Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
February 14, 2023

Administrator
Divine Providence Community Home
700 Third Avenue Northwest
Sleepy Eye, MN 56085

RE: CCN: 245599
Cycle Start Date: November 9, 2022

Dear Administrator:

On November 28, 2022, we notified you a remedy was imposed. On January 5, 2023 the Minnesota Department(s) of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of December 29, 2022.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective December 13, 2022 be discontinued as of December 29, 2022. (42 CFR 488.417 (b))

However, in our letter of November 28, 2022, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from December 13, 2022. This does not apply to or affect any previously imposed NATCEP loss.

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

Feel free to contact me if you have questions.

Sincerely,

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

February 14, 2023

Administrator
Divine Providence Community Home
700 Third Avenue Northwest
Sleepy Eye, MN 56085

Re: Reinspection Results
Event ID: TPB812

Dear Administrator:

On January 5, 2023 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on November 9, 2022. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us

Electronically delivered
November 28, 2022

Administrator
Divine Providence Community Home
700 Third Avenue Northwest
Sleepy Eye, MN 56085

RE: CCN: 245599
Cycle Start Date: November 9, 2022

Dear Administrator:

On November 9, 2022, a survey was completed at your facility by the Minnesota Department(s) of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy(ies) listed below to the CMS 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 December 13, 2022.

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

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective December 13, 2022. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective December 13, 2022.

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

This Department is also recommending that CMS impose:

- Civil money penalty (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS RO

only if CMS agrees with our recommendation.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $11,292; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by December 13, 2022, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Divine Providence Community Home will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from December 13, 2022. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions.

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

ELECTRONIC PLAN OF CORRECTION (ePOC)

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

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

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

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies

(those preceded by a "F" and/or an "E" tag), i.e., the plan of correction should be directed to:

Elizabeth Silkey, Unit Supervisor
Mankato District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
12 Civic Center Plaza, Suite #2105
Mankato, MN 56001
Email: elizabeth.silkey@state.mn.us
Office: (507) 344-2742 Mobile: (651) 368-3593

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 May 9, 2023 if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 488.412 and § 488.456.

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

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your

hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Steven.Delich@cms.hhs.gov

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

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 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 Steven Delich, Program Representative at (312) 886-5216. Information may also be emailed to Steven.Delich@cms.hhs.gov.

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

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

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

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

Sarah Lane

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245599	A. BUILDING _____ B. WING _____	C 11/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIVINE PROVIDENCE COMMUNITY HOME	700 THIRD AVENUE NORTHWEST SLEEPY EYE, MN 56085

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments On 11/6/22 through 11/9/22, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On 11/6/22 through 11/9/22, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were found to be UNSUBSTANTIATED: H5599042C (MN79963), H55995494C (MN87005), and H55995535C (MN87965). The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		12/09/2022

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

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F 000	Continued From page 1 regulations has been attained.	F 000		
F 676 SS=D	Activities Daily Living (ADLs)/Mntn Abilities CFR(s): 483.24(a)(1)(b)(1)-(5)(i)-(iii) §483.24(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that: §483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section ... §483.24(b) Activities of daily living. The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living: §483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care, §483.24(b)(2) Mobility-transfer and ambulation, including walking, §483.24(b)(3) Elimination-toileting, §483.24(b)(4) Dining-eating, including meals and snacks, §483.24(b)(5) Communication, including (i) Speech,	F 676		12/8/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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DIVINE PROVIDENCE COMMUNITY HOME	700 THIRD AVENUE NORTHWEST SLEEPY EYE, MN 56085

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F 676	Continued From page 2 (ii) Language, (iii) Other functional communication systems. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure activities of daily living (ADLs) were provided, including trimming of fingernails for 1 of 2 residents (R27) reviewed, who needed staff assistance to maintain good personal hygiene. Findings include: R27's quarterly Minimum Data Set (MDS) assessment, dated 10/5/22, indicated R27 had intact cognition and required assistance from staff to maintain personal hygiene. R27's care plan dated 10/24/22; indicated R27 required staff assist of 1 with dressing and to maintain personal hygiene. During an observation and interview on 11/06/22 at 3:20 p.m., R27 was sitting in recliner chair in room, fingernails long and jagged. R27 indicated he was becoming more independent with activities of daily living (ADL), and staff have him do more for himself, but still needed some assistance with dressing and hygiene cares. R27 stated trimming fingernails was difficult to complete independently, and had not asked for staff assistance with fingernail trimming, and staff had not offered to trim fingernails. R27 indicated would like staff assistance with nail cares. During observation on 11/07/22 at 1:02 p.m., R27 was sitting in recliner chair in room, long, jagged fingernails remained.	F 676	1. Corrective action will be accomplished for those residents found to have been affected by the deficient practice by; On 11/08/2022 R27 nails were trimmed to resident preference. 2. The facility will identify other residents having the potential to be affected by the same deficient practice by; All current residents in the facility were either asked (if cognitively intact) if their nails were cleaned/trimmed to their preference, or by observation (if not cognitively intact). Nail care provided to residents whom requested or were observed to have need for nail care. 3. Measures put into place or systemic changes made to ensure that the deficient practice will not recur are; Cart nurses to examine resident nail care after bathing during skin check, to ensure nail care completed to resident preference. Policy AM Cares updated 12/1/2022. 4. The facility will monitor its performance to make sure that solutions are effective by; Audit will be conducted per DON, or designated licensed nursing staff	

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F 676	Continued From page 3 During an interview on 11/08/22 at 7:15 a.m., nursing assistant (NA)-I indicated had worked at facility for 2 years. NA-A stated resident nail care was completed on bath day, indicating NAs able to trim resident fingernails unless diabetic or had difficulty trimming, would then have licensed nurse complete. While interviewed on 11/07/22 at 6:21 p.m., the director of nursing (DON) indicated resident nail care was completed on their bath days. DON stated NAs typically would trim fingernails and toenails needing to be trimmed if not diabetic, if diabetic or had difficulty with trimming nails, licensed nurse would complete. DON indicated R27 was independent with some cares, needed staff assistance with fingernail trimming, could be completed by NA as R27 was not diabetic. DON reviewed bath schedule for R27, and noted R27's fingernails should be checked for trimming on Saturdays. DON reviewed nursing documentation for R27's bath cares completed from 10/8/22-11/5/22, and verified there was no documentation for nail trimming over past month. DON was shown R27's fingernails, and confirmed fingernails were dirty, longer in length, and jagged. DON stated her expectation for staff was to check fingernails/toenails during resident scheduled bath, trim nails as appropriate and per resident request. During an observation and interview on 11/08/22 at 7:24 a.m., R27 appeared clean in appearance. R27's fingernails was observed to be clean and trimmed some. R27's right 4th fingernail observed to have continued jagged edges. R27 stated staff had trimmed fingernails last evening, right 4th fingernail remained slightly jagged due to	F 676	member, one time per week times four weeks, then one time per month times two months (to ensure residents are receiving/being offered nail care). Audits will continue if deemed necessary. Audit information will be reviewed at the quarterly Quality Assurance meeting. Staff will take a written test to ensure understanding and compliance of policy and procedure. Results will be reviewed per DON, or designated licensed staff member, with results discussed at the quarterly Quality Assurance meeting. 5.Dates when corrective action(s) will be completed are as follows; Nail care for resident found to be affected by the deficient practice completed on 11/08/2022, and weekly per residents preference. Residents having the potential to be affected by the same deficient practice were offered and/or given nail care per resident preference completed on 12/8/2022. Audit/staff test results to be reviewed and discussed at quarterly Quality Assurance meeting, date to be determined.	

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F 676	Continued From page 4 "crooked" finger. R27 indicated he preferred staff leave right 4th fingernail alone. Facility policy titled Policy A.M. Cares, revised 11/22, indicated cares are given daily to each resident requiring assistance, supervision is provided for residents able to self-care and assistance is given as needed, purpose of cares to promote cleanliness. Procedure consisted of residents on the bath list should be given a complete tub bath or shower including a shampoo and nail care per resident preference, licensed nurses will trim nails on diabetic residents, if toenails are too thick to be trimmed this will be reported to charge nurse.	F 676		
F 686 SS=G	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to assess, monitor and implement pressure relieving interventions for 1 of 3 residents (R1) reviewed who was at risk for	F 686	1. Corrective action will be accomplished for those residents found to have been affected by the deficient practice by;	12/29/22

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F 686	Continued From page 5 pressure ulcer development. The facility's failure resulted in R1 sustaining harm when the resident developed a Stage IV (extend into the muscle, tendon, ligament, cartilage or even bone) pressure ulcer to the sacral/coccyx (triangular bone found between end of lumbar 5 of the spine and coccyx (end of spine area) area. Findings include: R1's face sheet printed 11/7/22, included diagnoses of chronic obstructive pulmonary disease (airflow limitations), anxiety disorder, heart failure, peripheral vascular disease (narrowing, blockage or spasm in any vessels outside of the heart), and personal history of COVID-19. R1's quarterly Minimum Data Set (MDS) assessment dated 8/10/22, identified R1 as having intact cognition, understands and is understood and moderate hearing loss. The MDS further indicated R1 had no rejection of cares, required no staff assistance with mobility needs and used a walker and wheelchair. The MDS included R1 was at risk for pressure ulcers, currently had no skin issues and had a pressure reducing device for bed and chair. R1's discharge MDS assessment dated 10/24/22, identified R1 as requiring limited assist with transfers, was independent with bed mobility and required extensive assistance with dressing, personal hygiene and toileting. R1's Care Area Assessment (CAA) dated 5/30/22, indicated R1 had no pressure ulcers but had a history of healed pressure ulcers and the head of the bed is elevated all or most of the	F 686	Nursing staff will be receiving further training/re-education on pressure ulcer prevention/care by WOCNCB, DTBD. Policy labeled Pressure Ulcer Prevention and Managing Skin Integrity has been created. R1 has been educated and has signed a Shared Risk Agreement. 2. The facility will identify other residents having the potential to be affected by the same deficient practice by; All current residents at risk reviewed at 11/22/2022 IDT meeting, for any pressure ulcer reduction/maintaining skin integrity needs, and implemented as needed. Nursing staff will be receiving further training/re-education on pressure ulcer prevention/care by WOCNCB, DTBD. Policy labeled Pressure Ulcer Prevention and Managing Skin Integrity has been created. 3. Measures put into place or systemic changes made to ensure that the deficient practice will not recur are; Nursing staff will be receiving further training/re-education on pressure ulcer prevention/care by WOCNCB, DTBD. Policy labeled Pressure Ulcer Prevention and Managing Skin Integrity has been created. All nursing staff will receive training on new policy. 4. The facility will monitor its performance to make sure that solutions are effective by;	

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F 686	Continued From page 6 time. The CAA further stated R1's skin in good condition but remains at risk due to frail and fragile condition, weight declining but able to continue with activities of daily living and walking. R1 rests most of the time in bed, doesn't change position in bed and just keeps the same position on the right edge of bed so she can get up to the bathroom as she desires and chooses. R1's Braden Scale (the gold standard used to identify risk of developing a pressure injury) dated 5/23/22, indicated a score of 19/23 (indicating no risk). However, added text indicated R1 was at risk due to age, due to always laying on the same area on back and side and never alternated her position in bed, weight is low and bony prominence's at risk. R1's care plan dated 3/21/22, for skin care indicated nursing assistants (NA) was to use pressure redistribution devices on the bed, pillows to reduce pressure and friction between R1 and the bed or chair with cushion in wheelchair when used. Keep R1 clean and dry by providing pericare when needed and noting when incontinence pad needs changing. Report redness, check skin folds, keep dry, and treat as ordered. The goal was to keep skin healthy and intact and avoid injury. Record review revealed the following weekly skin assessments: 9/9/22: no open areas on skin. 9/16/22: bruise present on right knee and top of head which is resolving. 9/23/22: no open areas. 9/30/22: no open areas 10/7/22: red area under chin. 10/21/22: no new skin issues	F 686	Audit will be conducted per DON, or designated licensed nursing staff member (to ensure skin checks are being completed, appropriate skin charting, CP□s updated to reflect PU prevention needs, ect.) one time per week times four weeks, then one time per month times two months. Audits will continue if deemed necessary. Audit information will be reviewed at the quarterly Quality Assurance meeting. Staff will take a written test to ensure understanding and compliance of policy and procedure. Results will be reviewed per DON, or designated licensed staff member, with results discussed at the quarterly Quality Assurance meeting. 5. Dates when corrective action(s) will be completed are as follows; Audits/staff test results to be reviewed and discussed at quarterly Quality Assurance meeting, date to be determined. R1 education and signed Shared Risk Agreement complete. Further training/re-education on pressure ulcer prevention/care by WOCNCB, DTBD. Policy labeled Pressure Ulcer Prevention and Managing Skin Integrity has been created.	

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F 686	Continued From page 7 10/13/22: no current skin lesion or problems. Skin is within normal limits A progress note dated 10/17/22, at 7:41 a.m., indicated R1 tested positive for COVID-19. A progress note on 10/17/22, at 12:08 p.m., indicated R1 refused meal and acetaminophen. Oxygen saturation was 90% on 1 liter of oxygen. A progress note on 10/17/22, at 2:25 p.m. indicated R1 had been unresponsive a couple times during shift, refused meds and meal but refused to go to the hospital. A progress note dated 10/18/22, at 4:34 a.m., included R1 continued to refuse to be treated at the hospital and required assistance to the bathroom. A progress note dated 10/22/22, at 10:34 p.m. indicated R1 was feeling tired with very little energy and slept for most of the shift. A progress note dated 10/24/22, at 1:47 a.m. indicated acetaminophen 325 mg tablet was given for pain on R1's bottom and rated the pain at a 6. At 7:54 a.m., R1 was transferred to acute care hospital by ambulance for evaluation of breathing pattern that is fast, breath sounds abnormal, crackles heard, diminished. Cough was congested. Temperature was 99.6 degrees Fahrenheit. A "History and Physical" dated 10/24/22, from hospital admission indicated a 3 centimeter (cm) sacral ulcer was present with surrounding erythema (superficial reddening of the skin, as a result of injury or irritation) present. Wound not	F 686		

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F 686	Continued From page 8 deep enough to see the bone but extends through the subcutaneous fat. Inside the wound, the tissue is gray and black and foul smelling. Assessment and plan included "sacral decubitus ulcer" (pressure ulcer), stage IV. The nursing home reported they were unaware of this. Will clean the wound with microsyne wound spray (safe hypochlorous acid based antimicrobial treatment for the cleansing, irrigation and moistening of wounds) and bandage as appropriate. Nurses will frequently reposition. A hospital discharge summary dated 10/28/22, included "sacral decubitus ulcer" (pressure ulcer) stage 4: R1 was found to have a large sacral ulcer with surrounding erythema and severe tenderness. Area is very painful. PU has a small opening on the surface but is quite deep. There is a large amount of necrotic (death of cells) tissue within the wound. R1 is not a candidate for surgical debridement. Cleaning of the wound is done daily with microsyne wound spray and covering with Mepilex border dressing (absorbent, dressing that acts as a barrier to liquid and microorganisms). R1 will need ongoing wound care after discharge. It is extremely important to have an appropriate mattress and assist her to off load the sacral area. Physician orders dated 10/28/22, included: Cleanse wound on sacrum/coccyx with microsyne and change Mepilex on sacrum/coccyx daily until healed. Measure PU, explain condition, treatment, stage 4 on sacrum/coccyx 1 time per week starting Friday until healed. During observation and interview on 11/6/22, at 12:58 p.m., nursing assistant (NA)-D assisted R1	F 686		

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F 686	Continued From page 9	F 686		

to the bathroom. R1 had Mepilex on sacrum/coccyx. NA-D indicated R1 was in the hospital and returned with a pressure ulcer. R1 refused to be interviewed.

During observation on 11/6/22, 5:55 p.m. R1 was brought to the dining room in her wheelchair. R1's bottom was in the center of the chair and R1 was leaning back casing her to appear slouched in the wheelchair with pressure on sacral/coccyx area. R1 was able to sit up to eat and then would lean back again. R1 took her medications, ate 1/2 of her chicken noodle soup and requested to go back to her room. R1 was assisted back to her room, toileted with Mepilex still in place and settled into bed on her back with head of the bed observed to be at 30 degrees.

During observation on 11/7/22, at 12:41 p.m., R1 was laying in bed on her back with head of the bed at 30 degrees. Air mattress was present on bed.

During observation and interview on 11/7/22, at 1:32 p.m., registered nurse (RN)-B entered R1's room to complete a dressing change. RN-B indicated R1 returned from the hospital with wound at the end of October when she had COVID-19. RN-B indicated R1 had no redness or signs of a pressure ulcer prior to her transfer to the hospital. Trained medication assistant (TMA)-B rolled R1 onto her left side. RN-B removed Mepilex covering wound and per RN-B a moderate amount of serosanguinous drainage was present with a yellow-greenish tint. RN-B indicated the wound had increased redness around the edges and inside the wound, bone was visible with exudate (a mass of cells and fluid that has seeped out of blood vessels or an organ,

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F 686	Continued From page 10 especially in inflammation) present. RN-B cleansed wound with microsyne and gauze. RN-B measured tunneling of the wound which was 6.5 centimeters (cm). Wound length was 5 cm and 4 cm wide. Depth of wound was 1 cm. RN-B indicated the wound was larger, had more drainage and redness than previous on 11/4/22. A new Mepilex was placed on the wound. RN-B indicated the air mattress was placed on R1's bed when she returned from the hospital. RN-B said they have educated R1 about getting off her back and bottom but R1 refuses and prefers to lay on her back. A progress note on 10/28/22, at 11:49 a.m. indicated R1 was readmitted to the facility at 11:40 a.m. via ambulance from the acute care hospital. Hospital orders included wound care for stage 4 ulcer/coccyx and to cleanse wound with microsyne and cover with Mepilex daily and as needed. A transfer assessment completed on 10/28/22, at 1:05 p.m. indicated R1 could assist with standing, bear full weight for a least 4 seconds and follows directions. Transfer instructions included standing pivot with assist of 1 and gait belt. Stand in front of resident, pull resident to feet with both hands and gait belt and feet in a staggered stance. Pain present on buttocks. R1 is usually understood by others and usually understands others, but misses some part or intent of message but comprehends most conversation. A progress note dated 10/29/22, at 10:21 a.m. indicated PU stage 4, full thickness of skin and subcutaneous tissue loss, exposing muscle and or bone. Tissue type is slough (dead skin tissue yellow or white in appearance) with wound tissue	F 686		

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F 686	Continued From page 11 white. Light drainage, yellow in color noted on Mepilex when removed. Surrounding tissue is cyanotic (bluish discoloration of the skin resulting from poor circulation). Wound length was 4 cm, width, 3 cm and depth 2 cm. A Braden Scale completed on 10/31/22, indicated score of 17/23, meaning no risk. No mention of current pressure ulcer present. A progress note dated 11/4/22, indicated PU stage 4 with wound tissue yellow, surrounding tissue reddened, and no change with healing progress. Length of wound is 4 cm, width is 6 cm and depth 0.3 cm. A progress note dated 11/5/22, indicated PU stage 4, area was painful with dressing change and cleansing of the area. Brown drainage on changed Mepilex and has a foul odor. R1's care plan revised 11/7/22, indicated R1 had the potential for skin injury, bruise easily and developed a pressure ulcer due to poor tissue perfusion, saggy skin and wanting to lay in the position R1 chooses not be moved or have things in bed unless R1 requests it. In the past R1 had a history of open areas, bruises, moist skin folds and had lost so much weight that bony prominence's was at a great risk, also risk of slow healing because of minimal intake. R1 needs extra protection to prevent skin injury. R1 has a pressure reducing mattress to prevent and reduce risk of skin breakdown. R1 needs PU care and to stay off area, but doesn't like others to position her, as always R1 doesn't want anything changed in her cares. Keep good padding around bony areas as needed, report redness, check skin folds, keep dry and treat as	F 686		

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F 686	Continued From page 12 ordered. Keep wrinkles out of sheets as best as possible. Nurses need to reduce pressure and friction between R1 and the bed or chair, monitor nutrition, check skin weekly, monitor pressure areas especially the left hip due to always lying the same way in bed. During interview on 11/8/22, at 9:25 a.m. the director of nursing (DON) indicated R1 did not have a pressure ulcer when she was transferred to the hospital. The DON indicated she returned with a stage IV sacral ulcer. The DON indicated R1's last skin assessment at facility was normal prior to R1 discharging to the hospital and R1 is very independent and does her own thing. During interview on 11/8/22, at 9:40 a.m. RN-C indicated R1 had a history of PU but on her right hip. RN-C indicated she completes the quarterly assessments and always puts R1 as high risk even though her Braden Scale doesn't show she is high risk. RN-C indicated R1 always lays on her back, and has a history of PU on her right hip over 5 years ago, which is not the same area as this PU. RN-C indicated R1 has always wanted to maintain her independent and wants to be left alone. R1 had toileted, transferred and got around the facility by herself. RN-C added since R1 got COVID-19 in October, she now requires assistance for all her activities of daily living including transfers and toileting. During interview on 11/8/22, at 11:10 a.m. the DON indicated R1 had been at the facility a long time and had been independent with bed mobility, transfers and ambulation until she got COVID-19. The DON indicated there would not be any documentation about her refusing assistance with turning or education on risks and benefits of	F 686		

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F 686	Continued From page 13 refusing to stay off her bottom due to her length of stay at the facility. During interview on 11/08/22, at 11:13 a.m., RN-B indicated prior to, and after R1's hospitalization she had educated R1 about not laying on her bottom, but R1 refuses the use of pillows for positioning, or assistance with position changes, which is "probably how she got the PU to begin with". RN-B indicated R1 was independent with all her activities of daily living, but when she got COVID-19 in October, she needed assistance with transfers, bed mobility and toileting. RN-B did not think any barrier cream was used on R1 and indicated the air mattress was new when she returned following hospitalization. During interview on 11/8/22, at 11:29 a.m., nursing assistant (NA)-J indicated she cared for R1 throughout her isolation period for COVID-19. NA-J indicated R1 was very weak and required assistance with transfers and toileting. NA-J indicated she laid on her back in bed throughout her isolation until she went to the hospital. NA-J indicated she did notice redness on her sacral/coccyx area when assisting her with toileting but doesn't remember if she notified anyone about the redness. During interview on 11/8/22, at 12:25 p.m. RN-C indicated when R1 returned from hospitalization, she went into observe wound care and noted very saggy skin which required pulling up of the skin to visualize the wound. RN-C indicated "obviously we missed this". During interview on 11/8/22, at 12:36 p.m., NA-G indicated she cared for R1 while in isolation for COVID-19 while still at the facility. NA-G	F 686		

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F 686	Continued From page 14 indicated R1 had loose stools, was weak requiring assistance and wasn't eating. NA-G included R1 was normally independent but with COVID-19 required assistance to the bathroom and with all her cares, including eating, but refused to let us help her with eating. R1 wasn ' t patient with staff and would start to stand up before staff was ready for her to do so, therefor, NA-G didn't get a good look at R1's bottom. NA-G added she had never been aware of a repositioning program for R1. During observation and interview on 11/8/22, at 12:35 p.m., R1 returned to her room and with staff assistance laid down in her bed with head of bed at 30 degrees, oxygen on at 2 liters per nasal cannula. R1 indicated she just does not feel good and is so tired. R1 was asked if she would lay on her side and R1 stated "No". R1 was asked if staff ask her to lay on her side and R1 responded "I'm not going to". Continuous observation on 11/8/22 included: 12:35 p.m., laid down in bed on her back with head of the bed at 30 degrees. 12:54 p.m., no change in position. Room was dark and R1 is resting. 1:20 p.m., no change in position. 1:36 p.m., no change in position, no staff have checked on R1. 1:48 p.m., no change in position, room remains dark and R1 appears to be sleeping. 2:02 p.m., no change in position. 2:14 p.m., no change in position. 2:26 p.m., no change in position and no staff into room. 2:43 p.m. - no change in position. 2:56 p.m. - no change in position and no staff into room. R1 continued to rest in bed.	F 686		

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F 686	Continued From page 15 During interview on 11/8/22, at 3:06 p.m., the DON indicated when R1 had COVID-19 she was weak, always laying on the left side of the bed. The DON confirmed R1 had a change in condition when she had COVID-19 and does not believe she was reassessed during that time. The DON indicated a discussion was held on placing an air mattress on her bed but was worried as people have rolled off of them so choose not to implement prior to R1's hospitalization. The DON added that R1 will not turn and reposition even a slight tilt. Throughout the past the facility has tried protein supplements, including Magic Cup, Great Shakes and concentrated protein drinks but R1 refuses them. The DON confirmed the stage IV pressure ulcer was discovered on admission to the hospital per documentation and likely was present while she was at the facility but was not discovered. During interview on 11/8/22, at 12:47 p.m., the certified dietary manager (CDM) indicated R1 is on the registered dietician's risk list and being seen monthly. The CDM indicated monitoring R1's intake which varies from 0% to 100% of her meals. CDM indicated having tried Resources, Magic Cup and Arginade (supplements to support the unique nutritional needs of wound care) but she refuses to drink them. CDM did indicate R1 will eat ice cream with each of her meals but have not tried shakes with supplements because R1 likes things her way and likely will not drink those. Facility policy and procedure for prevention of pressure ulcers was requested and none was received. Facility policy and procedure titled Wound Care, Dressing Guidelines, last revised 12/2017	F 686		

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F 686	Continued From page 16 included care for skin tears, minor cuts or abrasions, surgical wounds, but did not include pressure ulcer wound care. A policy and procedure on "Wound Assessment" dated 4/2016 (Copyright: NPUAP) - Pressure ulcer definition as a pressure ulcer is a localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction. A number of contributing or confounding factors are also associated pressure ulcers. -Stage I: intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have visible blanching; its color may differ from the surrounding area. The area may be painful, firm, soft, warmer or cooler as compared to adjacent tissue. Stage I may be difficult to detect in individuals with dark skin tone. May indicate "at risk" person. - Stage II: Partial thickness loss of dermis (skin) presenting as a shallow open ulcer with a red pink wound bed, without slough. May also present as an intact or open/ruptured serum filled blister. Presents as a shiny or dry shallow ulcer without slough or bruising. Stage III: Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling of the wound. Stage IV: Full thickness loss with exposed bone, tendon or muscle. Slough or eschar may be present on some part of the wound bed and often include undermining and tunneling. The depth of stage IV pressure ulcer varies by anatomical	F 686		

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F 686	Continued From page 17 location. The bridge of the nose, ear, occiput and malleolus do not have subcutaneous tissue and these ulcers can be shallow. Stage IV ulcers can extend into muscle and/or supporting structures making osteomyelitis possible. Exposed bone/tendon is visible or directly palpable.	F 686		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide services to maintain and prevent further loss of range of motion (ROM) for 1 of 1 residents (R26) reviewed for hand contractures and limited ROM. Findings include: R26's face sheet printed on 11/9/22, indicated	F 688	1. Corrective action will be accomplished for those residents found to have been affected by the deficient practice by; Therapy orders have been requested, and received, to address deficient practice for R26 (Per therapy; R26 being seen 3x/week. Working on right left digit ROM and splint wear. “Wanted the splints when	12/29/22

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F 688	Continued From page 18 R26 was admitted on 12/20/21, and had a diagnoses of osteoarthritis. R26's quarterly Minimum Data Set (MDS) assessment dated 8/17/22, indicated R26 was cognitively intact, had adequate vision and hearing, clear speech, could understand others and be understood. R26 required extensive assistance of one staff for all activities of daily living (ADL's), except eating for which he was independent with set-up help. R26's care plan dated 8/31/22, indicated R26 had arthritis that affected his hands, and could do very little with his hands. No interventions were identified for arthritis of hands. Care plan dated 10/4/22, indicated R26 wanted to restore his ability to maintain independence and care for himself as much as possible. R26's physician orders did not include an order for therapy services. During an interview on 11/06/22, at 1:56 p.m., R26's fingers were observed bending away from the thumb on both hands. In addition, R26 had a dupuytren contracture (finger bent toward the palm and unable to straighten) of the middle finger of right hand. R26 was not able to straighten his fingers. R26 stated his fingers where like this when he was admitted to the facility. R26 stated he did not receive exercises to his hands to keep them limber and from tightening further. R26 stated, "I can feed myself now, but if it gets worse, I won't be able to hold my spoon." R26 stated he wanted to maintain as much independence as possible. During an interview on 11/07/22, at 1:37 p.m.,	F 688	surveyor asked him. With therapy has been refusing splints, doesn't want splints anymore, he states, I can do everything I want with my hands already"). Nursing implemented ROM program for R26, to be offered and educated, with resident rights to refuse services. 2. The facility will identify other residents having the potential to be affected by the same deficient practice by; All current residents in the facility have been reviewed for therapy needs, or for being at risk of same deficient practice, during IDT meeting on 11/22/2022. Therapy orders requested for those individual residents deemed having potential to be affected. 3. Measures put into place or systemic changes made to ensure that the deficient practice will not recur are; IDT meeting agenda has been created, with the addition of discussing any new admissions for that week, or any current residents, whom may benefit from therapy services or equipment. Policy titled "Rehabilitative Nursing Care" to be reviewed, revised as needed. 4. The facility will monitor its performance to make sure that solutions are effective by; Audit will be conducted per DON, or designated licensed nursing staff member (to ensure residents receiving ROM	

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F 688	Continued From page 19 nursing assistant (NA)-A verified she performed restorative services to residents. NA-A displayed a list of residents who received restorative services and R26 was not on the list. NA-A stated R26 did not require restorative services. Therapy documents provided by director of rehabilitation (DOR)-C dated 2/3/22, indicated R26 had a HEP (home exercise program) and would require 50% cues to complete the program accurately. The document indicated the goal had not been met due to lack of compliance with OT (occupational therapy) interventions. However, while the document indicated OT to BUE (bilateral upper extremities), it was in relation to R26 lifting small hand weights; there was nothing specific to maintaining and preventing loss of ROM to R26's fingers/hands. During an interview and observation on 11/08/22, at 2:44 p.m. in R26's room with DOR-C, observed R26's hands. R26 demonstrated how he himself decided to roll up a washcloth in his right hand and used that at night for comfort. DOR-C asked R26 if he would be interested in therapy recommendations for his hands to help to maintain and improve strength and flexibility of his fingers, and R26 stated he would, adding he wanted to maintain the ability to feed himself. During an interview on 11/09/22, at 10:38 a.m., (NA)-B stated R26 never had exercises for upper extremities or hands. If he was supposed to have exercises, the therapy department would have given the restorative aides a sheet of paper indicating what exercises should be done. NA-B stated they had never received an exercise sheet for R26.	F 688	treatments/services, CPs' updated as needed, ect.) one time per week times four weeks, then one time per month times two months. Audits will continue if deemed necessary. Audit information will be reviewed at the quarterly Quality Assurance meeting. Staff will take a written test to ensure understanding and compliance of policy and procedure. Results will be reviewed per DON, or designated licensed staff member, with results discussed at the quarterly Quality Assurance meeting. 5. Dates when corrective action(s) will be completed are as follows; R26 received therapy and has nursing ROM plan in place. IDT meeting on 11/22/2022 reviewed all current residents at risk for same deficient practice, therapy orders requested as needed. Policies/procedures to be reviewed and updated as needed by 12/29/2022. Audits/staff test results to be reviewed and discussed at quarterly Quality Assurance meeting, date to be determined.	

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F 688	Continued From page 20 During an interview on 11/09/22, at 10:55 a.m., the director of nursing (DON), stated she was aware of R26's arthritic hands and hand contractures. The DON was not aware if R26 had a therapy consult upon admission, but was aware he had not been receiving restorative services for his hands. The DON acknowledged a ROM program for R26's hands may help reduce his fingers from further contracting. The DON stated they should have done something...we missed that...should have talked about it at his care conference...ROM would definitely be helpful for him. Facility policy titled Rehabilitative Nursing Care, with revised date of 8/21, indicated the facility had a rehabilitative nurse care program directed toward assisting each resident to achieve or maintain an optimal level of self-care and independence. The residents care plan would reflect rehabilitative needs for each resident as needed. Rehab (rehabilitation) aides would assist residents to perform ROM exercises as developed by the physical therapist (PT), occupational therapist (OT) or speech therapist (ST) and to carry out prescribed exercises. Residents were referred to PT/OT/ST on admission if the RN assessment or physician orders so indicated.	F 688		
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 - §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	F 689		12/29/22

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F 689	Continued From page 21 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 ensure staff were educated and following fall risk intervention implemented for 1 of 3 (R34) residents identified at risk for falls to prevent further falls. Findings include: R34's facility Diagnosis Listing, printed 11/7/22, indicated R34 had diagnosis of dementia with behavioral disturbance (brain dysfunction causing abnormal behaviors, memory loss, impaired judgement), overactive bladder, macular degeneration (condition causing vision loss), and osteoporosis (condition causing weak and brittle bones). R34's admission Minimum Data Set (MDS) assessment dated 9/14/22, identified R34 had severely impaired cognition, had behaviors and would occasionally be physical towards others, occasionally rejected cares, occasionally wandered, needed 1 staff member to assist with transfers, toileting, and personal hygiene, needed 2 staff members to assist with walking in room or hallways, and was incontinent of bowel and bladder. , R34's admission fall risk assessment, dated 9/12/22, indicated R34 was at high risk for falls due to impaired cognition, was ambulatory with assistive devices, required staff assistance for elimination needs, had medical conditions, and took medications which may attribute to falling.	F 689	1. Corrective action will be accomplished for those residents found to have been affected by the deficient practice by: Therapy orders have been requested, and received, to address deficient practice for R34. CP has been updated, and staff have been re-educated on R34 plan of care in regards to fall prevention. 2. The facility will identify other residents having the potential to be affected by the same deficient practice by; All current residents in the facility at high risk for falls have been reviewed for fall reducing interventions, and implemented as needed, during IDT meeting on 11/22/2022. 3. Measures put into place or systemic changes made to ensure that the deficient practice will not recur are; Policy titled “Fall and Post Fall Assessment” to be reviewed and revised as needed. Re-enforced whom responsible for updating/completing tasks in regards to fall preventions/updates to CPs, relaying to staff, ect. 4. The facility will monitor its performance to make sure that solutions are effective by;	

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F 689	Continued From page 22 Facility incident and fall investigation report, dated 11/4/22, indicated R34 had an unwitnessed fall on 11/3/22 at 4:35 p.m. Report indicated R34 was found on floor in living room area, was lying on stomach, had bleeding from left side of head, was alert, would not respond to questions asked by staff. Report further indicated R34 was sent to emergency room (ER) for further evaluation of injury sustained from fall. ER report from 11/3/22 fall indicated R34 sustained a hematoma (pooling of blood) to left side of head. Facility incident and fall investigation report, dated 9/25/22, indicated R34 had an unwitnessed fall on 9/25/22 at 8:06 p.m. Report indicated R34 was found without injury on floor in living room area, legs stretched a foot away from wheelchair. IDT meeting notes indicated, fall prevention interventions consisted of settling R34 into bed after supper due to increased agitation after supper and attempting to self-transfer, if unable to put to bed, staff to place R34 in recliner in living room. R34's baseline care plan, printed on 11/7/22, indicated R34 required staff assistance with activities of daily living (ADL), including personal hygiene, dressing, bathing, and toileting; needed staff assistance with transfers and ambulation. R34's baseline care plan further indicated R34 was unaware of safety risks, would sometimes transfer self without help, required frequent checks for safety, needed staff assistance to guide R34 to room, recliner in room, or bathroom, required staff to anticipate needs and assess for unmet needs including behaviors of agitation, anxiety, aggression, delusions, hallucinations,	F 689	Audit will be conducted per DON, or designated licensed nursing staff member (to ensure residents fall preventions are relayed efficiently and effectively/being implemented, CPs updated as needed, ect.) one time per week times four weeks, then one time per month times two months. Audits will continue if deemed necessary. Audit information will be reviewed at the quarterly Quality Assurance meeting. Staff will take a written test to ensure understanding and compliance of policy and procedure. Results will be reviewed per DON, or designated licensed staff member, with results discussed at the quarterly Quality Assurance meeting. 5. Dates when corrective action(s) will be completed are as follows; R34 CP updated, staff re-educated/aware of fall preventions. IDT meeting on 11/22/2022 reviewed all current residents' resident at risk for falls. Policies/procedures to be reviewed and updated as needed by 12/29/2022. Audits/staff test results to be reviewed and discussed at quarterly Quality Assurance meeting, date to be determined.	

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F 689	Continued From page 23 and/or decreased inhibitions. R34's updated care plan, dated 11/7/22, included fall prevention measures of keeping an eye on behaviors, reporting any behaviors that might cause harm, frequent checks, take for walks, report signs of pain to nurse, explaining needs to others, discuss safety at IDT PRN (as needed). During an observation, on 11/06/22 at 2:14 p.m., R34 was observed in recliner chair in room, semi-reclined position, eyes closed, resting comfortably. R34 had call-light within reach, room appeared free of clutter, had fall mat next to bedside, bed in low position. While interviewed on 11/07/22 at 2:10 p.m., nursing assistant (NA)-I indicated awareness of R34's care needs, and indicated could find information for care needs on R34's care plan, also on NA assignment sheet. NA-I stated R34 was known to be impulsive and self-transferred. NA-I indicated R34's fall prevention measures included having a fall mat next to bedside and bed in lowest position. NA-I stated awareness of falls at facility, believed R34 had 1-2 falls, unsure if anything was updated in care plan since falls. NA-I indicated R34 was on a walking program at one time, but R34 often refused to walk. NA assignment sheet reviewed, NA-I indicated cares listed for R34 included if walking, stand-by to 1 staff assist with use of 4-wheeled walker and wheelchair to follow behind, always know where R34 was at due to wandering and gets up on own. During an observation on 11/07/22 at 2:15 p.m., R34 was observed sitting in wheelchair, rocking back and forth calmly, by nurse's station. R34's	F 689		

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F 689	Continued From page 24 left eye was noted to be slightly swollen, had reddish-purple discoloration surrounding entire left eye, had yellow discoloration over left cheekbone, and a hematoma approximately 2.5cm in diameter to left temporal region. While interviewed on 11/07/22 at 2:22 p.m., trained medical assistant (TMA)-B indicated R34 was at high risk for falls, would occasionally self-transfer, could be resistive with cares provided by staff. TMA-B stated awareness of R34's care needs, could be found in the care plan located in the electronic medical record (EMR) system. TMA-B indicated R34's fall prevention measures prior to her falls included toileting schedule every 2 hours, bed in lowest position. TMA-B stated unawareness of fall prevention measures put in place following 9/25/22 fall, thought a fall mat next to bedside was implemented following 11/3/22 fall. During an interview on 11/07/22 at 2:29 p.m., NA-B indicated awareness of R34's care needs; could find care information in R34's care plan, NA daily assignment sheet, and shift report. NA-B stated R34 was at risk for falls due to self-transferring and need for staff assistance. NA-B was aware of R34's recent falls, unaware of fall prevention measures put in place following falls. NA-B indicated prior to R34's falls, staff would toilet R34 every 2 hours, keep R34 involved in activities, closely supervised R34. NA-B stated R34 was on a walking program but became resistive towards staff, was no longer receiving restorative nursing services. While interviewed on 11/07/22 at 2:58 p.m., licensed practical nurse (LPN)-D indicated awareness of resident care needs, would look in	F 689		

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F 689	Continued From page 25 care plan, medical administration record (MAR), treatment administration record (TAR). LPN-D stated R34's cognition was impaired, especially when trying to express needs; was impulsive with self-transfers, could be resistive to staff cares being provided. LPN-D indicated R34 was at risk for falls, aware of 2 falls since admission. LPN-D stated R34's fall prevention measures included wander guard, bed alarm, close supervision, and toileting every 2 hours. LPN-D indicated with recent falls, re-education was provided to staff reminding R34's need for close supervision, hard to supervise R34 closely as impulsive and self-transfers. LPN-D stated process for resident falls included assessing resident immediately post fall, notifying physician and resident family member of fall, completing a fall incident report, putting in a fall intervention immediately post fall to prevent further falls, updating staff of fall incident and fall intervention put in place. During an interview on 11/07/22 at 3:17 p.m., the director of nursing (DON) indicated process for residents that fall, includes nursing immediately assessing resident condition, completing a post fall incident report and implementing a fall prevention measure to prevent further falls, and management review of incident and appropriateness of fall prevention measure at weekly IDT meeting. The DON stated R34 was at risk for falls due to dementia with behavioral disturbance, could be resistive with cares, occasionally impulsive with self-transfers. The DON indicated R34 had fall prevention measures in place and listed in care plan. The DON stated after R34's fall on 9/25/22, fall prevention measure implemented was to settle R34 in bed after supper due to increased agitation after supper and attempting to self-transfer, if unable	F 689		

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F 689	Continued From page 26 to put to bed, staff to place her in recliner in living room. The DON indicated R34's fall intervention following 11/3/22 fall had not been implemented yet, as R34 was sent to the ER and returned same day, and planned to discuss at scheduled IDT meeting tomorrow 11/8/22. The DON stated fall prevention measures implemented should be communicated with staff immediately upon fall, discussed during shift report, reviewed during IDT meeting and prevention measures communicated to MDS coordinators, MDS coordinators update new fall interventions in care plan within 7 days post fall. The DON reviewed R34's care plan, confirmed fall interventions for 9/25/22 were not updated in care plan, DON indicated it was her expectation fall interventions for 9/25/22 to have been in place, as MDS coordinators were responsible for creating resident care plans and ensuring updated when needed. While interviewed on 11/07/22 at 4:07 p.m., registered nurse (RN)-C indicated for residents at risk for falls, fall prevention measures should be care planned. RN-C stated if fall prevention was care planned, all staff would be able to see prevention measures in place in care plan by checking resident's EMR. RN-C reviewed R34's care plan, had safety care planned, included measures of; wander guard, reporting behaviors that could cause R34 harm, frequent checks, take for walks, report signs of pain, explain needs to others, redirect, discuss safety at IDT PRN. RN-C stated all staff should know R34 was at risk for falls, indicated R34 required staff assistance and use of gait belt with transfers and mobility. RN-C confirmed upon review of R34's care plan, fall prevention measures implemented following 9/25/22 fall consisting of, settling R34 in bed after supper due to increased agitation after supper	F 689		

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F 689	Continued From page 27 and attempting to self-transfer, if unable to put to bed, staff to place her in recliner in living room; had not been updated in care plan. RN-C indicated R34 had recliner care planned for in baseline care plan, dated 9/9/22, stated since recliner already in care plan, did not need to update following 9/25/22 fall. RN-C confirmed R34 had a recliner in her room, verified 9/25/22 fall prevention interventions entailed R34 to be placed in recliner in living room. Facility policy titled, Fall and Post-Fall Assessment, revised 7/18 consisted of; Policy: It is the policy of Divine Providence Community Home to assess each resident after a fall to assess condition, investigate cause of fall, develop strategies, and implement to prevent further falls/injury. Procedure included interventions will be added to the care plan and communicated to staff via NAR worksheets (if applicable), through shift report, and on the 24-hour flow sheet; the post fall assessment will be reviewed and evaluated by the interdisciplinary team at the first meeting following the fall. Periodic review will take place to monitor the effectiveness of interventions.	F 689		
F 732 SS=C	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for	F 732		12/15/22

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F 732	Continued From page 28 resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure nurse staff postings were accurate and up-to-date on a daily basis. Findings include: During observation on 11/6/22, at 4:30 p.m., staff posting dated 11/6/22 was located posted on a wall by the director of nursing office. The form	F 732	1. Corrective action will be accomplished for those residents found to have been affected by the deficient practice by; In a timely manner at the beginning of each shift, the Charge Nurse will update the Nursing Staffing Hours form to reflect any staff absences on that shift due to call-outs and illness. Form updated to include total number of staff instead of	

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F 732	Continued From page 29 included date, census, registered nurse (RN) , licensed practice nurse (LPN's), trained medication assistant (TMA) and nursing assistant (NA) for each scheduled shift with total hours all listed at 8 hours. A column was present for changes which was blank. Total hours was present on the bottom of the form but was blank. During interview on 11/6/22, at 5:30 p.m., RN-A indicated he was a RN, not LPN as the posting indicated. RN-A added he was working with a TMA-A and not an LPN-A as posting indicated. During interview on 11/6/22, at 5:40 p.m., TMA-A indicated she is an as needed employee and picked up 3:45 p.m. to 8 p.m. to help the facility out due to a call in. The Nursing staffing hours form (posted information) for 11/6/22 listed RN-A as an LPN working 2:45 p.m. to 11:15 p.m.. LPN-A working 2:45 p.m.. to 11:15 p.m. and NA's listed as NA-C, NA-D, NA-E and NA-F. The daily assignment sheet for 11/6/22 had LPN-A crossed out stated not coming with TMA-A added from 2:45 p.m. to 8:00 p.m., NA-C was crossed out with call in written next to the name and NA-A added until 6:30 p.m.. No total hours was present on the Nursing Staff hours form. Review of the "Daily Assignment" sheet for 11/5/22 for evening shift had RN as a no show with TMA-B written in from 5 p.m. to 9 p.m. and the director of nursing (DON) crossed off with LPN-B written next to the cross off. LPN-C was written in at 10 p.m. for the night shift. NA-C was crossed off with call in written through it with NA-H written in from 2:00 p.m. to 9:00 p.m. The Nursing Staffing hours posted had an RN hours	F 732	total hours per regulation. Charge Nurse will total number of staff on each shift. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice: New Policy, Nurse Staffing Information, written to include all required posting information and requirement to update the form on each shift if any changes occur. 3. What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur: Education provided to Charge Nurses responsible to implement new policy Nurse Staffing Information. 4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur: Audit will be conducted per DON, or designated staff member, one time per week times four weeks, then one time per month times two months. Audits will continue if deemed necessary. Audit information will be reviewed at the quarterly Quality Assurance meeting. 5. Date: New policy written 12/1/22, Form updated 12/1/22, Education completed by 12/15/22	

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F 732	Continued From page 30 listed from 2:45 p.m. to 11:15 p.m. and NA-C listed with 8 hours. The night shift did not include LPN or RN hours with 2 NA's listed at 8 hours each. No total hours was present on the Nursing Staffing hours form. During interview on 11/09/22, at 8:18 a.m., RN-A indicated the night shift fills out the Nursing Staffing hour sheets based on the daily assignment sheets that are completed by the DON and put in the staffing book for the week. Changes are made with call ins or no shows to the daily assignment sheets as they occur by the DON, but no one changes the Nursing Staffing hours sheets. RN-A indicated she has never been told to change it. During interview on 11/09/22, at 8:29 a.m., NA-G indicated they have call ins a lot especially on the evening shifts. NA-G indicated she is aware of the staffing hours being posted but didn't think it ever got changed with call ins. During interview on 11/09/22, 11:16 a.m., the DON indicated she completes the Daily Staffing sheets and night shift posts the Nursing Staffing hours sheet based on the daily staffing sheet. The DON indicated she did not believe the Nursing Staffing hours sheet was changed after posting for the day even if change occurs and wasn't aware they needed to change it. A policy and procedure on nursing staffing posts was requested but none received.	F 732		
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.	F 756		12/29/22

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F 756	Continued From page 31 §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. (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	F 756	1. Corrective action will be accomplished	

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F 756	Continued From page 32 facility failed to ensure consultant pharmacist drug regimen recommendations were evaluated and acted upon by attending physician for 1 of 5 residents (R13) reviewed for unnecessary medications. Findings include: R13's admission face sheet, printed on 11/9/22, identified R13 had a diagnosis of generalized anxiety disorder. R13's current physician orders, printed on 11/9/22, indicated R13 received cymbalta (antidepressant) 60 mg daily for generalized anxiety disorder and phantom limb syndrome with pain, alprazolam (xanax) (benzodiazepine) 0.25mg at bedtime as needed for generalized anxiety disorder. R13's consultant pharmacist recommendations were reviewed from 12/22/21-10/22/22. Concerns reported per consultant pharmacist included: --On 4/25/22, the consulting pharmacist recommended to discontinue prn xanax due to non-use, provider did not address. --On 5/23/22, the consulting pharmacist requested provider address use of prn xanax, indicated need for documentation of why prn use is appropriate for 14 days, explanatory note must be written to continue the prn order, and the duration of the order specified. The consulting pharmacist indicated xanax had been used a few times in May, requested to assess and document continued need for alprazolam, provider did not address. --On 6/13/22, the consulting pharmacist requested provider address use of prn xanax,	F 756	for those residents found to have been affected by the deficient practice by; Pharmacy consults for R13 have been reviewed by PCP, order renewed with medical reason/necessity for prn psychotropic medication. 2. The facility will identify other residents having the potential to be affected by the same deficient practice by; All current residents in the facility reviewed to determine any need for unnecessary medication use/renewal of prn psychotropic medication during IDT meeting on 11/22/2022. 3. Measures put into place or systemic changes made to ensure that the deficient practice will not recur are; Policy titled Pharmaceutical Services; Psychotropic Drugs to be reviewed and revised as needed. Consulting pharmacist added the following to consults/renewals _____ Disagree with recommendation to d/c lorazepam. Medical reason for continuation of medication_____. Continue for _____days. Order for 14-day renewal added to EMAR that automatically populates when prn psychotropic medication entered. Licensed Nursing staff/TMA will receive training on updated policy and procedure. 4. The facility will monitor its performance to make sure that solutions	

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F 756	Continued From page 33 provider did not address. --On 7/19/22, the consulting pharmacist requested provider address use of prn xanax, indicated need for documentation of why prn use was appropriate for 14 days, explanatory note must be written to continue the prn order, and the duration of the order specified. The consulting pharmacist indicated xanax had been used a few times in May, requested to assess and document continued need for alprazolam, provider did not address consultant pharmacist recommendations at time. Provider responded on 7/21/22, indicated Ativan (which was not medication ordered), used prn for anxiety and is helpful to patient per report. --On 8/17/22, the consulting pharmacist requested provider address use of prn xanax, provider did not address. --On 9/13/22, the consulting pharmacist requested provider address use of prn xanax, following 14 days note must be written to continue prn order, provider did not address. --On 10/10/22- the consulting pharmacist requested provider address use of prn xanax, document why prn use appropriate, needs new order, provider did not address. R13's behavior and mood monitoring documentation from 10/26/22 through 11/9/22, indicated R13 displayed no behaviors of asking repetitive questions, persistent anger, or being verbal, or physical towards others. R13's PHQ-9 (mood) assessment, completed on 11/2/22, indicated mild symptoms of depression. When interviewed on 11/09/22 at 1:36 p.m., licensed practical nurse (LPN)-E indicated R13 typically did not exhibit anxiety issues unless	F 756	are effective by; Audit will be conducted per DON, or designated licensed nursing staff member (to ensure resident pharmacy consults are being addressed accurately in a timely manner) one time per week times four weeks, then one time per month times two months. Audits will continue if deemed necessary. Audit information will be reviewed at the quarterly Quality Assurance meeting. Staff will take a written test to ensure understanding and compliance of policy and procedure. Results will be reviewed per DON, or designated licensed staff member, with results discussed at the quarterly Quality Assurance meeting. 5. Dates when corrective action(s) will be completed are as follows; R13 pharmacy consults have been reviewed and prn psychotropic medication has been renewed with medical reason, PCP educated. Policies/procedures to be reviewed and updated as needed by 12/29/2022. Audits/staff test results to be reviewed and discussed at quarterly Quality Assurance meeting, date to be determined.	

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F 756	Continued From page 34 having to leave facility to go to appointments alone. LPN-E stated she typically works day shift, and had not given R13 prn xanax. LPN-E indicated unaware of need for provider to review and renew prn psychotropic medications every 14 days. During an interview on 11/09/22 at 2:06 p.m., the director of nursing (DON) indicated awareness of R13's anxiety disorder and prn xanax order available for use if needed. DON stated R13 used prn xanax very seldom, 1-3 times per month, and only used when breathing became impaired, most of the time R13's anxiety could be reduced by talking and working through it, but facility liked to have xanax on hand if needed. DON indicated awareness of prn psychotropic medications needed new orders every 14 days. DON stated provider was unable to address pharmacist's recommendations during 4/22-6/22 due to email address issues and staff forgot to pull consultant pharmacist medication monitoring reports for provider to review. DON indicated provider addressed pharmacist recommendations for prn xanax on 7/21/22 (however this was not for ordered medication). DON stated when provider rounded for nursing home visit on 8/22/22, did not have time to review and address medication monitoring reports. DON indicated facility would have had provider address consultant pharmacist recommendations at next scheduled visit on 11/14/22. DON confirmed facility staff should have addressed consultant pharmacist recommendations, and stated "we dropped the ball." DON stated staff used to have prn medications needing to be reviewed/renewed identified in a calendar book, and staff was aware when new order for prn psychotropic medications were needed ahead of time. DON	F 756		

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F 756	Continued From page 35 indicated with frequent staffing changes, staff forgot or stopped placing prn psychotropic medication renewals for provider to review in calendar book, and needed to review process for changes. DON confirmed provider had not addressed R13's prn xanax since 7/2/122 (wrong medication addressed). When interviewed by telephone, on 11/09/22 at 3:26 p.m., consultant pharmacist indicated having issues sending pharmacy consult recommendations to DON but only during month of 4/22, DON's email address changed. Consultant pharmacist stated waiting for 3 months for provider to address recommendations was too long to wait. Consultant pharmacist indicated had no concerns for adverse effects for prn psychotropic medication use at this time. Facility policy titled Psychotropic Medication, revised date 3/22, indicated prn orders for psychotropic medications will be limited to 14 days unless the physician identifies the rationale to extend the medication beyond 14 days. Procedure consisted of the resident will be monitored for the behavior, non-pharmacological interventions and outcome, and use of the psychotropic drug to report to physician; if the physician believes the prn order should be extended beyond the 14 days, the physician must document rationale in the medical record; the pharmacist performing the monthly medication review will also review the resident's medical record to appropriately monitor the medication regimen and ensure that the medications each resident receive are clinically indicated.	F 756		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2)	F 812		12/15/22

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F 812	Continued From page 36 §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to date opened containers of food stored and failed to ensure expired food were identified and removed in one of three standup kitchen refrigerators, two of two walk-in coolers, and one of two walk-in freezers. This had the potential to affect all 39 residents who were served food and beverages from the facility kitchen. Findings include: During interview and observation of kitchen on 11/6/22 at 12:59 p.m., with dietary aide (DA)-A, observed food items in the standup refrigerators, walk-in coolers, walk-in freezer, and dry goods room that were not dated or marked and/or were	F 812	1. Corrective action will be accomplished for those residents found to have been affected by the deficient practice by; Dietary Manager checked coolers, freezers and dry storage for unmarked or outdated items and discarded the items on 11/10/22. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice: A dietary department meeting will be held to inform all staff on the findings of the state survey, and educate them on the importance of following the proper food	

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F 812	Continued From page 37 expired. DA-A indicated all kitchen staff were responsible for checking food for opened dates and expiration dates, all refrigerators, freezers, dry good room should be gone through daily to check for expired or damaged food. DA-A indicated if any food or drink was not dated when opened, it should be removed immediately. DA-A indicated all left-over prepared food and beverages when marked were good for 3 days from date opened per facility policy. The following items were observed during tour: Stand-up refrigerator: 1. Glenview Farms sour cream; 5lb container; ¾ full, unmarked/undated; expiration date 10/18/22 2. Glenview Farms liquid whole eggs with citric acid; 2lb container; ½ full; unmarked/undated; expiration date 12/31/22 3. Apricot halves; covered in facility plastic bowl, ½ full, dated 10/27/22; appeared dry and shriveling in center 4. Applesauce; covered in facility container; 2L full; dated 10/29/22 5. Diced pears; covered in facility container; 1.5L full; dated 10/28/22; diced pears appeared dry 6. Diced pears; covered in facility container; 2.5L full; dated 10/20/22; diced pears appeared dry, had root formation, had foul odor Stand-up refrigerator: 1. pickles; approximately ½ full; placed in facility plastic container, dated 4/16/22; no expiration date 2. sauerkraut; approximately ½ full; placed in facility plastic container, dated 4/9/22; no expiration date 3. sour cream; 4 oz. placed in facility plastic	F 812	storage procedures to keep foods safe, wholesome, and appetizing. Staff told that it is everyone's responsibility to rotate stock, label and date foods to identify the date that items have been opened, and expiration dates if not already on the items, to keep residents safe. 3. What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur: Daily, staff will check coolers, freezers and dry storage areas for unmarked or outdated items to be discarded. An audit sheet will be developed to document monitoring of food storage areas. Dietary manager will continue to coach staff, promote teamwork in the department, and review audit sheets for compliance. 4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur: The dietitian, or designated staff member will review audit sheet monthly for 6 months and do a random walk through of the food storage areas to look for outdated or unmarked items. Thereafter, the review will occur quarterly. Staff will be made aware of items discovered and reminded of proper food storage guidelines. Audit information will be	

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F 812	Continued From page 38 container; dated 4/9/22; no expiration date Walk-in cooler: 1. Kozyshack Smart gels fruit cup- single serve (13); unopened; expiration date 10/27/22 2. Shredded cheese in plastic bag; 1/4 full; not unmarked/undated; no expiration date; appeared clumped together, dried out in some areas Walk-in cooler: 1. 10 oz wholesale produce grape tomatoes; in original plastic container- unopened; no expiration date; skin of tomatoes appeared shriveled with small areas of dark discoloration 2. Head of lettuce (5); in original plastic wrapping; unmarked/undated; no expiration date; appeared to have increased moisture, leaves turning brown 4. Baby carrots in original small plastic bag; unopened; expiration date 11/5/22 appeared; to have increased moisture 9. Cross Valley Farms fresh tomatoes (17); appeared soft, mushy, shriveled, dark discoloration in areas Walk-in freezer: 1.Country fried chicken breasts in zip lock bag- (6); opened 6/16/22; no expiration date; appeared freezer burned When interviewed, on 11/6/22 at 1:23 p.m., DA-A indicated when food and beverage items were delivered to facility, staff would rotate food items, placed older food items towards the front, newer food items towards the back, older food items to be used up first. DA-A stated when food items were opened, staff were to mark date when opened so staff could be aware of when to discard items if beyond facility policy expiration date. DA-A indicated staff should be checking	F 812	reviewed at the quarterly Quality Assurance meeting. 5. Date: Staff education will take place by 12/15/22. Daily walk through of storage areas will take place by 12/15/2022.	

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F 812	Continued From page 39 fresh produce daily, if food appeared dry, discolored, had increased moisture, or was foul smelling, food should be discarded immediately. DA-A stated when food items opened, typically had 7 days to use then needed to discard. During an interview, on 11/9/22 at 11:20 a.m., certified dietary manager (CDM)-A indicated had worked at facility for 21 years, was unaware of any unmarked/undated or expired food/beverage found during kitchen tour, would expect all food/beverage items to be labeled/dated when opened, discarded within 7 days after opening or per expiration date if sooner per facility policy. Facility policy titled, Storage of Perishable Food Items, revised date 5/11, included leftover foods are put in the refrigerator in a shallow pan (2"-4" deep) so food may chill quickly to less than 40 degrees F; covered, dated, labeled, not mixed with fresh or raw foods; fruits and vegetable resorted regularly, and damaged or spoiled pieces are discarded; all food items in refrigerator are to be properly dated, labeled, and placed in containers with lids, or are loosely wrapped; all frozen foods dated, labeled, and wrapped in moisture-proof materials to prevent freezer burn. Facility policy titled, Food Storage Areas, revised date 5/11; indicated stock is rotated- first in, first out; items are dated and marked when not sealed in original containers.	F 812		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program	F 880		12/26/22

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F 880	Continued From page 40 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: (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	F 880		

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	245599	A. BUILDING _____ B. WING _____	C 11/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIVINE PROVIDENCE COMMUNITY HOME	700 THIRD AVENUE NORTHWEST SLEEPY EYE, MN 56085

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F 880	Continued From page 41 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: Based on observation, interview and document review, the facility failed to ensure use of personal protective equipment (PPE) was implemented to prevent the spread of Covid-19 per guidance by the Centers for Disease Control (CDC) when during a Covid-19 outbreak, residents and visitors were observed not wearing masks, and staff not wearing masks correctly. Further, the facility failed to ensure PPE and transmission based precautions (TPB) were used in accordance with the CDC guidance for Covid-19 for 1 of 1 resident (R20) reviewed for transmission-based precautions (TBP). Findings include:	F 880	1. Corrective action will be accomplished for those residents found to have been affected by the deficient practice by; R20 no longer in TBP□s. Staff education has been provided on donning/doffing when entering/leaving a room with resident on TBP□s, with audits to follow. 2. The facility will identify other residents having the potential to be affected by the same deficient practice by; All current residents in the facility have been reviewed for need to wear facemask	

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F 880	Continued From page 42 A sign was observed on 11/9/22, at approximately 12 noon, at the entrance to the facility, taped to the Covid-19 check-in station that indicated the facility was in Covid-19 outbreak status. R20's diagnosis listing printed on 11/7/22, indicated a diagnoses of personal history of Covid-19, dated 11/7/22. According to an interview with the director of nursing (DON) on 11/8/22, at 9:30 a.m., R20 tested positive for Covid-19 on 10/28/22. R20's annual Minimum Data Set (MDS) assessment dated 8/17/22, indicated severe cognitive impairment. R20 had adequate hearing, had visual impairment, clear speech, usually was understood and usually could understand. R20 required extensive assistance of one staff for most all activities of daily living (ADLs). R20's care plan dated 6/13/22, indicated R20 would be protected from exposure to Covid-19 and would need staff to follow all policies and procedures set forth by the facility and governing agencies to prevent exposure to Covid-19. The care plan did not indicate measures such as PPE and TBP's for R20's diagnosis of Covid-19 During an observation on 11/06/22, at 12:43 p.m., observed signage on the outside of the door to R20's room indicating he was in enhanced precautions. The sign instructed to keep the door closed if able, to wear a gown, N95 or higher level respirator, eye protection (goggles or face shield) and gloves when entering the room. R20's door was wide open. In addition, there were signs on the door outlining steps for donning and doffing PPE. A three-drawer plastic isolation cart was	F 880	(if in first 10 days of admission, or readmission to facility or resident with close contact) during IDT meeting on 11/22/2022. No longer in outbreak status, no residents on TBP□s, Community Transmission is not high as of 12/5/22. 3. Measures put into place or systemic changes made to ensure that the deficient practice will not recur are; Mask required sign for visitors and information for visitors to screen in at the front entrance posted by employee entrance (back entrance). Added Resident masking requirements based on outbreak status and community transmission level to Employee Masking Requirements already posted by Time clock to make staff aware of not only employee masking requirements but resident masking requirements. Larger quantity of facemasks will be available at front entrance/visitor screening station to ensure adequate supply and availability to visitors. Updated "A Response to COVID-19" policy to include admissions, readmissions, or residents with close contact should wear a mask for 10 days. All staff will be re-educated using "COVID-19 Source Control (Masking), PPE, and Testing Grid" provided by MDH. Re-education provided on proper donning	

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F 880	Continued From page 43 outside the room. During an observation and interview on 11/06/22, at 12:45 p.m., observed nursing assistant (NA)-K prepared to enter R20's room to bring in his lunch. NA-K stated the facility had an outbreak of Covid-19 a few weeks ago and R20 had been in precautions because he had tested positive for Covid-19. Observed NA-K don gown, gloves and face shield before entering R20's room, but not a N95 mask. N95 masks were observed in ample supply in the isolation cart outside R20's room. Upon exiting the room, NA-K stated she did not need to wear a N95 mask if she wore a face shield over her surgical mask. Together looked at the enhanced precaution sign on the door which indicated staff should wear an N95 mask and eye protection (goggles or face shield). NA-K acknowledged the sign and stated she had not been wearing a N95 mask when entering R20's room. In addition, NA-K did not change her surgical mask upon exiting R20's room. During an observation on 11/06/2, at 2:40 p.m., observed and followed four family members (FM)-E enter the facility though the employee entrance in the back of the facility. They did not have masks on. They walked through the entire facility to the front entrance, past staff and residents in the hallways. No staff stopped them to ask them to put on masks or to question where they were going. Once they reached the main entrance, which was a significant distance from resident rooms/nurses station, and therefore no staff close by, they were informed by the surveyor they would need to put masks on. The Covid-19 check-in station with masks at the facility entrance was pointed out to them. FM-E stated they came in the back door, they were from a	F 880	and doffing PPE. Staff will demonstrate competency to Staff Development RN. 4. The facility will monitor its performance to make sure that solutions are effective by; Audit will be conducted per DON, or designated licensed nursing staff member to ensure staff are adhering to CMS recommendations to prevent the spread of Covid 19 one time per week times four weeks, then one time per month times two months. Audits will continue if deemed necessary. Audit information will be reviewed at the quarterly Quality Assurance meeting. 5. Dates when corrective action(s) will be completed are as follows; Staff education on hand washing, donning/doffing PPE, proper way to wear face mask, and when residents and visitors need to wear a mask completed on 12/6/2022 & 12/7/202. Policies/procedures to be reviewed and updated as needed by 12/26/2022. Audit results to be reviewed and discussed at quarterly Quality Assurance meeting, date to be determined.	

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F 880	Continued From page 44 neighboring state and did not know they needed to wear masks. Following this encounter, (NA)-D was informed of the observation and interaction. NA-D stated she did not see FM-E enter the facility and confirmed they needed to wear masks. During an observation on 11/06/22, at 4:00 p.m., multiple residents were in the dining room playing bingo. Ten residents did not have masks on. Residents were sitting two or three to a table with other residents and visitors. During an observation on 11/06/22, at 4:01 p.m. in the common area between resident hallways and by the nurses station, observed unmasked (FM)-F talking to an unidentified NA. During the same observation, new admission from 11/2/22 -- R140, did not have a mask on, nor did R7. All were sitting either in side chairs or wheelchair in less than six feet from each other. (NA)-E was wearing mask below the nose. Did not observe staff remind or encourage residents to wear masks, despite some residents having masks hanging from the handles on the back of their wheelchairs. During an observation on 11/06/22, at 4:04 p.m., unmasked R2 and R9, returned from bingo, self-propelling in wheelchairs. Observations of the main entrance visitor Covid-19 check-in point and mask availability: 11/06/22, at 5:44 p.m. -- box of masks was empty. 11/07/22, at 9:04 a.m. -- masks replenished. 11/07/22, at 3:17 p.m. -- no masks. 11/08/22, at 6:50 a.m. -- no masks.	F 880		

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F 880	Continued From page 45 During an observation on 11/06/22, at 6:39 p.m., unmasked R7, R2, R9, and R26 was observed returning to their rooms from supper via wheelchairs through resident hallways. Did not observe staff remind or encourage residents to put on masks. Care plans did not indicate the resident refused or was not able to tolerate a mask. During an interview on 11/07/22, at 1:37 p.m., when asked if residents were supposed to wear masks since the facility was in outbreak status, (NA)-A stated she didn't know for sure, she would need to ask someone. During an observation 11/07/22, 4:08 p.m., maintenance (M)-A, housekeeping (H)-A, (NA)-L, (NA)-I, all had masks below nose. During an observation on 11/07/22, at 6:13 p.m., (NA)-I did not don PPE to deliver the evening meal to R20 who was in isolation for Covid-19. NA-I stated he did not don PPE if just delivering a meal to residents in isolation. NA-I stated he was aware of the PPE requirements posted on R20's door. During an observation and interview on 11/08/22, at 7:00 a.m., the following residents were observed sitting in the common area by the nurses station in wheelchairs or side chairs, closely together (less than three or four feet) without masks: R34, R140, R7, R28, R4, R33 and R9. During an interview, (NA)-G, stated she didn't know why residents were not wearing masks, adding maybe they didn't want to. Did not observe staff remind or encourage residents to put on masks despite some residents having masks hanging from handles on the back of their	F 880		

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F 880	Continued From page 46 wheelchairs. During an interview on 11/8/22, at 7:41 a.m., licensed practical nurse (LPN)-C stated she thought residents were supposed to be wearing masks since R20 was still in precautions for Covid-19, but did not know why they were not, adding that guess it hasn't been enforced. During an interview on 11/8/22, at 9:30 a.m., the DON was informed that while facility was in outbreak status, only a few residents were observed wearing masks at various times. Also informed new admissions R140 and R191, who according to CDC guidance should be masked for 10 days following admission were not masked. The DON stated staff encouraged residents to wear masks and that most residents wore masks. The DON was informed the majority of residents observed had not been wearing masks, and care plans did not identify if a resident was unable to wear them. The DON stated she had not noticed residents had not been wearing masks. The DON stated she was aware some visitors and family members always had to be instructed to wear masks. The DON was also informed of observations of staff entering R20's room without a N95 mask, without gown, gloves and eye protection, and exiting and re-entering the room without removing gown. The DON stated she was not aware of this and stated no auditing of staff to ensure compliance with appropriate use of PPE had been done recently. The DON stated she was aware of the CDC guidance related to Covid-19, including masking and proper use of PPE, and as infection preventionist acknowledged it was her responsibility to ensure regulations were adhered to in order to prevent further spread of Covid-19.	F 880		

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F 880	Continued From page 47 During an interview on 11/09/22, at 10:25 a.m., the DON stated when community transmission level was high, per regulation, facility had required visitors to wear masks except when in a residents room or if in a designated location. Further, the DON stated new admissions were not required to wear masks outside of their room for 10 days following admission...adding they had not been requiring it and had no policy on that. During an observation on 11/09/22, at 11:05 a.m., many residents in the TV area were being led in singing by activities staff. Nine residents were unmasked and three had masks under chin or nose. New admission from 11/3/22, ---R191, had mask below chin. All were sitting closer than six feet apart. During an observation on 11/09/22, at 1:09 p.m., RN-D was observed showing a new agency staff around the building, walking through resident hallways. The agency staff was unmasked. The DON was informed at 1:14 p.m. During an interview 11/09/22, at 2:23 p.m., RN-D was was asked for documentation NA-I had training on donning and doffing PPE. RN-D stated staff completed online learning modules for infection control upon hire and annually. The content of this training titled Infection Control and Prevention was provided and dated 2016, and included two short paragraphs on TBP, along with definitions of three types of TBP. It did not include specifics on donning and doffing for TBP. Documentation was provided by RN-D indicating NA-I completed this one-hour learning module on 11/5/22. The content of those modules were not provided. Evidence of training to ensure NA-I had	F 880		

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F 880	Continued From page 48 received training on proper donning and doffing of PPE was requested, but not received. During an interview on 11/09/22, at 2:45 p.m., the administrator was informed of infection control observations related to lack of resident masking during the Covid-19 outbreak, lack of residents masking who were new admissions, staff wearing masks inappropriately, and staff not following donning and doffing requirements when entering and exiting a Covid-19 positive resident room. The administrator was not aware of these findings and stated she thought they had been following the recommended regulatory guidance. The administrator acknowledged the importance of following the guidelines to prevent further Covid-19 outbreaks, and stated the findings would be addressed. Facility policy titled Indoor Visitation During Covid-19 Pandemic, with two revision dates of 3/10/22 and 4/22, indicated visitors would adhere to infection prevention and control safety practices in order to enter the setting for indoor visitation. Visitors that chose not to follow the practices may be asked not to visit. Visitors would be screened at the front entrance. Visitors must wear a well-fitting mask. Visitation would take place in designated areas such as resident room, snack shop, or outdoor courtyard. All visitors must maintain 6 feet social distancing. If the county Covid-19 community level of transmission was high, all residents and visitors, regardless of vaccination status would wear face masks and physically distance at all times. Facility policy titled Infection Control Program, with revision date of 3/22, indicated before any employee was asked to perform a new task, and	F 880		

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F 880	Continued From page 49 before being assigned to care for a resident under isolation precautions, the employee would be trained in how to perform the assigned task safely. The DON, or designee, was assigned responsibility as the infection control coordinator. All employees would be trained in infection control practices. Department managers were responsible for monitoring infection control compliance in their departments. All employees were expected to be familiar with policies and procedures, as well as standard practices and best practices for their particular positions. Failure to comply would be addressed by immediate supervisor and employees may be required to undergo retraining. Facility policy Interim Policy: A Response to Covid-19, with revised date of 6/22, had a section titled new admissions, however it did not include information on masking for 10 days following admission, as recommended by the CDC. Facility policy titled Isolation Procedures, with revised dated of 6/21, indicated nursing would be adequately instructed and trained in caring for residents in isolation areas. The policy described steps for donning and doffing PPE, but was not specific for Covid 19; N95 masks were not mentioned. In the event of epidemic or pandemic, guidance from the Minnesota Department of Health and/or CDC would over-ride the policy.	F 880		

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	245599	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**11/08/2022**

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 11/08/2022. At the time of this survey, Divine Providence Community Home was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.	K 000		

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

Electronically Signed | 12/08/2022

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

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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. Divine Providence Community Home is a 1-story building with no basement. The building was constructed in 1993 and was determined to be of Type II(111) construction. The building is fully fire sprinkler protected throughout. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors which is monitored for automatic fire department notification. The facility also has automatic smoke detection in all Resident Rooms.	K 000		

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DIVINE PROVIDENCE COMMUNITY HOME	**700 THIRD AVENUE NORTHWEST** **SLEEPY EYE, MN 56085**

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K 000	Continued From page 2 The facility has a capacity of 50 beds and had a census of 39 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 293 SS=E	Exit Signage CFR(s): NFPA 101 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.) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain exit signs per NFPA 101 (2012 edition), Life Safety Code, section 7.10.1.8. This deficient finding could have a patterned impact on the residents within the facility. Findings include: On 11/08/2022 between 10:00 AM to 12:00 PM, it was observed that the visibility of the exit sign in the Main Hallway was obstructed with craft decorations hanging from the ceiling. An interview with the Facility Administrator verified this finding at the time of discovery.	K 293	A detailed description of the corrective action taken or planned to correct the deficiency: On 11/8/22 decorations that blocked the visibility of the exit sign were removed. Address the measures that will be put in place to ensure the deficiency does not reoccur: Internal Message sent to remind staff to be aware of exit signs when decorating and make sure signs are still visible and not obstructed. Activity staff that do the majority of the decorating signed understanding. Indicate how the facility plans to monitor	12/1/22

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	245599	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**11/08/2022**

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K 293	Continued From page 3	K 293	future performance to ensure solutions are sustained. Daily Preventive Maintenance Schedule Checklist updated to include not only that exit lights are working but are not obstructed. Identify who is responsible for the corrective actions and monitoring of compliance. The Maintenance Director will be responsible for monitoring and ensuring continued compliance. Date of completion: 12/1/22	

Electronically delivered
November 28, 2022

Administrator
Divine Providence Community Home
700 Third Avenue Northwest
Sleepy Eye, MN 56085

Re: State Nursing Home Licensing Orders
Event ID: TPB811

Dear Administrator:

The above facility was surveyed on November 6, 2022 through November 9, 2022 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.

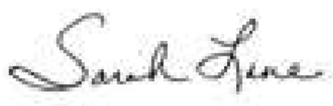
Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting 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:

Elizabeth Silkey, Unit Supervisor
Mankato District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
12 Civic Center Plaza, Suite #2105
Mankato, MN 56001
Email: elizabeth.silkey@state.mn.us
Office: (507) 344-2742 Mobile: (651) 368-359

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

Please feel free to call me with any questions.

Sincerely,



Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00040	A. BUILDING: _____ B. WING _____	C 11/09/2022

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 11/6/22 through 11/9/22, 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		

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2 000	Continued From page 1 these orders and identify the date when they will be completed. In addition, the following complaints were found to be UNSUBSTANTIATED: H5599042C (MN79963), H55995494C (MN87005), and H55995535C (MN87965). Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health.	2 000		

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2 000	Continued From page 2 PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES	2 000		
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 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 ensure staff were educated and following fall risk intervention implemented for 1 of 3 (R34) residents identified at risk for falls to prevent further falls. Findings include: R34's facility Diagnosis Listing, printed 11/7/22, indicated R34 had diagnosis of dementia with behavioral disturbance (brain dysfunction causing abnormal behaviors, memory loss, impaired judgement), overactive bladder, macular	2 830	Corrected	12/8/22

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2 830	Continued From page 3 degeneration (condition causing vision loss), and osteoporosis (condition causing weak and brittle bones). R34's admission Minimum Data Set (MDS) assessment dated 9/14/22, identified R34 had severely impaired cognition, had behaviors and would occasionally be physical towards others, occasionally rejected cares, occasionally wandered, needed 1 staff member to assist with transfers, toileting, and personal hygiene, needed 2 staff members to assist with walking in room or hallways, and was incontinent of bowel and bladder. , R34's admission fall risk assessment, dated 9/12/22, indicated R34 was at high risk for falls due to impaired cognition, was ambulatory with assistive devices, required staff assistance for elimination needs, had medical conditions, and took medications which may attribute to falling. Facility incident and fall investigation report, dated 11/4/22, indicated R34 had an unwitnessed fall on 11/3/22 at 4:35 p.m. Report indicated R34 was found on floor in living room area, was lying on stomach, had bleeding from left side of head, was alert, would not respond to questions asked by staff. Report further indicated R34 was sent to emergency room (ER) for further evaluation of injury sustained from fall. ER report from 11/3/22 fall indicated R34 sustained a hematoma (pooling of blood) to left side of head. Facility incident and fall investigation report, dated 9/25/22, indicated R34 had an unwitnessed fall on 9/25/22 at 8:06 p.m. Report indicated R34 was found without injury on floor in living room area,	2 830		

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2 830	Continued From page 4 legs stretched a foot away from wheelchair. IDT meeting notes indicated, fall prevention interventions consisted of settling R34 into bed after supper due to increased agitation after supper and attempting to self-transfer, if unable to put to bed, staff to place R34 in recliner in living room. R34's baseline care plan, printed on 11/7/22, indicated R34 required staff assistance with activities of daily living (ADL), including personal hygiene, dressing, bathing, and toileting; needed staff assistance with transfers and ambulation. R34's baseline care plan further indicated R34 was unaware of safety risks, would sometimes transfer self without help, required frequent checks for safety, needed staff assistance to guide R34 to room, recliner in room, or bathroom, required staff to anticipate needs and assess for unmet needs including behaviors of agitation, anxiety, aggression, delusions, hallucinations, and/or decreased inhibitions. R34's updated care plan, dated 11/7/22, included fall prevention measures of keeping an eye on behaviors, reporting any behaviors that might cause harm, frequent checks, take for walks, report signs of pain to nurse, explaining needs to others, discuss safety at IDT PRN (as needed). During an observation, on 11/06/22 at 2:14 p.m., R34 was observed in recliner chair in room, semi-reclined position, eyes closed, resting comfortably. R34 had call-light within reach, room appeared free of clutter, had fall mat next to bedside, bed in low position. While interviewed on 11/07/22 at 2:10 p.m., nursing assistant (NA)-I indicated awareness of R34's care needs, and indicated could find	2 830		

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2 830	Continued From page 5 information for care needs on R34's care plan, also on NA assignment sheet. NA-I stated R34 was known to be impulsive and self-transferred. NA-I indicated R34's fall prevention measures included having a fall mat next to bedside and bed in lowest position. NA-I stated awareness of falls at facility, believed R34 had 1-2 falls, unsure if anything was updated in care plan since falls. NA-I indicated R34 was on a walking program at one time, but R34 often refused to walk. NA assignment sheet reviewed, NA-I indicated cares listed for R34 included if walking, stand-by to 1 staff assist with use of 4-wheeled walker and wheelchair to follow behind, always know where R34 was at due to wandering and gets up on own. During an observation on 11/07/22 at 2:15 p.m., R34 was observed sitting in wheelchair, rocking back and forth calmly, by nurse's station. R34's left eye was noted to be slightly swollen, had reddish-purple discoloration surrounding entire left eye, had yellow discoloration over left cheekbone, and a hematoma approximately 2.5cm in diameter to left temporal region. While interviewed on 11/07/22 at 2:22 p.m., trained medical assistant (TMA)-B indicated R34 was at high risk for falls, would occasionally self-transfer, could be resistive with cares provided by staff. TMA-B stated awareness of R34's care needs, could be found in the care plan located in the electronic medical record (EMR) system. TMA-B indicated R34's fall prevention measures prior to her falls included toileting schedule every 2 hours, bed in lowest position. TMA-B stated unawareness of fall prevention measures put in place following 9/25/22 fall, thought a fall mat next to bedside was implemented following 11/3/22 fall.	2 830		

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2 830	Continued From page 6 During an interview on 11/07/22 at 2:29 p.m., NA-B indicated awareness of R34's care needs; could find care information in R34's care plan, NA daily assignment sheet, and shift report. NA-B stated R34 was at risk for falls due to self-transferring and need for staff assistance. NA-B was aware of R34's recent falls, unaware of fall prevention measures put in place following falls. NA-B indicated prior to R34's falls, staff would toilet R34 every 2 hours, keep R34 involved in activities, closely supervised R34. NA-B stated R34 was on a walking program but became resistive towards staff, was no longer receiving restorative nursing services. While interviewed on 11/07/22 at 2:58 p.m., licensed practical nurse (LPN)-D indicated awareness of resident care needs, would look in care plan, medical administration record (MAR), treatment administration record (TAR). LPN-D stated R34's cognition was impaired, especially when trying to express needs; was impulsive with self-transfers, could be resistive to staff cares being provided. LPN-D indicated R34 was at risk for falls, aware of 2 falls since admission. LPN-D stated R34's fall prevention measures included wander guard, bed alarm, close supervision, and toileting every 2 hours. LPN-D indicated with recent falls, re-education was provided to staff reminding R34's need for close supervision, hard to supervise R34 closely as impulsive and self-transfers. LPN-D stated process for resident falls included assessing resident immediately post fall, notifying physician and resident family member of fall, completing a fall incident report, putting in a fall intervention immediately post fall to prevent further falls, updating staff of fall incident and fall intervention put in place.	2 830		

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2 830	Continued From page 7 During an interview on 11/07/22 at 3:17 p.m., the director of nursing (DON) indicated process for residents that fall, includes nursing immediately assessing resident condition, completing a post fall incident report and implementing a fall prevention measure to prevent further falls, and management review of incident and appropriateness of fall prevention measure at weekly IDT meeting. The DON stated R34 was at risk for falls due to dementia with behavioral disturbance, could be resistive with cares, occasionally impulsive with self-transfers. The DON indicated R34 had fall prevention measures in place and listed in care plan. The DON stated after R34's fall on 9/25/22, fall prevention measure implemented was to settle R34 in bed after supper due to increased agitation after supper and attempting to self-transfer, if unable to put to bed, staff to place her in recliner in living room. The DON indicated R34's fall intervention following 11/3/22 fall had not been implemented yet, as R34 was sent to the ER and returned same day, and planned to discuss at scheduled IDT meeting tomorrow 11/8/22. The DON stated fall prevention measures implemented should be communicated with staff immediately upon fall, discussed during shift report, reviewed during IDT meeting and prevention measures communicated to MDS coordinators, MDS coordinators update new fall interventions in care plan within 7 days post fall. The DON reviewed R34's care plan, confirmed fall interventions for 9/25/22 were not updated in care plan, DON indicated it was her expectation fall interventions for 9/25/22 to have been in place, as MDS coordinators were responsible for creating resident care plans and ensuring updated when needed. While interviewed on 11/07/22 at 4:07 p.m., registered nurse (RN)-C indicated for residents at	2 830		

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2 830	Continued From page 8 risk for falls, fall prevention measures should be care planned. RN-C stated if fall prevention was care planned, all staff would be able to see prevention measures in place in care plan by checking resident's EMR. RN-C reviewed R34's care plan, had safety care planned, included measures of; wander guard, reporting behaviors that could cause R34 harm, frequent checks, take for walks, report signs of pain, explain needs to others, redirect, discuss safety at IDT PRN. RN-C stated all staff should know R34 was at risk for falls, indicated R34 required staff assistance and use of gait belt with transfers and mobility. RN-C confirmed upon review of R34's care plan, fall prevention measures implemented following 9/25/22 fall consisting of, settling R34 in bed after supper due to increased agitation after supper and attempting to self-transfer, if unable to put to bed, staff to place her in recliner in living room; had not been updated in care plan. RN-C indicated R34 had recliner care planned for in baseline care plan, dated 9/9/22, stated since recliner already in care plan, did not need to update following 9/25/22 fall. RN-C confirmed R34 had a recliner in her room, verified 9/25/22 fall prevention interventions entailed R34 to be placed in recliner in living room. Facility policy titled, Fall and Post-Fall Assessment, revised 7/18 consisted of; Policy: It is the policy of Divine Providence Community Home to assess each resident after a fall to assess condition, investigate cause of fall, develop strategies, and implement to prevent further falls/injury. Procedure included interventions will be added to the care plan and communicated to staff via NAR worksheets (if applicable), through shift report, and on the 24-hour flow sheet; the post fall assessment will be reviewed and evaluated by	2 830		

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2 830	Continued From page 9 the interdisciplinary team at the first meeting following the fall. Periodic review will take place to monitor the effectiveness of interventions. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could review/revise policies and procedures related to falls, accidents and resident supervision to assure proper assessment and interventions are being implemented. They could re-educate staff on the policies and procedures. A system for evaluating and monitoring consistent implementation of these policies could be developed, with the results of these audits being brought to the facility's Quality Assurance Committee for review. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		
2 895	MN Rule 4658.0525 Subp. 2.B Rehab - Range of Motion Subp. 2. Range of motion. A supportive program that is directed toward prevention of deformities through positioning and range of motion must be implemented and maintained. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: B. a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and to prevent further decrease in range of motion. This MN Requirement is not met as evidenced by:	2 895		12/29/22

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2 895	Continued From page 10 Based on observation, interview and document review, the facility failed to provide services to maintain and prevent further loss of range of motion (ROM) for 1 of 1 residents (R26) reviewed for hand contractures and limited ROM. Findings include: R26's face sheet printed on 11/9/22, indicated R26 was admitted on 12/20/21, and had a diagnoses of osteoarthritis. R26's quarterly Minimum Data Set (MDS) assessment dated 8/17/22, indicated R26 was cognitively intact, had adequate vision and hearing, clear speech, could understand others and be understood. R26 required extensive assistance of one staff for all activities of daily living (ADL's), except eating for which he was independent with set-up help. R26's care plan dated 8/31/22, indicated R26 had arthritis that affected his hands, and could do very little with his hands. No interventions were identified for arthritis of hands. Care plan dated 10/4/22, indicated R26 wanted to restore his ability to maintain independence and care for himself as much as possible. R26's physician orders did not include an order for therapy services. During an interview on 11/06/22, at 1:56 p.m., R26's fingers were observed bending away from the thumb on both hands. In addition, R26 had a dupuytren contracture (finger bent toward the palm and unable to straighten) of the middle finger of right hand. R26 was not able to straighten his fingers. R26 stated his fingers where like this when he was admitted to the	2 895	Corrected	

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2 895	Continued From page 11 facility. R26 stated he did not receive exercises to his hands to keep them limber and from tightening further. R26 stated, "I can feed myself now, but if it gets worse, I won't be able to hold my spoon." R26 stated he wanted to maintain as much independence as possible. During an interview on 11/07/22, at 1:37 p.m., nursing assistant (NA)-A verified she performed restorative services to residents. NA-A displayed a list of residents who received restorative services and R26 was not on the list. NA-A stated R26 did not require restorative services. Therapy documents provided by director of rehabilitation (DOR)-C dated 2/3/22, indicated R26 had a HEP (home exercise program) and would require 50% cues to complete the program accurately. The document indicated the goal had not been met due to lack of compliance with OT (occupational therapy) interventions. However, while the document indicated OT to BUE (bilateral upper extremities), it was in relation to R26 lifting small hand weights; there was nothing specific to maintaining and preventing loss of ROM to R26's fingers/hands. During an interview and observation on 11/08/22, at 2:44 p.m. in R26's room with DOR-C, observed R26's hands. R26 demonstrated how he himself decided to roll up a washcloth in his right hand and used that at night for comfort. DOR-C asked R26 if he would be interested in therapy recommendations for his hands to help to maintain and improve strength and flexibility of his fingers, and R26 stated he would, adding he wanted to maintain the ability to feed himself. During an interview on 11/09/22, at 10:38 a.m., (NA)-B stated R26 never had exercises for upper	2 895		

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2 895	Continued From page 12 extremities or hands. If he was supposed to have exercises, the therapy department would have given the restorative aides a sheet of paper indicating what exercises should be done. NA-B stated they had never received an exercise sheet for R26. During an interview on 11/09/22, at 10:55 a.m., the director of nursing (DON), stated she was aware of R26's arthritic hands and hand contractures. The DON was not aware if R26 had a therapy consult upon admission, but was aware he had not been receiving restorative services for his hands. The DON acknowledged a ROM program for R26's hands may help reduce his fingers from further contracting. The DON stated they should have done something...we missed that...should have talked about it at his care conference...ROM would definitely be helpful for him. Facility policy titled Rehabilitative Nursing Care, with revised date of 8/21, indicated the facility had a rehabilitative nurse care program directed toward assisting each resident to achieve or maintain an optimal level of self-care and independence. The residents care plan would reflect rehabilitative needs for each resident as needed. Rehab (rehabilitation) aides would assist residents to perform ROM exercises as developed by the physical therapist (PT), occupational therapist (OT) or speech therapist (ST) and to carry out prescribed exercises. Residents were referred to PT/OT/ST on admission if the RN assessment or physician orders so indicated. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review all residents at risk for limited range of motion to	2 895		

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2 895	Continued From page 13 assure they are receiving the necessary treatment/services to prevent further limitation in range of motion. The director of nursing or designee, could conduct random audits of the delivery of care to ensure appropriate care and services are implemented. The results of the audits could be brought to the quality assurance committee for review. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 895		
2 900	MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to assess, monitor and implement pressure relieving interventions for 1 of 3 residents (R1) reviewed who was at risk for	2 900	corrected	12/29/22

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2 900	Continued From page 14 pressure ulcer development. The facility's failure resulted in R1 sustaining harm when the resident developed a Stage IV (extend into the muscle, tendon, ligament, cartilage or even bone) pressure ulcer to the sacral/coccyx (triangular bone found between end of lumbar 5 of the spine and coccyx (end of spine area) area. Findings include: R1's face sheet printed 11/7/22, included diagnoses of chronic obstructive pulmonary disease (airflow limitations), anxiety disorder, heart failure, peripheral vascular disease (narrowing, blockage or spasm in any vessels outside of the heart), and personal history of COVID-19. R1's quarterly Minimum Data Set (MDS) assessment dated 8/10/22, identified R1 as having intact cognition, understands and is understood and moderate hearing loss. The MDS further indicated R1 had no rejection of cares, required no staff assistance with mobility needs and used a walker and wheelchair. The MDS included R1 was at risk for pressure ulcers, currently had no skin issues and had a pressure reducing device for bed and chair. R1's discharge MDS assessment dated 10/24/22, identified R1 as requiring limited assist with transfers, was independent with bed mobility and required extensive assistance with dressing, personal hygiene and toileting. R1's Care Area Assessment (CAA) dated 5/30/22, indicated R1 had no pressure ulcers but had a history of healed pressure ulcers and the head of the bed is elevated all or most of the time. The CAA further stated R1's skin in good	2 900		

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2 900	Continued From page 15 condition but remains at risk due to frail and fragile condition, weight declining but able to continue with activities of daily living and walking. R1 rests most of the time in bed, doesn't change position in bed and just keeps the same position on the right edge of bed so she can get up to the bathroom as she desires and chooses. R1's Braden Scale (the gold standard used to identify risk of developing a pressure injury) dated 5/23/22, indicated a score of 19/23 (indicating no risk). However, added text indicated R1 was at risk due to age, due to always laying on the same area on back and side and never alternated her position in bed, weight is low and bony prominence's at risk. R1's care plan dated 3/21/22, for skin care indicated nursing assistants (NA) was to use pressure redistribution devices on the bed, pillows to reduce pressure and friction between R1 and the bed or chair with cushion in wheelchair when used. Keep R1 clean and dry by providing pericare when needed and noting when incontinence pad needs changing. Report redness, check skin folds, keep dry, and treat as ordered. The goal was to keep skin healthy and intact and avoid injury. Record review revealed the following weekly skin assessments: 9/9/22: no open areas on skin. 9/16/22: bruise present on right knee and top of head which is resolving. 9/23/22: no open areas. 9/30/22: no open areas 10/7/22: red area under chin. 10/21/22: no new skin issues 10/13/22: no current skin lesion or problems. Skin is within normal limits	2 900		

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2 900	Continued From page 16 A progress note dated 10/17/22, at 7:41 a.m., indicated R1 tested positive for COVID-19. A progress note on 10/17/22, at 12:08 p.m., indicated R1 refused meal and acetaminophen. Oxygen saturation was 90% on 1 liter of oxygen. A progress note on 10/17/22, at 2:25 p.m. indicated R1 had been unresponsive a couple times during shift, refused meds and meal but refused to go to the hospital. A progress note dated 10/18/22, at 4:34 a.m., included R1 continued to refuse to be treated at the hospital and required assistance to the bathroom. A progress note dated 10/22/22, at 10:34 p.m. indicated R1 was feeling tired with very little energy and slept for most of the shift. A progress note dated 10/24/22, at 1:47 a.m. indicated acetaminophen 325 mg tablet was given for pain on R1's bottom and rated the pain at a 6. At 7:54 a.m., R1 was transferred to acute care hospital by ambulance for evaluation of breathing pattern that is fast, breath sounds abnormal, crackles heard, diminished. Cough was congested. Temperature was 99.6 degrees Fahrenheit. A "History and Physical" dated 10/24/22, from hospital admission indicated a 3 centimeter (cm) sacral ulcer was present with surrounding erythema (superficial reddening of the skin, as a result of injury or irritation) present. Wound not deep enough to see the bone but extends through the subcutaneous fat. Inside the wound, the tissue is gray and black and foul smelling.	2 900		

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2 900	Continued From page 17 Assessment and plan included "sacral decubitus ulcer" (pressure ulcer), stage IV. The nursing home reported they were unaware of this. Will clean the wound with microsyne wound spray (safe hypochlorous acid based antimicrobial treatment for the cleansing, irrigation and moistening of wounds) and bandage as appropriate. Nurses will frequently reposition. A hospital discharge summary dated 10/28/22, included "sacral decubitus ulcer" (pressure ulcer) stage 4: R1 was found to have a large sacral ulcer with surrounding erythema and severe tenderness. Area is very painful. PU has a small opening on the surface but is quite deep. There is a large amount of necrotic (death of cells) tissue within the wound. R1 is not a candidate for surgical debridement. Cleaning of the wound is done daily with microsyne wound spray and covering with Mepilex border dressing (absorbent, dressing that acts as a barrier to liquid and microorganisms). R1 will need ongoing wound care after discharge. It is extremely important to have an appropriate mattress and assist her to off load the sacral area. Physician orders dated 10/28/22, included: Cleanse wound on sacrum/coccyx with microsyne and change Mepilex on sacrum/coccyx daily until healed. Measure PU, explain condition, treatment, stage 4 on sacrum/coccyx 1 time per week starting Friday until healed. During observation and interview on 11/6/22, at 12:58 p.m., nursing assistant (NA)-D assisted R1 to the bathroom. R1 had Mepilex on sacrum/coccyx. NA-D indicated R1 was in the hospital and returned with a pressure ulcer. R1 refused to be interviewed.	2 900		

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2 900	Continued From page 18 During observation on 11/6/22, 5:55 p.m. R1 was brought to the dining room in her wheelchair. R1's bottom was in the center of the chair and R1 was leaning back casing her to appear slouched in the wheelchair with pressure on sacral/coccyx area. R1 was able to sit up to eat and then would lean back again. R1 took her medications, ate 1/2 of her chicken noodle soup and requested to go back to her room. R1 was assisted back to her room, toileted with Mepilex still in place and settled into bed on her back with head of the bed observed to be at 30 degrees. During observation on 11/7/22, at 12:41 p.m., R1 was laying in bed on her back with head of the bed at 30 degrees. Air mattress was present on bed. During observation and interview on 11/7/22, at 1:32 p.m., registered nurse (RN)-B entered R1's room to complete a dressing change. RN-B indicated R1 returned from the hospital with wound at the end of October when she had COVID-19. RN-B indicated R1 had no redness or signs of a pressure ulcer prior to her transfer to the hospital. Trained medication assistant (TMA)-B rolled R1 onto her left side. RN-B removed Mepilex covering wound and per RN-B a moderate amount of serosanguinous drainage was present with a yellow-greenish tint. RN-B indicated the wound had increased redness around the edges and inside the wound, bone was visible with exudate (a mass of cells and fluid that has seeped out of blood vessels or an organ, especially in inflammation) present. RN-B cleansed wound with microsyne and gauze. RN-B measured tunneling of the wound which was 6.5 centimeters (cm). Wound length was 5 cm and 4 cm wide. Depth of wound was 1 cm.	2 900		

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2 900	Continued From page 19 RN-B indicated the wound was larger, had more drainage and redness than previous on 11/4/22. A new Mepilex was placed on the wound. RN-B indicated the air mattress was placed on R1's bed when she returned from the hospital. RN-B said they have educated R1 about getting off her back and bottom but R1 refuses and prefers to lay on her back. A progress note on 10/28/22, at 11:49 a.m. indicated R1 was readmitted to the facility at 11:40 a.m. via ambulance from the acute care hospital. Hospital orders included wound care for stage 4 ulcer/coccyx and to cleanse wound with microsyne and cover with Mepilex daily and as needed. A transfer assessment completed on 10/28/22, at 1:05 p.m. indicated R1 could assist with standing, bear full weight for a least 4 seconds and follows directions. Transfer instructions included standing pivot with assist of 1 and gait belt. Stand in front of resident, pull resident to feet with both hands and gait belt and feet in a staggered stance. Pain present on buttocks. R1 is usually understood by others and usually understands others, but misses some part or intent of message but comprehends most conversation. A progress note dated 10/29/22, at 10:21 a.m. indicated PU stage 4, full thickness of skin and subcutaneous tissue loss, exposing muscle and or bone. Tissue type is slough (dead skin tissue yellow or white in appearance) with wound tissue white. Light drainage, yellow in color noted on Mepilex when removed. Surrounding tissue is cyanotic (bluish discoloration of the skin resulting from poor circulation). Wound length was 4 cm, width, 3 cm and depth 2 cm.	2 900		

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2 900	Continued From page 20 A Braden Scale completed on 10/31/22, indicated score of 17/23, meaning no risk. No mention of current pressure ulcer present. A progress note dated 11/4/22, indicated PU stage 4 with wound tissue yellow, surrounding tissue reddened, and no change with healing progress. Length of wound is 4 cm, width is 6 cm and depth 0.3 cm. A progress note dated 11/5/22, indicated PU stage 4, area was painful with dressing change and cleansing of the area. Brown drainage on changed Mepilex and has a foul odor. R1's care plan revised 11/7/22, indicated R1 had the potential for skin injury, bruise easily and developed a pressure ulcer due to poor tissue perfusion, saggy skin and wanting to lay in the position R1 chooses not be moved or have things in bed unless R1 requests it. In the past R1 had a history of open areas, bruises, moist skin folds and had lost so much weight that bony prominence's was at a great risk, also risk of slow healing because of minimal intake. R1 needs extra protection to prevent skin injury. R1 has a pressure reducing mattress to prevent and reduce risk of skin breakdown. R1 needs PU care and to stay off area, but doesn't like others to position her, as always R1 doesn't want anything changed in her cares. Keep good padding around bony areas as needed, report redness, check skin folds, keep dry and treat as ordered. Keep wrinkles out of sheets as best as possible. Nurses need to reduce pressure and friction between R1 and the bed or chair, monitor nutrition, check skin weekly, monitor pressure areas especially the left hip due to always lying the same way in bed.	2 900		

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2 900	Continued From page 21 During interview on 11/8/22, at 9:25 a.m. the director of nursing (DON) indicated R1 did not have a pressure ulcer when she was transferred to the hospital. The DON indicated she returned with a stage IV sacral ulcer. The DON indicated R1's last skin assessment at facility was normal prior to R1 discharging to the hospital and R1 is very independent and does her own thing. During interview on 11/8/22, at 9:40 a.m. RN-C indicated R1 had a history of PU but on her right hip. RN-C indicated she completes the quarterly assessments and always puts R1 as high risk even though her Braden Scale doesn't show she is high risk. RN-C indicated R1 always lays on her back, and has a history of PU on her right hip over 5 years ago, which is not the same area as this PU. RN-C indicated R1 has always wanted to maintain her independent and wants to be left alone. R1 had toileted, transferred and got around the facility by herself. RN-C added since R1 got COVID-19 in October, she now requires assistance for all her activities of daily living including transfers and toileting. During interview on 11/8/22, at 11:10 a.m. the DON indicated R1 had been at the facility a long time and had been independent with bed mobility, transfers and ambulation until she got COVID-19. The DON indicated there would not be any documentation about her refusing assistance with turning or education on risks and benefits of refusing to stay off her bottom due to her length of stay at the facility. During interview on 11/08/22, at 11:13 a.m., RN-B indicated prior to, and after R1's hospitalization she had educated R1 about not laying on her bottom, but R1 refuses the use of pillows for positioning, or assistance with position changes,	2 900		

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2 900	Continued From page 22 which is "probably how she got the PU to begin with". RN-B indicated R1 was independent with all her activities of daily living, but when she got COVID-19 in October, she needed assistance with transfers, bed mobility and toileting. RN-B did not think any barrier cream was used on R1 and indicated the air mattress was new when she returned following hospitalization. During interview on 11/8/22, at 11:29 a.m., nursing assistant (NA)-J indicated she cared for R1 throughout her isolation period for COVID-19. NA-J indicated R1 was very weak and required assistance with transfers and toileting. NA-J indicated she laid on her back in bed throughout her isolation until she went to the hospital. NA-J indicated she did notice redness on her sacral/coccyx area when assisting her with toileting but doesn't remember if she notified anyone about the redness. During interview on 11/8/22, at 12:25 p.m. RN-C indicated when R1 returned from hospitalization, she went into observe wound care and noted very saggy skin which required pulling up of the skin to visualize the wound. RN-C indicated "obviously we missed this". During interview on 11/8/22, at 12:36 p.m., NA-G indicated she cared for R1 while in isolation for COVID-19 while still at the facility. NA-G indicated R1 had loose stools, was weak requiring assistance and wasn't eating. NA-G included R1 was normally independent but with COVID-19 required assistance to the bathroom and with all her cares, including eating, but refused to let us help her with eating. R1 wasn ' t patient with staff and would start to stand up before staff was ready for her to do so, therefor, NA-G didn't get a good look at R1's bottom.	2 900		

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2 900	Continued From page 23 NA-G added she had never been aware of a repositioning program for R1. During observation and interview on 11/8/22, at 12:35 p.m., R1 returned to her room and with staff assistance laid down in her bed with head of bed at 30 degrees, oxygen on at 2 liters per nasal cannula. R1 indicated she just does not feel good and is so tired. R1 was asked if she would lay on her side and R1 stated "No". R1 was asked if staff ask her to lay on her side and R1 responded "I'm not going to". Continuous observation on 11/8/22 included: 12:35 p.m., laid down in bed on her back with head of the bed at 30 degrees. 12:54 p.m., no change in position. Room was dark and R1 is resting. 1:20 p.m., no change in position. 1:36 p.m., no change in position, no staff have checked on R1. 1:48 p.m., no change in position, room remains dark and R1 appears to be sleeping. 2:02 p.m., no change in position. 2:14 p.m., no change in position. 2:26 p.m., no change in position and no staff into room. 2:43 p.m. - no change in position. 2:56 p.m. - no change in position and no staff into room. R1 continued to rest in bed. During interview on 11/8/22, at 3:06 p.m., the DON indicated when R1 had COVID-19 she was weak, always laying on the left side of the bed. The DON confirmed R1 had a change in condition when she had COVID-19 and does not believe she was reassessed during that time. The DON indicated a discussion was held on placing an air mattress on her bed but was worried as people have rolled off of them so choose not to implement prior to R1's	2 900		

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2 900	Continued From page 24 hospitalization. The DON added that R1 will not turn and reposition even a slight tilt. Throughout the past the facility has tried protein supplements, including Magic Cup, Great Shakes and concentrated protein drinks but R1 refuses them. The DON confirmed the stage IV pressure ulcer was discovered on admission to the hospital per documentation and likely was present while she was at the facility but was not discovered. During interview on 11/8/22, at 12:47 p.m., the certified dietary manager (CDM) indicated R1 is on the registered dietician's risk list and being seen monthly. The CDM indicated monitoring R1's intake which varies from 0% to 100% of her meals. CDM indicated having tried Resources, Magic Cup and Arginade (supplements to support the unique nutritional needs of wound care) but she refuses to drink them. CDM did indicate R1 will eat ice cream with each of her meals but have not tried shakes with supplements because R1 likes things her way and likely will not drink those. Facility policy and procedure for prevention of pressure ulcers was requested and none was received. Facility policy and procedure titled Wound Care, Dressing Guidelines, last revised 12/2017 included care for skin tears, minor cuts or abrasions, surgical wounds, but did not include pressure ulcer wound care. A policy and procedure on "Wound Assessment" dated 4/2016 (Copyright: NPUAP) - Pressure ulcer definition as a pressure ulcer is a localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction. A number of	2 900		

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2 900	Continued From page 25 contributing or confounding factors are also associated pressure ulcers. -Stage I: intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have visible blanching; its color may differ from the surrounding area. The area may be painful, firm, soft, warmer or cooler as compared to adjacent tissue. Stage I may be difficult to detect in individuals with dark skin tone. May indicate "at risk" person. - Stage II: Partial thickness loss of dermis (skin) presenting as a shallow open ulcer with a red pink wound bed, without slough. May also present as an intact or open/ruptured serum filled blister. Presents as a shiny or dry shallow ulcer without slough or bruising. Stage III: Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling of the wound. Stage IV: Full thickness loss with exposed bone, tendon or muscle. Slough or eschar may be present on some part of the wound bed and often include undermining and tunneling. The depth of stage IV pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have subcutaneous tissue and these ulcers can be shallow. Stage IV ulcers can extend into muscle and/or supporting structures making osteomyelitis possible. Exposed bone/tendon is visible or directly palpable. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review all residents at risk for pressure ulcers to assure they are receiving the necessary treatment/services to prevent pressure ulcers	2 900		

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2 900	Continued From page 26 from developing and to promote healing of pressure ulcers. The director of nursing or designee, could conduct random audits of the delivery of care; to ensure appropriate care and services are implemented; to reduce the risk for pressure ulcer development. The results of the audits could be brought to the quality assurance committee for review. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	2 900		
2 915	MN Rule 4658.0525 Subp. 6 A Rehab - ADLs Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that: A. a resident is given the appropriate treatments and services to maintain or improve abilities in activities of daily living unless deterioration is a normal or characteristic part of the resident's condition. For purposes of this part, activities of daily living includes the resident's ability to: (1) bathe, dress, and groom; (2) transfer and ambulate; (3) use the toilet; (4) eat; and (5) use speech, language, or other functional communication systems; and This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure activities of	2 915	corrected	12/8/22

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2 915	Continued From page 27 daily living (ADLs) were provided, including trimming of fingernails for 1 of 2 residents (R27) reviewed, who needed staff assistance to maintain good personal hygiene. Findings include: R27's quarterly Minimum Data Set (MDS) assessment, dated 10/5/22, indicated R27 had intact cognition and required assistance from staff to maintain personal hygiene. R27's care plan dated 10/24/22; indicated R27 required staff assist of 1 with dressing and to maintain personal hygiene. During an observation and interview on 11/06/22 at 3:20 p.m., R27 was sitting in recliner chair in room, fingernails long and jagged. R27 indicated he was becoming more independent with activities of daily living (ADL), and staff have him do more for himself, but still needed some assistance with dressing and hygiene cares. R27 stated trimming fingernails was difficult to complete independently, and had not asked for staff assistance with fingernail trimming, and staff had not offered to trim fingernails. R27 indicated would like staff assistance with nail cares. During observation on 11/07/22 at 1:02 p.m., R27 was sitting in recliner chair in room, long, jagged fingernails remained. During an interview on 11/08/22 at 7:15 a.m., nursing assistant (NA)-I indicated had worked at facility for 2 years. NA-A stated resident nail care was completed on bath day, indicating NAs able to trim resident fingernails unless diabetic or had difficulty trimming, would then have licensed	2 915		

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2 915	Continued From page 28 nurse complete. While interviewed on 11/07/22 at 6:21 p.m., the director of nursing (DON) indicated resident nail care was completed on their bath days. DON stated NAs typically would trim fingernails and toenails needing to be trimmed if not diabetic, if diabetic or had difficulty with trimming nails, licensed nurse would complete. DON indicated R27 was independent with some cares, needed staff assistance with fingernail trimming, could be completed by NA as R27 was not diabetic. DON reviewed bath schedule for R27, and noted R27's fingernails should be checked for trimming on Saturdays. DON reviewed nursing documentation for R27's bath cares completed from 10/8/22-11/5/22, and verified there was no documentation for nail trimming over past month. DON was shown R27's fingernails, and confirmed fingernails were dirty, longer in length, and jagged. DON stated her expectation for staff was to check fingernails/toenails during resident scheduled bath, trim nails as appropriate and per resident request. During an observation and interview on 11/08/22 at 7:24 a.m., R27 appeared clean in appearance. R27's fingernails was observed to be clean and trimmed some. R27's right 4th fingernail observed to have continued jagged edges. R27 stated staff had trimmed fingernails last evening, right 4th fingernail remained slightly jagged due to "crooked" finger. R27 indicated he preferred staff leave right 4th fingernail alone. Facility policy titled Policy A.M. Cares, revised 11/22, indicated cares are given daily to each resident requiring assistance, supervision is provided for residents able to self-care and assistance is given as needed, purpose of cares	2 915		

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2 915	Continued From page 29 to promote cleanliness. Procedure consisted of residents on the bath list should be given a complete tub bath or shower including a shampoo and nail care per resident preference, licensed nurses will trim nails on diabetic residents, if toenails are too thick to be trimmed this will be reported to charge nurse. SUGGESTED METHOD OF CORRECTION: The director of nursing and/or designee could educate responsible staff to provide care to residents' requiring staff assistance, based on residents' comprehensively assessed needs. The DON or designee could conduct audits of resident cares to ensure their personal hygiene needs are met consistently. The results of the audits could be brought to the quality assurance committee for review. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 915		
21095	MN Rule 4658.0650 Subp. 4 Food Supplies; Storage of Nonperishable food Subp. 4. Storage of nonperishable food. Containers of nonperishable food must be stored a minimum of six inches above the floor in a manner that protects the food from splash and other contamination, and that permits easy cleaning of the storage area. Containers may be stored on equipment such as dollies, racks, or pallets, provided the equipment is easily movable and constructed to allow for easy cleaning. Nonperishable food and containers of nonperishable food must not be stored under exposed or unprotected sewer lines or similar sources of potential contamination. The storage of nonperishable food in toilet rooms or	21095		12/15/22

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21095	Continued From page 30 vestibules is prohibited. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to date opened containers of food stored and failed to ensure expired food were identified and removed in one of three standup kitchen refrigerators, two of two walk-in coolers, and one of two walk-in freezers. This had the potential to affect all 39 residents who were served food and beverages from the facility kitchen. Findings include: During interview and observation of kitchen on 11/6/22 at 12:59 p.m., with dietary aide (DA)-A, observed food items in the standup refrigerators, walk-in coolers, walk-in freezer, and dry goods room that were not dated or marked and/or were expired. DA-A indicated all kitchen staff were responsible for checking food for opened dates and expiration dates, all refrigerators, freezers, dry good room should be gone through daily to check for expired or damaged food. DA-A indicated if any food or drink was not dated when opened, it should be removed immediately. DA-A indicated all left-over prepared food and beverages when marked were good for 3 days from date opened per facility policy. The following items were observed during tour: Stand-up refrigerator: 1. Glenview Farms sour cream; 5lb container; ¾ full, unmarked/undated; expiration date 10/18/22 2. Glenview Farms liquid whole eggs with citric acid; 2lb container; ½ full; unmarked/undated;	21095	corrected	

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21095	Continued From page 31 expiration date 12/31/22 3. Apricot halves; covered in facility plastic bowl, ½ full, dated 10/27/22; appeared dry and shriveling in center 4. Applesauce; covered in facility container; 2L full; dated 10/29/22 5. Diced pears; covered in facility container; 1.5L full; dated 10/28/22; diced pears appeared dry 6. Diced pears; covered in facility container; 2.5L full; dated 10/20/22; diced pears appeared dry, had root formation, had foul odor Stand-up refrigerator: 1. pickles; approximately ½ full; placed in facility plastic container, dated 4/16/22; no expiration date 2. sauerkraut; approximately ½ full; placed in facility plastic container, dated 4/9/22; no expiration date 3. sour cream; 4 oz. placed in facility plastic container; dated 4/9/22; no expiration date Walk-in cooler: 1. Kozyshack Smart gels fruit cup- single serve (13); unopened; expiration date 10/27/22 2. Shredded cheese in plastic bag; 1/4 full; not unmarked/undated; no expiration date; appeared clumped together, dried out in some areas Walk-in cooler: 1. 10 oz wholesale produce grape tomatoes; in original plastic container- unopened; no expiration date; skin of tomatoes appeared shriveled with small areas of dark discoloration 2. Head of lettuce (5); in original plastic wrapping; unmarked/undated; no expiration date; appeared to have increased moisture, leaves turning brown 4. Baby carrots in original small plastic bag; unopened; expiration date 11/5/22 appeared; to have increased moisture	21095		

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21095	Continued From page 32 9. Cross Valley Farms fresh tomatoes (17); appeared soft, mushy, shriveled, dark discoloration in areas Walk-in freezer: 1.Country fried chicken breasts in zip lock bag-(6); opened 6/16/22; no expiration date; appeared freezer burned When interviewed, on 11/6/22 at 1:23 p.m., DA-A indicated when food and beverage items were delivered to facility, staff would rotate food items, placed older food items towards the front, newer food items towards the back, older food items to be used up first. DA-A stated when food items were opened, staff were to mark date when opened so staff could be aware of when to discard items if beyond facility policy expiration date. DA-A indicated staff should be checking fresh produce daily, if food appeared dry, discolored, had increased moisture, or was foul smelling, food should be discarded immediately. DA-A stated when food items opened, typically had 7 days to use then needed to discard. During an interview, on 11/9/22 at 11:20 a.m., certified dietary manager (CDM)-A indicated had worked at facility for 21 years, was unaware of any unmarked/undated or expired food/beverage found during kitchen tour, would expect all food/beverage items to be labeled/dated when opened, discarded within 7 days after opening or per expiration date if sooner per facility policy. Facility policy titled, Storage of Perishable Food Items, revised date 5/11, included leftover foods are put in the refrigerator in a shallow pan (2"-4" deep) so food may chill quickly to less than 40 degrees F; covered, dated, labeled, not mixed with fresh or raw foods; fruits and vegetable	21095		

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21095	Continued From page 33 resorted regularly, and damaged or spoiled pieces are discarded; all food items in refrigerator are to be properly dated, labeled, and placed in containers with lids, or are loosely wrapped; all frozen foods dated, labeled, and wrapped in moisture-proof materials to prevent freezer burn. Facility policy titled, Food Storage Areas, revised date 5/11; indicated stock is rotated- first in, first out; items are dated and marked when not sealed in original containers. SUGGESTED METHOD OF CORRECTION: The dietary manager, registered dietician, or administrator, could ensure appropriate security and sanitation of food items and or equipment in the kitchen and dining areas. The facility should also ensure appropriate storage of food occurs. The facility could update or create policies and procedures and educate staff on these changes and perform competencies. The dietary manager, registered dietician, or administrator could perform audits and report audit findings to the Quality Assurance Performance Improvement (QAPI) for further recommendations or to determine compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21095		
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.	21375		12/29/22

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21375	Continued From page 34 This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure use of personal protective equipment (PPE) was implemented to prevent the spread of Covid-19 per guidance by the Centers for Disease Control (CDC) when during a Covid-19 outbreak, residents and visitors were observed not wearing masks, and staff not wearing masks correctly. Further, the facility failed to ensure PPE and transmission based precautions (TPB) were used in accordance with the CDC guidance for Covid-19 for 1 of 1 resident (R20) reviewed for transmission-based precautions (TBP). Findings include: A sign was observed on 11/9/22, at approximately 12 noon, at the entrance to the facility, taped to the Covid-19 check-in station that indicated the facility was in Covid-19 outbreak status. R20's diagnosis listing printed on 11/7/22, indicated a diagnoses of personal history of Covid-19, dated 11/7/22. According to an interview with the director of nursing (DON) on 11/8/22, at 9:30 a.m., R20 tested positive for Covid-19 on 10/28/22. R20's annual Minimum Data Set (MDS) assessment dated 8/17/22, indicated severe cognitive impairment. R20 had adequate hearing, had visual impairment, clear speech, usually was understood and usually could understand. R20 required extensive assistance of one staff for most all activities of daily living (ADLs). R20's care plan dated 6/13/22, indicated R20 would be protected from exposure to Covid-19	21375	corrected	

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21375	Continued From page 35 and would need staff to follow all policies and procedures set forth by the facility and governing agencies to prevent exposure to Covid-19. The care plan did not indicate measures such as PPE and TBP's for R20's diagnosis of Covid-19 During an observation on 11/06/22, at 12:43 p.m., observed signage on the outside of the door to R20's room indicating he was in enhanced precautions. The sign instructed to keep the door closed if able, to wear a gown, N95 or higher level respirator, eye protection (goggles or face shield) and gloves when entering the room. R20's door was wide open. In addition, there were signs on the door outlining steps for donning and doffing PPE. A three-drawer plastic isolation cart was outside the room. During an observation and interview on 11/06/22, at 12:45 p.m., observed nursing assistant (NA)-K prepared to enter R20's room to bring in his lunch. NA-K stated the facility had an outbreak of Covid-19 a few weeks ago and R20 had been in precautions because he had tested positive for Covid-19. Observed NA-K don gown, gloves and face shield before entering R20's room, but not a N95 mask. N95 masks were observed in ample supply in the isolation cart outside R20's room. Upon exiting the room, NA-K stated she did not need to wear a N95 mask if she wore a face shield over her surgical mask. Together looked at the enhanced precaution sign on the door which indicated staff should wear an N95 mask and eye protection (goggles or face shield). NA-K acknowledged the sign and stated she had not been wearing a N95 mask when entering R20's room. In addition, NA-K did not change her surgical mask upon exiting R20's room. During an observation on 11/06/2, at 2:40 p.m.,	21375		

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21375	Continued From page 36 observed and followed four family members (FM)-E enter the facility though the employee entrance in the back of the facility. They did not have masks on. They walked through the entire facility to the front entrance, past staff and residents in the hallways. No staff stopped them to ask them to put on masks or to question where they were going. Once they reached the main entrance, which was a significant distance from resident rooms/nurses station, and therefore no staff close by, they were informed by the surveyor they would need to put masks on. The Covid-19 check-in station with masks at the facility entrance was pointed out to them. FM-E stated they came in the back door, they were from a neighboring state and did not know they needed to wear masks. Following this encounter, (NA)-D was informed of the observation and interaction. NA-D stated she did not see FM-E enter the facility and confirmed they needed to wear masks. During an observation on 11/06/22, at 4:00 p.m., multiple residents were in the dining room playing bingo. Ten residents did not have masks on. Residents were sitting two or three to a table with other residents and visitors. During an observation on 11/06/22, at 4:01 p.m. in the common area between resident hallways and by the nurses station, observed unmasked (FM)-F talking to an unidentified NA. During the same observation, new admission from 11/2/22 -- R140, did not have a mask on, nor did R7. All were sitting either in side chairs or wheelchair in less than six feet from each other. (NA)-E was wearing mask below the nose. Did not observe staff remind or encourage residents to wear masks, despite some residents having masks hanging from the handles on the back of their	21375		

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21375	Continued From page 37 wheelchairs. During an observation on 11/06/22, at 4:04 p.m., unmasked R2 and R9, returned from bingo, self-propelling in wheelchairs. Observations of the main entrance visitor Covid-19 check-in point and mask availability: 11/06/22, at 5:44 p.m. -- box of masks was empty. 11/07/22, at 9:04 a.m. -- masks replenished. 11/07/22, at 3:17 p.m. -- no masks. 11/08/22, at 6:50 a.m. -- no masks. During an observation on 11/06/22, at 6:39 p.m., unmasked R7, R2, R9, and R26 was observed returning to their rooms from supper via wheelchairs through resident hallways. Did not observe staff remind or encourage residents to put on masks. Care plans did not indicate the resident refused or was not able to tolerate a mask. During an interview on 11/07/22, at 1:37 p.m., when asked if residents were supposed to wear masks since the facility was in outbreak status, (NA)-A stated she didn't know for sure, she would need to ask someone. During an observation 11/07/22, 4:08 p.m., maintenance (M)-A, housekeeping (H)-A, (NA)-L, (NA)-I, all had masks below nose. During an observation on 11/07/22, at 6:13 p.m., (NA)-I did not don PPE to deliver the evening meal to R20 who was in isolation for Covid-19. NA-I stated he did not don PPE if just delivering a meal to residents in isolation. NA-I stated he was aware of the PPE requirements posted on R20's door.	21375		

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21375	Continued From page 38 During an observation and interview on 11/08/22, at 7:00 a.m., the following residents were observed sitting in the common area by the nurses station in wheelchairs or side chairs, closely together (less than three or four feet) without masks: R34, R140, R7, R28, R4, R33 and R9. During an interview, (NA)-G, stated she didn't know why residents were not wearing masks, adding maybe they didn't want to. Did not observe staff remind or encourage residents to put on masks despite some residents having masks hanging from handles on the back of their wheelchairs. During an interview on 11/8/22, at 7:41 a.m., licensed practical nurse (LPN)-C stated she thought residents were supposed to be wearing masks since R20 was still in precautions for Covid-19, but did not know why they were not, adding that guess it hasn't been enforced. During an interview on 11/8/22, at 9:30 a.m., the DON was informed that while facility was in outbreak status, only a few residents were observed wearing masks at various times. Also informed new admissions R140 and R191, who according to CDC guidance should be masked for 10 days following admission were not masked. The DON stated staff encouraged residents to wear masks and that most residents wore masks. The DON was informed the majority of residents observed had not been wearing masks, and care plans did not identify if a resident was unable to wear them. The DON stated she had not noticed residents had not been wearing masks. The DON stated she was aware some visitors and family members always had to be instructed to wear masks. The DON was also informed of observations of staff entering R20's room without	21375		

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21375	Continued From page 39 a N95 mask, without gown, gloves and eye protection, and exiting and re-entering the room without removing gown. The DON stated she was not aware of this and stated no auditing of staff to ensure compliance with appropriate use of PPE had been done recently. The DON stated she was aware of the CDC guidance related to Covid-19, including masking and proper use of PPE, and as infection preventionist acknowledged it was her responsibility to ensure regulations were adhered to in order to prevent further spread of Covid-19. During an interview on 11/09/22, at 10:25 a.m., the DON stated when community transmission level was high, per regulation, facility had required visitors to wear masks except when in a residents room or if in a designated location. Further, the DON stated new admissions were not required to wear masks outside of their room for 10 days following admission...adding they had not been requiring it and had no policy on that. During an observation on 11/09/22, at 11:05 a.m., many residents in the TV area were being led in singing by activities staff. Nine residents were unmasked and three had masks under chin or nose. New admission from 11/3/22, ---R191, had mask below chin. All were sitting closer than six feet apart. During an observation on 11/09/22, at 1:09 p.m., RN-D was observed showing a new agency staff around the building, walking through resident hallways. The agency staff was unmasked. The DON was informed at 1:14 p.m. During an interview 11/09/22, at 2:23 p.m., RN-D was was asked for documentation NA-I had training on donning and doffing PPE. RN-D stated	21375		

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21375	Continued From page 40 staff completed online learning modules for infection control upon hire and annually. The content of this training titled Infection Control and Prevention was provided and dated 2016, and included two short paragraphs on TBP, along with definitions of three types of TBP. It did not include specifics on donning and doffing for TBP. Documentation was provided by RN-D indicating NA-I completed this one-hour learning module on 11/5/22. The content of those modules were not provided. Evidence of training to ensure NA-I had received training on proper donning and doffing of PPE was requested, but not received. During an interview on 11/09/22, at 2:45 p.m., the administrator was informed of infection control observations related to lack of resident masking during the Covid-19 outbreak, lack of residents masking who were new admissions, staff wearing masks inappropriately, and staff not following donning and doffing requirements when entering and exiting a Covid-19 positive resident room. The administrator was not aware of these findings and stated she thought they had been following the recommended regulatory guidance. The administrator acknowledged the importance of following the guidelines to prevent further Covid-19 outbreaks, and stated the findings would be addressed. Facility policy titled Indoor Visitation During Covid-19 Pandemic, with two revision dates of 3/10/22 and 4/22, indicated visitors would adhere to infection prevention and control safety practices in order to enter the setting for indoor visitation. Visitors that chose not to follow the practices may be asked not to visit. Visitors would be screened at the front entrance. Visitors must wear a well-fitting mask. Visitation would take place in designated areas such as resident room,	21375		

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21375	Continued From page 41 snack shop, or outdoor courtyard. All visitors must maintain 6 feet social distancing. If the county Covid-19 community level of transmission was high, all residents and visitors, regardless of vaccination status would wear face masks and physically distance at all times. Facility policy titled Infection Control Program, with revision date of 3/22, indicated before any employee was asked to perform a new task, and before being assigned to care for a resident under isolation precautions, the employee would be trained in how to perform the assigned task safely. The DON, or designee, was assigned responsibility as the infection control coordinator. All employees would be trained in infection control practices. Department managers were responsible for monitoring infection control compliance in their departments. All employees were expected to be familiar with policies and procedures, as well as standard practices and best practices for their particular positions. Failure to comply would be addressed by immediate supervisor and employees may be required to undergo retraining. Facility policy Interim Policy: A Response to Covid-19, with revised date of 6/22, had a section titled new admissions, however it did not include information on masking for 10 days following admission, as recommended by the CDC. Facility policy titled Isolation Procedures, with revised dated of 6/21, indicated nursing would be adequately instructed and trained in caring for residents in isolation areas. The policy described steps for donning and doffing PPE, but was not specific for Covid 19; N95 masks were not mentioned. In the event of epidemic or pandemic, guidance from the Minnesota Department of	21375		

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21375	Continued From page 42 Health and/or CDC would over-ride the policy. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could re-educate all staff on CMS (Centers for Medicare & Medicaid Services) Covid-19 recommendations for health care workers during outbreak status, and re-educate staff on proper masking, and donning and doffing PPE when caring for residents in TBP (transmission based precautions). The DON or designee could monitor to ensure staff are adhering to recommendations by CMS, Centers for Disease Control (CDC) and State Agency to prevent the spread of COVID-19. The DON or designee could perform audits to ensure recommendations and policies are being followed. The results of these audits could be reviewed by the quality assurance committee. 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	21530		12/29/22

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21530	Continued From page 43 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 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 consultant pharmacist drug regimen recommendations were evaluated and acted upon by attending physician for 1 of 5 residents (R13) reviewed for unnecessary medications. Findings include: R13's admission face sheet, printed on 11/9/22, identified R13 had a diagnosis of generalized anxiety disorder.	21530	corrected	

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21530	Continued From page 44 R13's current physician orders, printed on 11/9/22, indicated R13 received cymbalta (antidepressant) 60 mg daily for generalized anxiety disorder and phantom limb syndrome with pain, alprazolam (xanax) (benzodiazepine) 0.25mg at bedtime as needed for generalized anxiety disorder. R13's consultant pharmacist recommendations were reviewed from 12/22/21-10/22/22. Concerns reported per consultant pharmacist included: --On 4/25/22, the consulting pharmacist recommended to discontinue prn xanax due to non-use, provider did not address. --On 5/23/22, the consulting pharmacist requested provider address use of prn xanax, indicated need for documentation of why prn use is appropriate for 14 days, explanatory note must be written to continue the prn order, and the duration of the order specified. The consulting pharmacist indicated xanax had been used a few times in May, requested to assess and document continued need for alprazolam, provider did not address. --On 6/13/22, the consulting pharmacist requested provider address use of prn xanax, provider did not address. --On 7/19/22, the consulting pharmacist requested provider address use of prn xanax, indicated need for documentation of why prn use was appropriate for 14 days, explanatory note must be written to continue the prn order, and the duration of the order specified. The consulting pharmacist indicated xanax had been used a few times in May, requested to assess and document continued need for alprazolam, provider did not address consultant pharmacist recommendations at time. Provider responded on 7/21/22,	21530		

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21530	Continued From page 45 indicated Ativan (which was not medication ordered), used prn for anxiety and is helpful to patient per report. --On 8/17/22, the consulting pharmacist requested provider address use of prn xanax, provider did not address. --On 9/13/22, the consulting pharmacist requested provider address use of prn xanax, following 14 days note must be written to continue prn order, provider did not address. --On 10/10/22- the consulting pharmacist requested provider address use of prn xanax, document why prn use appropriate, needs new order, provider did not address. R13's behavior and mood monitoring documentation from 10/26/22 through 11/9/22, indicated R13 displayed no behaviors of asking repetitive questions, persistent anger, or being verbal, or physical towards others. R13's PHQ-9 (mood) assessment, completed on 11/2/22, indicated mild symptoms of depression. When interviewed on 11/09/22 at 1:36 p.m., licensed practical nurse (LPN)-E indicated R13 typically did not exhibit anxiety issues unless having to leave facility to go to appointments alone. LPN-E stated she typically works day shift, and had not given R13 prn xanax. LPN-E indicated unaware of need for provider to review and renew prn psychotropic medications every 14 days. During an interview on 11/09/22 at 2:06 p.m., the director of nursing (DON) indicated awareness of R13's anxiety disorder and prn xanax order available for use if needed. DON stated R13 used prn xanax very seldom, 1-3 times per month, and only used when breathing became	21530		

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21530	Continued From page 46 impaired, most of the time R13's anxiety could be reduced by talking and working through it, but facility liked to have xanax on hand if needed. DON indicated awareness of prn psychotropic medications needed new orders every 14 days. DON stated provider was unable to address pharmacist's recommendations during 4/22-6/22 due to email address issues and staff forgot to pull consultant pharmacist medication monitoring reports for provider to review. DON indicated provider addressed pharmacist recommendations for prn xanax on 7/21/22 (however this was not for ordered medication). DON stated when provider rounded for nursing home visit on 8/22/22, did not have time to review and address medication monitoring reports. DON indicated facility would have had provider address consultant pharmacist recommendations at next scheduled visit on 11/14/22. DON confirmed facility staff should have addressed consultant pharmacist recommendations, and stated "we dropped the ball." DON stated staff used to have prn medications needing to be reviewed/renewed identified in a calendar book, and staff was aware when new order for prn psychotropic medications were needed ahead of time. DON indicated with frequent staffing changes, staff forgot or stopped placing prn psychotropic medication renewals for provider to review in calendar book, and needed to review process for changes. DON confirmed provider had not addressed R13's prn xanax since 7/2/122 (wrong medication addressed). When interviewed by telephone, on 11/09/22 at 3:26 p.m., consultant pharmacist indicated having issues sending pharmacy consult recommendations to DON but only during month of 4/22, DON's email address changed. Consultant pharmacist stated waiting for 3	21530		

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21530	Continued From page 47 months for provider to address recommendations was too long to wait. Consultant pharmacist indicated had no concerns for adverse effects for prn psychotropic medication use at this time. Facility policy titled Psychotropic Medication, revised date 3/22, indicated prn orders for psychotropic medications will be limited to 14 days unless the physician identifies the rationale to extend the medication beyond 14 days. Procedure consisted of the resident will be monitored for the behavior, non-pharmacological interventions and outcome, and use of the psychotropic drug to report to physician; if the physician believes the prn order should be extended beyond the 14 days, the physician must document rationale in the medical record; the pharmacist performing the monthly medication review will also review the resident's medical record to appropriately monitor the medication regimen and ensure that the medications each resident receive are clinically indicated. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee and the consulting pharmacist should develop and/or revise policies to monitor medications to ensure recommendations are acted upon. The director of nursing (DON) or designee and the consulting pharmacist should educate physicians and staff on the importance of ensuring recommendations are acted upon. Audits should be developed to monitor timeliness of action from physician, using appropriate timeframes for a specific and measurable amount of time. The DON and/or designee should take those findings/education to the Quality Assurance Performance Improvement (QAPI) committee to determine compliance or the need for further monitoring.	21530		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIVINE PROVIDENCE COMMUNITY HOME	700 THIRD AVENUE NORTHWEST SLEEPY EYE, MN 56085

(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
21530	Continued From page 48 TIME PERIOD FOR CORRECTION: Twenty-one 21 days.	21530		