DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

PLEASE NOTE THAT THE HEALTH AND LIFE SAFETY CODE SURVEYS HAVE BEEN PROCESSED IN SEPERATE ENFORCEMENT CYCLES. THIS LETTER IS FOR THE LIFE SAFETY CODE SURVEY ENFORCEMENT CYCLE.

Electronically delivered
October 17, 2023

Administrator
Seasons Healthcare
303 Broadway Avenue South
Trimont, MN 56176

RE: CCN: 245315
Cycle Start Date: August 8, 2023

Dear Administrator:

On October 9, 2023, we notified you a remedy was imposed. On October 13, 2023 the Minnesota Department of 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 August 9, 2023.

As authorized by CMS the remedy of:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective November 8, 2023 did not go into effect. (42 CFR 488.417 (b))

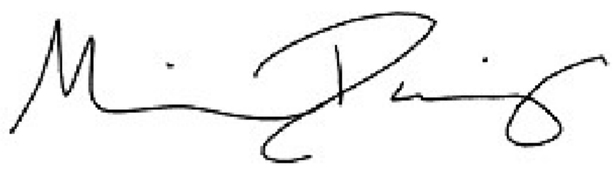
In our letter of August 28, 2023, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from November 8, 2023 due to denial of payment for new admissions. Since your facility attained substantial compliance on August 9, 2023, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

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

Correction of the Life Safety Code deficiency(ies) cited under K918 at the time of the August 8, 2023 survey, has not yet been verified. Your plan of correction for this deficiency / these deficiencies, including your request for a temporary waiver with a date of completion of November 30, 2023, has been forwarded to the Region V Office of the Centers for Medicare and Medicaid Services (CMS) for their review and determination. Failure to come into substantial compliance with this deficiency / these deficiencies by the date indicated in your plan of correction may result in the imposition of enforcement remedies.

Feel free to contact me if you have questions.

Sincerely,



Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

October 9, 2023

Administrator
Seasons Healthcare
303 Broadway Avenue South
Trimont, MN 56176

RE: CCN: 245315
Cycle Start Date: August 8, 2023

Dear Administrator:

On August 28, 2023, we informed you that we may impose enforcement remedies.

On October 5, 2023, the Minnesota Department of Public Safety completed a revisit and it has been determined that your facility is not in substantial compliance. The most serious deficiencies in your facility were found to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567, whereby 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:

- Mandatory Denial of Payment for new Mediare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective November 8, 2023

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective November 8, 2023. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective November 8, 2023.

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 a civil money penalty. You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

- Civil money penalty. (42 CFR 488.430 through 488.444)

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $11,995, has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by November 8, 2023, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Seasons Healthcare will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from November 8, 2023. 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.

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by February 8, 2024 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 488.412 and § 488.456.

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

APPEAL RIGHTS

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

copy of the hearing request shall be submitted electronically to:

Steven.Delich@cms.hhs.gov

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

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

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

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

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245315	A. BUILDING **01** B. WING _____	R **10/13/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEASONS HEALTHCARE	**303 BROADWAY AVENUE SOUTH** **TRIMONT, MN 56176**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{K 000}	INITIAL COMMENTS The Facility's request for a temporary waiver of the Life Safety Code (LSC) deficiency was previously forwarded to the CMS Region V Office for there review determination: K 918- Electrical Systems Approval of the waiver was recommended.	{K 000}		
{K 918} SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and	{K 918}		

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

Electronically Signed | 10/17/2023

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245315	A. BUILDING **01** B. WING _____	R **10/13/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEASONS HEALTHCARE	**303 BROADWAY AVENUE SOUTH** **TRIMONT, MN 56176**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{K 918}	Continued From page 1 readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: The Facility's request for a temporary waiver of the Life Safety Code (LSC) deficiency was previously forwarded to the CMS Region V Office for there review determination: K 918- Electrical Systems Approval of the waiver was recommended.	{K 918}	Waivered tag: no plan of correction required.	

Protecting, Maintaining and Improving the Health of All Minnesotans

PLEASE NOTE THAT THE HEALTH AND LIFE SAFETY CODE SURVEYS ARE BEING PROCESSED IN SEPERATE ENFORCEMENT CYCLES. THIS LETTER IS FOR THE HEALTH SURVEY.

Electronically delivered
August 9, 2023

Administrator
Seasons Healthcare
303 Broadway Avenue South
Trimont, MN 56176

RE: CCN: 245315
Cycle Start Date: July 20, 2023

Dear Administrator:

On July 20, 2023, a survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

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.

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.

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend

to the CMS Region V Office that one or more of the following remedies be imposed:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by an "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, Minnesota 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, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the 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 THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by October 20, 2023 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by January 20, 2024 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

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.

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245315	A. BUILDING _____ B. WING _____	C 07/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEASONS HEALTHCARE	303 BROADWAY AVENUE SOUTH TRIMONT, MN 56176

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments On 8/8/23, following a Life Safety Code survey for compliance with Appendix Z, Emergency Preparedness Requirements for Long Term Care facilities, §483.73(b)(6) was conducted. The facility was NOT in compliance. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulation has been attained.	E 000		
E 041 SS=F	Hospital CAH and LTC Emergency Power CFR(s): 483.73(e) §482.15(e) Condition for Participation: (e) Emergency and standby power systems. The hospital must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section and in the policies and procedures plan set forth in paragraphs (b)(1)(i) and (ii) of this section. §483.73(e), §485.625(e), §485.542(e) (e) Emergency and standby power systems. The [LTC facility CAH and REH] must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section. §482.15(e)(1), §483.73(e)(1), §485.542(e)(1), §485.625(e)(1)	E 041		8/15/23

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

Electronically Signed | 08/17/2023

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245315	A. BUILDING _____ B. WING _____	C 07/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEASONS HEALTHCARE	303 BROADWAY AVENUE SOUTH TRIMONT, MN 56176

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245315	A. BUILDING _____ B. WING _____	C 07/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEASONS HEALTHCARE	303 BROADWAY AVENUE SOUTH TRIMONT, MN 56176

(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 041	Continued From page 2 inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the Federal Register to announce the changes. (1) National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169, www.nfpa.org, 1.617.770.3000. (i) NFPA 99, Health Care Facilities Code, 2012 edition, issued August 11, 2011. (ii) Technical interim amendment (TIA) 12-2 to NFPA 99, issued August 11, 2011. (iii) TIA 12-3 to NFPA 99, issued August 9, 2012. (iv) TIA 12-4 to NFPA 99, issued March 7, 2013. (v) TIA 12-5 to NFPA 99, issued August 1, 2013. (vi) TIA 12-6 to NFPA 99, issued March 3, 2014. (vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011. (viii) TIA 12-1 to NFPA 101, issued August 11, 2011. (ix) TIA 12-2 to NFPA 101, issued October 30, 2012. (x) TIA 12-3 to NFPA 101, issued October 22, 2013. (xi) TIA 12-4 to NFPA 101, issued October 22, 2013. (xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009.. This REQUIREMENT is not met as evidenced by:	E 041		

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	245315	A. BUILDING _____ B. WING _____	C 07/20/2023

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E 041	Continued From page 3 Based on interview and record review, the facility failed to provide emergency generator testing in accordance with the 2012 Edition of Life Safety Code (NFPA 101), section 9.1.3.1, and the 2010 Edition of NFPA 110, Standard for Emergency and Standby Power Systems. Findings include: During a Life Safety Code survey occurring on 08/08/23 between 9:30 a.m. and 12:30 p.m., it was revealed by a review of available documentation, that no documentation was presented to confirm that 36 month - 4-hour load bank testing in occurring. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	E 041	It is the practice of Seasons Healthcare to assure generator testing is completed for proper function. No residents were directly impacted by the deficient practice. The facility recognizes that all residents, staff, and visitors have the potential of being affected by the deficient practice. The Environmental Service Director (ESD) contacted Generator System Services, Inc. (GSS) on 8/8/2023 after the deficient practice was identified by the Fire Marshal during the Life Safety Code Survey. GSS completed the 36 month, 4-hour load bank testing on 8/15/2023. Education was provided to the ESD regarding the testing of the generator regarding the 36 month, 4-hour load bank testing. The ESD added the 36 month load bank test to the PM section of TAB 12 - Emergency Generator Section of the Life Safety Binder. The Administrator will check yearly with the ESD to ensure that scheduling this test in the correct year is completed.	
F 000	INITIAL COMMENTS On 7/17/23-7/20/23, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed with NO	F 000		

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F 000	Continued From page 4 deficiencies cited: H53153576C (MN00093972), H53153577C (MN00091096), H53153578C (MN00089194), H53153579C (MN00088156), and H53153580C (MN00085332). The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F 000		
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft.	F 584		7/21/23

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F 584	Continued From page 5 §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure a clean, home-like environment to provide routine sanitation of resident room lighting fixtures for 4 of 4 residents (R2, R3, R8, R19), reviewed for environmental concerns. Findings include: R3's admission, Minimum Data Set (MDS) assessment dated 6/2823, indicated R3 was cognitively intact, required 2 person physical assist with bed mobility, transfer, dressing, toilet use, and personal hygiene, utilized a wheelchair, diagnoses included neurological conditions, heart failure, hypertension (high blood pressure), and long-term current use of anticoagulants	F 584	Corrective action accomplished for affected resident's (R2, R3,R8, R19) - Environmental Services Director cleaned out the affected residents light ballasts on 07/19/2023. To identify other residents that may have been affected by the deficient practice, the ESD inspected all other resident rooms and facility lights. There was 1 other resident room in which the lights had some dead bugs in the ballasts. This room was cleaned immediately by the ESD on 07/20/2023. Environmental Rounds Observation Form was reviewed and ESD was instructed by the Administrator to complete all tasks on the	

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F 584	Continued From page 6 (blood thinner). During an observation and interview, on 7/17/23 at 1:06 p.m., R3's room ceiling lighting fixture observed to have a large amount of dried dead bugs and debris. R2 indicated unawareness of bugs to ceiling lighting fixture, and confirmed the bugs in his lights, and voiced the lights need to be cleaned. R2's quarterly MDS assessment, dated 6/22/23, indicated R2 had intact cognition and required limited assistance of 1 staff to meet activities of daily living (ADL) needs. R2's MDS preferences for customary routine and activities assessment, dated 3/26/23, indicated, R2's preferences to have personal things taken care of was very important to him. R2's care plan, last reviewed on 6/27/23, indicated R2's needs would be met, dignity always promoted, and wishes would be followed. R8's significant change in status MDS assessment, dated 6/1/23, indicated R8 had severely impaired cognition and required total assistance by 1-2 staff to meet ADL needs. The MDS further indicated R8's preferences for personal things to be taken care of was very important to her. R8's care plan, last reviewed on 6/9/23, indicated R8's needs would be met, dignity always promoted, and wishes would be followed. R19's significant change in status MDS assessment, dated 5/9/23, indicated R19 had intact cognition and required extensive assist of 1 staff to meet ADL needs. The MDS further	F 584	form. Measures put into place to ensure that the deficient practice doesn't recur- The ESD educated his housekeeping staff regarding the deficient practice. This was completed on 07/19/203 and 07/20/2023. The housekeeping checklist was updated to include visually inspecting all light fixtures in each resident room daily. They are to report any issues to the ESD immediately. The issue will be corrected by the ESD or housekeeping staff if ESD is unavailable within 24 hours. The Environmental Policy and Procedure was reviewed. The ESD will conduct weekly audits of the housekeeper's checklist and work performed. Corrective actions put in place to ensure that the deficient practice is being corrected and will not recur - Light fixture and Environmental Rounds Observation Form audits will be performed by the Administrative Assistant or designated person(s) weekly for 1 month. If no issues are found, audits will then go to twice per month. If all audits are satisfactory, then audits will be conducted monthly. These audits will be reviewed at our monthly and quaterly QA meeting for 2 quarters.	

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F 584	Continued From page 7 indicated R19's preferences for personal things to be taken care of was very important to her. R19's care plan, last reviewed on 5/9/23, indicated R19's needs would be met, dignity always promoted, and wishes would be followed. During an observation and interview, on 7/17/23 at 2:22 p.m., R2's room ceiling lighting fixture observed to have a large amount of dried dead bugs and debris. R2 indicated unawareness of bugs to ceiling lighting fixture, stated he liked room to be clean and of sanitary condition. While observed, on 7/17/23 at 5:39 p.m., R8's room ceiling lighting fixture observed to have a moderate amount of dried dead bugs and debris, unable to interview due to non-verbal status. During an observation and interview, on 7/17/23 at 5:40 p.m., R19's room ceiling lighting fixture observed to have a moderate amount of dried dead bugs and debris. R19 indicated unawareness of bugs to ceiling lighting fixture, stated she liked room to be clean and of sanitary condition. While interviewed, on 7/19/23 at 7:34 a.m., nursing assistant (NA)-D indicated unawareness of dead bugs to resident room ceiling lighting fixtures, stated housekeeping or maintenance staff were responsible for ensuring cleanliness and sanitation of all resident room ceiling lighting fixtures. During observation and interview, on 7/19/23 at 7:37 a.m., maintenace (M)-A indicated was responsible for checking and cleaning all resident room ceiling lighting fixtures monthly, was	F 584		

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F 584	Continued From page 8 unaware of any environmental concerns with dried dead bugs and debris to resident room ceiling lighting fixtures. M-A indicated task for cleaning and sanitization of ceiling lighting fixtures to all resident rooms was documented on facility's environmental rounds observation form and had completed task monthly, although had not documented completion of task on facility form, as forgot. M-A was shown R2, R3, R8, and R19's room ceiling lighting fixtures, M-A confirmed ceiling lighting fixtures contained dried dead bugs and debris and should have been cleaned/sanitized per the assigned facility monthly environmental rounds observation form. M-A indicated would clean and sanitize resident room ceiling lighting fixtures today. While interviewed, on 7/19/23 at 10:46 a.m., the administrator indicated unawareness of any environmental concerns with dried dead bugs and debris to resident room ceiling lighting fixtures, would expect staff to report any environmental concerns right away for maintenance to follow-up on. The administrator indicated maintenance should be inspecting, cleaning/sanitizing resident room ceiling lighting fixtures monthly and as needed. The facility Environment policy dated 10/20/22, indicated to promote an environment that residents feel safe and at home in, housekeeping and maintenance will maintain the resident room and facility in a sanitary, orderly, and comfortable manner.	F 584		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans	F 656		8/1/23

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F 656	Continued From page 9 §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this	F 656		

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F 656	Continued From page 10 section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure a comprehensive care plan was developed and maintained for 2 of 2 residents reviewed, (R3) who required assistance with activities of daily living (ADL) and incontinence of bowel and bladder, and (R20) with edema. Findings include: R3's admission Minimum Data Set (MDS) assessment dated 6/2823, indicated R3 was cognitively intact, required 2 person physical assist with bed mobility, transfer, dressing, toilet use, and personal hygiene, utilized a wheelchair, occasionally incontinent of bowel and bladder, diagnoses included neurological conditions, heart failure, hypertension (high blood pressure), and long-term current use of anticoagulants (blood thinner). R3's document titled healthcare 48 hour resident care plan undated, identified alert/cognitively intact, glasses, own teeth-missing a lot, did not walk, assist x2 Hoyer, grooming total assist, physical therapy (PT), occupation therapy (OT), speech therapy (ST), transfers assist x2 mechanical lift, diet order 200 mg sodium restriction, 2000 ml fluid restriction, meal set up independent and assist, set up oral hygiene, continent bladder assist x2, toileting plan urine, bedpan, and was signed by registered nurse	F 656	Corrective action was accomplished for residents (R3, R20) found to have been affected by the deficient practice - MDS Coordinator and Director of Nursing (DON) updated the affected residents care plans to be more person-centered on 07/18/2023 and 07/19/2023. To identify other residents having the potential to be affected by the same deficient practice - The MDS Coordinator reviewed all the care plans for the other residents to ensure that they were comprehensive, and person-centered. Areas of improvement were found, concerning preferences, toileting needs, and Activities of Daily Living (ADL). Measures put into place to ensure that the deficient practice will not recur - On 07/17/2023 the "Person-Centered Comprehensive Care Plans" education was provided to the DON, MDS Coordinator, Resident Life Coordinator, Certified Food Protection Manager, and charge nurses to give guidance to create a care plan that is comprehensive and person-centered. A copy of this information was placed at the nurse's station for guidance. The policy and procedure was reviewed on 07/20/2023. The DON and MDS Coordinator reviewed	

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F 656	Continued From page 11 (RN)-A. R3's Care Area Assessment (CAA) dated 6/28/23, indicated R3 triggered for urinary incontinent due to needing assistance toileting and incontinence, contributing factors include the resident's recent hospitalization/weakness, co-morbidities, and baseline status of needing to use Hoyer lift for transfers, risk factors include skin break downs. The CAA further indicated will proceed to care plan to help prevent any further skin breakdown/moisture associated skin break down; and location of the information POC (point of care), nursing note. R3's CAA for ADL's triggered due to the resident needing assistance with mobility and balance, contributing factors R3 at baseline requires this assistance with mobility and balance, co-morbidities; risk factors include being at risk for skin breakdown and pressure injuries, will proceed to care plan to help prevent complications associated with needing staff assistance with mobility, transferring and balance. R3's care plan reviewed 7/3/23, indicated problem: urinary incontinence R3 experiences bladder incontinence and goal indicated R3 will maintain current level of bladder continence and will not have any further moisture, associated/incontinence associated skin breakdown through the next review, and approach indicated provide incontinence care after each incontinent episode. The care plan indicated R3 required ADL assistance and tasks should be broken down into subtasks, be allowed rest breaks to prevent fatigue, R3 will assist with ADL completion as best he can and staff will provide ADL assistance that R3 is not able to complete on his own, the approach indicated provide adequate rest periods between activities.	F 656	and completed changes on every residents care plan between the dates of 07/18/2023 and 08/01/2023. Those changes included how a resident is tolieted, whether they are continent or not with bladder and bowel, their personal preferences on showering, and other specific ADL cares. Updates to the care plans will be conducted Quarterly, Annually, and with Signficant Changes for residents or as needed. All new admissions will have a Comprehensive Care Plan completed within 7 days. Corrective actions put in place to ensure that the deficient practice is being corrected and will not recur- Audits will be performed monthly by the DON or designated person(s). The Administrator will ensure that audits are reviewed at the monthly and quarterly QA meetings for 2 quarters.	

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F 656	Continued From page 12 The care plan lacked any interventions related to specific toileting needs, specific ADL care, lacked ADL care required for urinary incontinence, bowel incontinence, showering, and required assistance needed. CNA (certified nursing assistant) assignment sheet document dated 7/17/23, indicated R3: 2 assist with use of Hoyer, use a power wheelchair, daily weight. On 7/17/23 at 6:34 p.m.. nursing assistant (NA)-B stated she would toilet resident when he pushed his call light and stated R3 required assistance with toileting, and stated she was not sure how the resident toileted and used the CNA assignment sheet. On 7/17/23 at 7:17 p.m., licensed practical nurse (LPN)-A stated R3 required an assist of two with toileting, preferred to lay down in bed during urination, used the urinal, and used a bariatric sized bed pan with bowel movements. LPN-A confirmed the information was not on the care plan and expected the information to be available in the care plan. On 7/18/23 at 9:02 a.m., NA-B stated she was an agency staff, and used the care plan to know how a resident was toileted and specific information related to the residents need with ADL care. On 7/18/23 at 8:28 a.m., NA-C stated R3 required assistance with morning ADL cares and provided peri care, washed face and hands, and combed hair. NA-C stated R3 was occasionally incontinent of bowel and urine and required assist of two staff to assist with toileting, and resident was provided a urinal per request.	F 656		

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F 656	Continued From page 13 On 7/18/23 at 8:57 a.m., the director of nursing (DON) stated the care plan was expected to indicate the cares the resident required for ADL care and toileting. The DON stated the staff used the care plan for resident interventions. On 7/18/23 at 3:19 p.m., registered nurse (RN)-A stated would expect the care plans to include specific information related to the residents and would expect how the resident toileted, assistive devices used for toileting, and showering included on the care plan. RN-A stated any nurse was responsible for adding information to the care plan. RN-A stated she completed R3's admission MDS assessments and added information to the care plan the CAA triggers. RN-A stated the information from R3's baseline care plan was expected to have been included on the comprehensive care plan. RN-A further stated she was new to the role. R20's face sheet, printed on 7/19/23, indicated diagnoses to include, congestive heart failure (CHF), lymphedema (swelling/fluid retention of lymphatic vessels), xerosis cutis (dry, scaling, cracked skin), morbid obesity, and type 2 diabetes mellitus (Type 2 DM- abnormal blood sugar disorder), R20's admission MDS assessment, dated 5/17/23, indicated R20 had intact cognition, required extensive assist of 2 staff for transfers, extensive assist of 1 staff for hygiene and locomotion on/off unit, and limited assist of 1 staff for dressing. R20's physician order report, printed on 7/19/23, indicated start date orders for PT/OT to evaluate	F 656		

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F 656	Continued From page 14 and treat on 5/10/23, administering furosemide (diuretic medication) 60mg daily for CHF on 5/10/23, monitoring of daily weights on 5/17/23, and applying compression wraps to legs for lymphedema on 5/25/23. R20's admission skin assessment, dated 5/10/23, indicated moderate to severe swelling to BLEs. Provider's visit note, dated 5/16/23, indicated R20 was evaluated for new admission visit/new admission to facility, had diagnosis including lymphedema and plan to initiate lymphedema therapy. During an observation and interview, on 7/17/23 at 1:44 p.m., R20 was observed sitting in recliner chair in room watching TV, bilateral lower extremities (BLEs) had blisters present to skin of upper inner thighs, ace bandages securely wrapped from bilateral knee extending down towards foot. R20's BLEs observed as very edematous (swollen), bilateral foot was covered by gripper socks, resting on floor. R20 indicated was admitted to facility approximately 2 months ago following hospitalization for respiratory infection and swelling to legs, came to facility for strengthening of BLEs and planned to return home after therapy goals met. R20 further indicated for edema to BLEs, staff were wrapping BLEs with ace wraps, administering a diuretic medication, and monitoring her weight daily. R20's care plan reviewed/revised on 5/24/23, failed to identify edema as a focus area. As a result, the care plan lacked interventions/tasks related to providing comprehensive care for management of edema and measures to take to reduce and/or maintain the edema.	F 656		

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F 656	Continued From page 15 During an interview and observation, on 7/19/23 at 8:26 a.m., nursing assistant (NA)-C indicated awareness R20 had edema with blisters to BLEs, stated NAs were not responsible for R20's edema cares, only licensed nursing staff were to apply ace wraps to BLEs and administer fluid pill. NA-C indicated NAs provided lotion to R20's BLEs with routine cares. NA-C stated resident cares to be reviewed and/or provided per NAs could be found in the electronic medical record (EMR) system, MatrixCare, under the specific resident profile tab, approaches tab, care plan tab, and diagnosis tab. NA-C observed to review R20's profile tab, approaches tab, care plan tab, and diagnosis tab, stated edema was present under diagnosis tab for R20, confirmed R20 did not have any cares to be completed per NAs to manage edema. While interviewed, on 7/19/23 at 10:04 a.m., NA-F indicated awareness R20 had edema and blisters to BLEs since time of admission, unaware of any cares assigned to NAs to complete for R20's edema other than weighing R20 daily. NA-F reported awareness licensed nursing staff were applying ace wraps to R20's BLEs daily for edema, indicated when she worked, she would encourage R20 to elevate BLEs when in room sitting in recliner chair. During an interview, on 7/19/23 at 11:11 a.m., registered nurse (RN)-B, indicated was an agency nurse, today was first day working at facility. RN-B stated awareness of edema to R20's BLEs and blistering to bilateral inner thighs. RN-B indicated nursing management for R20's edema included application of ace wraps to BLEs, administration of diuretic medications, and monitoring weight daily. RN-B stated R20's	F 656		

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F 656	Continued From page 16 medical information and cares to be completed were found in MatrixCare under orders, medication administration record (MAR), task administration record (TAR), and in care plan. RN-B indicated unawareness if cares to be completed for edema management were noted in R20's care plan, would need to check further into that. While interviewed, on 7/19/23 at 11:12 a.m., the director of nursing (DON) stated R20 had been admitted to facility on 5/10/23, following hospitalization for respiratory infection, lymphedema, and cellulitis. The DON indicated process for developing resident's care plan started at time of admission, charge nurse reviewed resident discharge paperwork received from previous entity and completed a head-to-toe nursing assessment upon resident arrival to facility. The DON stated charge nurse completed a 48-hour care plan, written in paper form, to include in care plan anything pertaining to physician admission orders received; diagnosis, medications, treatments, functional status, resident preferences, dietary orders, mood/behaviors, therapy services. The DON indicated once charge nurse completed 48-hour care plan, it was reviewed, revised as needed per the DON or MDS coordinator, the DON or MDS coordinator would input resident information into the EMR system to create resident's comprehensive care plan. The DON indicated the process for developing and implementing care plans had been challenging, confirmed resident care plans developed and initiated had many errors. The DON stated a charge nurse who had completed many of the residents' admission assessments and created the 48-hour care plans, had inaccurately assessed residents,	F 656		

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F 656	Continued From page 17 and forgot to put pertinent resident information into the 48-hour care plans, created inaccuracies when completing comprehensive care plans, charge nurse no longer working at facility. Furthermore, the DON reported facility hired a new MDS coordinator a few months ago, MDS coordinator just recently completed MDS classes, MDS coordinator was still learning how to develop more personalized centered care plans for residents, resident care plans in place at time were not comprehensive and personalized as should be care planned for. The DON reviewed R20's care plan, verified based on R20's hospital discharge orders and medical diagnosis, R20's care plan should have included focus area and interventions for edema. The facility Care Planning Process policy dated 5/3/23, indicated: Purpose: to ensure a comprehensive approach to meeting the care needs of the resident. Procedure: 1. The facility will develop a comprehensive care plan for each resident that includes measurable goals and timetables to meet a resident's medical, nursing, mental and psychosocial needs that are identified in the comprehensive assessment and provider notes. 2. Care plans must be person centered and reflect the residents' goals and desired outcomes. A comprehensive plan must be: a. developed within 7 days after the completion of the comprehensive assessment. b. prepared by an interdisciplinary team, that includes the physician, a RN with the responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and to the extent practical the participation of the resident and/or resident's	F 656		

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F 656	Continued From page 18 legal representative and c. periodically reviewed and revised by a team of qualified persons after each assessment. 4. Resident goal set the expectations for the care and services the resident wishes to receive. Resident's preferences need to be addressed. The comprehensive care plan must list measurable objectives and timetables to meet the residents long and short-term goals for medical, nursing, mental, psychosocial needs that are identified in the comprehensive resident assessment, including any trauma. The comprehensive care plan must include the individual abuse prevention plan. 5. A comprehensive plan of care must be available used by all personnel involved in the care of the resident The facility Edema and Weight Monitoring policy reviewed 2/3/20, consisted of, to ensure residents with diagnosis that may cause edema is monitored and treated in a timely manner, responsibility of RN/licensed practical nurses (LPNs), DON, dietary. Purpose to assess residents for fluid retention, evaluate effect of diuretics, evaluate client adherence to prescribed medications, diet, and activity. Procedure included, address any changes needed in the care plan immediately.	F 656		
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	F 688		8/1/23

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F 688	Continued From page 19 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 exercises to maintain strength and mobility for 1 of 3 residents (R14) reviewed for range of motion (ROM). Findings include: R14's quarterly Minimum Data Set (MDS) assessment dated 6/28/23, indicated moderate cognitive impairment, no rejection of care, required one person physical assist with bed mobility, transfer, dressing, eating, personal hygiene; two person physical assist with toilet use; upper and lower extremity impairment on one side, used wheelchair; zero days when restorative programs was performed with passive/active range of motion; diagnoses included hemiplegia and hemiparesis (paralysis and weakness) of total body function on one side of the body, following cerebral infarction (stroke) affecting left dominant side. R14's care plan dated 4/24/23, indicated weakness to left upper extremity, staff will assist R14 to do his dowel exercises (exercises to	F 688	Corrective action was accomplished for resident (R14) found to have been affected by the deficient practice - Director of Nursing (DON) addressed the lack of Range of Motion (ROM)/Restorative Program with the Restorative Nursing Assistant (NA-C) regarding the failure to provide services to the affected resident on 07/20/2023. Restorative Nursing Assistant (NA-C) completed ROM/Restorative services on the affected resident on 07/20/2023. To identify other residents having the potential to be affected by the same deficient practice - DON reviewed the Restorative binder on 07/21/2023 and found that other residents in the program had not received the services from 05/2023 to 07/19/2023. The review did show that on 07/20/2023 all residents in the Restorative program received ROM/Restorative services. Measures put into place to ensure that the	

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F 688	Continued From page 20 improve arm movement and strength) after passive range of motion to left upper extremity 3 to 5 times a week; contractures of the lt (left) hand d/t (due to) CVA recommendation from restorative: please provide a 1 # dowel with 2# leg weight wrapped in middle, will need assistance placing hands on dowel, then will need hand over hand assist completing the exercise on net page 3 times weekly reps 10 times each. Restorative care program document dated 3/22/23, indicated R14 goals were maintain strength of LE (left extremities) and maintain transfers with 2WW (wheeled walker), recommendations included 3-5/week complete supine LE exercises sheet for exercises, 3-5x/week have R14 complete static standing 3-4x with 2WW and stance time varies to his tolerance, left side neglect will need verbal and tactile cues to complete. Restorative nursing progress notes documented indicated weekly written progress notes for R14 on 3/5/23, 3/12/23, 3/26/23, 4/2/23, 6/11/23. There was no weekly progress note documentation indicated for 5/14/23, 5/21/23, 5/28/23, 6/4/23, and the last weekly progress note was 6/11/23. R14's untitled document that staff used to document ROM indicated R14 received ROM exercises on 4/5/23, 4/9/23, and 6/10/23. On 7/17/23 at 4:35 p.m., R14 stated staff did not complete or assist with exercises related to range of motion, on the upper or lower body. On 7/18/23 at 8:31 a.m., nursing assistant (NA)-C stated R14 was expected to have exercises	F 688	deficient practice will not recur - DON updated the ROM policy and procedure to reflect definitions and examples of ROM. The updated policy and procedures were given to the nursing staff on 07/24/2023 and asked to sign off in acknowledgement. Education was also provided at the Mandatory All Staff Skills and Competency meetings held between 07/25/2023 and 07/28/2023. Skills were explained in step-by-step detail using the MN Nurse Aide Candidate Handbook by the DON and Director of Rehab (DOR). All nursing assistants and licensed nurses were asked to demonstrate or verbalize back. The Restorative Aide (NA-C) reviewed with the DOR and DON the competency checklist dated 06/29/2023 showing that the Restorative Aide (NA-C) was trained and competent to complete the program. Corrective actions put in place to ensure that the deficient practice is being corrected and will not recur - Audits will be performed weekly by the DON or designated person(s) for 1 month. If audits show satisfactory results, the audits will go to monthly. These audits will be reviewed at the monthly and quarterly QA meetings for 2 quarters.	

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F 688	Continued From page 21	F 688		

completed 3-5 times per week and was the responsibility of the bath aide. NA-C stated she was the bath aide and was responsible for resident's ROM and restorative cares; and further stated resident's ROM was completed very infrequently due to staffing and stated the residents were expected to have ROM 3-5 times per week. NA-C stated therapy provided the resident's orders, the orders were placed in the binder, and she made a list herself which indicated what residents had exercises and how many days a week the resident needed to complete the exercises. NA-C confirmed R14 only had ROM completed once last month and stated she charted on the ROM in the restorative binder located at the nursing station and was expected to let PT (physical therapy) know if ROM was not being done and had not made PT aware. NA-C stated last week she had communicated to the DON the ROM was not being done and was instructed by the DON to let PT know when ROM was not completed.

On 7/18/23 at 8:37 a.m., Occupational Therapy Assistant (OTA)-C and stated restorative care and range of motion is the responsibility of the nursing staff at the facility.

On 7/18/23 at 11:24 a.m., NA-E stated the bath aid was responsible for resident's ROM responsible for the ROM, and NA's help when able, and further stated the EMR will show if staff needed to complete ROM.

On 7/18/23 at 11:49 a.m., licensed practical nurse (LPN)-A stated an order for ROM came from PT or OT as a hard copy, the nurse entered the order into the computer and a copy of the order was placed in the hall book binder. LPN-A was

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F 688	Continued From page 22 observed to look for R14's ROM order in the binder and stated she could not find the order but would expect the order in the hallway binder. LPN-A further stated the bath aide was expected to complete the resident's ROM. On 7/18/23 4:35 p.m., the director of rehabilitation (DOR) stated she met with NA-C last week and discussed ROM education and ROM not completed was not communicated. The DOR stated residents ROM recommendations were expected followed and completed. On 7/20/23 at 9:00 a.m., the director of nursing (DON) stated ROM was the responsibility of the bath aide. The DON stated she was not aware residents had not received ROM as ordered and confirmed R14's ROM had not been completed as ordered. The facility Range of Motion policy dated 11/10/21, indicated. Policy: exercise is a basic physical need. Residents are unable to do active exercise by themselves need to be exercised by the staff of Seasons Healthcare through range of motion to avoid a decrease in their range of motion in the possible development of contractures. It is the responsibility of each member of the health care team to recognize risks for contracture formation and implement preventive therapy. Purpose: to provide an effective method of identifying and providing a residence identified at risk for decreased range of motion and/or contracture development and to set up a program of rehabilitation goals and interventions to avoid deterioration up their range of motion (ROM)	F 688		

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F 688	Continued From page 23 Procedure: 1. Staff to identify residents at risk for ROM using the Seasons Health Care facility indicators or based on personal knowledge of the individual resident. 2. Once identified staff need to obtain a written order for physical therapy and/or occupational therapy. 3. When orders are returned the therapy staff will do an assessment to identify the ROM exercises the resident needs to do to avoid deterioration in his/her ROM. 4. The assessment will be given to the DON the MDS coordinator. 5. The PT & OT staff will put instructions in writing for the NAR's what exercises need to be done each day with AM and PM cares and the number of repetitions necessary to avoid further deterioration of their residents ROM. this information will always be made available to the NAR's and will be placed in the hall books (labeled north and south) 6. The MDS coordinator and/or director of nursing will review the personal exercise programs on quarterly basis coinciding with quarterly MDS reviews and care plan development process to determine the appropriateness of the plan.	F 688		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is	F 690		7/28/23

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F 690	Continued From page 24 not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure appropriate management and routine care was provided for 1 of 1 resident (R2) who had an indwelling urinary catheter. Findings include: R2's face sheet, received on 7/19/23, included	F 690	Corrective action was accomplished for resident (R2) found to have been affected by the deficient practice - A new strap and anchor for the affected resident was put in place on 07/20/2023. Step by step instructions were placed in the hall assignment books on 07/21/2023 to ensure that all staff were made aware of the procedure on catheter care. The DON	

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F 690	Continued From page 25 diagnoses of congestive heart failure (CHF), obesity, cerebrovascular disease (stroke), Type 2 diabetes mellitus (Type 2 DM, (blood sugar disorder)), obstructive and reflux uropathy (urinary disorder), acute kidney failure, benign prostatic hyperplasia (BPH) with lower urinary tract symptoms (prostate disorder causing urinary abnormal urinary symptoms), retention of urine, weakness, and edema. R2's quarterly Minimum Data Set (MDS) assessment dated 6/22/23, indicated R2 was cognitively intact, had visual impairment and wore glasses, had minimal difficulty hearing, had clear speech, was able to make self-understood and could understand others. R2 was mainly independent with activities of daily living (ADLs), required extensive assist of 1 staff for toileting and limited assist of 1 staff for hygiene cares. Furthermore, the MDS indicated R2 had an indwelling urinary catheter. R2's physician order report, received on 7/19/23, included to change Foley catheter, 16 Fr and 10cc saline in balloon every month for retention of urine, to complete on the 13th day of each month. R2's care plan, received on 7/19/23, indicated R2 had an indwelling catheter and instructed staff to assess the urinary drainage each shift- record amount, type, color, odor, observe for leakage; change collection bag once weekly and as needed (PRN)- during the week rinse collection bag once daily with vinegar, change measuring graduate once weekly and PRN, provide catheter care each shift and PRN, report signs of urinary tract infection (UTI), use large collection bag only due to (D/T) wraps on bilateral lower legs (BLEs)- store collection bag inside protective dignity	F 690	spoke with the nursing assistant (NA-G) regarding the deficient practice via telephone on 07/21/2023 and asked that she attend the meeting on 07/25/2023 for catheter care, which nursing assistant (NA-G) attended. Nursing assistant (NA-G) did not work 07/20/2023 until after the meeting on 07/25/2023. To identify other residents having the potential to be affected by the same deficient practice - At this time no other residents were affected by the deficient practices as no other residents residing in the facility have in-dwelling catheters. Measures put into place to ensure that the deficient practice will not recur - DON conducted a mandatory skills/competency education in-service with the nursing department on 07/25/2023 to 07/28/2023. A copy of the MN Nurse Aide Candidate Handbook on "Catheter Care for a (Fe)Male Resident with Hand Washing" was given to all nursing assistants. This handbook has step by step instructions that the DON went over and had all nursing assistants and licensed nurses demonstrate or verbalize back. A copy of the step by step instructions was added to the orientation checklist for agency staff on 07/21/2023. All staff and agency staff will be asked to demonstrate or verbally communicate that they are competent prior to being on the floor alone. Corrective actions put in place to ensure that the deficient practice is being correct and will not recur - Audits will be	

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F 690	Continued From page 26 pouch, do not allow tubing or any part of drainage system to touch the floor, position catheter bag below level of bladder, maintain hygiene, staff will ensure needs are met and care plans are being followed. Care plan did not identify use of catheter holder. During an observation and interview, on 7/17/23 at 2:26 p.m., R2 was observed sitting in recliner chair in room, urinary bag visualized in protective dignity pouch and secured in place to R2's walker off flooring, walker positioned in front of R2 and recliner chair. A urinary catheter holder to secure urinary tubing was observed on R2's bed. R2 indicated he did not like catheter holder used, stated catheter holder loosened and fell towards foot on multiple occasions throughout the day when worn daily. R2 indicated he had reported to staff that catheter holder does not fit securely to his leg, staff continue to use same type of catheter holder despite R2's concerns. R2 stated had bladder and genital pain from Foley catheter pulling downwards only when urine bag became too full, indicated staff were emptying drainage bag frequently throughout the day to prevent Foley catheter from pulling downwards causing pain. During an observation and interview of clean catheter care procedure, on 7/19/23 at 8:47 a.m., nursing assistant (NA)-G was observed to cleanse hands with hand sanitizer upon entering R2's room, grabbed R2's basin and put water in basin from R2's bathroom sink. NA-G placed wash cloth in R2's water basin, wrung wash cloth out in basin, began to cleanse Foley catheter tubing, (only visualized portions of Foley catheter located on outside of R2's brief), and urinary drainage tubing, performing in downward fashion.	F 690	performed by the DON or designated person(s) weekly with a different nursing assistant for 1 month. If all audits are satisfactory, then audits will be conducted monthly. These audits will be reviewed at the monthly and quarterly QA meetings for 2 quarters. Any audits that are unsatisfactory, those individuals will be provided with additional catheter care education.	

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F 690	Continued From page 27 NA-G then placed wash cloth in basin, grabbed clean towel and dried Foley catheter tubing and urinary bag tubing. NA-G discarded gloves, was about to leave R2's room when asked by surveyor if peri-care had been completed, NA-G stated R2 always refused staff to provide peri-care, R2 stated no staff had ever asked him to provide peri-care, R2 indicated would allow staff to perform peri-care. NA-G observed to sanitize hands and apply clean gloves, asked R2 to stand up and pull pants/brief down to provide peri-care. R2 stood up and removed pants/brief, surveyor visualized loose catheter holder resting upon R2's ankle, NA-G proceeded to perform peri-care,dried areas with clean towel, reapplied R2's catheter holder to upper right thigh ensuring catheter holder fit snug in place. NA-G informed R2 he could pull brief/pants back up. NA-G then discarded supplies, hand sanitized and left R2's room. NA-G was asked if aware of R2's catheter holder loose and concerns of always falling towards foot. NA-G stated she did hear about concerns with R2's catheter holder being loose and falling towards foot from other staff, was not informed of any further interventions to try. NA-G indicated worked for agency, did not work at facility often enough to know all resident care needs, including R2's care needs. During an interview, on 7/19/23 at 10:01 a.m., NA-F indicated awareness of R2's catheter holder being loose and slipping below knee, stated typically occurs when urinary drainage bag was full of urine, staff checked urine in drainage bag frequently throughout shift and emptied when full. NA-F stated she had reported concerns of R2's catheter holder not fitting appropriately to licensed nursing staff in past, indicated R2 would report pain to catheter insertion site when leg strap	F 690		

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F 690	Continued From page 28	F 690		

loosened and slid down, staff had encouraged R2 to use a new catheter holder, but R2 refused.

During interview on 7/19/23 at 10:49 a.m., the director of nursing (DON) indicated was aware of R2's catheter holder not fitting properly, was loose and slid down leg, stated was informed of issue a few months ago per staff. DON indicated had advised nursing staff of R2's available catheter supplies and to try a new catheter holder. DON stated was unaware concern still persisted, would have expected staff to notify her if catheter holder was still not fitting appropriately in order for DON to order a new type of device.

The facility Catheter Care: Draining a catheter policy reviewed 10/22/22, indicated purpose to maintain aseptic technique while managing and/or draining catheter leg/drainage bags.

The facility Foley Catheter Care and UTI Monitoring policy revised 10/22/22, indicated purpose to assure that residents, who have a long-term Foley catheter in place receive appropriate treatment. Policy further indicated Foley catheter care must be done AM and PM and PRN- again risk UTI and good hygiene practice.

The facility Pool Agency Orientation policy revised 5/6/21, indicated Seasons Healthcare strives to provide its own staff as available to care for its residents, however, there are occasions when agency personnel are needed to provide adequate safe staffing. Purpose to provide proper orientation for all employees working in the facility, applies to employees of the facility and temporary agency staff that work at the facility through an outside agency, orientation will

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F 690	Continued From page 29 allow the employee to function in a safe and respectful manner while providing care for residents, orientation checklist will be renewed if the pool agency staff member has not worked in the facility in the past 6 months since initial orientation to the facility. Procedure: Temporary agency staff will be oriented to the following areas by the supervising nurse or designee before allowing working on the floor and included, facility policy manuals, ADL data collection/charting, care plans, infection control, reporting information to nurses/supervisors, and who to report to. Upon completion of the orientation, temporary staff will be expected to fulfill their responsibility as a staff member including compliance with all state and federal regulations and facility policies.	F 690		
F 699 SS=D	Trauma Informed Care CFR(s): 483.25(m) §483.25(m) Trauma-informed care The facility must ensure that residents who are trauma survivors receive culturally competent, trauma-informed care in accordance with professional standards of practice and accounting for residents' experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to comprehensively assess past trauma and implement care plan interventions utilizing a trauma-informed approach for 1 of 1 resident (R18), reviewed who had post-traumatic stress disorder (PTSD). Findings include:	F 699	Corrective action was accomplished for resident (R18) found to have been affected by the deficient practice - Resident Life Coordinator (RLC) completed a Trauma Assessment and updated the care plan for the affected resident on 07/18/2023. Staff were informed of the triggers and interventions via written communication.	8/24/23

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F 699	Continued From page 30 R18's quarterly Minimum Data Set (MDS) assessment dated 4/8/23, indicated R18 had intact cognition, exhibited symptoms of mild depression, and took an antidepressant medication, had no behaviors, and was mainly independent with activities of daily living (ADLs), but did require limited assistance by 1 staff for toileting and bathing cares. The MDS further indicated R18's diagnoses included depression (mood disorder), anxiety, and post-traumatic stress disorder (PTSD), (a mental disorder caused by a terrifying event). R18's care plan, last reviewed/revised on 5/10/23, failed to identify PTSD/trauma as a focus area. As a result, the care plan lacked individualized trauma-informed approaches or interventions and lacked identification of triggers to avoid potential re-traumatization related to PTSD. During an interview, on 7/18/23 at 8:20 a.m., R18 indicated growing up in a household consisting of physical/mental abuse, suffered sexual molestation during preschool years, lacked friendship and socialization throughout life thereafter. R18 stated he had never discussed his feelings or traumatic events of childhood until facility admission, spoke with social worker and provider regarding his PTSD. R18 indicated he was considering counseling recommended per physician, stated mood at time of interview was stable with medication regimen prescribed. While interviewed, on 7/18/23 at 8:48 a.m., nursing assistant (NA)-C indicated unawareness R18 had PTSD, stated awareness R18 had depression. NA-C reported on days when R18 appeared more down in mood, staff increased supervision, tried to involve R18 in activities,	F 699	To identify other residents having the potential to be affected by the same deficient practice - RLC completed Trauma Assessments with each resident in the facility on 7/21/2023 to 07/26/2023. The findings were documented in the residents medical records. The assessments indicated 2 residents were at risk for trauma. The care plans for these 3 residents were updated to reflect trauma. The RLC provided written communication to staff regarding the triggers and interventions related to trauma for these 3 residents. Measures put into place to ensure that the deficient practice will not recur - The Trauma Informed Care policy and procedure was updated on 07/24/2023 to indicate that a Risk Assessment would be completed at the time of admission as well as annually or with any significant changes. Any changes found will be communicated by the RLC to staff to reflect triggers and interventions added to the resident care plan. Staff were educated on the policy and procedure on 07/24/2023. A Mandatory All Staff Education in-service on Trauma Informed Care will be held on 08/24/2023. Any staff unable to attend will receive the written educational materials. Corrective actions put in place to ensure that the deficient practice is being corrected and will not recur - Audits will be performed after each new admission by the Administrator or designated person(s).	

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F 699	Continued From page 31 provided 1:1 conversation. NA-C indicated if R18's mood continued to be down or worsening, would report to charge nurse right away. During an interview, on 7/18/23 at 9:56 a.m., social services (SS)-A indicated awareness of R18's PTSD, discussed at time of admission on 7/27/22, confirmed she had not care planned for R18's PTSD, stated was unsure how much detail to provide staff regarding R18's trauma history, did not want staff reviewing PTSD/trauma information R18 had provided only for curiosity. SS-A indicated awareness R18 exhibited symptoms of depression related to PTSD, R18 would display occasional mood behaviors including, low mood and isolation, stated when R18 displayed mood behaviors, staff would attempt to increase social interaction with R18 and provide increased supervision while in room. SS-A indicated offering R18 counseling services for PTSD management, R18 refused services, R18 stated he didn't want to be placed on more medication. While interviewed, on 7/18/23 at 10:57 a.m., licensed practical nurse (LPN)-A indicated was aware R18 had PTSD, PTSD was listed on R18's diagnosis list, stated an incident occurred shortly after R18's facility admission, LPN-A was scheduled to provide pain medication to R18, LPN-A asked R18 if he was having pain prior to pain medication administration per facility protocol, R18 became upset and stated was in pain all the time, had been suffering since childhood. LPN-A indicated awareness the word pain was a trigger for R18, stated avoided the word pain since event when conducting R18's pain assessment. LPN-A indicated was unaware if other staff knew R18 had PTSD, verified R18's	F 699	These audits will be reviewed at the monthly and quarterly QA meetings for 2 quarters.	

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F 699	Continued From page 32 care plan did not include PTSD and should have for staff awareness to avoid triggers. During an interview, on 7/18/23 at 11:11 a.m., the director of nursing (DON) indicated awareness R18 had PTSD, stated was on diagnosis list and was screened for symptoms at time of facility admission, although unable to provide documentation of R18's PTSD/trauma screen upon request. The DON confirmed PTSD was not in R18's care plan and should have been for staff awareness, avoidance of triggers, implementation of appropriate interventions, and provision of additional resources if needed. Upon request of R18's medical record, observed R18's care plan had been updated on 7/18/23 to include PTSD. The facility Trauma Informed Care policy dated 2/1/23, consisted of ensuring residents who are trauma survivors receive culturally competent, trauma-informed care in accordance with professional standards of practice, as well as residents' preferences and experiences, to provide treatment and services to attain the highest practicable level of mental and psychosocial wellbeing, ensure that an individualized resident centered care plan is developed for the resident that has experienced a traumatic event.	F 699		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the	F 761		7/31/23

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F 761	Continued From page 33 appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure doses of controlled substances were stored in a manner to reduce the risk of theft and/or diversion in 1 of 1 refrigerator observed in use for medication storage. This had potential to affect 2 of 2 residents (R6, R8) who received controlled medications. Findings include: On 7/17/23 at 6:37 p.m., a tour of the medication storage room was conducted with licensed practical nurse (LPN)-A. Medication storage room door was locked, upon entering the medication room, a portable (moveable) refrigerator was observed sitting on top of	F 761	Corrective action was accomplished for residents R6 and R8 found to have been affected by the deficient practice - Nursing department contacted the Hospice provider that prescribed the refrigerated controlled substance for the affected resident R6 on 7/17/2023 and the provider discontinued the medication due to lack of use. The refrigerated controlled substance for resident R8 was a discontinued medication that had not been destroyed. The medications were destroyed by the DON and LPN-A on duty on 7/17/2023 following our facility medication destruction policy and procedure.	

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F 761	Continued From page 34 medication counter. LPN-A unlocked portable refrigerator door, observed a small clear locked E-kit container. E-Kit container visualized and consisted of 2 small vials of injectable lorazepam (an anti-anxiety medication/controlled substance) on shelving rack, a bottle of diazepam (an anti-anxiety/sedative medication/controlled substance) prescribed for R6, and a bottle of lorazepam prescribed to R8 was in rack of portable refrigerator side door. Although, the medications were double locked, the refrigerator was not permanently affixed. During an interview, on 7/17/23 at 6:53 p.m., LPN-A indicated awareness that controlled substance medications needed to be stored in an area providing 2 separately locked compartments, stated was not aware controlled substance medications needed to be locked in a permanently affixed compartment. LPN-A indicated she thought controlled substance medications stored in facility portable refrigerator, ensuring portable refrigerator was always locked unless in use, was sufficient for storage. While interviewed, on 7/17/23 at 7:01 p.m., the director of nursing (DON) indicated awareness that controlled substance medications needed to be stored in an area providing 2 separately locked compartments, stated was not aware controlled substance medications needed to be locked in a permanently affixed compartment. The DON indicated controlled substance medications were kept in facility locked medication storage room, within a locked portable refrigerator, stated she thought process used for controlled medication substance storage was sufficient at time, would ensure process for controlled medication storage was corrected immediately.	F 761	No other residents had the potential of being harmed by this deficient practice. A review of the refrigerator was conducted by DON to ensure that no other controlled substance for any other residents were located in the refrigerator on 7/17/2023. Measures put in place to ensure that the deficient practice will not recur - the DON spoke with the Medical Director and Consulting Pharmacist at the Quarterly QA meeting which was held on the afternoon of 7/17/2023 regarding this deficient practice. The Medical Director recommended that for future controlled substance that need to be refrigerated that we consult the prescribing provider for an alternative form. Due to the potential of not always being able to use an alternative form a new refrigerator was purchased and installed on 7/31/2023 with an affixed lock box inside of the refrigerator and a lock was placed on the exterior of the refrigerator to provide double locking of the controlled substance. A policy and procedure was developed on 7/17/2023, and the licensed nurses were given a copy and educated on the new policy and procedure. Corrective actions put in place to ensure that the deficient practice is being corrected and will not recur - audits will be performed monthly by the DON or designated person(s) to ensure controlled substance are double locked per policy. These audit's will be reviewed at monthly and quarterly QA meetings for 2 quarters.	

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F 761	Continued From page 35 The faility Medication Storage policy dated 4/21/20, indicated a process for ensuring medications were stored in a safe, secure, and orderly manner, and was the responsibility of licensed nursing staff. The policy further indicated compartments containing medications were locked when not in use, (compartments included, but were not limited to drawers, cabinets, rooms, refrigerators, carts, and boxes), all drugs requiring refrigeration shall be stored separately in a refrigerator that is locked and in a locked room that is used exclusively for medications and medication adjunct, all controlled drugs were stored under double-lock and key.	F 761		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced	F 812		7/26/23

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F 812	Continued From page 36 by: Based on observation, interview, and document review, the facility failed to label, date opened containers of food stored, ensure expired food was identified and removed from two stand-up refrigerators, and stand-up freezers. This had the potential to affect all 25 residents who were served food and beverages from the facility kitchen. Findings include During observation and interview of facility kitchen, on 7/17/23 at 11:41 p.m., with certified food protection manager (CFPM)-A, observed food items in two stand-up refrigerators, and two stand-up freezers, that was not dated or marked and/or were expired. The following items were observed during tour: Double door, stand-up refrigerator: 1.Great value prune juice-approximately (approx) ¼ full, unmarked/undated, expired (exp) date 426/24 2. Facility pour pitcher (2- 1 gallon), crystal light fruit punch, both containers approx. ½ full, exp. date labeled 7/6/23, observed to have sedimentation, white discoloration at bottom of pitchers 3.Westby light sour cream, 1 gallon container, approx. 1/4 full, unmarked/undated, exp. date 7/4/23, small amount of clear liquid present to top surface of sour cream 4. Harvest value whipped salad dressing, 1 gallon container, approx. ¾ full, opened date 5/5/23, no exp. date 5. Premium green seedless grapes in plastic bag, approx. ¾ full, white discoloration with fuzzy	F 812	It is the practice of Seasons Healthcare to ensure that food is properly labeled and removed upon expiration. No residents were directly affected, however all residents had the potential to be affected by this deficient practice. The Certified Food Protection Manager (CFPM) disposed of all food that was unmarked, undated, expired or freezer burnt found in the refrigerators and freezers on 07/17/2023. Measures put into place to ensure that the deficient practice will not recur - CFPM created a policy and procedure regarding Product Dating on 07/21/2023. The policy and procedure was provided to the dietary staff to review and acknowledge. Education was provided regarding product dating and the time limit for ready to use items,taking products from their original containers and how they need to be stored correctly in Ziploc bags and container, and on how products must be labeled with a received date, open date, and a use by date, or expiration date on 7/25/2023 and 7/26/2023. The education will be provided with all new dietary staff. Staff will inspect on a daily basis all refrigerators and freezers for expired products or unlabeled items and dispose of as needed. Staff will document their findings. To ensure ongoing competency regarding the deficient practice an annual in-service will be conducted for all dietary staff. Corrective actions put in place to ensure	

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F 812	Continued From page 37 growth observed on bottom grape, no exp. date 6. Great value cottage cheese-small curd- 4% milkfat, 48 oz. container, approx. ½ full, unmarked/undated, exp. date 8/1/23 Single door, stand-up refrigerator: 1.Low-moisture part-skim mozzarella cheese, 5lb bag, approx. 1/4 left full, unmarked/undated, no exp. date 2. Mrs. Gerry's fresh coleslaw, 5lb. container, approx. ¼ full, unmarked/undated, exp. date on container 7/24/23, watery in appearance 3. Bongard's shredded cheese, 5lb bag, approx. ½ full, unmarked/undated, no exp. date 4. Mrs. Gerry's country style potato salad, 5lb. container, unopened, exp date 7/11/23 5. Molly's kitchen ham salad, 5lb container, approx. ½ full, opened date 5/16/23, exp. date on container 7/31/23 Masterbilt 3-door stand-up freezer: 1.Classic vegetables cauliflower, 2lb. bag, approx. 1/4 full, unmarked/undated, exp. date 4/20/22. 2.Classic vegetables cauliflower (5 bags), 2lb. bag, unopened, exp. date 4/20/22 Beverage-air 3-door stand-up freezer: 1.Frozen meatballs in large plastic bag, approx.1/4 full, unmarked/undated, no exp date on bag, freezer burned 2. Frozen diced ham cubes in large plastic bag, approx. ½ full, unmarked/undated, no exp. date on bag, freezer burned 3. Ready bread cod in facility ziplock bag, dated 3/24/23, no exp. date on bag, bag unsealed, freezer burned 4. BBQ ribs in facility container, approx. ½ full, dated 4/7/23, no exp. date on container, freezer	F 812	that the deficient practice is being corrected and will not recur - Audits will be performed weekly by the CFPM or designated person(s). Random audits will be performed by the Consulting Registered Dietician, Administrator, or designated person(s). These audits will be reviewed at the monthly and quarterly QA meetings for 2 quarters.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245315	A. BUILDING _____ B. WING _____	C 07/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEASONS HEALTHCARE	303 BROADWAY AVENUE SOUTH TRIMONT, MN 56176

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 38 burned 5. Ribs in facility container, approx. ¼ full, dated 8/26/22, no exp. date on container, freezer burned 6. Taco meat in facility container, approx. 1/4 full, dated 12/15/22, no exp. date, freezer burned During an interview, on 7/17/23 at 12:07 p.m., CFPM-A indicated in discussion of unmarked/undated and expired/damaged food items, all dietary staff were responsible to go through all kitchen room refrigerators and freezers to check food items and remove all food items noted to be unmarked/undated and/or expired/damaged daily. CFPM-A indicated all left-over food and beverage items were used and discarded within 5 days from preparation, opened containers of salad dressings were used within 21 days of date opened, prepared frozen foods were used and discarded within 3 months of date prepared, and any damaged containers of food noted per dietary staff were sent back to food vendor, US Foods. The facility Food Storage policy reviewed 4/17/23, consisted of; to provide sufficient storage to keep food safe, wholesome, and appetizing; date marking will be visible on all high risk food to indicate the date by which is ready-to-eat, all containers must be legible and accurately labeled and dated, leftover food will be stored in covered containers or wrapped carefully and securely, each item will be clearly labeled and dated before being refrigerated, leftover food is used within 7 days or discarded.	F 812		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)	F 880		8/22/23

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F 880	Continued From page 39 §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (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,	F 880		

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F 880	Continued From page 40 depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the infection control program included ongoing surveillance, trending and analysis of resident infections. This deficient practice had the potential to affect all 25 residents currently residing in the facility. Findings include: Review of the facility's resident illness not requiring antibiotic therapy dated 4/23, 5/23, 6/23 included the following information: date, resident	F 880	No individual residents were identified as being affected by the deficient practice. Seasons Healthcare wants to ensure the best possible care is provided to the residents and understands that this deficient practice had the potential to affect all the residents currently residing at the facility. The July and August infection control data was entered into the ICAR spreadsheet tool, this was completed on 08/10/2023. The data did not identify any	

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F 880	Continued From page 41 name, room number, signs/symptoms, treatment. The logs lacked information regarding location of resident, infection date, type of infection, diagnosis, medications. Review of facility documentation indicated the antibiotic medication report for 4/23, 5/23, 6/23, and 7/23, included the resident name, start and end date, order description, ordered by, diagnosis, and category. The report lacked documentation related to the date of onset of infection, date cultures taken, organisms noted from culture obtained, if resistant to antibiotic, how organism was acquired, isolation precautions, communication with physician of resident status while on antibiotic therapy. Review of monthly surveillance control logs dated 1/23, 2/23, 3/23, 4/23, 5/23, 6/23, included floor plan of facility. Surveillance included resident room numbers listed, and key at bottom of floor plan had COVID (yellow mark), loose BM (bowel movement) (purple mark), cough (yellow mark), boils, and GI upset (blue mark). The floor plan did not include any information related to infection such as, type of infection, symptoms, date infection was first noted, culture and results, antibiotic order, resolution date and outcome. The logs lacked ongoing surveillance and trending of all infections which included food-borne illness, and other illnesses caused by other viruses or infections. On 7/18/23 at 2:05 p.m., the director of nursing (DON) stated she was responsible for the infection control program, including infection surveillance. DON confirmed education completion of infection control/prevention and antibiotic stewardship program. The DON stated	F 880	residents with new infections. Measures put into place to ensure that the deficient practice will not recur - Each resident's case will be reviewed to ensure infections are treated timely and appropriate precautions/measures are taken. The infection surveillance log will be completed by the Director of Nursing (DON) weekly using the ICAR spreadsheet tool and floor plan to ensure proper surveillance of infections is being carried out. By maintaining the infection control log and floor plan, infections will be tracked to identify infections early and to provide prompt and appropriate treatments as well as to prevent other residents from potential infections. Tracking this data will display trends in which could prevent other residents from potential infections. The policy and procedure for Infection Control Resident Surveillance was revised by the DON on 08/16/2023. The floor plan was also revised to correlate with the ICAR spreadsheet tool. Education was provided and reviewed by the DON regarding the ICAR tool. Education related to the policy and procedure revision was provided to the licensed nursing staff and asked to acknowledge the changes. Corrective actions put in place to ensure that the deficient practice is being corrected and will not recur - The infection surveillance spreadsheet and floor plan will be audited monthly by the MDS Coordinator to ensure the spreadsheet and floor plan is maintained and	

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F 880	Continued From page 42 awareness of any resident infections, new symptoms or residents placed on antibiotics was discussed during daily stand-up meetings to keep up with resident status. The DON stated the residents who were not prescribed an antibiotic were listed on a monthly resident illness report with date, signs/symptoms, and treatment. The DON confirmed she had not been tracking and trending all infections in the facility. The DON was not aware, and did not have a current list of reportable communicable diseases, and did not know where to find the list of communicable reportable diseases. The DON confirmed ongoing surveillance had not been completed with incidence of infections determined or analyzed, and the infection control program had room for improvement. The facility Infection Control Resident Surveillance policy dated 12/1/17, indicated Purpose: Surveillance date will be used to: Plan infection control activities Educational programs Prevent infectious transmission to others Detect infections that need treatment improve outcomes and processes To have knowledge of resident infection so appropriate actions/follow up may be done To guide prevention activities Procedure: 1. the matrix system will be used to track infectious diseases/antimicrobial usage 2. The infection control nurse and/or director of nursing will analyze the collected data and the incidence of infections will be determined on a monthly or as needed basis they will use the following sources of information: matrix system,	F 880	corresponding treatments carried out. Audits will be reviewed at the monthly and quarterly QA meetings for 2 quarters.	

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F 880	Continued From page 43 infection summary/monthly control logs, lab, X-ray and other diagnostic reports, nurses notes, physician progress notes, clinical observation, staff concerns and reports, prescribed antibiotics, 3. Data collected will be on the monthly infection log and infection summary 4. Monthly data will be reviewed by the infection control nurse and the director of nursing 5. Analysis of infection control data will also occur quarterly. This is reported to the QA committee members at their quarterly meeting. 6. Control measures won't be instituted as appropriate to identify problems including sentinel events 7. Antimicrobial tracking will also be used to monitor trends/frequency.	F 880		
F 881 SS=F	Antibiotic Stewardship Program CFR(s): 483.80(a)(3) §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)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to implement a process for antibiotic review to determine appropriate indications, dosage, duration, trends of antibiotic use and resistance. This had the potential to affect any of the 25 residents who resided in the facility who might use antibiotics.	F 881	No individual residents were identified as being affected by the deficient practice. Seasons Healthcare wants to ensure the best possible care is provided to the residents and understands that this deficient practice had the potential to affect all the residents currently residing at	8/22/23

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F 881	Continued From page 44 Findings include: Review of facility documentation indicated the antibiotic medication report for 4/23, 5/23, 6/23, and 7/23, included the resident name, start and end date, order description, ordered by, diagnosis, and category. The report lacked documentation related to the date of onset of infection, date cultures taken, organisms noted from culture obtained, if resistant to antibiotic, how organism was acquired, isolation precautions, communication with physician of resident status while on antibiotic therapy. Review of monthly surveillance control logs dated 1/23, 2/23, 3/23, 4/23, 5/23, 6/23, included floor plan of facility. Surveillance included resident room numbers listed, and key at bottom of floor plan had COVID (yellow mark), loose BM (bowel movement) (purple mark), cough (yellow mark), boils, and GI upset (blue mark). The floor plan did not include any information related to infection such as, type of infection, symptoms, date infection was first noted, culture and results, antibiotic order, resolution date and outcome. On 7/18/23 at 2:05 p.m., the director of nursing (DON) stated she was responsible for the infection control program, including antibiotic stewardship. DON confirmed education completion of infection control/prevention and antibiotic stewardship program. The DON stated awareness of any resident infections, new symptoms or residents placed on antibiotics was discussed during daily stand-up meetings to keep up with resident status. The DON stated the residents who were not prescribed an antibiotic were listed on a monthly resident illness report with date, signs/symptoms, and treatment. DON	F 881	the facility. The July and August infection control data was entered into the ICAR spreadsheet tool, this was completed on 08/10/2023. The data did not identify any residents with new infections. Measures put into place to ensure that the deficient practice will not recur - The Director of Nursing (DON)/ Infection Preventionist (IP) will ensure the ICAR spreadsheet tool and floor plan will be completed weekly to include labs and cultures which aid in appropriate antibiotic decision making for each resident's case. By reviewing cases for which cultures, labs, and antibiotics are prescribed for each resident, prompt and appropriate treatment can be carried forth in a way to minimize antibiotic use as well as the most appropriate antibiotic for that individual resident. The policy and procedure Antibiotic Stewardship Program (ASP) was revised by the DON/IP on 08/16/2023. Education of the revised policy and procedure was provided to the licensed nursing staff along with reporting antibiotic use and other illness and/or infections to DON/IP. Corrective actions put in place to ensure that the deficient practice is being corrected and will not recur - Antibiotic usage and corresponding labs and cultures will be audited monthly by the MDS Coordinator to ensure the spreadsheet and floor plan is maintained and corresponding treatments carried out. Audits will be reviewed at the monthly and quarterly QA meetings for 2 quarters.	

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F 881	Continued From page 45 confirmed a tracking and monitoring process for residents placed on an antibiotic included the use of the electronic medical record (EMR) antibiotic medication report, and included the resident name, start and end date, order description, ordered by, diagnosis, and category. The DON stated she reviewed the antibiotic orders and information, but had not set up a program to include the requirements for Antibiotic Stewardship and confirmed the antibiotics were not tracked for cultures, source, location of infection, symptoms when placed on antibiotic. The DON stated she does not review or track culture results to ensure proper antibiotics were prescribed or have a tracking log. The facility Antibiotic Stewardship Program (ASP) policy dated 10/20/22, indicated: Purpose: Antibiotic stewardship programs (ASPs) are designed to minimize the harmful effects of inappropriate antibiotic use. The most serious concern with antibiotic resistance is that some bacteria have become resistant to some of the easily available antibiotics (Multi-Drug Resistant Organisms or MDROs), these bacteria can cause serious disease, and this is a major public health problem. Utilizing stewardship actions such as measuring a facility's antibiotic use promotes prudent use and management of antimicrobial agents, reduces antibiotic resistance, and increase optimal patient outcomes. Procedure: D. Actions: Review of current antimicrobial use Observations of trends of antimicrobial use, Communication with providers in selecting antimicrobial therapy based on evidence based	F 881		

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F 881	Continued From page 46 practices. Review of culture and sensitivity reports Education for nursing staff regarding monitoring residents with an infection including response to antimicrobial therapy, plan of care for the resident with an infection Facility wide surveillance of all diagnosed infections Tracking and Reporting DON and licensed nurses track all prescribed antimicrobials by prescriber, resident, indication, and antibiotic. Additional information to be tracked: Resident information Infection Culture results Antimicrobial Duration Symptoms Other information (transmission based precautions/symptom resolution. Data is collected weekly and logged. Data is reported to the ASP team monthly and at Quarterly QA meetings.	F 881		

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	245315	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/08/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEASONS HEALTHCARE	**303 BROADWAY AVENUE SOUTH** **TRIMONT, MN 56176**

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 08/08/2023. At the time of this survey, SEASONS HEALTH CARE 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 | 08/30/2023

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. SEASONS HEALTH CARE is a 1 story building with partial basement. The building was constructed at 2 different times. The original building was constructed in 1963, one-story with partial basement, and was determined to be of Type II (111) construction. In 1992 a Chapel addition was constructed, one-story with no basement, having a 2-hour separation from the original building, and was	K 000		

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K 000	Continued From page 2 determined to be of Type V(111) construction. Because the original building and additions are compatible construction types allowed for existing buildings of this height, the facility was surveyed as one building as allowed in the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies. The facility is fully protected throughout by an automatic sprinkler system and has a fire alarm system with smoke detection in corridors and spaces open to the corridors which is monitored for automatic fire department notification. The facility has a capacity of 26 beds and had a census of 24 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidence by:	K 000		
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source	K 353		8/9/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245315	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/08/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEASONS HEALTHCARE	**303 BROADWAY AVENUE SOUTH** **TRIMONT, MN 56176**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 353	Continued From page 3 _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to maintain the sprinkler system in accordance with NFPA 101 (2012 edition), Life Safety Code, sections 4.6.12, 9.7.5, 9.7.6 and NFPA 25 (2011 edition) Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, section(s), 5.2.2.2 . These deficient findings could have a widespread impact on the residents within the facility. Findings include: 1. On 08/08/2023 between 9:30 AM and 12:30 PM, it was revealed by observation that in the Boiler Room that L.P. piping was resting upon and presenting weight loading to the sprinkler system piping. 2. On 08/08/2023 between 9:30 AM and 12:30 PM, it was revealed by observation that in the Basement Chapel Stairwell piping was resting upon and presenting weight loading to the sprinkler system piping. 3. On 08/08/2023 between 9:30 AM and 12:30 PM, it was revealed by observation that in the Basement Corridor that L.P. piping was resting upon and presenting weight loading to the sprinkler system piping. An interview with the Maintenance Director	K 353	Corrective Action - the pipe hanger for the LP pipeline in the basement corridor and basement chapel stairwell was replaced. Replacing the hanger provided clearance between the LP line and sprinkler line. The hanger attached to the sprinkler line in the boiler room was removed. A hanger was installed from the ceiling to support the LP line. To Track and Prevent - inspecting sprinkler lines for clearance and that nothing is attached to them was added to weekly Environmental Rounds Observation checklist. This will be reviewed monthly at the Safety Committee Meeting. The Environmental Service Director is responsible for the corrective actions and montioring for compliance.	

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K 353	Continued From page 4 verified these deficient findings at the time of discovery.	K 353		
K 374 SS=D	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the smoke barrier doors per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.7.8 and 8.5.4.1. This deficient finding could have a isolated impact on the residents within the facility. Findings include: On 08/08/2023 between 9:30 AM and 12:30 PM, it was revealed by observation that Chapel smoke barrier doors bound upon testing and did not allow the doors to fully close and seal the opening An interview with the Maintenance Director verified this deficient finding at the time of	K 374	Corrective Action - The Environmental Service Director adjusted the upper strike latch hardware and door closure to ensure the doors open and close/latch properly and completely. To Track and Prevent - Testing of and inspecting of fire doors was added to the Environmental Rounds Observation checklist and the Fire Drill Report Sheet. These items will be addressed and reviewed at the monthly Safety Committee Meeting. The Environmental Service Director is responsible for the corrective action and	8/8/23

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SEASONS HEALTHCARE	**303 BROADWAY AVENUE SOUTH** **TRIMONT, MN 56176**

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K 374	Continued From page 5 discovery.	K 374	monitoring of ongoing compliance.	
K 761 SS=D	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This REQUIREMENT is not met as evidenced by: Based on document review and staff interview the facility failed to inspect and test doors per NFPA 101 (2012 edition), Life Safety Code, sections 4.6.12, 19.7.3, 19.7.6, 7.2.1.6.1. This deficient finding could have a isolated impact on the residents within the facility. Findings include: On 08/08/2023 between 9:30 AM and 12:30 PM, it was revealed by observation that the Chapel fire rated exit door, having delayed egress hardware, upon testing did not operate properly. The delayed egress hardware malfunctioned upon testing and would not allow reset of the arming mechanism and closure of the door.	K 761	Corrective Action - The Environmental Service Director adjusted the upper strike latch hardware to allow complete and proper closure and seal. Loctite was used on the bolt that had become loose in order to help prevent reoccurrence. To Track and Prevent - Exit doors opening/closing/functioning properly was added to the Environmental Rounds Observation checklist. It will be reviewed and addressed at the monthly Safety Committee Meeting. The Environmental Service Director is responsible for the corrective action and monitoring of ongoing compliance.	8/9/23

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K 761	Continued From page 6 An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 761		
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations.	K 918		8/15/23

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K 918	Continued From page 7 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on observation, review of available documentation and staff interview, the facility failed to test the on-site emergency generator system per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.4.4.1.1.3, 6.4.4.2 and NFPA 110 (2010 edition), Standard for Emergency and Standby Power Systems, 8.4.9. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 08/08/2023 between 9:30 AM and 12:30 PM, it was revealed by a review of available documentation, that no documentation was presented to confirm that 36 month - 4-hour load bank testing in occurring. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 918	Corrective Action - The Environmental Service Director contacted Generator System Service, Inc. (GSS) on 8/8/23 after the deficient practice was identified. GSS performed the test on 8/15/23. Education was provided to the Environmental Service Director regarding the testing of the generator regarding the 36 month, 4-hour load bank testing. To Track and Prevent - The Environmental Service Director added the 36 month load bank test to the PM section of TAB 12 - Emergency Generator Section of the Life Safety Binder. The Administrator will check yearly with the Environmental Service Director to ensure that scheduling this test in the correct year is completed timely.	

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
August 9, 2023

Administrator
Seasons Healthcare
303 Broadway Avenue South
Trimont, MN 56176

Re: State Nursing Home Licensing Orders
Event ID: U9X011

Dear Administrator:

The above facility was surveyed on July 17, 2023 through July 20, 2023 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, Minnesota 56001
Email: elizabeth.silkey@state.mn.us
Office: (507) 344-2742 Mobile: (651) 368-3593

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.

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00365	A. BUILDING: _____ B. WING _____	C 07/20/2023

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SEASONS HEALTHCARE	303 BROADWAY AVENUE SOUTH TRIMONT, MN 56176

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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 7/17/23-7/20/23, a licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was 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 these orders and	2 000		

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2 000	Continued From page 1 identify the date when they will be completed. The following complaints were reviewed during the survey: H53153576C (MN00093972), H53153577C (MN00091096), H53153578C (MN00089194), H53153579C (MN00088156), and H53153580C (MN00085332). and NO licensing orders were issued. 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 ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES. http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm. 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. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. 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.	2 000		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident.	2 565		8/1/23

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2 565	Continued From page 3 This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure a comprehensive care plan was developed and maintained for 2 of 2 residents reviewed, (R3) who required assistance with activities of daily living (ADL) and incontinence of bowel and bladder, and (R20) with edema. Findings include: R3's admission Minimum Data Set (MDS) assessment dated 6/2823, indicated R3 was cognitively intact, required 2 person physical assist with bed mobility, transfer, dressing, toilet use, and personal hygiene, utilized a wheelchair, occasionally incontinent of bowel and bladder, diagnoses included neurological conditions, heart failure, hypertension (high blood pressure), and long-term current use of anticoagulants (blood thinner). R3's document titled healthcare 48 hour resident care plan undated, identified alert/cognitively intact, glasses, own teeth-missing a lot, did not walk, assist x2 Hoyer, grooming total assist, physical therapy (PT), occupation therapy (OT), speech therapy (ST), transfers assist x2 mechanical lift, diet order 200 mg sodium restriction, 2000 ml fluid restriction, meal set up independent and assist, set up oral hygiene, continent bladder assist x2, toileting plan urine, bedpan, and was signed by registered nurse (RN)-A. R3's Care Area Assessment (CAA) dated 6/28/23, indicated R3 triggered for urinary incontinent due to needing assistance toileting	2 565	Corrected	

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2 565	Continued From page 4 and incontinence, contributing factors include the resident's recent hospitalization/weakness, co-morbidities, and baseline status of needing to use Hoyer lift for transfers, risk factors include skin break downs. The CAA further indicated will proceed to care plan to help prevent any further skin breakdown/moisture associated skin break down; and location of the information POC (point of care), nursing note. R3's CAA for ADL's triggered due to the resident needing assistance with mobility and balance, contributing factors R3 at baseline requires this assistance with mobility and balance, co-morbidities; risk factors include being at risk for skin breakdown and pressure injuries, will proceed to care plan to help prevent complications associated with needing staff assistance with mobility, transferring and balance. R3's care plan reviewed 7/3/23, indicated problem: urinary incontinence R3 experiences bladder incontinence and goal indicated R3 will maintain current level of bladder continence and will not have any further moisture, associated/incontinence associated skin breakdown through the next review, and approach indicated provide incontinence care after each incontinent episode. The care plan indicated R3 required ADL assistance and tasks should be broken down into subtasks, be allowed rest breaks to prevent fatigue, R3 will assist with ADL completion as best he can and staff will provide ADL assistance that R3 is not able to complete on his own, the approach indicated provide adequate rest periods between activities. The care plan lacked any interventions related to specific toileting needs, specific ADL care, lacked ADL care required for urinary incontinence, bowel incontinence, showering, and required assistance needed.	2 565		

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2 565	Continued From page 5 CNA (certified nursing assistant) assignment sheet document dated 7/17/23, indicated R3: 2 assist with use of Hoyer, use a power wheelchair, daily weight. On 7/17/23 at 6:34 p.m.. nursing assistant (NA)-B stated she would toilet resident when he pushed his call light and stated R3 required assistance with toileting, and stated she was not sure how the resident toileted and used the CNA assignment sheet. On 7/17/23 at 7:17 p.m., licensed practical nurse (LPN)-A stated R3 required an assist of two with toileting, preferred to lay down in bed during urination, used the urinal, and used a bariatric sized bed pan with bowel movements. LPN-A confirmed the information was not on the care plan and expected the information to be available in the care plan. On 7/18/23 at 9:02 a.m., NA-B stated she was an agency staff, and used the care plan to know how a resident was toileted and specific information related to the residents need with ADL care. On 7/18/23 at 8:28 a.m., NA-C stated R3 required assistance with morning ADL cares and provided peri care, washed face and hands, and combed hair. NA-C stated R3 was occasionally incontinent of bowel and urine and required assist of two staff to assist with toileting, and resident was provided a urinal per request. On 7/18/23 at 8:57 a.m., the director of nursing (DON) stated the care plan was expected to indicate the cares the resident required for ADL care and toileting. The DON stated the staff used the care plan for resident interventions.	2 565		

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2 565	Continued From page 6 On 7/18/23 at 3:19 p.m., registered nurse (RN)-A stated would expect the care plans to include specific information related to the residents and would expect how the resident toileted, assistive devices used for toileting, and showering included on the care plan. RN-A stated any nurse was responsible for adding information to the care plan. RN-A stated she completed R3's admission MDS assessments and added information to the care plan the CAA triggers. RN-A stated the information from R3's baseline care plan was expected to have been included on the comprehensive care plan. RN-A further stated she was new to the role. R20's face sheet, printed on 7/19/23, indicated diagnoses to include, congestive heart failure (CHF), lymphedema (swelling/fluid retention of lymphatic vessels), xerosis cutis (dry, scaling, cracked skin), morbid obesity, and type 2 diabetes mellitus (Type 2 DM- abnormal blood sugar disorder), R20's admission MDS assessment, dated 5/17/23, indicated R20 had intact cognition, required extensive assist of 2 staff for transfers, extensive assist of 1 staff for hygiene and locomotion on/off unit, and limited assist of 1 staff for dressing. R20's physician order report, printed on 7/19/23, indicated start date orders for PT/OT to evaluate and treat on 5/10/23, administering furosemide (diuretic medication) 60mg daily for CHF on 5/10/23, monitoring of daily weights on 5/17/23, and applying compression wraps to legs for lymphedema on 5/25/23. R20's admission skin assessment, dated 5/10/23, indicated moderate to severe swelling to BLEs.	2 565		

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2 565	Continued From page 7 Provider's visit note, dated 5/16/23, indicated R20 was evaluated for new admission visit/new admission to facility, had diagnosis including lymphedema and plan to initiate lymphedema therapy. During an observation and interview, on 7/17/23 at 1:44 p.m., R20 was observed sitting in recliner chair in room watching TV, bilateral lower extremities (BLEs) had blisters present to skin of upper inner thighs, ace bandages securely wrapped from bilateral knee extending down towards foot. R20's BLEs observed as very edematous (swollen), bilateral foot was covered by gripper socks, resting on floor. R20 indicated was admitted to facility approximately 2 months ago following hospitalization for respiratory infection and swelling to legs, came to facility for strengthening of BLEs and planned to return home after therapy goals met. R20 further indicated for edema to BLEs, staff were wrapping BLEs with ace wraps, administering a diuretic medication, and monitoring her weight daily. R20's care plan reviewed/revised on 5/24/23, failed to identify edema as a focus area. As a result, the care plan lacked interventions/tasks related to providing comprehensive care for management of edema and measures to take to reduce and/or maintain the edema. During an interview and observation, on 7/19/23 at 8:26 a.m., nursing assistant (NA)-C indicated awareness R20 had edema with blisters to BLEs, stated NAs were not responsible for R20's edema cares, only licensed nursing staff were to apply ace wraps to BLEs and administer fluid pill. NA-C indicated NAs provided lotion to R20's BLEs with routine cares. NA-C stated resident cares to be	2 565		

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2 565	Continued From page 8 reviewed and/or provided per NAs could be found in the electronic medical record (EMR) system, MatrixCare, under the specific resident profile tab, approaches tab, care plan tab, and diagnosis tab. NA-C observed to review R20's profile tab, approaches tab, care plan tab, and diagnosis tab, stated edema was present under diagnosis tab for R20, confirmed R20 did not have any cares to be completed per NAs to manage edema. While interviewed, on 7/19/23 at 10:04 a.m., NA-F indicated awareness R20 had edema and blisters to BLEs since time of admission, unaware of any cares assigned to NAs to complete for R20's edema other than weighing R20 daily. NA-F reported awareness licensed nursing staff were applying ace wraps to R20's BLEs daily for edema, indicated when she worked, she would encourage R20 to elevate BLEs when in room sitting in recliner chair. During an interview, on 7/19/23 at 11:11 a.m., registered nurse (RN)-B, indicated was an agency nurse, today was first day working at facility. RN-B stated awareness of edema to R20's BLEs and blistering to bilateral inner thighs. RN-B indicated nursing management for R20's edema included application of ace wraps to BLEs, administration of diuretic medications, and monitoring weight daily. RN-B stated R20's medical information and cares to be completed were found in MatrixCare under orders, medication administration record (MAR), task administration record (TAR), and in care plan. RN-B indicated unawareness if cares to be completed for edema management were noted in R20's care plan, would need to check further into that. While interviewed, on 7/19/23 at 11:12 a.m., the	2 565		

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2 565	Continued From page 9 director of nursing (DON) stated R20 had been admitted to facility on 5/10/23, following hospitalization for respiratory infection, lymphedema, and cellulitis. The DON indicated process for developing resident's care plan started at time of admission, charge nurse reviewed resident discharge paperwork received from previous entity and completed a head-to-toe nursing assessment upon resident arrival to facility. The DON stated charge nurse completed a 48-hour care plan, written in paper form, to include in care plan anything pertaining to physician admission orders received; diagnosis, medications, treatments, functional status, resident preferences, dietary orders, mood/behaviors, therapy services. The DON indicated once charge nurse completed 48-hour care plan, it was reviewed, revised as needed per the DON or MDS coordinator, the DON or MDS coordinator would input resident information into the EMR system to create resident's comprehensive care plan. The DON indicated the process for developing and implementing care plans had been challenging, confirmed resident care plans developed and initiated had many errors. The DON stated a charge nurse who had completed many of the residents' admission assessments and created the 48-hour care plans, had inaccurately assessed residents, and forgot to put pertinent resident information into the 48-hour care plans, created inaccuracies when completing comprehensive care plans, charge nurse no longer working at facility. Furthermore, the DON reported facility hired a new MDS coordinator a few months ago, MDS coordinator just recently completed MDS classes, MDS coordinator was still learning how to develop more personalized centered care plans for residents, resident care plans in place at time were not comprehensive and personalized as	2 565		

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2 565	Continued From page 10 should be care planned for. The DON reviewed R20's care plan, verified based on R20's hospital discharge orders and medical diagnosis, R20's care plan should have included focus area and interventions for edema. The facility Care Planning Process policy dated 5/3/23, indicated: Purpose: to ensure a comprehensive approach to meeting the care needs of the resident. Procedure: 1. The facility will develop a comprehensive care plan for each resident that includes measurable goals and timetables to meet a resident's medical, nursing, mental and psychosocial needs that are identified in the comprehensive assessment and provider notes. 2. Care plans must be person centered and reflect the residents' goals and desired outcomes. A comprehensive plan must be: a. developed within 7 days after the completion of the comprehensive assessment. b. prepared by an interdisciplinary team, that includes the physician, a RN with the responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and to the extent practical the participation of the resident and/or resident's legal representative and c. periodically reviewed and revised by a team of qualified persons after each assessment. 4. Resident goal set the expectations for the care and services the resident wishes to receive. Resident's preferences need to be addressed. The comprehensive care plan must list measurable objectives and timetables to meet the residents long and short-term goals for medical, nursing, mental, psychosocial needs that are identified in the comprehensive resident assessment, including any trauma. The	2 565		

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2 565	Continued From page 11 comprehensive care plan must include the individual abuse prevention plan. 5. A comprehensive plan of care must be available used by all personnel involved in the care of the resident The facility Edema and Weight Monitoring policy reviewed 2/3/20, consisted of, to ensure residents with diagnosis that may cause edema is monitored and treated in a timely manner, responsibility of RN/licensed practical nurses (LPNs), DON, dietary. Purpose to assess residents for fluid retention, evaluate effect of diuretics, evaluate client adherence to prescribed medications, diet, and activity. Procedure included, address any changes needed in the care plan immediately. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee should review and revise policies and procedures related to creating and implementing and/or revising a comprehensive care plan as needed to ensure cares meet the specific needs of each individual resident. The director of nursing or designee should develop a system to educate staff and develop a monitoring system such as measurable audits to ensure individual care plans are created, and/or revised and implemented. The results of those audits should be taken to the QAPI committee to determine compliance or the need for further monitoring. The administrator should be responsible to ensure this occurs. TIME PERIOD FOR CORRECTION: Twenty-one (21) day	2 565		
2 835	MN Rule 4658.0520 Subp. 2 A Adequate and Proper Nursing Care; Criteria	2 835		7/28/23

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2 835	Continued From page 12 Subp. 2. Criteria for determining adequate and proper care. The criteria for determining adequate and proper care include: Evidence of adequate care and kind and considerate treatment at all times. Privacy must be respected and safeguarded. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure appropriate management and routine care was provided for 1 of 1 resident (R2) who had an indwelling urinary catheter. Findings include: R2's face sheet, received on 7/19/23, included diagnoses of congestive heart failure (CHF), obesity, cerebrovascular disease (stroke), Type 2 diabetes mellitus (Type 2 DM, (blood sugar disorder)), obstructive and reflux uropathy (urinary disorder), acute kidney failure, benign prostatic hyperplasia (BPH) with lower urinary tract symptoms (prostate disorder causing urinary abnormal urinary symptoms), retention of urine, weakness, and edema. R2's quarterly Minimum Data Set (MDS) assessment dated 6/22/23, indicated R2 was cognitively intact, had visual impairment and wore glasses, had minimal difficulty hearing, had clear speech, was able to make self-understood and could understand others. R2 was mainly independent with activities of daily living (ADLs), required extensive assist of 1 staff for toileting and limited assist of 1 staff for hygiene cares. Furthermore, the MDS indicated R2 had an	2 835	Corrected	

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2 835	Continued From page 13 indwelling urinary catheter. R2's physician order report, received on 7/19/23, included to change Foley catheter, 16 Fr and 10cc saline in balloon every month for retention of urine, to complete on the 13th day of each month. R2's care plan, received on 7/19/23, indicated R2 had an indwelling catheter and instructed staff to assess the urinary drainage each shift- record amount, type, color, odor, observe for leakage; change collection bag once weekly and as needed (PRN)- during the week rinse collection bag once daily with vinegar, change measuring graduate once weekly and PRN, provide catheter care each shift and PRN, report signs of urinary tract infection (UTI), use large collection bag only due to (D/T) wraps on bilateral lower legs (BLEs)- store collection bag inside protective dignity pouch, do not allow tubing or any part of drainage system to touch the floor, position catheter bag below level of bladder, maintain hygiene, staff will ensure needs are met and care plans are being followed. Care plan did not identify use of catheter holder. During an observation and interview, on 7/17/23 at 2:26 p.m., R2 was observed sitting in recliner chair in room, urinary bag visualized in protective dignity pouch and secured in place to R2's walker off flooring, walker positioned in front of R2 and recliner chair. A urinary catheter holder to secure urinary tubing was observed on R2's bed. R2 indicated he did not like catheter holder used, stated catheter holder loosened and fell towards foot on multiple occasions throughout the day when worn daily. R2 indicated he had reported to staff that catheter holder does not fit securely to his leg, staff continue to use same type of catheter holder despite R2's concerns. R2 stated	2 835		

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2 835	Continued From page 14 had bladder and genital pain from Foley catheter pulling downwards only when urine bag became too full, indicated staff were emptying drainage bag frequently throughout the day to prevent Foley catheter from pulling downwards causing pain. During an observation and interview of clean catheter care procedure, on 7/19/23 at 8:47 a.m., nursing assistant (NA)-G was observed to cleanse hands with hand sanitizer upon entering R2's room, grabbed R2's basin and put water in basin from R2's bathroom sink. NA-G placed wash cloth in R2's water basin, wrung wash cloth out in basin, began to cleanse Foley catheter tubing, (only visualized portions of Foley catheter located on outside of R2's brief), and urinary drainage tubing, performing in downward fashion. NA-G then placed wash cloth in basin, grabbed clean towel and dried Foley catheter tubing and urinary bag tubing. NA-G discarded gloves, was about to leave R2's room when asked by surveyor if peri-care had been completed, NA-G stated R2 always refused staff to provide peri-care, R2 stated no staff had ever asked him to provide peri-care, R2 indicated would allow staff to perform peri-care. NA-G observed to sanitize hands and apply clean gloves, asked R2 to stand up and pull pants/brief down to provide peri-care. R2 stood up and removed pants/brief, surveyor visualized loose catheter holder resting upon R2's ankle, NA-G proceeded to perform peri-care,dried areas with clean towel, reapplied R2's catheter holder to upper right thigh ensuring catheter holder fit snug in place. NA-G informed R2 he could pull brief/pants back up. NA-G then discarded supplies, hand sanitized and left R2's room. NA-G was asked if aware of R2's catheter holder loose and concerns of always falling towards foot. NA-G stated she did hear about	2 835		

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2 835	Continued From page 15 concerns with R2's catheter holder being loose and falling towards foot from other staff, was not informed of any further interventions to try. NA-G indicated worked for agency, did not work at facility often enough to know all resident care needs, including R2's care needs. During an interview, on 7/19/23 at 10:01 a.m., NA-F indicated awareness of R2's catheter holder being loose and slipping below knee, stated typically occurs when urinary drainage bag was full of urine, staff checked urine in drainage bag frequently throughout shift and emptied when full. NA-F stated she had reported concerns of R2's catheter holder not fitting appropriately to licensed nursing staff in past, indicated R2 would report pain to catheter insertion site when leg strap loosened and slid down, staff had encouraged R2 to use a new catheter holder, but R2 refused. During interview on 7/19/23 at 10:49 a.m., the director of nursing (DON) indicated was aware of R2's catheter holder not fitting properly, was loose and slid down leg, stated was informed of issue a few months ago per staff. DON indicated had advised nursing staff of R2's available catheter supplies and to try a new catheter holder. DON stated was unaware concern still persisted, would have expected staff to notify her if catheter holder was still not fitting appropriately in order for DON to order a new type of device. The facility Catheter Care: Draining a catheter policy reviewed 10/22/22, indicated purpose to maintain aseptic technique while managing and/or draining catheter leg/drainage bags. The facility Foley Catheter Care and UTI Monitoring policy revised 10/22/22, indicated purpose to assure that residents, who have a	2 835		

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2 835	Continued From page 16 long-term Foley catheter in place receive appropriate treatment. Policy further indicated Foley catheter care must be done AM and PM and PRN- again risk UTI and good hygiene practice. The facility Pool Agency Orientation policy revised 5/6/21, indicated Seasons Healthcare strives to provide its own staff as available to care for its residents, however, there are occasions when agency personnel are needed to provide adequate safe staffing. Purpose to provide proper orientation for all employees working in the facility, applies to employees of the facility and temporary agency staff that work at the facility through an outside agency, orientation will allow the employee to function in a safe and respectful manner while providing care for residents, orientation checklist will be renewed if the pool agency staff member has not worked in the facility in the past 6 months since initial orientation to the facility. Procedure: Temporary agency staff will be oriented to the following areas by the supervising nurse or designee before allowing working on the floor and included, facility policy manuals, ADL data collection/charting, care plans, infection control, reporting information to nurses/supervisors, and who to report to. Upon completion of the orientation, temporary staff will be expected to fulfill their responsibility as a staff member including compliance with all state and federal regulations and facility policies. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review all physician orders for residents with catheters to ensure cares are performed as ordered. The director of nursing or designee, could conduct routine audits to ensure appropriate care and services were implemented as ordered. The	2 835		

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2 835	Continued From page 17 results of those audits should be taken to the QAPI committee for a determined amount of time to ensure compliance or the need for further monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	2 835		
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: Based on observation, interview and document review, the facility failed to provide exercises to maintain strength and mobility for 1 of 3 residents (R14) reviewed for range of motion (ROM). Findings include: R14's quarterly Minimum Data Set (MDS) assessment dated 6/28/23, indicated moderate cognitive impairment, no rejection of care, required one person physical assist with bed	2 895	Corrected	8/1/23

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2 895	Continued From page 18 mobility, transfer, dressing, eating, personal hygiene; two person physical assist with toilet use; upper and lower extremity impairment on one side, used wheelchair; zero days when restorative programs was performed with passive/active range of motion; diagnoses included hemiplegia and hemiparesis (paralysis and weakness) of total body function on one side of the body, following cerebral infarction (stroke) affecting left dominant side. R14's care plan dated 4/24/23, indicated weakness to left upper extremity, staff will assist R14 to do his dowel exercises (exercises to improve arm movement and strength) after passive range of motion to left upper extremity 3 to 5 times a week; contractures of the lt (left) hand d/t (due to) CVA recommendation from restorative: please provide a 1 # dowel with 2# leg weight wrapped in middle, will need assistance placing hands on dowel, then will need hand over hand assist completing the exercise on net page 3 times weekly reps 10 times each. Restorative care program document dated 3/22/23, indicated R14 goals were maintain strength of LE (left extremities) and maintain transfers with 2WW (wheeled walker), recommendations included 3-5/week complete supine LE exercises sheet for exercises, 3-5x/week have R14 complete static standing 3-4x with 2WW and stance time varies to his tolerance, left side neglect will need verbal and tactile cues to complete. Restorative nursing progress notes documented indicated weekly written progress notes for R14 on 3/5/23, 3/12/23, 3/26/23, 4/2/23, 6/11/23. There was no weekly progress note documentation indicated for 5/14/23, 5/21/23,	2 895		

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2 895	Continued From page 19 5/28/23, 6/4/23, and the last weekly progress note was 6/11/23. R14's untitled document that staff used to document ROM indicated R14 received ROM exercises on 4/5/23, 4/9/23, and 6/10/23. On 7/17/23 at 4:35 p.m., R14 stated staff did not complete or assist with exercises related to range of motion, on the upper or lower body. On 7/18/23 at 8:31 a.m., nursing assistant (NA)-C stated R14 was expected to have exercises completed 3-5 times per week and was the responsibility of the bath aide. NA-C stated she was the bath aide and was responsible for resident's ROM and restorative cares; and further stated resident's ROM was completed very infrequently due to staffing and stated the residents were expected to have ROM 3-5 times per week. NA-C stated therapy provided the resident's orders, the orders were placed in the binder, and she made a list herself which indicated what residents had exercises and how many days a week the resident needed to complete the exercises. NA-C confirmed R14 only had ROM completed once last month and stated she charted on the ROM in the restorative binder located at the nursing station and was expected to let PT (physical therapy) know if ROM was not being done and had not made PT aware. NA-C stated last week she had communicated to the DON the ROM was not being done and was instructed by the DON to let PT know when ROM was not completed. On 7/18/23 at 8:37 a.m., Occupational Therapy Assistant (OTA)-C and stated restorative care and range of motion is the responsibility of the nursing staff at the facility.	2 895		

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2 895	Continued From page 20 On 7/18/23 at 11:24 a.m., NA-E stated the bath aid was responsible for resident's ROM responsible for the ROM, and NA's help when able, and further stated the EMR will show if staff needed to complete ROM. On 7/18/23 at 11:49 a.m., licensed practical nurse (LPN)-A stated an order for ROM came from PT or OT as a hard copy, the nurse entered the order into the computer and a copy of the order was placed in the hall book binder. LPN-A was observed to look for R14's ROM order in the binder and stated she could not find the order but would expect the order in the hallway binder. LPN-A further stated the bath aide was expected to complete the resident's ROM. On 7/18/23 4:35 p.m., the director of rehabilitation (DOR) stated she met with NA-C last week and discussed ROM education and ROM not completed was not communicated. The DOR stated residents ROM recommendations were expected followed and completed. On 7/20/23 at 9:00 a.m., the director of nursing (DON) stated ROM was the responsibility of the bath aide. The DON stated she was not aware residents had not received ROM as ordered and confirmed R14's ROM had not been completed as ordered. The facility Range of Motion policy dated 11/10/21, indicated. Policy: exercise is a basic physical need. Residents are unable to do active exercise by themselves need to be exercised by the staff of Seasons Healthcare through range of motion to avoid a decrease in their range of motion in the	2 895		

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2 895	Continued From page 21 possible development of contractures. It is the responsibility of each member of the health care team to recognize risks for contracture formation and implement preventive therapy. Purpose: to provide an effective method of identifying and providing a residence identified at risk for decreased range of motion and/or contracture development and to set up a program of rehabilitation goals and interventions to avoid deterioration up their range of motion (ROM) Procedure: 1. Staff to identify residents at risk for ROM using the Seasons Health Care facility indicators or based on personal knowledge of the individual resident. 2. Once identified staff need to obtain a written order for physical therapy and/or occupational therapy. 3. When orders are returned the therapy staff will do an assessment to identify the ROM exercises the resident needs to do to avoid deterioration in his/her ROM. 4. The assessment will be given to the DON the MDS coordinator. 5. The PT & OT staff will put instructions in writing for the NAR's what exercises need to be done each day with AM and PM cares and the number of repetitions necessary to avoid further deterioration of their residents ROM. this information will always be made available to the NAR's and will be placed in the hall books (labeled north and south) 6. The MDS coordinator and/or director of nursing will review the personal exercise programs on quarterly basis coinciding with quarterly MDS reviews and care plan development process to determine the appropriateness of the plan.	2 895		

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2 895	Continued From page 22 SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review all residents at risk for limited range of motion to 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		
21100	MN Rule 4658.0650 Subp. 5 Food Supplies; Storage of Perishable food Subp. 5. Storage of perishable food. All perishable food must be stored off the floor on washable, corrosion-resistant shelving under sanitary conditions, and at temperatures which will protect against spoilage. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to label, date opened containers of food stored, ensure expired food was identified and removed from two stand-up refrigerators, and stand-up freezers. This had the potential to affect all 25 residents who were served food and beverages from the facility kitchen. Findings include During observation and interview of facility	21100	Corrected	7/26/23

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21100	Continued From page 23 kitchen, on 7/17/23 at 11:41 p.m., with certified food protection manager (CFPM)-A, observed food items in two stand-up refrigerators, and two stand-up freezers, that was not dated or marked and/or were expired. The following items were observed during tour: Double door, stand-up refrigerator: 1.Great value prune juice-approximately (approx) ¼ full, unmarked/undated, expired (exp) date 426/24 2. Facility pour pitcher (2- 1 gallon), crystal light fruit punch, both containers approx. ½ full, exp. date labeled 7/6/23, observed to have sedimentation, white discoloration at bottom of pitchers 3.Westby light sour cream, 1 gallon container, approx. 1/4 full, unmarked/undated, exp. date 7/4/23, small amount of clear liquid present to top surface of sour cream 4. Harvest value whipped salad dressing, 1 gallon container, approx. ¾ full, opened date 5/5/23, no exp. date 5. Premium green seedless grapes in plastic bag, approx. ¾ full, white discoloration with fuzzy growth observed on bottom grape, no exp. date 6. Great value cottage cheese-small curd- 4% milkfat, 48 oz. container, approx. ½ full, unmarked/undated, exp. date 8/1/23 Single door, stand-up refrigerator: 1.Low-moisture part-skim mozzarella cheese, 5lb bag, approx. 1/4 left full, unmarked/undated, no exp. date 2. Mrs. Gerry's fresh coleslaw, 5lb. container, approx. ¼ full, unmarked/undated, exp. date on container 7/24/23, watery in appearance 3. Bongard's shredded cheese, 5lb bag, approx. ½ full, unmarked/undated, no exp. date	21100		

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21100	Continued From page 24 4. Mrs. Gerry's country style potato salad, 5lb. container, unopened, exp date 7/11/23 5. Molly's kitchen ham salad, 5lb container, approx. ½ full, opened date 5/16/23, exp. date on container 7/31/23 Masterbilt 3-door stand-up freezer: 1.Classic vegetables cauliflower, 2lb. bag, approx. 1/4 full, unmarked/undated, exp. date 4/20/22. 2.Classic vegetables cauliflower (5 bags), 2lb. bag, unopened, exp. date 4/20/22 Beverage-air 3-door stand-up freezer: 1.Frozen meatballs in large plastic bag, approx.1/4 full, unmarked/undated, no exp date on bag, freezer burned 2. Frozen diced ham cubes in large plastic bag, approx. ½ full, unmarked/undated, no exp. date on bag, freezer burned 3. Ready bread cod in facility ziplock bag, dated 3/24/23, no exp. date on bag, bag unsealed, freezer burned 4. BBQ ribs in facility container, approx. ½ full, dated 4/7/23, no exp. date on container, freezer burned 5. Ribs in facility container, approx. ¼ full, dated 8/26/22, no exp. date on container, freezer burned 6. Taco meat in facility container, approx. 1/4 full, dated 12/15/22, no exp. date, freezer burned During an interview, on 7/17/23 at 12:07 p.m., CFPM-A indicated in discussion of unmarked/undated and expired/damaged food items, all dietary staff were responsible to go through all kitchen room refrigerators and freezers to check food items and remove all food items noted to be unmarked/undated and/or expired/damaged daily. CFPM-A indicated all	21100		

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21100	Continued From page 25 left-over food and beverage items were used and discarded within 5 days from preparation, opened containers of salad dressings were used within 21 days of date opened, prepared frozen foods were used and discarded within 3 months of date prepared, and any damaged containers of food noted per dietary staff were sent back to food vendor, US Foods. The facility Food Storage policy reviewed 4/17/23, consisted of; to provide sufficient storage to keep food safe, wholesome, and appetizing; date marking will be visible on all high risk food to indicate the date by which is ready-to-eat, all containers must be legible and accurately labeled and dated, leftover food will be stored in covered containers or wrapped carefully and securely, each item will be clearly labeled and dated before being refrigerated, leftover food is used within 7 days or discarded. SUGGESTED METHOD OF CORRECTION: The administrator, registered dietician, or designee could ensure foods are stored and labeled properly to prevent potential degraded food served to residents of the facility. The facility could update or create policies and procedures, and educate staff on specific requirements or interventions related to food storage and labeling. The administrator, registered dietician, or designee could perform audits for a designated amount of time as determined by the Quality Assurance Performance Improvement (QAPI) committee to ensure food items are stored and labeled appropriately. The facility could report those findings to QAPI for further recommendations and determine the need for further monitoring or compliance. TIME PERIOD FOR CORRECTION: Twenty-one	21100		

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21100	Continued From page 26 (21) days.	21100		
21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure the infection control program included ongoing surveillance, trending and analysis of resident infections. This deficient practice had the potential to affect all 25 residents currently residing in the facility. Findings include: Review of the facility's resident illness not requiring antibiotic therapy dated 4/23, 5/23, 6/23 included the following information: date, resident name, room number, signs/symptoms, treatment. The logs lacked information regarding location of resident, infection date, type of infection, diagnosis, medications. Review of facility documentation indicated the antibiotic medication report for 4/23, 5/23, 6/23, and 7/23, included the resident name, start and end date, order description, ordered by, diagnosis, and category. The report lacked documentation related to the date of onset of infection, date cultures taken, organisms noted from culture obtained, if resistant to antibiotic, how organism was acquired, isolation precautions, communication with physician of	21375	Corrected	8/22/23

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21375	Continued From page 27 resident status while on antibiotic therapy. Review of monthly surveillance control logs dated 1/23, 2/23, 3/23, 4/23, 5/23, 6/23, included floor plan of facility. Surveillance included resident room numbers listed, and key at bottom of floor plan had COVID (yellow mark), loose BM (bowel movement) (purple mark), cough (yellow mark), boils, and GI upset (blue mark). The floor plan did not include any information related to infection such as, type of infection, symptoms, date infection was first noted, culture and results, antibiotic order, resolution date and outcome. The logs lacked ongoing surveillance and trending of all infections which included food-borne illness, and other illnesses caused by other viruses or infections. On 7/18/23 at 2:05 p.m., the director of nursing (DON) stated she was responsible for the infection control program, including infection surveillance. DON confirmed education completion of infection control/prevention and antibiotic stewardship program. The DON stated awareness of any resident infections, new symptoms or residents placed on antibiotics was discussed during daily stand-up meetings to keep up with resident status. The DON stated the residents who were not prescribed an antibiotic were listed on a monthly resident illness report with date, signs/symptoms, and treatment. The DON confirmed she had not been tracking and trending all infections in the facility. The DON was not aware, and did not have a current list of reportable communicable diseases, and did not know where to find the list of communicable reportable diseases. The DON confirmed ongoing surveillance had not been completed with incidence of infections determined or analyzed,	21375		

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21375	Continued From page 28 and the infection control program had room for improvement. The facility Infection Control Resident Surveillance policy dated 12/1/17, indicated Purpose: Surveillance date will be used to: Plan infection control activities Educational programs Prevent infectious transmission to others Detect infections that need treatment improve outcomes and processes To have knowledge of resident infection so appropriate actions/follow up may be done To guide prevention activities Procedure: 1. the matrix system will be used to track infectious diseases/antimicrobial usage 2. The infection control nurse and/or director of nursing will analyze the collected data and the incidence of infections will be determined on a monthly or as needed basis they will use the following sources of information: matrix system, infection summary/monthly control logs, lab, X-ray and other diagnostic reports, nurses notes, physician progress notes, clinical observation, staff concerns and reports, prescribed antibiotics, 3. Data collected will be on the monthly infection log and infection summary 4. Monthly data will be reviewed by the infection control nurse and the director of nursing 5. Analysis of infection control data will also occur quarterly. This is reported to the QA committee members at their quarterly meeting. 6. Control measures won't be instituted as appropriate to identify problems including sentinel events 7. Antimicrobial tracking will also be used to monitor trends/frequency.	21375		

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21375	Continued From page 29 Suggested Method of Correction: The DON (director of nursing) or designee should review/revise facility policies to ensure they contain all components of an infection control program to mitigate transmission of potential infections. The DON or designee could educate all staff on existing or revised policies and perform audits to ensure the policies are being followed. The results of those audits should be taken to Quality Assurance Performance Improvement committee to determine compliance and the need for further monitoring. The Director of Nursing or designated person to determine how the deficiency occurred, review policies and procedures related to infection control with catheter caare, provide education and monitor to ensure compliance. Time Period for Correction: Twenty-one (21) days.	21375		
21615	MN Rule 4658.1340 Subp. 2 MedicineCabinet & Preparation Area;ScheduleII Subp. 2. Storage of Schedule II drugs. A nursing home must provide separately locked compartments, permanently affixed to the physical plant or medication cart for storage of controlled drugs listed in Minnesota Statutes, section 152.02, subdivision 3. This MN Requirement is not met as evidenced by: Based on observation and interview, the facility failed to ensure doses of controlled substances were stored in a manner to reduce the risk of theft and/or diversion in 1 of 1 refrigerator	21615	Corrected	7/31/23

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21615	Continued From page 30 observed in use for medication storage. This had potential to affect 2 of 2 residents (R6, R8) who received controlled medications. Findings include: On 7/17/23 at 6:37 p.m., a tour of the medication storage room was conducted with licensed practical nurse (LPN)-A. Medication storage room door was locked, upon entering the medication room, a portable (moveable) refrigerator was observed sitting on top of medication counter. LPN-A unlocked portable refrigerator door, observed a small clear locked E-kit container. E-Kit container visualized and consisted of 2 small vials of injectable lorazepam (an anti-anxiety medication/controlled substance) on shelving rack, a bottle of diazepam (an anti-anxiety/sedative medication/controlled substance) prescribed for R6, and a bottle of lorazepam prescribed to R8 was in rack of portable refrigerator side door. Although, the medications were double locked, the refrigerator was not permanently affixed. During an interview, on 7/17/23 at 6:53 p.m., LPN-A indicated awareness that controlled substance medications needed to be stored in an area providing 2 separately locked compartments, stated was not aware controlled substance medications needed to be locked in a permanently affixed compartment. LPN-A indicated she thought controlled substance medications stored in facility portable refrigerator, ensuring portable refrigerator was always locked unless in use, was sufficient for storage. While interviewed, on 7/17/23 at 7:01 p.m., the director of nursing (DON) indicated awareness that controlled substance medications needed to	21615		

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21615	Continued From page 31 be stored in an area providing 2 separately locked compartments, stated was not aware controlled substance medications needed to be locked in a permanently affixed compartment. The DON indicated controlled substance medications were kept in facility locked medication storage room, within a locked portable refrigerator, stated she thought process used for controlled medication substance storage was sufficient at time, would ensure process for controlled medication storage was corrected immediately. The faility Medication Storage policy dated 4/21/20, indicated a process for ensuring medications were stored in a safe, secure, and orderly manner, and was the responsibility of licensed nursing staff. The policy further indicated compartments containing medications were locked when not in use, (compartments included, but were not limited to drawers, cabinets, rooms, refrigerators, carts, and boxes), all drugs requiring refrigeration shall be stored separately in a refrigerator that is locked and in a locked room that is used exclusively for medications and medication adjunct, all controlled drugs were stored under double-lock and key. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON) and consulting pharmacist could review and revise policies and procedures for proper storage of medications. Nursing staff could be educated as necessary to the importance of properly securing medications. The DON or designee, along with the pharmacist, could conduct audits on a regular basis to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21615		

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	00365	A. BUILDING: _____ B. WING _____	C 07/20/2023

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21695	Continued From page 32	21695		
21695	MN Rule 4658.1415 Subp. 4 Plant Housekeeping, Operation, & Maintenance Subp. 4. Housekeeping. A nursing home must provide housekeeping and maintenance services necessary to maintain a clean, orderly, and comfortable interior, including walls, floors, ceilings, registers, fixtures, equipment, lighting, and furnishings. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure a clean, home-like environment to provide routine sanitation of resident room lighting fixtures for 4 of 4 residents (R2, R3, R8, R19), reviewed for environmental concerns. Findings include: R3's admission, Minimum Data Set (MDS) assessment dated 6/2823, indicated R3 was cognitively intact, required 2 person physical assist with bed mobility, transfer, dressing, toilet use, and personal hygiene, utilized a wheelchair, diagnoses included neurological conditions, heart failure, hypertension (high blood pressure), and long-term current use of anticoagulants (blood thinner). During an observation and interview, on 7/17/23 at 1:06 p.m., R3's room ceiling lighting fixture observed to have a large amount of dried dead bugs and debris. R2 indicated unawareness of bugs to ceiling lighting fixture, and confirmed the bugs in his lights, and voiced the lights need to be cleaned.	21695	Corrected	7/21/23

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21695	Continued From page 33 R2's quarterly MDS assessment, dated 6/22/23, indicated R2 had intact cognition and required limited assistance of 1 staff to meet activities of daily living (ADL) needs. R2's MDS preferences for customary routine and activities assessment, dated 3/26/23, indicated, R2's preferences to have personal things taken care of was very important to him. R2's care plan, last reviewed on 6/27/23, indicated R2's needs would be met, dignity always promoted, and wishes would be followed. R8's significant change in status MDS assessment, dated 6/1/23, indicated R8 had severely impaired cognition and required total assistance by 1-2 staff to meet ADL needs. The MDS further indicated R8's preferences for personal things to be taken care of was very important to her. R8's care plan, last reviewed on 6/9/23, indicated R8's needs would be met, dignity always promoted, and wishes would be followed. R19's significant change in status MDS assessment, dated 5/9/23, indicated R19 had intact cognition and required extensive assist of 1 staff to meet ADL needs. The MDS further indicated R19's preferences for personal things to be taken care of was very important to her. R19's care plan, last reviewed on 5/9/23, indicated R19's needs would be met, dignity always promoted, and wishes would be followed. During an observation and interview, on 7/17/23 at 2:22 p.m., R2's room ceiling lighting fixture observed to have a large amount of dried dead	21695		

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21695	Continued From page 34 bugs and debris. R2 indicated unawareness of bugs to ceiling lighting fixture, stated he liked room to be clean and of sanitary condition. While observed, on 7/17/23 at 5:39 p.m., R8's room ceiling lighting fixture observed to have a moderate amount of dried dead bugs and debris, unable to interview due to non-verbal status. During an observation and interview, on 7/17/23 at 5:40 p.m., R19's room ceiling lighting fixture observed to have a moderate amount of dried dead bugs and debris. R19 indicated unawareness of bugs to ceiling lighting fixture, stated she liked room to be clean and of sanitary condition. While interviewed, on 7/19/23 at 7:34 a.m., nursing assistant (NA)-D indicated unawareness of dead bugs to resident room ceiling lighting fixtures, stated housekeeping or maintenance staff were responsible for ensuring cleanliness and sanitation of all resident room ceiling lighting fixtures. During observation and interview, on 7/19/23 at 7:37 a.m., maintenace (M)-A indicated was responsible for checking and cleaning all resident room ceiling lighting fixtures monthly, was unaware of any environmental concerns with dried dead bugs and debris to resident room ceiling lighting fixtures. M-A indicated task for cleaning and sanitization of ceiling lighting fixtures to all resident rooms was documented on facility's environmental rounds observation form and had completed task monthly, although had not documented completion of task on facility form, as forgot. M-A was shown R2, R3, R8, and R19's room ceiling lighting fixtures, M-A confirmed ceiling lighting fixtures contained dried dead bugs	21695		

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21695	Continued From page 35 and debris and should have been cleaned/sanitized per the assigned facility monthly environmental rounds observation form. M-A indicated would clean and sanitize resident room ceiling lighting fixtures today. While interviewed, on 7/19/23 at 10:46 a.m., the administrator indicated unawareness of any environmental concerns with dried dead bugs and debris to resident room ceiling lighting fixtures, would expect staff to report any environmental concerns right away for maintenance to follow-up on. The administrator indicated maintenance should be inspecting, cleaning/sanitizing resident room ceiling lighting fixtures monthly and as needed. The facility Environment policy dated 10/20/22, indicated to promote an environment that residents feel safe and at home in, housekeeping and maintenance will maintain the resident room and facility in a sanitary, orderly, and comfortable manner. SUGGESTED METHOD OF CORRECTION: The administrator, maintenance supervisor, or designee could ensure a preventative maintenance program was developed to accurately reflect ongoing preventative maintenance scheduled or needed in the facility on a routine basis. The facility could create policies and procedures, educate staff on these changes and perform environmental rounds/audits periodically to ensure preventative maintenance is adequately completed. The facility could report those findings to the quality assurance performance improvement (QAPI) committee for further recommendations to ensure ongoing compliance.	21695		

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21695	Continued From page 36 TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21695		