director with ongoing auditing of monitoring for	10/11/21

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	245313	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/24/2021**

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MEADOW LANE RESTORATIVE CARE CENTER	**2209 UTAH AVENUE** **BENSON, MN 56215**

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K 345	Continued From page 3 Findings include: On 08/24/2021, between 9:30 AM to 1:30 PM, it was revealed that the facility could not provide evidence of completing a semi-annual fire alarm inspection. This deficient condition was verified by the Facilities Maintenance Director.	K 345	compliance with conducting semi-annual fire alarm inspections. 3. The findings will be brought to the monthly quality assurance committee to monitor and provide further recommendations. 4. Maintenance Director is responsible for the monitoring of compliance. 5. The completion date is October 11th, 2021.	

FIRE SAFETY SURVEY REPORT - 2012 LIFE SAFETY CODE HEALTHCARE

1. (A) PROVIDER NUMBER	1. (B) MEDICAID I.D. NO.
K1 245313	K2

PART I — Life Safety Code, New and Existing
PART II — Health Care Facilities Code, New and Existing
PART III — Recommendation for Waiver
PART IV – Crucial Data Extract
OPTIONAL — Chapter 4 – NFPA 101A - Fire Safety Evaluation System for Health Care Occupancies – CMS-2786T

Identifying information as shown in applicable records. Enter changes, if any, alongside each item, giving date of change.

2. NAME OF FACILITY	2. (A) MULTIPLE CONSTRUCTION (BLDGS)	2. (B) ADDRESS OF FACILITY (STREET, CITY, STATE, ZIP CODE)	
Meadow Lane Restorative Care Center	A. BUILDING 01 B. WING C. FLOOR K3	2209 Utah Avenue Benson, MN 56215	A. (●) Fully Sprinklered (All required areas are sprinklered) B. ( ) Partially Sprinklered (Not all required areas are sprinklered) C. ( ) None (No sprinkler system) K0180

3. SURVEY FOR	4. DATE OF SURVEY	DATE OF PLAN APPROVAL	SURVEY UNDER
[✔] MEDICARE [✔] MEDICAID	08/24/2021 K4	K6	5. (●) 2012 EXISTING 6. ( ) 2012 NEW K7

5. SURVEY FOR CERTIFICATION OF

1. ( ) HOSPITAL 2. (●) SKILLED/NURSING FACILITY 4. ( ) ICF/IID UNDER HEALTH CARE 5. ( ) HOSPICE

IF "2" OR "5" ABOVE IS MARKED, CHECK APPROPRIATE ITEM(S) BELOW

1. [✔] ENTIRE FACILITY 2. [ ] DISTINCT PART OF (SPECIFY) _____

3. [ ] IF DISTINCT PART OF HOSPITAL, IS HOSPITAL ACCREDITED? a. [ ] YES b. [ ] NO

6. BED COMPOSITION a. TOTAL NO. OF BEDS IN THE FACILITY	b. NUMBER OF HOSPITAL BEDS CERTIFIED FOR MEDICARE	c. NUMBER OF SKILLED BEDS CERTIFIED FOR MEDICARE	d. NUMBER OF SKILLED BEDS CERTIFIED FOR MEDICAID	e. NUMBER OF NF or ICF/IID BEDS CERTIFIED FOR MEDICAID
56	0	37	37	19

7. A. (●) THE FACILITY MEETS THE STANDARD, BASED UPON (CHECK ALL APPROPRIATE BOXES)
1. ( ) COMPLIANCE WITH ALL PROVISIONS 2. (●) ACCEPTANCE OF A PLAN OF CORRECTION 3. [ ] RECOMMENDED WAIVERS 4. [ ] FSES 5. [ ] PERFORMANCE BASED DESIGN

B. ( ) THE FACILITY DOES NOT MEET THE STANDARD
K9

SURVEYOR (S	TITLE	OFFICE	DATE
Kimberly Swenson	Deputy State Fire Marshal	Minnesota State Fire Marshal Division	08/27/2021
SURVEYOR ID 34764 K10			
FIRE AUTHORITY OFFIC William Abderhalden 37009	TITLE Fire Safety Supervisor	OFFICE Minnesota State Fire Marshal Division	DATE 09/20/2021

CMS FORMS SHALL BE COMPLETED AND RETAINED AS PART OF THE SURVEY RECORD.

ID PREFIX		MET	NOT MET	N/A	REMARKS
	PART I – NFPA 101 LSC REQUIREMENTS (Items in italics relate to the FSES)				
	SECTION 1 – GENERAL REQUIREMENTS				
K100	**General Requirements – Other** List in the REMARKS section any LSC Section 18.1 and 19.1 General Requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567.	◉	○	○	
K111	**Building Rehabilitation** ***Repair, Renovation, Modification, or Reconstruction*** Any building undergoing repair, renovation, modification, or reconstruction complies with both of the following: • Requirements of Chapter 18 and 19. • Requirements of the applicable Sections 43.3, 43.4, 43.5, and 43.6. 18.1.1.4.3, 19.1.1.4.3, 43.1.2.1 ***Change of Use or Change of Occupancy*** Any building undergoing change of use or change of occupancy classification complies with the requirements of Section 43.7, unless permitted by 18.1.1.4.2 or 19.1.1.4.2. 18.1.1.4.2 (4.6.7 and 4.6.11), 19.1.1.4.2 (4.6.7 and 4.6.11), 43.1.2.2 (43.7) ***Additions*** Any building undergoing an addition shall comply with the requirements of Section 43.8. If the building has a common wall with a nonconforming building, the common wall is a fire barrier having at least a two hour fire resistance rating constructed of materials as required for the addition. Communicating openings occur only in corridors and are protected by approved self-closing fire doors with at least a 1-1/2 hour fire resistance rating. Additions comply with the requirements of Section 43.8. 18.1.1.4.1 (4.6.7 and 4.6.11), 18.1.1.4.1.1 (8.3), 18.1.1.4.1.2, 18.1.1.4.1.3, 19.1.1.4.1 (4.6.7 and 4.6.11), 19.1.1.4.1.1 (8.3), 19.1.1.4.1.2, 19.1.1.4.1.3, 43.1.2.3(43.8)	○	○	◉	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K112	**Sprinkler Requirements for Major Rehabilitation** If a nonsprinklered smoke compartment has undergone major rehabilitation the automatic sprinkler requirements of 18.3.5 have been applied to the smoke compartment. In cases where the building is not protected throughout by a sprinkler system, the requirements of 18.4.3.2, 18.4.3.3, and 18.4.3.8 are also met. Note: Major rehabilitation involves the modification of more than 50 percent, or more than 4500 ft² of the area of the smoke compartment. 18.1.1.4.3.3, 19.1.1.4.3.3	○	○	◉	
K131	**Multiple Occupancies – Sections of Health Care Facilities** Sections of health care facilities classified as other occupancies meet all of the following: • They are not intended to serve four or more inpatients for purposes of housing, treatment, or customary access. • They are separated from areas of health care occupancies by construction having a minimum two hour fire resistance rating in accordance with Chapter 8. • The entire building is protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7. Hospital outpatient surgical departments are required to be classified as an Ambulatory Health Care Occupancy regardless of the number of patients served. 18.1.3.3, 19.1.3.3, 42 CFR 482.41, 42 CFR 485.623	◉	○	○	
K132	**Multiple Occupancies – Contiguous Non-Health Care Occupancies** Non-health care occupancies that are located immediately next to a Health Care Occupancy, but are primarily intended to provide outpatient services are permitted to be classified as Business or Ambulatory Health Care Occupancies, provided the facilities are separated by construction having not less than two hour fire resistance-rated construction, and are not intended to provide services simultaneously for four or more inpatients. Outpatient surgical departments must be classified as Ambulatory Health Care Occupancy regardless of the number of patients served. 18.1.3.4.1, 19.1.3.4.1	○	○	◉	

<table>
<tr><th>ID PREFIX</th><th></th><th>MET</th><th>NOT MET</th><th>N/A</th><th>REMARKS</th></tr>
<tr><td>K133</td><td>Multiple Occupancies – Construction Type
Where separated occupancies are in accordance with 18/19.1.3.2 or 18/19.1.3.4, the most stringent construction type is provided throughout the building, unless a two hour separation is provided in accordance with 8.2.1.3, in which case the construction type is determined as follows:
• The construction type and supporting construction of the health care occupancy is based on the story in which it is located in the building in accordance with 18/19.1.6 and Tables 18/19.1.6.1.
• The construction type of the areas of the building enclosing the other occupancies shall be based on the applicable occupancy chapters.
18.1.3.5, 19.1.3.5, 8.2.1.3</td><td>○</td><td>○</td><td>◉</td><td></td></tr>
<tr><td>K161</td><td>Building Construction Type and Height
2012 EXISTING
Building construction type and stories meets Table 19.1.6.1, unless otherwise permitted by 19.1.6.2 through 19.1.6.7
19.1.6.4, 19.1.6.5
<table>
<tr><th></th><th></th><th>Construction Type</th><th></th></tr>
<tr><td>1</td><td>○</td><td>I (442), I (332), II (222)</td><td>Any number of stories non-sprinklered or sprinklered</td></tr>
<tr><td>2</td><td>○</td><td>II (111)</td><td>One story non-sprinklered
Maximum 3 stories sprinklered</td></tr>
<tr><td>3</td><td>○</td><td>II (000)</td><td rowspan="4">Not allowed non-sprinklered
Maximum 2 stories sprinklered</td></tr>
<tr><td>4</td><td>○</td><td>III (211)</td></tr>
<tr><td>5</td><td>○</td><td>IV (2HH)</td></tr>
<tr><td>6</td><td>○</td><td>V (111)</td></tr>
<tr><td>7</td><td>○</td><td>III (200)</td><td rowspan="2">Not allowed non-sprinklered
Maximum 1 story sprinklered</td></tr>
<tr><td>8</td><td>◉</td><td>V (000)</td></tr>
</table>
Sprinklered stories must be sprinklered throughout by an approved, supervised automatic system in accordance with section 9.7. (See 19.3.5)
Give a brief description, in REMARKS, of the construction, the number of stories, including basements, floors on which patients are located, location of smoke or fire barriers and dates of approval. Complete sketch or attach small floor plan of the building as appropriate.</td><td>◉</td><td>○</td><td>○</td><td>Meadow Lane is a 1 story building with a partial basement. The building was constructed at 3 different times. The original building was constructed in 1958, it is an NF2 facility and was determined to be of Type V (000) construction. In 1970, the SNF/NF facility was built that was determined to be of Type II(222) construction. In 1976 an addition was added to connect the SNF/NF building to the NF2 building which was determined to be of Type II(000) construction. Because the original building and the 2 additions meet the construction types allowed for existing buildings, the facility was surveyed as one building. Type V(000)</td></tr>
</table>

ID PREFIX		MET	NOT MET	N/A	REMARKS
K161	2012 NEW Building construction type and stories meets Table 18.1.6.1, unless otherwise permitted by 18.1.6.2 through 18.1.6.7 18.1.6.4, 18.1.6.5	○	○	●	

		Construction Type	
1	○	I (442), I (332), II (222)	Not allowed non-sprinklered Any number of stories sprinklered
2	○	II (111)	Not allowed non-sprinklered Maximum 3 stories sprinklered
3	○	II (000)	Not allowed non-sprinklered Maximum 1 story sprinklered
4	○	III (211)	
5	○	IV (2HH)	
6	○	V (111)	
7	○	III (200)	Not allowed non-sprinklered
8	○	V (000)	

Sprinklered stories must be sprinklered throughout by an approved, supervised automatic system in accordance with section 9.7. (See 18.3.5)

Give a brief description, in REMARKS, of the construction, the number of stories, including basements, floors on which patients are located, location of smoke or fire barriers and dates of approval. Complete sketch or attach small floor plan of the building as appropriate.

K162	**Roofing Systems Involving Combustibles** 2012 EXISTING Buildings of Type I (442), Type I (332), Type II (222), or Type II (111) having roof systems employing combustible roofing supports, decking or roofing meet the following: 1. roof covering meets Class C requirements. 2. roof is separated from occupied building portions with a noncombustible floor assembly using not less than 2½ inches concrete or gypsum fill. 3. attic or other space is either unoccupied or protected throughout by an approved automatic sprinkler system. 19.1.6.2*, ASTM E108, ANSI/UL 790	●	○	○	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K162	2012 NEW Buildings of Type I (442), Type I (332), Type II (222), Type II (111) having roof systems employing combustible roofing supports, decking or roofing meet the following: 1. roof covering meets Class A requirements. 2. roof is separated from occupied building portions with 2 hour fire resistive noncombustible floor assembly using not less than 2½ inches concrete or gypsum fill. 3. the structural elements supporting the rated floor assembly meet the required fire resistance rating of the building. 18.1.6.2, ASTM E108, ANSI/UL 790	○	○	◉	
K163	**Interior Nonbearing Wall Construction** Interior nonbearing walls in Type I or II construction are constructed of noncombustible or limited-combustible materials. Interior nonbearing walls required to have a minimum 2 hour fire resistance rating are permitted to be fire-retardant-treated wood enclosed within noncombustible or limited-combustible materials, provided they are not used as shaft enclosures. 18.1.6.4, 18.1.6.5, 19.1.6.4, 19.1.6.5	◉	○	○	
	SECTION 2 – MEANS OF EGRESS REQUIREMENTS				
K200	**Means of Egress Requirements – Other** List in the REMARKS section any LSC Section 18.2 and 19.2 Means of Egress requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. 18.2, 19.2	◉	○	○	
K211	**Means of Egress – General** Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1	◉	○	○	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K221	**Patient Sleeping Room Doors** Locks on patient sleeping room doors are not permitted unless the key-locking device that restricts access from the corridor does not restrict egress from the patient room, or the locking arrangement is permitted for patient clinical, security or safety needs in accordance with 18.2.2.2.5 or 19.2.2.2.5. 18.2.2.2, 19.2.2.2, TIA 12-4	◉	○	○	
K222	**Egress Doors** Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: ☐ CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 ☐ SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4	◉	○	○	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K222	☐ DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ☐ ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ☐ ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4	◉	○	○	
K223	**Doors with Self-Closing Devices** Doors in an exit passageway, stairway enclosure, or horizontal exit, smoke barrier, or hazardous area enclosure are self-closing and kept in the closed position, unless held open by a release device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke compartment or entire facility upon activation of: • Required manual fire alarm system; and • Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and • Automatic sprinkler system, if installed; and • Loss of power. 18.2.2.2.7, 18.2.2.2.8, 19.2.2.2.7, 19.2.2.2.8	◉	○	○	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K224	**Horizontal-Sliding Doors** Horizontal-sliding doors permitted by 7.2.1.14 that are not automatic-closing are limited to a single leaf and shall have a latch or other mechanism to ensure the door will not rebound. Horizontal-sliding doors serving an occupant load fewer than 10 shall be permitted, providing all of the following criteria are met: • Area served by the door has no high hazard contents. • Door is operable from either side without special knowledge or effort. • Force required to operate the door in the direction of travel is ≤ 30 lbf to set the door in motion and ≤ 15 lbf to close or open to the required width. • Assembly is appropriately fire rated, and where rated, is self-or automatic-closing by smoke detection per 7.2.1.8, and installed per NFPA 80. • Where required to latch, the door has a latch or other mechanism to ensure the door will not rebound. 18.2.2.2.10, 19.2.2.2.10	○	○	◉	
K225	**Stairways and Smokeproof Enclosures** Stairways and Smokeproof enclosures used as exits are in accordance with 7.2. 18.2.2.3, 18.2.2.4, 19.2.2.3, 19.2.2.4, 7.2	◉	○	○	
K226	**Horizontal Exits** Horizontal exits, if used, are in accordance with 7.2.4 and the provisions of 18.2.2.5.1 through 18.2.2.5.7, or 19.2.2.5.1 through 19.2.2.5.4. 18.2.2.5, 19.2.2.5	◉	○	○	
K227	**Ramps and Other Exits** Ramps, exit passageways, fire and slide escapes, alternating tread devices, and areas of refuge are in accordance with the provisions 7.2.5 through 7.2.12. 18.2.2.6 to 18.2.2.10 or 19.2.2.6 to 19.2.2.10	◉	○	○	
K231	**Means of Egress Capacity** The capacity of required means of egress is in accordance with 7.3. 18.2.3.1, 19.2.3.1	◉	○	○	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K232	**Aisle, Corridor or Ramp Width** 2012 EXISTING The width of aisles or corridors (clear or unobstructed) serving as exit access shall be at least 4 feet and maintained to provide the convenient removal of nonambulatory patients on stretchers, except as modified by 19.2.3.4, exceptions 1-5. 19.2.3.4, 19.2.3.5	◉	○	○	
	2012 NEW The width of aisles or corridors (clear and unobstructed) serving as exit access in hospitals and nursing homes shall be at least 8 feet. In limited care facility and psychiatric hospitals, width of aisles or corridors shall be at least 6 feet, except as modified by the 18.2.3.4 or 18.2.3.5 exceptions. 18.2.3.4, 18.2.3.5	○	○	◉	
K233	**Clear Width of Exit and Exit Access Doors** 2012 EXISTING Exit access doors and exit doors are of the swinging type and are at least 32 inches in clear width. Exceptions are provided for existing 34-inch doors and for existing 28-inch doors where the fire plan does not require evacuation by bed, gurney, or wheelchair. 19.2.3.6, 19.2.3.7	◉	○	○	
	2012 NEW Exit access doors and exit doors are of the swinging type and are at least 41.5 inches in clear width. In psychiatric hospitals or limited care facilities, doors are at least 32 inches wide. Doors not subject to patient use, in exit stairway enclosures, or serving newborn nurseries shall be no less than 32 inches in clear width. If using a pair of doors, the doors shall be provided with a rabbet, bevel, or astragal at the meeting edge, at least one of the doors shall provide 32 inches in clear width, and the inactive leaf of the pair shall be secured with automatic flush bolts. 18.2.3.6, 18.2.3.7	○	○	◉	
K241	**Number of Exits – Story and Compartment** Not less than two exits, remote from each other, and accessible from every part of every story are provided for each story. Each smoke compartment shall likewise be provided with two distinct egress paths to exits that do not require the entry into the same adjacent smoke compartment. 18.2.4.1-18.2.4.4, 19.2.4.1-19.2.4.4	◉	○	○	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K251	**Dead-End Corridors and Common Path of Travel** 2012 EXISTING Dead-end corridors shall not exceed 30 feet. Existing dead-end corridors greater than 30 feet shall be permitted to be continued to be used if it is impractical and unfeasible to alter them. 19.2.5.2	○	○	◉	
K251	2012 NEW Dead-end corridors shall not exceed 30 feet. Common path of travel shall not exceed 100 feet. 18.2.5.2, 18.2.5.3	○	○	◉	
K252	**Number of Exits – Corridors** Every corridor shall provide access to not less than two approved exits in accordance with Sections 7.4 and 7.5 without passing through any intervening rooms or spaces other than corridors or lobbies. 18.2.5.4, 19.2.5.4	◉	○	○	
K253	**Number of Exits – Patient Sleeping and Non-Sleeping Rooms** Patient sleeping rooms of more than 1,000 square feet or nonsleeping rooms of more than 2,500 square feet have at least two exit access doors remotely located from each other. 18.2.5.5.1, 18.2.5.5.2, 19.2.5.5.1, 19.2.5.5.2	○	○	◉	
K254	**Corridor Access** All habitable rooms not within suites have a door leading directly outside to grade or have a door leading to an exit access corridor. Patient sleeping rooms with less than eight patient beds may have one room intervening to reach an exit access corridor provided the intervening room is equipped with an approved automatic smoke detection system. 18.2.5.6.1 through 18.2.5.6.4, 19.2.5.6.1 through 19.2.5.6.4	◉	○	○	
K255	**Suite Separation, Hazardous Content, and Subdivision** All suites are separated from the remainder of the building (including from other suites) by construction meeting the separation provisions for corridor construction (18.3.6.2-18.3.6.5 or 19.3.6.2-19.3.6.5). Existing approved barriers shall be allowed to continue to be used provided they limit the transfer of smoke. Intervening rooms have no hazardous areas and hazardous areas within suites comply with 18/19.2.5.7.1.3. Subdivision of suites shall be by noncombustible or limited-combustible construction. 18.2.5.7.1.2 through 18.2.5.7.1.4, 19.2.5.7.1.2, 19.2.5.7.1.3, 19.2.5.7.1.4	○	○	◉	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K256	**Sleeping Suites** Occupants shall have exit access to a corridor or direct access to a horizontal exit. Where ≥ 2 exits are required, one exit access door may be to a stairway, passageway or to the exterior. Suites shall be provided with constant staff supervision. Staff shall have direct visual supervision of patient sleeping rooms, from a constantly attended location or the room shall be provided with an automatic smoke detection system. Suites more than 1,000 ft² shall have 2 or more remote exits. One means of egress from the suite shall be to a corridor and one may be into an adjacent suite separated in accordance with corridor requirements. Suites shall not exceed the following size limitations: • 5,000 square feet if the suite is not fully smoke detected or fully sprinklered. • 7,500 square feet if the suite is either fully smoke detected or fully sprinklered. • 10,000 square feet if the suite is both fully smoke detected and fully sprinklered and the sleeping rooms have direct supervision from a constantly attended location. Travel distance between any point in a suite to exit access shall not exceed 100 feet and distance to an exit shall not exceed 150 feet (200 feet if building is fully sprinklered). 18.2.5.7.2, 19.2.5.7.2	◉	○	○	
K257	**Non-Sleeping Suites** Occupants shall have exit access to a corridor or direct access to a horizontal exit. Where ≥ 2 exits are required, one exit access door may be to a stairway, passageway or to the exterior. Suites more than 2,500 ft² shall have 2 or more remote exits. One means of egress from the suite shall be to a corridor and one may be into an adjacent suite separated in accordance with corridor requirements. Suites shall not exceed 10,000 ft². Travel distance between any point in a suite to exit access shall not exceed 100 feet and distance to an exit shall not exceed 150 feet (200 feet if building is fully sprinklered). 18.2.5.7.3, 19.2.5.7.3	○	○	◉	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K261	**Travel Distance to Exits** Travel distance (excluding suites) to exits are measured in accordance with 7.6. • From any point in the room or suite to exit less than or equal to 150 feet (less than or equal to 200 feet if the building is fully sprinklered). • Point in a room to room door less than or equal to 50 feet. 18.2.6, 19.2.6	◉	○	○	
K271	**Discharge from Exits** Exit discharge is arranged in accordance with 7.7, provides a level walking surface meeting the provisions of 7.1.7 with respect to changes in elevation and shall be maintained free of obstructions. Additionally, the exit discharge shall be a hard packed all-weather travel surface. 18.2.7, 19.2.7	◉	○	○	
K281	**Illumination of Means of Egress** Illumination of means of egress, including exit discharge, is arranged in accordance with 7.8 and shall be either continuously in operation or capable of automatic operation without manual intervention. 18.2.8, 19.2.8	◉	○	○	
K291	**Emergency Lighting** Emergency lighting of at least 1-1/2 hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1	◉	○	○	
K292	**Life Support Means of Egress** 2012 NEW (INDICATE N/A FOR EXISTING) Buildings equipped with or requiring the use of life support systems (electro-mechanical or inhalation anesthetics) have illumination of means of egress, emergency lighting equipment, exit, and directional signs supplied by the life safety branch of the electrical system described in NFPA 99. (Indicate N/A if life support equipment is for emergency purposes only.) 18.2.9.2, 18.2.10.5	○	○	◉	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K293	**Exit Signage** 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.)	◉	○	○	
	2012 NEW Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 18.2.10.1	○	○	◉	
	SECTION 3 – PROTECTION				
K300	**Protection – Other** List in the REMARKS section any LSC Section 18.3 and 19.3 Protection requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567.	◉	○	○	
K311	**Vertical Openings – Enclosure** 2012 EXISTING Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least 1-hour. An atrium may be used in accordance with 8.6. 19.3.1.1 through 19.3.1.6 *If all vertical openings are properly enclosed with construction providing at least a 2 hour fire resistance rating, also check this box.* ☐	◉	○	○	
	2012 NEW Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least 2 hours connecting four or more stories. (1-hour for single story building and buildings up to three stories in height.) An atrium may be used in accordance with 8.6.7. 18.3.1 through 18.3.1.5	○	○	◉	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K321	**Hazardous Areas – Enclosure** 2012 EXISTING Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with ¾ hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. *Describe the floor and zone locations of hazardous areas that are deficient in REMARKS.* 19.3.2.1, 19.3.5.9	◉	○	○	

Area	Automatic Sprinkler	Separation	N/A
a. Boiler and Fuel-Fired Heater Rooms	☑	☑	☐
b. Laundries (larger than 100 sq. ft.)	☑	☑	☐
c. Repair, Maintenance, and Paint Shops	☑	☑	☐
d. Soiled Linen Rooms (exceeding 64 gal.)	☑	☑	☐
e. Trash Collection Rooms (exceeding 64 gal.)	☑	☑	☐
f. Combustible Storage Rooms/Spaces (over 50 sq. ft.)	☑	☑	☐
g. Laboratories (if classified as Severe Hazard - see K322)	☐	☐	☑

ID PREFIX		MET	NOT MET	N/A	REMARKS
K321	2012 NEW Hazardous areas are protected in accordance with 18.3.2.1. The areas shall be enclosed with a 1-hour fire-rated barrier, with a ¾ hour fire-rated door without windows (in accordance with 8.7.1.1). Doors shall be self-closing or automatic-closing in accordance with 7.2.1.8. Hazardous areas are protected by a sprinkler system in accordance with 9.7, 18.3.2.1, and 8.4. *Describe the floor and zone locations of hazardous areas that are deficient in REMARKS.* 18.3.2.1, 7.2.1.8, 8.4, 8.7, 9.7		○	○	◉	

Area	Automatic Sprinkler	Separation	N/A
a. Boiler and Fuel-Fired Heater Rooms	☐	☐	☐
b. Laundries (larger than 100 sq. ft.)	☐	☐	☐
c. Repair, Maintenance, and Paint Shops	☐	☐	☐
d. Soiled Linen Rooms (exceeding 64 gal.)	☐	☐	☐
e. Trash Collection Rooms (exceeding 64 gal.)	☐	☐	☐
f. Combustible Storage Rooms/Spaces (over 50 and less than 100 sq. ft.)	☐	☐	☐
g. Combustible Storage Rooms/Spaces (over 100 sq. ft.)	☐	☐	☐
h. Laboratories (if classified as Severe Hazard - see K322)	☐	☐	☐

ID PREFIX		MET	NOT MET	N/A	REMARKS
K322	**Laboratories** Laboratories employing quantities of flammable, combustible, or hazardous materials that are considered a severe hazard are protected by 1-hour fire resistance-rated separation, automatic sprinkler system, and are in accordance with 8.7 and with NFPA 99. Laboratories not considered a severe hazard are protected as hazardous areas (see K321). Laboratories using chemicals are in accordance with NFPA 45, *Standard on Fire Protection for Laboratories Using Chemicals*. Gas appliances are of appropriate design and installed in accordance with NFPA 54. Shutoff valves are marked to identify material they control. Devices requiring medical grade oxygen from the piped distribution system meet the requirements under 11.4.2.2 (NFPA 99). 18.3.2.2, 19.3.2.2, 8.7, 8.7.4.1 (LSC) 9.3.1.2, 11.4.3.2, 15.4 (NFPA 99)	○	○	◉	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K323	**Anesthetizing Locations** Areas designated for administration of general anesthesia (i.e., inhalation anesthetics) are in accordance with 8.7 and NFPA 99. Zone valves are: located immediately outside each life-support, critical care, and anesthetizing location of moderate sedation, deep sedation, or general anesthesia for medical gas or vacuum; readily accessible in an emergency; and arranged so shutting off any one anesthetizing location will not affect others. Area alarm panels are provided to monitor all medical gas, medical-surgical vacuum, and piped WAGD systems. Panels are at locations that provide for surveillance, indicate medical gas pressure decreases of 20 percent and vacuum decreases of 12 inch gauge HgV, and provide visual and audible indication. Alarm sensors are installed either on the source side of individual room zone valve box assemblies or on the patient/use side of each of the individual zone box valve assemblies. The EES critical branch supplies power for task illumination, fixed equipment, select receptacles, and select power circuits, and EES equipment system supplies power to ventilation system. Heating, cooling, and ventilation are in accordance with ASHRAE 170. Medical supply and equipment manufacturer's instructions for use are considered before reducing humidity levels to those allowed by ASHRAE, per S&C 13-58. 18.3.2.3, 19.3.2.3 (LSC) 5.1.4.8.7, 5.1.4.8.7.2, 5.1.9.3, 5.1.9.3.4, 6.4.2.2.4.2 (NFPA 99)	○	○	◉	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K324	**Cooking Facilities** Cooking equipment is protected in accordance with NFPA 96, *Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations*, unless: • residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2. • cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or • cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2	◉	○	○	
K325	**Alcohol Based Hand Rub Dispenser (ABHR)** ABHRs are protected in accordance with 8.7.3.1, unless all conditions are met: • Corridor is at least 6 feet wide. • Maximum individual dispenser capacity is 0.32 gallons (0.53 gallons in suites) of fluid and 18 ounces of Level 1 aerosols. • Dispensers shall have a minimum of four foot horizontal spacing. • Not more than an aggregate of 10 gallons of fluid or 1135 ounces of aerosol are used in a single smoke compartment outside a storage cabinet, excluding one individual dispenser per room. • Storage in a single smoke compartment greater than 5 gallons complies with NFPA 30. • Dispensers are not installed within 1 inch of an ignition source. • Dispensers over carpeted floors are in sprinklered smoke compartments. • ABHR does not exceed 95 percent alcohol. • Operation of the dispenser shall comply with Section 18.3.2.6(11) or 19.3.2.6(11). • ABHR is protected against inappropriate access. 18.3.2.6, 19.3.2.6, 42 CFR Parts 403, 418, 460, 482, 483, and 485	◉	○	○	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K331	**Interior Wall and Ceiling Finish** 2012 EXISTING Interior wall and ceiling finishes, including exposed interior surfaces of buildings such as fixed or movable walls, partitions, columns, and have a flame spread rating of Class A or Class B. The reduction in class of interior finish for a sprinkler system as prescribed in 10.2.8.1 is permitted. 10.2, 19.3.3.1, 19.3.3.2 *Indicate flame spread rating(s).* Class A	◉	○	○	
	2012 NEW Interior wall and ceiling finishes, including exposed interior surfaces of buildings such as fixed or movable walls, partitions and columns have a flame spread rating of Class A. The reduction in class of interior finish for a sprinkler system as prescribed in 10.2.8.1 is permitted. Individual rooms not exceeding four persons may have a Class A or B finish. Lower half of corridor walls, not exceeding 4 feet in height, may have a Class A or B flame spread rating. 10.2, 18.3.3.1, 18.3.3.2 *Indicate flame spread rating(s).* _____	○	○	◉	
K332	**Interior Floor Finish** 2012 NEW (Indicate N/A for 2012 EXISTING) Interior finishes shall comply with 10.2. Floor finishes in exit enclosures and exit access corridors and spaces not separated by walls that resist the passage of smoke shall be Class I or II. 18.3.3.3.1, 18.3.3.3.2, 18.3.3.3.3, 10.2, 10.2.7.1, 10.2.7.2	○	○	◉	
K341	**Fire Alarm System – Installation** A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, *National Electric Code,* and NFPA 72, *National Fire Alarm Code* to provide effective warning of fire in any part of the building. In areas not continuously occupied, detection is installed at each fire alarm control unit. In new occupancy, detection is also installed at notification appliance circuit power extenders, and supervising station transmitting equipment. Fire alarm system wiring or other transmission paths are monitored for integrity. 18.3.4.1, 19.3.4.1, 9.6, 9.6.1.8	◉	○	○	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K342	**Fire Alarm System – Initiation** Initiation of the fire alarm system is by manual means and by any required sprinkler system alarm, detection device, or detection system. Manual alarm boxes are provided in the path of egress near each required exit. Manual alarm boxes in patient sleeping areas shall not be required at exits if manual alarm boxes are located at all nurse's stations or other continuously attended staff location, provided alarm boxes are visible, continuously accessible, and 200' travel distance is not exceeded. 18.3.4.2.1, 18.3.4.2.2, 19.3.4.2.1, 19.3.4.2.2, 9.6.2.5	◉	○	○	
K343	**Fire Alarm – Notification** 2012 EXISTING Positive alarm sequence in accordance with 9.6.3.4 are permitted in buildings protected throughout by a sprinkler system. Occupant notification is provided automatically in accordance with 9.6.3 by audible and visual signals. In critical care areas, visual alarms are sufficient. The fire alarm system transmits the alarm automatically to notify emergency forces in the event of a fire. 19.3.4.3, 19.3.4.3.1, 19.3.4.3.2, 9.6.4, 9.7.1.1(1)	◉	○	○	
	2012 NEW Positive alarm sequence in accordance with 9.6.3.4 are permitted. Occupant notification is provided automatically in accordance with 9.6.3 by audible and visual signals. In critical care areas, visual alarms are sufficient. The fire alarm system transmits the alarm automatically to notify emergency forces in the event of a fire. Annunciation and annunciation zoning for fire alarm and sprinklers shall be provided by audible and visual indicators and zones shall not be larger than 22,500 square feet per zone. 18.3.4.3 through 18.3.4.3.3, 9.6.4	○	○	◉	
K344	**Fire Alarm – Control Functions** The fire alarm automatically activates required control functions and is provided with an alternative power supply in accordance with NFPA 72. 18.3.4.4, 19.3.4.4, 9.6.1, 9.6.5, NFPA 72	◉	○	○	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K345	**Fire Alarm System – Testing and Maintenance** A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, *National Electric Code,* and NFPA 72, *National Fire Alarm and Signaling Code.* Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72	○	◉	○	On 08/24/2021 between 9:30 AM to 1:30 PM, it was revealed that the facility could not provide evidence of completing a semi-annual fire alarm inspection.
K346	**Fire Alarm – Out of Service** Where required fire alarm system is out of services for more than 4 hours in a 24 hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.6	◉	○	○	
K347	**Smoke Detection** 2012 EXISTING Smoke detection systems are provided in spaces open to corridors as required by 19.3.6.1. 19.3.4.5.2	◉	○	○	
	2012 NEW Smoke detection systems are provided in spaces open to corridors as required by 18.3.6.1 In nursing homes, an automatic smoke detection system is installed in the corridors of all smoke compartments containing resident sleeping rooms, unless the resident sleeping rooms have: • smoke detection, or • automatic door closing devices with integral smoke detectors on the room side that provide occupant notification. Such detectors are electrically interconnected to the fire alarm system. 18.3.4.5.2, 18.3.4.5.3	○	○	◉	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K351	**Sprinkler System – Installation** 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, *Standard for the Installation of Sprinkler Systems.* In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 ft² and sprinkler coverage covers the closet footprint as required by NFPA 13, *Standard for Installation of Sprinkler Systems.* 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1)	◉	○	○	
	2012 NEW Buildings are to be protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, *Standard for the Installation of Sprinkler Systems.* In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where State and local regulations prohibit sprinklers. Listed quick-response or listed residential sprinklers are used throughout smoke compartments with patient sleeping rooms. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 ft² and sprinkler coverage covers the closet footprint as required by NFPA 13, *Standard for Installation of Sprinkler Systems.* 18.3.5.1, 18.3.5.4, 18.3.5.5, 18.3.5.6, 9.7, 9.7.1.1(1), 18.3.5.10	○	○	◉	
K352	**Sprinkler System – Supervisory Signals** Automatic sprinkler system supervisory attachments are installed and monitored for integrity in accordance with NFPA 72, *National Fire Alarm and Signaling Code,* and provide a signal that sounds and is displayed at a continuously attended location or approved remote facility when sprinkler operation is impaired. 9.7.2.1, NFPA 72	◉	○	○	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K353	**Sprinkler System – Maintenance and Testing** Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, *Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems.* Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked. 07/20/2021 b) Who provided system test. Viking c) Water system supply source. City Water *Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system.* 9.7.5, 9.7.7, 9.7.8, and NFPA 25	◉	○	○	
K354	**Sprinkler System – Out of Service** Where the sprinkler system is impaired, the extent and duration of the impairment has been determined, areas or buildings involved are inspected and risks are determined, recommendations are submitted to management or designated representative, and the fire department and other authorities having jurisdiction have been notified. Where the sprinkler system is out of service for more than 10 hours in a 24 hour period, the building or portion of the building affected are evacuated or an approved fire watch is provided until the sprinkler system has been returned to service. 18.3.5.1, 19.3.5.1, 9.7.5, 15.5.2 (NFPA 25)	◉	○	○	
K355	**Portable Fire Extinguishers** Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, *Standard for Portable Fire Extinguishers.* 18.3.5.12, 19.3.5.12, NFPA 10	◉	○	○	
K361	**Corridors – Areas Open to Corridor** Spaces (other than patient sleeping rooms, treatment rooms and hazardous areas), waiting areas, nurse's stations, gift shops, and cooking facilities, open to the corridor are in accordance with the criteria under 18.3.6.1 and 19.3.6.1. 18.3.6.1, 19.3.6.1	◉	○	○	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K362	**Corridors – Construction of Walls** 2012 EXISTING Corridors are separated from use areas by walls constructed with at least ½ hour fire resistance rating. In fully sprinklered smoke compartments, partitions are only required to resist the transfer of smoke. In nonsprinklered buildings, walls extend to the underside of the floor or roof deck above the ceiling. Corridor walls may terminate at the underside of ceilings where specifically permitted by Code. Fixed fire window assemblies in corridor walls are in accordance with Section 8.3, but in sprinklered compartments there are no restrictions in area or fire resistance of glass or frames. *If the walls have a fire resistance rating, give the rating* smoke resistant *if the walls terminate at the underside of the ceiling, give brief description in REMARKS, describing the ceiling throughout the floor area.* 19.3.6.2, 19.3.6.2.7	◉	○	○	
	2012 NEW Corridor walls shall form a barrier to limit the transfer of smoke. Such walls shall be permitted to terminate at the ceiling where the ceiling is constructed to limit the transfer of smoke. No fire resistance rating is required for the corridor walls. 18.3.6.2	○	○	◉	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K363	**Corridor – Doors** 2012 EXISTING Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1¾ inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5lbf is applied, whether or not power is applied. Clearance between bottom of door and floor covering is not exceeding 1 inch. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc.	◉	○	○	
	2012 NEW Doors protecting corridor openings shall be constructed to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have self-latching and positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5lbf is applied, whether or not power is applied. Clearance between bottom of door and floor covering is not exceeding 1 inch. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 18.3.6.3.6 are permitted. 18.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatic closing devices, etc.	○	○	◉	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K364	**Corridor – Openings** Transfer grilles are not used in corridor walls or doors. Auxiliary spaces that do not contain flammable or combustible materials are permitted to have louvers or be undercut. In other than smoke compartments containing patient sleeping rooms, miscellaneous openings are permitted in vision panels or doors, provided the openings per room do not exceed 20 in² and are at or below half the distance from floor to ceiling. In sprinklered rooms, the openings per room do not exceed 80 in². Vision panels in corridor walls or doors shall be fixed window assemblies in approved frames. (In fully sprinklered smoke compartments, there are no restrictions in the area and fire resistance of glass and frames.) 18.3.6.5.1, 19.3.6.5.2, 8.3	◉	○	○	
K371	**Subdivision of Building Spaces – Smoke Compartments** 2012 EXISTING Smoke barriers shall be provided to form at least two smoke compartments on every sleeping floor with a 30 or more patient bed capacity. Size of compartments cannot exceed 22,500 square feet or a 200-foot travel distance from any point in the compartment to a door in the smoke barrier. 19.3.7.1, 19.3.7.2 *Detail in REMARKS zone dimensions including length of zones and dead-end corridors.*	◉	○	○	
	2012 NEW Smoke barriers shall be provided to form at least two smoke compartments on every floor used by inpatients for sleeping or treatment, and on every floor with an occupant load of 50 or more persons, regardless of use. Size of compartments cannot exceed 22,500 square feet or a 200-foot travel distance from any point in the compartment to a door in the smoke barrier. Smoke subdivision requirements do not apply to any of the stories or areas described in 18.3.7.2. 18.3.7.1, 18.3.7.2 *Detail in REMARKS zone dimensions including length of zones and dead-end corridors.*	○	○	◉	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K372	**Subdivision of Building Spaces – Smoke Barrier Construction** 2012 EXISTING Smoke barriers shall be constructed to a ½ hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) *Describe any mechanical smoke control system in REMARKS.*	◉	○	○	
	2012 NEW Smoke barriers shall be constructed to provide at least a 1-hour fire resistance rating and constructed in accordance with 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations of fully ducted HVAC systems. 18.3.7.3, 18.3.7.4, 18.3.7.5, 8.3 *Describe any mechanical smoke control system in REMARKS.*	○	○	◉	
K373	**Subdivision of Building Spaces – Accumulation Space** Space shall be provided on each side of smoke barriers to adequately accommodate the total number of occupants in adjoining compartments. 18.3.7.5.1, 18.3.7.5.2, 19.3.7.5.1, 19.3.7.5.2	◉	○	○	
K374	**Subdivision of Building Spaces – Smoke Barrier Doors** 2012 EXISTING Doors in smoke barriers are 1¾-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 in for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9	◉	○	○	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K374	2012 NEW Doors in smoke barriers have at least a 20-minute fire protection rating or are at least 1¾-inch thick solid bonded core wood. Required clear widths are provided per 18.3.7.6(4) and (5). Nonrated protective plates of unlimited height are permitted. Horizontal-sliding doors comply with 7.2.1.14. Swinging doors shall be arranged so that each door swings in an opposite direction. Doors shall be self-closing and rabbets, bevels, or astragals are required at the meeting edges. Positive latching is not required. 18.3.7.6, 18.3.7.7, 18.3.7.8	○	○	◉	
K379	**Smoke Barrier Door Glazing** 2012 EXISTING Openings in smoke barrier doors shall be fire-rated glazing or wired glass panels in steel frames. 19.3.7.6, 19.3.7.6.2, 8.5	◉	○	○	
	2012 NEW Windows in smoke barrier doors shall be installed in each cross corridor swinging or horizontal-sliding door protected by fire-rated glazing or by wired glass panels in approved frames. 18.3.7.9	○	○	◉	
K381	**Sleeping Room Outside Windows and Doors** Every patient sleeping room has an outside window or outside door. In new occupancies, sill height does not exceed 36 inches above the floor. Windows in atrium walls are considered outside windows. Newborn nurseries and rooms intended for occupancy less than 24 hours have no outside window or door requirements. Window sills in special nursing care areas (e.g., ICU, CCU, hemodialysis, neonatal) do not exceed 60 inches above the floor. 42 CFR 403, 418, 460, 482, 483, and 485	◉	○	○	
	SECTION 4 – SPECIAL PROVISIONS				
K400	**Special Provisions – Other** List in the REMARKS section any LSC Section 18.4 and 19.4 Special Provisions requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567.	◉	○	○	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K421	**High-Rise Buildings** 2012 EXISTING High-rise buildings are protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7 within 12 years of LSC final rule effective date. 19.4.2	○	○	◉	
	2012 NEW High-rise buildings comply with section 11.8. 18.4.2	○	○	◉	
	SECTION 5 – BUILDING SERVICES				
K500	**Building Services – Other** List in the REMARKS section any LSC Section 18.5 and 19.5 Building Services requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567.	◉	○	○	
K511	**Utilities – Gas and Electric** Equipment using gas or related gas piping complies with NFPA 54, *National Fuel Gas Code*, electrical wiring and equipment complies with NFPA 70, *National Electric Code*. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2	◉	○	○	
K521	**HVAC** Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2	◉	○	○	
K522	**HVAC – Any Heating Device** Any heating device, other than a central heating plant, is designed and installed so combustible materials cannot be ignited by device, and has a safety feature to stop fuel and shut down equipment if there is excessive temperature or ignition failure. If fuel fired, the device also: • is chimney or vent connected. • takes air for combustion from outside. • provides for a combustion system separate from occupied area atmosphere. 18.5.2.2, 19.5.2.2	◉	○	○	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K523	**HVAC – Suspended Unit Heaters** Suspended unit heaters are permitted provided the following are met: • Not located in means of egress or in patient rooms. • Located high enough to be out of reach of people in the area. • Has a safety feature to stop fuel and shut down equipment if there is excessive temperature or ignition failure. 18.5.2.3(1), 19.5.2.3(1)	○	○	◉	
K524	**HVAC – Direct-Vent Gas Fireplaces** Direct-vent gas fireplaces, as defined in NFPA 54, inside of all smoke compartments containing patient sleeping areas comply with the requirements of 18.5.2.3(2), 19.5.2.3(2). 18.5.2.3(2), 19.5.2.3(2), NFPA 54	○	○	◉	
K525	**HVAC – Solid Fuel-Burning Fireplaces** Solid fuel-burning fireplaces are permitted in other than patient sleeping areas provided: • Areas are separated by 1-hour fire resistance construction. • Fireplace complies with 9.2.2. • Fireplace enclosure resists breakage up to 650°F and has heat-tempered glass. • Room has supervised CO detection per 9.8. 18.5.2.3(3) and 19.5.2.3(3)	○	○	◉	
K531	**Elevators** 2012 EXISTING Elevators comply with the provision of 9.4. Elevators are inspected and tested as specified in ASME A17.1, *Safety Code for Elevators and Escalators.* Firefighter's Service is operated monthly with a written record. Existing elevators conform to ASME/ANSI A17.3, *Safety Code for Existing Elevators and Escalators.* All existing elevators, having a travel distance of 25 feet or more above or below the level that best serves the needs of emergency personnel for firefighting purposes, conform with Firefighter's Service Requirements of ASME/ANSI A17.3. (Includes firefighter's service Phase I key recall and smoke detector automatic recall, firefighter's service Phase II emergency in-car key operation, machine room smoke detectors, and elevator lobby smoke detectors.) 19.5.3, 9.4.2, 9.4.3	◉	○	○	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K531	2012 NEW Elevators comply with the provision of 9.4. Elevators are inspected and tested as specified in ASME A17.1, *Safety Code for Elevators and Escalators.* Firefighter's Service is operated monthly with a written record. New elevators conform to ASME/ANSI A17.1, *Safety Code for Elevators and Escalators,* including Firefighter's Service Requirements. (Includes firefighter's Phase I key recall and smoke detector automatic recall, firefighter's service Phase II emergency in-car key operation, machine room smoke detectors, and elevator lobby smoke detectors.) 18.5.3, 9.4.2, 9.4.3	○	○	◉	
K532	**Escalators, Dumbwaiters, and Moving Walks** 2012 EXISTING Escalators, dumbwaiters, and moving walks comply with the provisions of 9.4. All existing escalators, dumbwaiters, and moving walks conform to the requirements of ASME/ANSI A17.3, *Safety Code for Existing Elevators and Escalators.* (Includes escalator emergency stop buttons and automatic skirt obstruction stop. For power dumbwaiters, includes hoistway door locking to keep doors closed except for floor where car is being loaded or unloaded.) 19.5.3, 9.4.2.2	○	○	◉	
	2012 NEW Escalators, dumbwaiters, and moving walks comply with the provisions of 9.4. 18.5.3, 9.4.2.2	○	○	◉	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K541	**Rubbish Chutes, Incinerators, and Laundry Chutes** 2012 EXISTING (1) Any existing linen and trash chute, including pneumatic rubbish and linen systems, that opens directly onto any corridor shall be sealed by fire resistive construction to prevent further use or shall be provided with a fire door assembly having a fire protection rating of 1-hour. All new chutes shall comply with 9.5. (2) Any rubbish chute or linen chute, including pneumatic rubbish and linen systems, shall be provided with automatic extinguishing protection in accordance with 9.7. (3) Any trash chute shall discharge into a trash collection room used for no other purpose and protected in accordance with 8.4. (Existing laundry chutes permitted to discharge into same room are protected by automatic sprinklers in accordance with 19.3.5.9 or 19.3.5.7.) (4) Existing fuel-fed incinerators shall be sealed by fire resistive construction to prevent further use. 19.5.4, 9.5, 8.4, NFPA 82	○	○	◉	
	2012 NEW Rubbish chutes, incinerators, and laundry chutes shall comply with the provisions of Section 9.5, unless otherwise specified in 18.5.4.2. • The fire resistance rating of chute charging room shall not be required to exceed 1-hour. • Any rubbish chute or linen chute shall be provided with automatic extinguishing protection in accordance with Section 9.7. • Chutes shall discharge into a trash collection room used for no other purpose and shall be protected in accordance with 8.7. 18.5.4.2, 8.7, 9.5, 9.7, NFPA 82	○	○	◉	
	SECTION 6 – RESERVED				
	SECTION 7 – OPERATING FEATURES				
K700	**Operating Features – Other** List in the REMARKS section any LSC Section 18.7 and 19.7 Operating Features requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included in Form CMS-2567.	◉	○	○	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K711	**Evacuation and Relocation Plan** There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. Employees are periodically instructed and kept informed with their duties under the plan, and a copy of the plan is readily available with telephone operator or with security. The plan addresses the basic response required of staff per 18/19.7.2.1.2 and provides for all of the fire safety plan components per 18/19.7.2.2. 18.7.1.1 through 18.7.1.3, 18.7.2.1.2, 18.7.2.2, 18.7.2.3, 19.7.1.1 through 19.7.1.3, 19.7.2.1.2, 19.7.2.2, 19.7.2.3	◉	○	○	
K712	**Fire Drills** Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 18.7.1.4 through 18.7.1.7, 19.7.1.4 through 19.7.1.7	◉	○	○	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K741	**Smoking Regulations** Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. (2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (3) Smoking by patients classified as not responsible shall be prohibited. (4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision. (5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted. 18.7.4, 19.7.4	◉	○	○	
K751	**Draperies, Curtains, and Loosely Hanging Fabrics** Draperies, curtains including cubicle curtains and loosely hanging fabric or films shall be in accordance with 10.3.1. Excluding curtains and draperies: at showers and baths; on windows in patient sleeping room located in sprinklered compartments; and in non-patient sleeping rooms in sprinklered compartments where individual drapery or curtain panels do not exceed 48 square feet or total area does not exceed 20 percent of the wall. 18.7.5.1, 18.3.5.11, 19.7.5.1, 19.3.5.11, 10.3.1	◉	○	○	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K752	**Upholstered Furniture and Mattresses** Newly introduced upholstered furniture meets Class I or char length, and heat release criteria in accordance with 10.3.2.1 and 10.3.3, unless the building is fully sprinklered. Newly introduced mattresses shall meet char length and heat release criteria in accordance with 10.3.2.2 and 10.3.4, unless the building is fully sprinklered. Upholstered furniture and mattresses belonging to nursing home residents do not have to meet these requirements as all nursing homes are required to be fully sprinklered. Newly introduced upholstered furniture and mattresses means purchased on or after the LSC final rule effective date. 18.7.5.2, 18.7.5.4, 19.7.5.2, 19.7.5.4	◉	○	○	
K753	**Combustible Decorations** Combustible decorations shall be prohibited unless one of the following is met: • Flame retardant or treated with approved fire-retardant coating that is listed and labeled for product. • Decorations meet NFPA 701. • Decorations exhibit heat release less than 100 kilowatts in accordance with NFPA 289. • Decorations, such as photographs, paintings and other art are attached to the walls, ceilings and non-fire-rated doors in accordance with 18.7.5.6(4) or 19.7.5.6(4). • The decorations in existing occupancies are in such limited quantities that a hazard of fire development or spread is not present. 18.7.5.6, 19.7.5.6	◉	○	○	
K761	**Maintenance, Inspection & Testing - Doors** Fire doors assemblies are inspected and tested annually in accordance with NFPA 80 *Standard for Fire Doors and Other Opening Protectives*. Fire doors that are not located in required fire barriers, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspection and testing have an understanding of the operating components of the doors. Written records of inspection and testing are maintained and are available for review. 18.7.6, 19.7.6, 8.3.3.1 (LSC), 5.2, 5.2.3 (NFPA 80)	◉	○	○	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K754	**Soiled Linen and Trash Containers** Soiled linen or trash collection receptacles shall not exceed 32 gallons in capacity. The average density of container capacity in a room or space shall not exceed 0.5 gallons/square feet. A total container capacity of 32 gallons shall not be exceeded within any 64 square feet area. Mobile soiled linen or trash collection receptacles with capacities greater than 32 gallons shall be located in a room protected as a hazardous area when not attended. Containers used solely for recycling are permitted to be excluded from the above requirements where each container is ≤ 96 gal. unless attended, and containers for combustibles are labeled and listed as meeting FM Approval Standard 6921 or equivalent. 18.7.5.7, 19.7.5.7	◉	○	○	
K771	**Engineer Smoke Control Systems** 2012 EXISTING When installed, engineered smoke control systems are tested in accordance with established engineering principles. Test documentation is maintained on the premises. 19.7.7	○	○	◉	
	2012 NEW When installed, engineered smoke control systems are tested in accordance with NFPA 92, *Standard for Smoke Control Systems*. Test documentation is maintained on the premises. 18.7.7	○	○	◉	
K781	**Portable Space Heaters** Portable space heating devices shall be prohibited in all health care occupancies. Unless used in nonsleeping staff and employee areas where the heating elements do not exceed 212 degrees Fahrenheit (100 degrees Celsius). 18.7.8, 19.7.8	◉	○	○	
K791	**Construction, Repair, and Improvement Operations** Construction, repair, and improvement operations shall comply with 4.6.10. Any means of egress in any area undergoing construction, repair, or improvements shall be inspected daily to ensure its ability to be used instantly in case of emergency and compliance with NFPA 241. 18.7.9, 19.7.9, 4.6.10, 7.1.10.1	◉	○	○	

ID PREFIX		MET	NOT MET	N/A	REMARKS
	PART II – HEALTH CARE FACILITIES CODE REQUIREMENTS				
K900	**Health Care Facilities Code - Other** List in the REMARKS section any NFPA 99 requirements (excluding Chapter 7, 8, 12, and 13) that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Health Care Facilities Code or NFPA standard citation, should be included on Form CMS-2567.	◉	○	○	
K901	**Fundamentals – Building System Categories** Building systems are designed to meet Category 1 through 4 requirements as detailed in NFPA 99. Categories are determined by a formal and documented risk assessment procedure performed by qualified personnel. Chapter 4 (NFPA 99)	◉	○	○	
K902	**Gas and Vacuum Piped Systems – Other** List in the REMARKS section any NFPA 99 Chapter 5 Gas and Vacuum Systems requirements that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Chapter 5 (NFPA 99)	○	○	◉	
K903	**Gas and Vacuum Piped Systems – Categories** Medical gas, medical air, surgical vacuum, WAGD, and air supply systems are designated: ☐ Category 1. Systems in which failure is likely to cause major injury or death. ☐ Category 2. Systems in which failure is likely to cause minor injury. ☐ Category 3. Systems in which failure is not likely to cause injury, but can cause discomfort. Deep sedation and general anesthesia are not to be administered using a Category 3 medical gas system. 5.1.1.1, 5.2.1, 5.3.1.1, 5.3.1.5 (NFPA 99)	○	○	◉	
K904	**Gas and Vacuum Piped Systems – Warning Systems** All master, area, and local alarm systems used for medical gas and vacuum systems comply with appropriate Category warning system requirements, as applicable. 5.1.9, 5.2.9, 5.3.6.2.2 (NFPA 99)	○	○	◉	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K905	**Gas and Vacuum Piped Systems – Central Supply System Identification and Labeling** Containers, cylinders and tanks are designed, fabricated, tested, and marked in accordance with 5.1.3.1.1 through 5.1.3.1.7. Locations containing only oxygen or medical air have doors labeled with "Medical Gases, NO Smoking or Open Flame". Locations containing other gases have doors labeled "Positive Pressure Gases, NO Smoking or Open Flame, Room May Have Insufficient Oxygen, Open Door and Allow Room to Ventilate Before Opening." 5.1.3.1, 5.2.3.1, 5.3.10 (NFPA 99)	○	○	◉	
K906	**Gas and Vacuum Piped Systems – Central Supply System Operations** Adaptors or conversion fittings are prohibited. Cylinders are handled in accordance with 11.6.2. Only cylinders, reusable shipping containers, and their accessories are stored in rooms containing central supply systems or cylinders. No flammable materials are stored with cylinders. Cryogenic liquid storage units intended to supply the facility are not used to transfill. Cylinders are kept away from sources of heat. Valve protection caps are secured in place, if supplied, unless cylinder is in use. Cylinders are not stored in tightly closed spaces. Cylinders in use and storage are prevented from exceeding 130°F, and nitrous oxide and carbon dioxide cylinders are prevented from reaching temperatures lower than manufacture recommendations or 20°F. Full or empty cylinders, when not connected, are stored in locations complying with 5.1.3.3.2 through 5.1.3.3.3, and are not stored in enclosures containing motor-driven machinery, unless for instrument air reserve headers. 5.1.3.2, 5.1.3.3.17, 5.1.3.3.1.8, 5.1.3.3.4, 5.2.3.2, 5.2.3.3, 5.3.6.20.4, 5.6.20.5, 5.3.6.20.7, 5.3.6.20.8, 5.3.6.20.9 (NFPA 99)	○	○	◉	
K907	**Gas and Vacuum Piped Systems – Maintenance Program** Medical gas, vacuum, WAGD, or support gas systems have documented maintenance programs. The program includes an inventory of all source systems, control valves, alarms, manufactured assemblies, and outlets. Inspection and maintenance schedules are established through risk assessment considering manufacturer recommendations. Inspection procedures and testing methods are established through risk assessment. Persons maintaining systems are qualified as demonstrated by training and certification or credentialing to the requirements of AASE 6030 or 6040. 5.1.14.2.1, 5.1.14.2.2, 5.1.15, 5.2.14, 5.3.13.4.2 (NFPA 99)	○	○	◉	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K908	**Gas and Vacuum Piped Systems – Inspection and Testing Operations** The gas and vacuum systems are inspected and tested as part of a maintenance program and include the required elements. Records of the inspections and testing are maintained as required. 5.1.14.2.3, B.5.2, 5.2.13, 5.3.13, 5.3.13.4 (NFPA 99)	○	○	◉	
K909	**Gas and Vacuum Piped Systems – Information and Warning Signs** Piping is labeled by stencil or adhesive markers identifying the gas or vacuum system, including the name of system or chemical symbol, color code (Table 5.1.11), and operating pressure if other than standard. Labels are at intervals not more than 20 feet, are in every room, at both sides of wall penetrations, and on every story traversed by riser. Piping is not painted. Shutoff valves are identified with the name or chemical symbol of the gas or vacuum system, room or area served, and caution to not use the valve except in emergency. 5.1.14.3, 5.1.11.1, 5.1.11.2, 5.2.11, 5.3.13.3, 5.3.11 (NFPA 99)	○	○	◉	
K910	**Gas and Vacuum Piped Systems – Modifications** Whenever modifications are made that breach the pipeline, any necessary installer and verification test specified in 5.1.2 is conducted on the downstream portion of the medical gas piping system. Permanent records of all tests required by system verification tests are maintained. 5.1.14.4.1, 5.1.14.4.6, 5.2.13, 5.3.13.4.3 (NFPA 99)	○	○	◉	
K911	**Electrical Systems – Other** List in the REMARKS section any NFPA 99 Chapter 6 Electrical Systems requirements that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Chapter 6 (NFPA 99)	◉	○	○	
K912	**Electrical Systems – Receptacles** Power receptacles have at least one, separate, highly dependable grounding pole capable of maintaining low-contact resistance with its mating plug. In pediatric locations, receptacles in patient rooms, bathrooms, play rooms, and activity rooms, other than nurseries, are listed tamper-resistant or employ a listed cover. If used in patient care room, ground-fault circuit interrupters (GFCI) are listed. 6.3.2.2.6.2 (F), 6.3.2.2.4.2 (NFPA 99)	◉	○	○	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K913	**Electrical Systems – Wet Procedure Locations** Operating rooms are considered wet procedure locations, unless otherwise determined by a risk assessment conducted by the facility governing body. Operating rooms defined as wet locations are protected by either isolated power or ground-fault circuit interrupters. A written record of the risk assessment is maintained and available for inspection. 6.3.2.2.8.4, 6.3.2.2.8.7, 6.4.4.2	○	○	◉	
K914	**Electrical Systems – Maintenance and Testing** Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of ≤ 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals ≤ 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99)	◉	○	○	
K915	**Electrical Systems – Essential Electric System Categories** ○ Critical care rooms (Category 1) in which electrical system failure is likely to cause major injury or death of patients, including all rooms where electric life support equipment is required, are served by a Type 1 EES. ○ General care rooms (Category 2) in which electrical system failure is likely to cause minor injury to patients (Category 2) are served by a Type 1 or Type 2 EES. ◉ Basic care rooms (Category 3) in which electrical system failure is not likely to cause injury to patients and rooms other than patient care rooms are not required to be served by an EES. Type 3 EES life safety branch has an alternate source of power that will be effective for 1 1/2 hours. 3.3.138, 6.3.2.2.10, 6.6.2.2.2, 6.6.3.1.1 (NFPA 99), TIA 12-3	◉	○	○	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K916	**Electrical Systems – Essential Electric System Alarm Annunciator** A remote annunciator that is storage battery powered is provided to operate outside of the generating room in a location readily observed by operating personnel. The annunciator is hard-wired to indicate alarm conditions of the emergency power source. A centralized computer system (e.g., building information system) is not to be substituted for the alarm annunciator. 6.4.1.1.17, 6.4.1.1.17.5 (NFPA 99)	◉	○	○	
K917	**Electrical Systems – Essential Electric System Receptacles** Electrical receptacles or cover plates supplied from the life safety and critical branches have a distinctive color or marking. 6.4.2.2.6, 6.5.2.2.4.2, 6.6.2.2.3.2 (NFPA 99)	◉	○	○	
K918	**Electrical Systems – Essential Electric System Maintenance and Testing** The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70)	◉	○	○	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K919	**Electrical Equipment – Other** List in the REMARKS section any NFPA 99 Chapter 10, *Electrical Equipment*, requirements that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Chapter 10 (NFPA 99)	◉	○	○	
K920	**Electrical Equipment – Power Cords and Extension Cords** Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5	◉	○	○	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K921	**Electrical Equipment – Testing and Maintenance Requirements** The physical integrity, resistance, leakage current, and touch current tests for fixed and portable patient-care related electrical equipment (PCREE) is performed as required in 10.3. Testing intervals are established with policies and protocols. All PCREE used in patient care rooms is tested in accordance with 10.3.5.4 or 10.3.6 before being put into service and after any repair or modification. Any system consisting of several electrical appliances demonstrates compliance with NFPA 99 as a complete system. Service manuals, instructions, and procedures provided by the manufacturer include information as required by 10.5.3.1.1 and are considered in the development of a program for electrical equipment maintenance. Electrical equipment instructions and maintenance manuals are readily available, and safety labels and condensed operating instructions on the appliance are legible. A record of electrical equipment tests, repairs, and modifications is maintained for a period of time to demonstrate compliance in accordance with the facility's policy. Personnel responsible for the testing, maintenance and use of electrical appliances receive continuing training. 10.3, 10.5.2.1, 10.5.2.1.2, 10.5.2.5, 10.5.3, 10.5.6, 10.5.8	◉	○	○	
K922	**Gas Equipment – Other** List in the REMARKS section any NFPA 99 Chapter 11 Gas Equipment requirements that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Chapter 11 (NFPA 99)	◉	○	○	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K923	**Gas Equipment – Cylinder and Container Storage** **≥ 3,000 cubic feet** Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. **> 300 but <3,000 cubic feet** Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. **≤ 300 cubic feet** In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of ≤ 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING". Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99)	◉	○	○	
K924	**Gas Equipment – Testing and Maintenance Requirements** Anesthesia apparatus are tested at the final path to patient after any adjustment, modification or repair. Before the apparatus is returned to service, each connection is checked to verify proper gas and an oxygen analyzer is used to verify oxygen concentration. Defective equipment is immediately removed from service. Areas designated for servicing of oxygen equipment are clean and free of oil, grease, or other flammables. Manufacturer service manuals are used to maintain equipment and a scheduled maintenance program is followed. 11.4.1.3, 11.5.1.3, 11.6.2.5, 11.6.2.6 (NFPA 99)	○	○	◉	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K925	**Gas Equipment – Respiratory Therapy Sources of Ignition** Smoking materials are removed from patients receiving respiratory therapy. When a nasal cannula is delivering oxygen outside of a patient's room, no sources of ignition are within in the site of intentional expulsion (1-foot). When other oxygen deliver equipment is used or oxygen is delivered inside a patient's room, no sources of ignition are within the area are of administration (15-feet). Solid fuel-burning appliances is not in the area of administration. Nonmedical appliances with hot surfaces or sparking mechanisms are not within oxygen-delivery equipment or site of intentional expulsion. 11.5.1.1, TIA 12-6 (NFPA 99)	○	○	◉	
K926	**Gas Equipment – Qualifications and Training of Personnel** Personnel concerned with the application, maintenance and handling of medical gases and cylinders are trained on the risk. Facilities provide continuing education, including safety guidelines and usage requirements. Equipment is serviced only by personnel trained in the maintenance and operation of equipment. 11.5.2.1 (NFPA 99)	◉	○	○	
K927	**Gas Equipment – Transfilling Cylinders** Transfilling of oxygen from one cylinder to another is in accordance with CGA P-2.5, *Transfilling of High Pressure Gaseous Oxygen Used for Respiration*. Transfilling of any gas from one cylinder to another is prohibited in patient care rooms. Transfilling to liquid oxygen containers or to portable containers over 50 psi comply with conditions under 11.5.2.3.1 (NFPA 99). Transfilling to liquid oxygen containers or to portable containers under 50 psi comply with conditions under 11.5.2.3.2 (NFPA 99). 11.5.2.2 (NFPA 99)	○	○	◉	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K928	**Gas Equipment – Labeling Equipment and Cylinders** Equipment listed for use in oxygen-enriched atmospheres are so labeled. Oxygen metering equipment and pressure reducing regulators are labeled "OXYGEN-USE NO OIL". Flowmeters, pressure reducing regulators, and oxygen-dispensing apparatus are clearly and permanently labeled designating the gases for which they are intended. Oxygen-metering equipment, pressure reducing regulators, humidifiers, and nebulizers are labeled with name of manufacturer or supplier. Cylinders and containers are labeled in accordance with CGA C-7. Color coding is not utilized as the primary method of determining cylinder or container contents. All labeling is durable and withstands cleaning or disinfecting. 11.5.3.1 (NFPA 99)	◉	○	○	
K929	**Gas Equipment – Precautions for Handling Oxygen Cylinders and Manifolds** Handling of oxygen cylinders and manifolds is based on CGA G-4, Oxygen. Oxygen cylinders, containers, and associated equipment are protected from contact with oil and grease, from contamination, protected from damage, and handled with care in accordance with precautions provided under 11.6.2.1 through 11.6.2.4 (NFPA 99). 11.6.2 (NFPA 99)	◉	○	○	
K930	**Gas Equipment – Liquid Oxygen Equipment** The storage and use of liquid oxygen in base reservoir containers and portable containers comply with sections 11.7.2 through 11.7.4 (NFPA 99). 11.7 (NFPA 99)	◉	○	○	
K931	**Hyperbaric Facilities** All occupancies containing hyperbaric facilities comply with construction, equipment, administration, and maintenance requirements of NFPA 99. Chapter 14 (NFPA 99)	○	○	◉	
K932	**Features of Fire Protection – Other** List in the REMARKS section any NFPA 99 Chapter 15 Features of Fire Protection requirements that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Chapter 15 (NFPA 99)	◉	○	○	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K933	**Features of Fire Protection – Fire Loss Prevention in Operating Rooms** Periodic evaluations are made of hazards that could be encountered during surgical procedures, and fire prevention procedures are established. When flammable germicides or antiseptics are employed during surgeries utilizing electrosurgery, cautery or lasers: • packaging is non-flammable. • applicators are in unit doses. • Preoperative "time-out" is conducted prior the initiation of any surgical procedure to verify: o application site is dry prior to draping and use of surgical equipment. o pooling of solution has not occurred or has been corrected. o solution-soaked materials have been removed from the OR prior to draping and use of surgical devices. o policies and procedures are established outlining safety precautions related to the use of flammable germicide or antiseptic use. Procedures are established for operating room emergencies including alarm activation, evacuation, equipment shutdown, and control operations. Emergency procedures include the control of chemical spills, and extinguishment of drapery, clothing and equipment fires. Training is provided to new OR personnel (including surgeons), continuing education is provided, incidents are reviewed monthly, and procedures are reviewed annually. 15.13 (NFPA 99)	○	○	◉	

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

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

PROVISION NUMBER(S)	JUSTIFICATION
K400	

Surveyor *(Signature)*	Title	Office	Date
Fire Authority Official *(Signature)*	Title	Office	Date

PART IV - FIRE SAFETY SURVEY REPORT
CRUCIAL DATA EXTRACT
(TO BE USED WITH CMS 2786 FORMS)

Provider Number	Facility Name	Survey Date
K1		*K4

K6 DATE OF PLAN APPROVAL

K3 MULTIPLE CONSTRUCTION ☐

TOTAL NUMBER OF BUILDINGS _____

NUMBER OF THIS BUILDING _____

A. BUILDING
B. WING
C. FLOOR
D. APARTMENT UNIT

LSC FORM INDICATOR

HEALTH CARE FORM		
12	2786R	2012 EXISTING
13	2786R	2012 NEW

AHCO FORM		
14	2786U	2012 EXISTING
15	2786U	2012 NEW

ICF/IID FORM		
16	2786V, W, X	2012 EXISTING
17	2786V, W, X	2012 NEW

*K7 ☐ SELECT NUMBER OF FORM USED FROM ABOVE

COMPLETE IF ICF/IID IS SURVEYED UNDER CHAPTER 33, EXISTING

SMALL (16 BEDS OR LESS)

K8 ☐
1. PROMPT
2. SLOW
3. IMPRACTICAL

LARGE

K8 ☐
4. PROMPT
5. SLOW
6. IMPRACTICAL

APARTMENT HOUSE

K8 ☐
7. PROMPT
8. SLOW
9. IMPRACTICAL

(Check if K321 or K351 are marked as not applicable in the 2786 M, R, T, U, V, W, X, and Y.)

K321: ☐ K351: ☐

COMPLETE IF ICF/IID IS SURVEYED UNDER CHAPTER 33, EXISTING

ENTER E – SCORE

K5: ☐ e.g. 2.5

*K9 FACILITY MEETS LSC BASED ON *(Check all that Apply)*

A1. ☐	A2. ☐	A3. ☐	A4. ☐	A5. ☐
(COMP. WITH ALL PROVISIONS)	(ACCEPTABLE POC)	(WAIVERS)	(FSES)	(PERFORMANCE BASED DESIGN)

FACILITY DOES NOT MEET LSC

B. ☐

K0180

A. ☐	B. ☐	C. ☐
FULLY SPRINKLERED (All required areas are sprinklered)	PARTIALLY SPRINKLERED (Not all required areas are sprinklered)	NONE (No sprinkler system)

*MANDATORY

FIRE SAFETY SURVEY REPORT
CRUCIAL DATA EXTRACT
(TO BE USED WITH CMS-2786 FORMS)

PROVIDER NUMBER	FACILITY NAME	SURVEY DATE
K1 245313	**MEADOW LANE RESTORATIVE CARE CENTER**	*K4 **08/24/2021**

K6 DATE OF PLAN APPROVAL

K3 : MULTIPLE CONSTRUCTION

TOTAL NUMBER OF BUILDINGS 1

NUMBER OF THIS BUILDING 01

[A]

A BUILDING
B WING
C FLOOR
D APARTMENT UNIT

LSC FORM INDICATOR

Health Care Form		
12	2786 R	2012 EXISTING
13	2786 R	2012 NEW

ASC Form		
14	2786 U	2012 EXISTING
15	2786 U	2012 NEW

ICF/MR Form		
16	2786 V, W, X	2012 EXISTING
17	2786 V, W, X	2012 NEW

*K7 [12] SELECT NUMBER OF FORM USED FROM ABOVE

(Check if K321 or K351 are marked as not applicable in the 2786 M, R, T, U, V, W, X, Y and Z.)

K321: [3] K351: [3]

COMPLETE IF ICF/MR IS SURVEYED UNDER CHAPTER 21

SMALL (16 BEDS OR LESS)

K8: [ ]

1 PROMPT
2 SLOW
3 IMPRACTICAL

LARGE

K8: [ ]

4 PROMPT
5 SLOW
6 IMPRACTICAL

APARTMENT HOUSE

K8: [ ]

7 PROMPT
8 SLOW
9 IMPRACTICAL

ENTER E-SCORE HERE

K5: [ ] e.g 2.5

*K9 : FACILITY MEETS LSC BASED ON: (*Check all that apply*)

A1	A2	A3	A4	A5
[ ]	[X]	[ ]	[ ]	[ ]
(COMP. WITH ALL PROVISIONS)	(ACCEPTABLE POC)	(WAIVERS)	(FSES)	(PERFORMANCE BASED DESIGN)

FACILITY DOES NOT MEET LSC:

B. [ ]

K180:

A.	B.	C.
[X]	[ ]	[ ]
FULLY SPRINKLERED (All required areas are sprinklered)	PARTIALLY SPRINKLERED (Not all required areas are sprinklered)	NONE (No sprinkler system)

*MANDATORY