Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
February 20, 2025

Administrator
Mother of Mercy Senior Living
230 Church Avenue, Box 676
Albany, MN 56307

RE: CCN: 245339
Cycle Start Date: December 20, 2024

Dear Administrator:

On January 16, 2025, we notified you a remedy was imposed. On February 12, 2025, the Minnesota Departments of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of February 5, 2025.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective January 31, 2025, be discontinued as of February 5, 2025. (42 CFR 488.417 (b))

In our letter of January 16, 2025, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from January 31, 2025. This does not apply to or affect any previously imposed NATCEP loss.

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

Feel free to contact me if you have questions.

Sincerely,

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Orville L. Freeman Building | HRD 3A 3rd Floor
Office: 651-201-4384
Email: holly.zahler@state.mn.us

Electronically delivered
January 16, 2025

Administrator
Mother of Mercy Senior Living
230 Church Avenue, Box 676
Albany, MN 56307

RE: CCN: 245339
Cycle Start Date: December 20, 2024

Dear Administrator:

On December 20, 2024, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy(ies) listed below to the CMS location for imposition. The CMS location concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective January 31, 2025.

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective January 31, 2025. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective January 31, 2025.

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

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

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval

of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $12,924; 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 January 31, 2025, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Mother of Mercy Senior Living will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from January 31, 2025. 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)

The purpose of the ePoC submission is to confirm your allegation of compliance and preparedness for a revisit.

Within ten (10) calendar days after your receipt of this notice, a provider should develop and submit an effective ePOC for the deficiencies cited. A revisit will determine if substantial compliance has been achieved.

A provider's ePOC must include the following:

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

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by a "F" and/or an "E" tag), i.e., the plan of correction should be directed to:

Judy Loecken, Regional Operations Supervisor
St. Cloud B District Office
Health Regulation Division
Minnesota Department of Health
4140 Thielman Lane
Saint Cloud, Minnesota 56301-4557
Email: judy.loecken@state.mn.us
Office: (320) 223-7300 Mobile: (320) 241-7797

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

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 ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

We will also recommend to the CMS location and/or the Minnesota Department of Human Services that your provider agreement be terminated by June 20, 2025, 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)

In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, 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: https://forms.web.health.state.mn.us/form/NHDisputeResolution

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. 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.

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited

deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. 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: https://forms.web.health.state.mn.us/form/NHDisputeResolution

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

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

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

Feel free to contact me if you have questions.

Sincerely,

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Orville L. Freeman Building | HRD 3A 3rd Floor
PO Box 64900
625 Robert Street North
St. Paul, MN 55155
Office: 651-201-4384
Email: holly.zahler@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245339	A. BUILDING _____ B. WING _____	C 12/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOTHER OF MERCY SENIOR LIVING	230 CHURCH AVENUE, BOX 676 ALBANY, MN 56307

(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 12/16/24, a survey for compliance with Appendix Z, Emergency Preparedness Requirements for Long Term Care facilities, §483.73 was conducted during a standard recertification survey. The facility was NOT in compliance. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulation has been attained.	E 000		
E 007 SS=F	EP Program Patient Population CFR(s): 483.73(a)(3) §403.748(a)(3), §416.54(a)(3), §418.113(a)(3), §441.184(a)(3), §460.84(a)(3), §482.15(a)(3), §483.73(a)(3), §483.475(a)(3), §484.102(a)(3), §485.68(a)(3), §485.542(a)(3), §485.625(a)(3), §485.727(a)(3), §485.920(a)(3), §491.12(a)(3), §494.62(a)(3). [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following:] (3) Address [patient/client] population, including, but not limited to, persons at-risk; the type of services the [facility] has the ability to provide in an emergency; and continuity of operations,	E 007		2/5/25

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

Electronically Signed | 01/27/2025

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

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E 007	Continued From page 1 including delegations of authority and succession plans.** *[For LTC facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do all of the following: (3) Address resident population, including, but not limited to, persons at-risk; the type of services the LTC facility has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans. *NOTE: ["Persons at risk" does not apply to: ASC, hospice, PACE, HHA, CORF, CMCH, RHC/FQHC, or ESRD facilities.] This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to complete a facility risk assessment. This had the potential to effect all 57 residents residing in the facility. Findings include: Review of the Facility Emergency Preparedness Plan (EPP) lacked a facility risk assessment addressing the facility's patient population that would be at risk during and emergency event ant the types of services the facility has the ability to provide to those resident populations in an emergency. During an interview on 12/20/24 at 1:00 p.m., Administrator stated she had completed this with the assistance of the maintenance supervisor in July. However, the form that was provided was a	E 007	E007 Facility risk assessment 1. Immediate action taken for those residents identified: No residents identified, however all residents at risk of the deficient practice. Facility assessment completed on 1/22/2025 to reflect resident population. 2. Measures put in place: Emergency Operation Plan completed to include resident population, vulnerable resident population, services the facility would be able to provide during an emergency, and how the facility plans to continue operations during an emergency. 3. Measures put into place/ system changes: The emergency operations plan will be reviewed and discussed in safety committee, leadership meeting, QAPI and shall be reviewed at least annually or	

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E 007	Continued From page 2 "Hazard and Vulnerability Assessment Tool" which addressed the likelihood of naturally occurring events. DON confirmed the tool did not include resident population information. After further discussion, DON stated she had a risk assessment, however, one was never provided. Facility All Hazards Vulnerability Assessment policy, revised April 2019 was provided. However, lacked direction to assess resident population, persons at-risk, and the types of services the facility has the ability to provide in an emergency	E 007	more often to reflect necessary changes. The Emergency Operations Plan now includes facilities population that would be at risk during an emergency. The facility has registered with the Central and West Central Coalition Healthcare Preparedness Coalition to coordinate Emergency Operations Plan. Results will be discussed in Safety Committee meeting and monthly QAPI. Facility Assessment will be reviewed and revised annually in January. Next review scheduled for January 2026.	
E 026 SS=F	Roles Under a Waiver Declared by Secretary CFR(s): 483.73(b)(8) §403.748(b)(8), §416.54(b)(6), §418.113(b)(6)(C)(iv), §441.184(b)(8), §460.84(b)(9), §482.15(b)(8), §483.73(b)(8), §483.475(b)(8), §485.542(b)(7), §485.625(b)(8), §485.920(b)(7), §494.62(b)(7). [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:] (8) [(6), (6)(C)(iv), (7), or (9)] The role of the [facility] under a waiver declared by the Secretary, in accordance with section 1135 of the Act, in the provision of care and treatment at an alternate	E 026		2/5/25

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E 026	Continued From page 3 care site identified by emergency management officials. *[For RNHCIs at §403.748(b):] Policies and procedures. (8) The role of the RNHCI under a waiver declared by the Secretary, in accordance with section 1135 of Act, in the provision of care at an alternative care site identified by emergency management officials. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure their emergency preparedness plan (EPP) included policies and procedures to address and identify the facility under a waiver declared by the Secretary, in accordance with section 1135 of the Act, (a waiver designed to waive specific regulatory requirements in order to more easily provide needed care in an emergency situation) in the provision of care and treatment at an alternate care site identified by emergency management officials. This had the potential to affect all 57 residents currently residing in the facility. Findings include: The facility's EPP dated 7//24, was reviewed. The EPP lacked a policy or procedure for addressing the facility's role under a 1135 waiver declared by the Secretary during an emergency to provide services at an alternate site for their residents. During interview on 12/20/24 at 1:00 p.m., administrator verified she developed and oversaw the facility's emergency preparedness program. Administrator stated she was unaware of anything pertaining to the procedures or policies	E 026	E026 " Immediate action taken for those residents identified: No residents identified, however all residents at risk of the deficient practice. " What corrective actions will be put in place for those residents affected by the deficient practice. All residents have the potential to be affected by this deficient practice. No residents were harmed. 1135 waiver added to emergency preparedness binders. All staff will be in-serviced of waiver during the all staff in-service scheduled for February 5th, 2025 at 6am and 2:00pm. " The facility has registered with the Central and West Central Coalition Healthcare Preparedness Coalition to coordinate Emergency Operations Plan.. " Facility will continue to work with community to coordinate evacuation plan, sign contracts needed for transportation, lodging, medication agreement with pharmacy. " Review of Policy and Procedures to include 1135 waiver and Emergency Preparedness Plan. " Measures put in place/system	

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E 026	Continued From page 4 relating to a 1135 waiver declaration.	E 026	changes will be made to ensure that the deficient practice does not recur: The Emergency Operations Plan will be reviewed in QAPI and in the safety committee meetings to ensure compliance. Results will be discussed in Safety Committee meeting and monthly QAPI 2/28/2025.	
E 039 SS=F	EP Testing Requirements CFR(s): 483.73(d)(2) §416.54(d)(2), §418.113(d)(2), §441.184(d)(2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2), §483.475(d)(2), §484.102(d)(2), §485.68(d)(2), §485.542(d)(2), §485.625(d)(2), §485.727(d)(2), §485.920(d)(2), §491.12(d)(2), §494.62(d)(2). *[For ASCs at §416.54, CORFs at §485.68, REHs at §485.542, OPO, "Organizations" under §485.727, CMHCs at §485.920, RHCs/FQHCs at §491.12, and ESRD Facilities at §494.62]: (2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following: (i) Participate in a full-scale exercise that is community-based every 2 years; or (A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or (B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event.	E 039		1/30/25

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E 039	Continued From page 5 (ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed. *[For Hospices at 418.113(d):] (2) Testing for hospices that provide care in the patient's home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the following: (i) Participate in a full-scale exercise that is community based every 2 years; or (A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full scale community-based exercise or individual facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years,	E 039		

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E 039	Continued From page 6 opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (3) Testing for hospices that provide inpatient care directly. The hospice must conduct exercises to test the emergency plan twice per year. The hospice must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual facility-based functional exercise; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospice is exempt from engaging in its next required full-scale community based or facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop led by a facilitator that includes a group discussion using a	E 039		

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	245339	A. BUILDING _____ B. WING _____	C 12/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOTHER OF MERCY SENIOR LIVING	230 CHURCH AVENUE, BOX 676 ALBANY, MN 56307

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E 039	Continued From page 7 narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the hospice's emergency plan, as needed. *[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):] (2) Testing. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the [PRTF, Hospital, CAH] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant	E 039		

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E 039	Continued From page 8 emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the [facility's] emergency plan, as needed. *[For PACE at §460.84(d):] (2) Testing. The PACE organization must conduct exercises to test the emergency plan at least annually. The PACE organization must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the PACE experiences an actual natural or man-made emergency that requires activation of the emergency plan, the PACE is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency	E 039		

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E 039	Continued From page 9 scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the PACE's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the PACE's emergency plan, as needed. *[For LTC Facilities at §483.73(d):] (2) The [LTC facility] must conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The [LTC facility, ICF/IID] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. (B) If the [LTC facility] facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required a full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.	E 039		

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E 039	Continued From page 10 (iii) Analyze the [LTC facility] facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [LTC facility] facility's emergency plan, as needed. *[For ICF/IIDs at §483.475(d)]: (2) Testing. The ICF/IID must conduct exercises to test the emergency plan at least twice per year. The ICF/IID must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or. (B) If the ICF/IID experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID is exempt from engaging in its next required full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the ICF/IID's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID's emergency plan, as needed.	E 039		

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E 039	Continued From page 11 *[For HHAs at §484.102] (d)(2) Testing. The HHA must conduct exercises to test the emergency plan at least annually. The HHA must do the following: (i) Participate in a full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise every 2 years; or. (B) If the HHA experiences an actual natural or man-made emergency that requires activation of the emergency plan, the HHA is exempt from engaging in its next required full-scale community-based or individual, facility based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the HHA's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the HHA's emergency plan, as needed.	E 039		

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E 039	Continued From page 12 *[For OPOs at §486.360] (d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following: (i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. If the OPO experiences an actual natural or man-made emergency that requires activation of the emergency plan, the OPO is exempt from engaging in its next required testing exercise following the onset of the emergency event. (ii) Analyze the OPO's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. *[RNCHIs at §403.748]: (d)(2) Testing. The RNHCI must conduct exercises to test the emergency plan. The RNHCI must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the RNHCI's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the RNHCI's emergency plan, as needed. This REQUIREMENT is not met as evidenced by: Based on interview and document review the	E 039	E039	

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E 039	Continued From page 13 facility failed to conduct exercises to test their emergency preparedness program (EPP) plan at least twice per year. This had the potential to affect all 57 residents who currently resided in the facility. Findings include: Review of the facility's EPP identified the facility failed to conduct exercises to test the emergency plan at least twice per year. Evidence of training for an active shooter was presented. However, there was no evidence of an after action plan or discussion of the facilities response. During an interview on 12/20/24 at 1:00 p.m., administrator stated the facility had conducted a training on an active shooter and they continue to use that training in orientation. However, there was no documentation of discussion or evaluation of the exercise. Facility Disaster Training, revised April 2019, was provided. However, lacked exercises were required twice per year: must participate in an annual full-scale exercise that is community based; or conduct an annual individual facility based functional exercise.	E 039	1. What specific corrective actions will be taken for affected residents? No residents affected by deficient practice. 2. How will other potentially impacted residents be identified?, All residents have the potential for being affected. 3. What systemic changes will be implemented to prevent recurrence? Facility has scheduled a missing resident drill for January 30th at 1:30pm. Second drill scheduled of Medical Emergency scheduled for February 4th at 10:00am. Discussion will be held and document the outcome of the drill. Tabletop exercises will include group discussions led by facilitator, using a narrated, clinically-relevant emergency scenario, and set of problem statements, directed messages, or prepared questions designed to challenge our emergency preparedness plan. Facility will keep record of all drills, tabletop exercises, and emergency events, and revise our emergency response plan as necessary. 4. How will the facility monitor the corrective actions?, The emergency preparedness plan will be discussed in safety committee, leadership team and QAPI. The emergency preparedness plan will be reviewed annually to reflect changes in the resident population and potential emergent situations the facility may encounter.	

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F 000	INITIAL COMMENTS On 12/16/24 through 12/20/24, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed with NO deficiencies cited: H53392122C MN00108804 H53391985C MN00108733 H53392741C MN00108720 H53392742C MN00108321 H53392740C MN00107817 The following complaints were reviewed: H53392782C (MN109222 / MN109064) - with deficiences cited at F552, F580, F657, F684, F726 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 552 SS=D	Right to be Informed/Make Treatment Decisions CFR(s): 483.10(c)(1)(4)(5) §483.10(c) Planning and Implementing Care. The resident has the right to be informed of, and	F 552		1/30/25

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F 552	Continued From page 15 participate in, his or her treatment, including: §483.10(c)(1) The right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition. §483.10(c)(4) The right to be informed, in advance, of the care to be furnished and the type of care giver or professional that will furnish care. §483.10(c)(5) The right to be informed in advance, by the physician or other practitioner or professional, of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options and to choose the alternative or option he or she prefers. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure changes in medication were communicated to 1 of 1 residents (R33) reviewed for notification of change in medications. Findings include: R33's significant change Minimum Data Set (MDS) dated 10/30/24, indicated diagnoses included dementia, chronic diastolic congestive heart failure (CHF), atrial fibrillation (irregular heartbeat), peripheral neuropathy (nerve damage), and diabetes. R33's cardiology clinic note dated 2/28/24, indicated R33 presented with family member (FM)-B for a cardiology provider visit on 2/26/24. R33 had CHF with noted congestion in lungs and reported occasional shortness of breath and	F 552	F552 Right to be informed/ make treatment decisions. Facility failed to notify R33 of changes in medication. This Plan of Correction is submitted as required under Federal and State regulation and statues applicable to long term care providers. This Plan of Correction does not constitute an admission of liability on the part of the facility, and such liability is hereby specifically denied. The submission of the plan of correction does not constitute an agreement by the facility that the surveyors findings or conclusions are accurate, that the findings constitute a deficiency, or that the scope and severity regarding any of the deficiencies cited are correctly applied. 1. Corrective action for the resident	

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F 552	Continued From page 16 lower extremity edema. R33 needed to follow up with the cardiologist in one year, or sooner as needed. On 2/26/24, the cardiologist ordered furosemide (Lasix) 20mg daily as needed (PRN) for lung congestion and/or lower extremity edema related to CHF. R33's progress note dated 3/26/24 at 3:24 p.m., indicated "Pharmacist recommendation of "PRN Lasix 20 mg to give for 'lung congestion or edema'. If it is to continue, please add specific parameters for when to administer Lasix 20 mg QD PRN. i.e.. give for 5# weight gain in a week, 3# in a day, or give for 3+ BLE (Bilateral Lower Extremity), etc.". This was reviewed and agreed to by PA. However, the progress note did not indicate what the provider agreed upon. R33's medication administration record (MAR) dated March 2024, indicated R33's furosemide 20mg daily PRN for lung congestion and/or lower extremity edema was discontinued on 3/26/24. However, R33's chart lacked evidence R33's representative had been notified of the change in medication. On 12/18/24 at 9:46 a.m., FM-B stated she brought R33 to the cardiologist in February of 2024 and a PRN order for Lasix was provided for lower extremity edema related to CHF. On 12/12/24, FM-B brought R33 for a prosthetic diagnostic fitting. Because R33 experienced an increase in edema, they were unable to apply the prosthetic. Upon return to facility, FM-B inquired about the PRN Lasix. The director of nursing (DON) informed FM-B the PRN Lasix had been discontinued on 3/26/24. FM-B stated the facility had not notified her of this medication change nor would not have agreed to discontinue the Lasix	F 552	affected by the alleged deficient practice: R33 continues to reside in the facility. R33 on daily weights, perimeters put in place for Lasix use. DAILY WEIGHT IN AM; Report any change in shortness of breath/edema in legs or abdomen as well as weight changes: Gain of 3 lbs overnight, Gain of 5 lbs in one week, or loss of 5 lbs from goal weight to update provider. The Nurse manager who supervised the unit R33 resides on is no longer employed at the facility. 2. Corrective action taken for those residents having the potential to be affected by the alleged deficient practice: Residents that require daily weights have the potential to be affected. Residents with orders for daily weights reviewed, physician orders reviewed, care plans updated. Staff educated on daily weights & when to notify physician. Staff education will be completed by the date of compliance by DON, staff educator and designee. 3. Measures/Systemic changes put in place to assure alleged deficient practice does not re occur: Licensed nursing to be in serviced by Staff Development Coordinator, DON or designee on policy and procedure on daily weights. Medication administration related to residents' weight and when to notifying residents physician. All active licensed nurses will have completed education by the date of compliance. Orientation of new nurses will include procedure for daily weights and medication. 5. Corrective actions will be monitored to	

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F 552	Continued From page 17 On 12/20/24 at 4:18 p.m., DON confirmed progress notes failed to indicate R33's family had been notified the PRN Lasix had been discontinued. DON stated FM-B should have been made aware of the change to medications. It was important to communicate medication changes to residents and their family to ensure coordination of care. The facility's Change in a Resident's Condition or Status Policy, revised 2/2021, indicated the facility would promptly notify the resident/representative of any changes in medical care or nursing treatments.	F 552	ensure the alleged deficient practice will not re occur: Unit managers will audit daily weights to include if a resident required medication related to daily weight 5 times a week and review in clinical meeting. DON will audit 2 times a week X 4 weeks. Audits then will continue 1 time a week X 3 months, and then DON will spot audit quarterly as needed to ensure 100% compliance is maintained. Audit results will be reported monthly in QAPI for further review and recommendations.	
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the	F 578		1/30/25

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F 578	Continued From page 18 facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure advanced directives for emergency care and treatment were accurately reflected in all areas of the medical chart to ensure resident wishes would be implemented correctly in an emergent situation for 1 of 24 residents (R13) reviewed for advanced directives. Findings include: R13's admission Minimum Data Set (MDS) dated 10/23/24, indicated R13 admission date of 10/16/2024, was moderately cognitively impaired and had the following diagnoses: hypertension (HTN) (high blood pressure), arthritis, osteoporosis (bones becomes weak and brittle), and asthma.	F 578	F578 1. What specific corrective action will be taken to affected residents? Resident #13 care plan has been updated to reflect code status per physician order. POLST, order, and Banner in PCC all corrected with current MD order. (revised on 12/17/2024). 2. How will other potentially impacted residents be identified? Residents with Advanced Directives have been identified as having the potential to be affected. By (1/30/2025) the unit managers and/or designee reviewed each resident Care Plan to validate Care Plans are reflective of code status and physician orders. Residents order, POLST, Banner	

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F 578	Continued From page 19 R13's Provider Orders for Life-Sustaining Treatment (POLST) dated 10/17/24, indicated R13's resuscitation wishes were "Do Not Attempt Resuscitation/DNR". The document was signed by R13's Heath care agent, and the Physician's assistant. On 12/16/24 R13's resuscitation status in the electronic medical record (EMR) banner was FULL CODE. On 12/16/24 at 12:12 p.m., the registered nurse manager (RN)-D stated upon admission the nurse would review resuscitation options with the resident or family member, fill out the paper form and have the resident or family member sign off. The physician would review and sign, then the facility would upload it to the EMR. RN-D stated in an instance where they found someone unresponsive, staff would call for help, check the banner in the EMR, and proceed with the residents wishes. RN-D reviewed R13's current code status and stated R13 was a full code, RN-D checked R13's POLST. RN-D stated the orders and the POLST did not match. RN-D got up, and left. RN-D returned shortly and stated if the instance of finding orders that do not match, they would clarify them immediately as she just had done and updated the resident's medical record. RN-D stated when checking a resuscitation status, staff would always check the banner of the EMR, and then verify with the POLST. On 12/16/24 at 1:21 p.m., the director of nursing (DON) expected resuscitation orders were reviewed by the nurse upon admission, with the resident or resident family. A POLST form was initiated and a provider signed off. The DON	F 578	and care plan all reflect residents current advance directive order, reflecting the same information. 3. What systemic changes will be implemented to prevent recurrence? Unit managers were educated by the Director of Nursing (DON) on updating the plan of care to reflect the resident's Advanced Directives. Unit managers are responsible to assure advance directives/POLST are obtained and match physician orders. Advanced directives/POLST uploaded in resident electronic medical record. 1/30/2025 all paper charts will be removed from nurses' stations. Advanced directives/POLST will be found in resident's electronic medical record. 4. How will the facility monitor the corrective actions? Weekly for eight weeks the unit managers or designee will audit five residents, including new admissions Advanced Directives, to validate correct code status is reflective in the plan of care. Results of the audits will be presented by the unit managers in the monthly Quality Assurance and Performance Improvement (QAPI) Meeting monthly for three months. The QAPI Committee will review the audits and make recommendations to assure compliance.	

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F 578	Continued From page 20 stated their expectation if a resident was found unresponsive, was the staff would review the code status on the EMR banner and verify with the POLST. The DON confirmed the EMR banner and POLST form did not match prior to survey start on 12/16/24. In this instance the DON's expectation was staff would verify the order and update when/if needed, and the POLST was the most current information On 12/19/24, R13's EMR indicated a physician order for Full Code dated 10/16/24 and discontinued on 12/16/24. Physician order for DNR dated 12/16/24 and care plan was revised to include DNR on 12/17/24. Changes to the EMR were noted to have been made after survey entrance. The facility's Advanced directive policy dated 2001, indicated if the resident or representative indicates the resident does not have an established advance directive, the facility will offer assistance in establishing advanced directives.	F 578		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial	F 580		1/30/25

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F 580	Continued From page 21 status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on interview and document review, the	F 580	F580	

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F 580	Continued From page 22 facility failed to notify and consult provider for 2 of 2 residents (R33, R43) reviewed for heart failure monitoring. Findings include: R33's significant change Minimum Data Set (MDS) dated 10/30/24, indicated diagnoses included dementia, chronic diastolic congestive heart failure (CHF), atrial fibrillation (irregular heartbeat), peripheral neuropathy (nerve damage), and diabetes. R33's Physician Fax Order Form dated 12/4/24, indicated an order for Lasix (a diuretic) 20mg daily as needed (PRN) for 3-pound (lb.) gain in a day or 5-lb. gain in a week. R33's weight summary and/or treatment administration record (TAR), printed 12/18/24, indicated the following daily weights from 12/5/24 to 12/18/24: 12/18 - 212 12/17 - no weight indicated 12/16 - 214.5 12/15 - 211 12/14 - 211 12/13 - 211.5 12/12 - 211 12/11 - 212 12/10 - no weight indicated 12/9 - 212 12/8 - 208 12/7 - 211 12/6 - 211 12/5 - 210.5 R33's weight summary and/or TAR, printed	F 580	1. Root cause: The Administrator and Interim Director of Nursing discussed on 1/20/2025 to identify the root cause of this alleged non-compliance. Root cause analysis conducted revealed; the alleged non-compliance resulted from weights being missed and physician not notified with change in resident R33 and R43 weights. Nurse failed to properly inform the physician of a change in condition (Residents #R33, R43). Physician was notified of R33 & R43 missed weights. R33 currently has daily weight orders and R43 has weights 3x a week. Orders to update physician as needed. 2. How will other potentially impacted residents be identified? For other residents with a diagnosis of heart failure has the potential to be affected. 3. What systemic changes will be implemented to prevent recurrence? Facility plan to prevent re-occurrence: Effective 1/30/2025 and moving forward, licensed nursing staff will ensure residents change in condition will be notified to the Physician (MD). the Interim Director of Nursing, and/or Unit managers will complete 100% education for all licensed nursing staff, to include full time, part time and as needed employee. The education will include, notification of a change in condition will be reported to the Responsible Party and the Physicians. Any licensed nurses not educated by 1/30/2025 will not be allowed to work until educated. Facility provider Twin City Physicians has a portal system used to communicate with the physician. Licensed staff trained and	

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F 580	Continued From page 23 12/18/24, indicated R33 had a 3.5-lbs weight gain from 12/15/24 to 12/16/24 and a 4-lbs weight gain from 12/8/24 to 12/9/24 R33's medication administration record (MAR), printed 12/18/24, indicated Lasix 20mg daily PRN had not been administered 12/16/14 or 12/9/24 as ordered for weight gain. On 12/19/24 at 2:20 p.m., registered nurse (RN)-A confirmed R33 had an order for daily weights and to give Lasix 20mg daily PRN for 3-lb gain in a day or 5-lb. gain in a week. RN-A confirmed Lasix 20mg had not been administered to R33 on 12/16/24 nor 12/9/24 as ordered. R43's quarterly minimum data set (MDS) dated 10/16/24 indicated R43 was admitted to facility on 8/8/23 and had the following diagnoses: acute on chronic congestive heart failure, hypertensive heart disease with heart failure, history of transient ischemic attack and cerebral infarct. The MDS further indicated R43 was cognitively intact. R43's care plan with a last review date of 6/19/24 indicated a focus area of alteration in cardiac status related to diagnosis of hypertension (high pressure in the arteries that carry blood from the heart to the rest of the body), congestive heart failure (CHF)(a progressive disease that affects pumping action of the heart muscles), angina (a condition characterized by chest pain due to insufficient oxygen-rich blood reaching the heart muscle), atrial fibrillation (an irregular and often fast heartbeat) and deep vein thrombosis (a blood clot in a deep vein). Interventions included: administer oxygen as ordered; appointments with cardiology as directed; observe for signs and	F 580	educated on how to use the portal to communicate change of condition to provider. On 1/8/2025 Licensed staff trained & educated on urgent fax & phoning the provider. Faciliy has implemented a portal system to notify the provider of all non-emergent reports. 4. How will the facility monitor the corrective actions? Effective 1/24/2025, the Interim Director of Nursing, Unit Managers and designee will review 24-hour report and incident reports during the morning clinical meeting to ensure if a change in a residents condition was reported to MD. Monitoring: Effective 1/30/2025, the Interim Director of Nursing or designee to monitor the nurses notes, 24-hour report and incident logs daily, five days a week for four weeks, then three days a week for four additional weeks to ensure notification of RP and the residents MD of any change in condition. Administrator and/or Interim Director of Nursing will report findings of this monitoring process to the Performance Improvement Committee for any additional monitoring or modification of this plan monthly for three months, or until the pattern of compliance is maintained. The QAPI committee can modify this plan to ensure the facility remains in substantial compliance. Responsible Party: The Administrator and the Interim Director of Nursing will be ultimately responsible to ensure implementation of this plan of correction for this alleged non-compliance to ensure the facility remains in substantial compliance.	

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F 580	Continued From page 24 symptoms of CHF exacerbation including not limited to edema, shortness of breath, weight gain, adventitious lung sounds, cough, decreased oxygen saturations, weakness, increased heart rate, distended neck veins. The care plan indicated obtain weights as directed and update MD as ordered. An order summary dated 11/20/24 indicated R43 had an order for furosemide oral tablet 20 mg twice daily related to acute on chronic congestive heart failure. The bottom of the document had a handwritten provider note indicating the following: D/C Lasix (furosemide); Bumex 1mg BID; Labs-TSH, BNP, BMP in 1.5 weeks. Weights MWF. DX: CHF. An unsigned order summary dated 12/20/24 indicated an order for Bumex 1mg tablet -give Bumex 1mg by mouth in the afternoon related to acute on chronic congestive heart failure, and Bumex 1mg tablet-give Bumex 2mg by mouth in the morning for acute on chronic congestive heart failure. The order summary lacked a documented order for weights to be obtained on Monday, Wednesday and Friday as ordered on 11/20/24. Review of R43's documented weights indicated between 8/2/2024 through 8/30/24 seven out of thirteen opportunities for weight were missed. The record lacked evidence of provider notification of the missed weights. Review of R43's documented weights indicated between 9/2/24 through 9/30/24 eight of thirteen opportunities for weight were missed. The record lacked evidence of provider notification of the missed weights. Review of R43's documented weights indicated	F 580		

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F 580	Continued From page 25 between 10/2/24 through 10/30/24 seven of thirteen opportunities for weight were missed. The record lacked evidence of provider notification of the missed weights. Review of R43's documented weights indicated between 11/1/24 through 11/29/24 nine of thirteen opportunities for weight were missed. The record lacked evidence of provider notification of the missed weights. Physician progress note dated 11/18/24 indicated R43 told provider she felt like she was gaining water weight and her legs felt tighter than usual. The note went on to indicate R43's weight had increased from 261.5 on 11/1 to 265.5 on 11/11 to 268.5 on 11/18. The progress note confirmed R43's order to check weights MWF but were not getting done consistently. Physician progress note dated 11/24/24 indicated resident had a history of heart failure and had been seen a few times earlier in 2024 for the same issue. The note indicated R43's baseline weight was around 245 to 250 pounds, but she had been experiencing a gradual increase over the past few months. Review of R43's documented weights indicated between 12/2/24 through 12/16/24 three of seven opportunities for weight were missed. The record lacked evidence of provider notification of the missed weights. Physician progress note dated 12/3/24 indicated R43 reported to the provider her weight was recorded once during week, despite being scheduled for weigh-in on Monday, Wednesday, and Friday. The provider indicated ongoing concerns and despite orders for weights 3 times weekly, nursing staff had only completed once	F 580		

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F 580	Continued From page 26 weekly. During interview on 12/20/2024 at 4:11 p.m., director of nursing (DON) confirmed R43 had an order for weights three times weekly on Monday, Wednesday, and Friday. DON stated nursing staff is responsible for obtaining, documenting, and communicating any concerns for residents with an order for scheduled weights. DON stated if a scheduled weight was not performed the nursing staff should notify the physician. Further, DON confirmed R33 had not received PRN Lasix on 12/16/24 nor 12/9/24, as indicated by R33's weight gain. DON stated nurses were expected to administer the Lasix 20mg PRN if R33 had a weight gain that met the physician ordered parameters. DON further stated if a weight had been missed, nurses were expected to reach out to the provider to notify and request direction. DON stated this process was important for maintaining resident health and to avoid an acute episode of heart failure. The facility's Change in a Resident's Condition or Status Policy, revised 2/2021, indicated the facility promptly notified the resident attending physician of changes in resident's medical/mental condition and/or status. Findings include:	F 580		
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to	F 625		1/30/25

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F 625	Continued From page 27 the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide a written notice of a bed-hold at the time of transfer for two hospitalizations for 1 of 2 residents (R33) reviewed for hospitalization. Findings include: R33's significant change Minimum Data Set (MDS) dated 10/30/24, indicated diagnoses included dementia, chronic diastolic congestive heart failure (CHF), atrial fibrillation (irregular heartbeat), peripheral neuropathy (nerve damage), and diabetes.	F 625	F625 1. What specific corrective action will be taken to affected residents? Facility obtained a written notice of bed hold for resident R33. Resident has returned to facility. 2. How will other potentially impacted residents be identified? All residents who reside in the facility have the potential to be affected by this finding.	

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F 625	Continued From page 28 R33's progress note dated 8/14/24 at 12:52 p.m., indicated R33 was transferred via ambulance to the hospital for increased redness and swelling in the left foot, and a verbal bed-hold was received from FM-B. R33's progress note dated 8/14/24 at 6:20 p.m., indicated R33 was admitted to the hospital for intravenous (IV) antibiotic treatment. A subsequent progress noted dated 8/20/24 at 11:57 p.m., indicated R33 returned from the hospital. R33's Bed-hold Policy form, dated 8/14/24, indicated a bed-hold telephone consent was obtained verbally from R33's family member (FM)-B. The form was signed and dated by the registered nurse (RN) on 8/14/24. However, R33's record lacked evidence a written bed-hold notice was received by the resident/representative at the time of transfer. R33's progress note dated 12/18/24 at 11:57 p.m., indicated R33 was transferred via ambulance to the hospital for increased pain and change in transfers, a verbal bed-hold from the "POA" (power of attorney) was noted, and orders/MAR were sent. R33's progress note dated 12/19/24 at 5:06 a.m., indicated R33 was admitted to the hospital Telemetry unit for congestive heart failure (CHF) and possible hip fracture. On 12/19/24 at 8:23 a.m., FM-B stated she gave a verbal consent for a bed-hold on 12/18/24. FM-B stated the family had questions regarding the policy and potential costs but had not received a written copy from the facility, nor was a	F 625	3. What systemic changes will be implemented to prevent recurrence? All residents sent to the hospital within the past 30 days audit to ensure paper work for bed hold was sent with resident and documented. Licensed nurses educated on bed hold policy and procedure 1/29/2025. A full audit of all current residents and those discharged was completed with a 30 day look back by the Medical Records Director by 1/30/2025. Any and all residents transferred/discharged from the audit have been given a notice of the bed hold policy. 4. How will the facility monitor the corrective actions? The Medical Record Director/Designee will be responsible for the Bed Hold Compliance Audit. We will monitor all bed hold compliances daily 5x/week X 4weeks, 3X/week x 4weeks, 2x/week X 4 months. Results of the audits will be reviewed in QAPI.	

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F 625	Continued From page 29 copy sent with R33's information provided by the facility for the hospital at the time of transfer. On 12/20/24 at 10:56 a.m., social services designee (SS)-A, stated the nurses were trained to review the Bed-hold Policy with the resident/responsible party at the time of transfer, and obtain verbal consent or a signature on the form. A copy of evidence a written bed-hold notice was received by the resident/representative at the time of transfer for 8/14/24 was requested. However, SS-A only provided a copy of the telephone consent from 8/14/24. On 12/20/24 at 4:18 p.m., director of nursing (DON) verified evidence a written bed-hold notice was received by the resident/representative at the time of transfer for 8/14/24 and 12/18/24 were not stated written bed-hold information needed to be provided at the time of transfer, or with 24 hours for emergent transfers. The DON expected staff to have the Bed-hold Policy signed by the resident/representative at the time of transfer or send a copy of the Bed-hold Policy with the resident at the time of transfer. If a signature was not obtained by the resident/representative at the time of transfer, the DON expected social services (SS) or the nurse manager to follow-up until a signed form was obtained. DON stated written bed-hold information was important, so residents/representatives understood their rights and what a bed-hold entailed. On 12/23/24 at 5:18 p.m., the facility provided a copy of R33's Therapeutic Leave of Absence Day (Bed-hold Policy) form which indicated a bed-hold telephone consent was obtained from R33's family member (FM)-B. The form was signed and	F 625		

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F 625	Continued From page 30 dated by the registered nurse (RN) on 12/18/24. However, R33's record lacked evidence a written bed-hold notice was received by the resident/representative at the time of transfer. The facility's Bed-Holds and Returns Policy, revised 10/2022, indicated residents/representatives were provided written information regarding the bed-hold policies, which addressed holding or reserving a resident's bed during periods of absence at the time of transfer or, if the transfer was an emergency, within 24 hours.	F 625		
F 640 SS=D	Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4) §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death. (vi) Background (face-sheet) information, if there is no admission assessment. §483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by	F 640		1/30/25

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F 640	Continued From page 31 CMS and the State. §483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following: (i)Admission assessment. (ii) Annual assessment. (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly assessment. (vi) Quarterly review. (vii) A subset of items upon a resident's transfer, reentry, discharge, and death. (viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment. §483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to complete and transmit a discharge return not anticipated Minimum Data Set (MDS) for 2 of 2 residents (R25, R48) reviewed for transmission of resident assessment. Findings include: R25's significant change MDS dated 7/2/24, included an admission date of 6/4/24. R25 was cognitively intact with a primary diagnosis of	F 640	F640 640 Encoding and Transmitting Resident Assessments 1. The plan for correcting the specific deficiency: The deficiency occurred when MDS coordinator failed to complete a discharge assessment and failed to transmit on resident R25 & R48. The discharge assessment was corrected on 1/24/2025.	

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F 640	Continued From page 32 osteoarthritis of the right hip (the tissue of the joint breaks down over time) with joint replacement. R25's facility assessment titled Post Discharge Plan of Care dated 6/21/24, included a discharge date of 6/21/24. Assessment included R25 participated in the discharge plan. R25's medical record lacked evidence a discharge MDS was completed. R48's admission MDS dated 8/9/24, included an admission date of 8/2/24. R48 was cognitively intact with a primary diagnosis of hyponatremia (low sodium level). R48's progress note dated 9/5/24, included R48 left the facility and stated she would not be returning. Facility noted a Minnesota Adult Abuse Reporting Center (MAARC) report was filed. R48's progress noted dated 9/6/24, included R48 returned to the facility to collect belongings and medication. R48's medical record lacked evidence a discharge MDS was completed. During interview on 12/20/24 at 11:21 a.m., MDS registered nurse (RN)-A confirmed she completed MDS assessments for the facility. RN-A worked offsite and relied on the facility to update her when residents admitted, discharged, or had a significant change. RN-A confirmed a discharge MDS was not completed for both R25 and R48. RN-A thought this may have been due her not being updated on the discharge and noted young staff and frequent turn over of leadership.	F 640	2. Process for identifying potential residents affected by deficient practice: " All residents discharged in the last 30 days were audited by MDS coordinator and all corrections needed were made to the MDS assessments by MDS coordinator on 1/24/2025 to ensure that all discharge assessments were completed. " MDS coordinator was educated by interim Director of Nursing on 1/21/2025 on accurately encoding and transmitting resident assessments. 3. Monitoring the plan " 5 MDS assessments will be audited monthly for 3 months by MDS coordinator. " Effective 1/24/2025 MDS coordinator will report the findings of the audits and reviews to the Quality Assurance and Performance Committee for any additional monitoring or modification of this plan monthly for 3 months. The Quality Assurance and Performance Improvement Committee can modify this plan to ensure the facility remains in compliance. 4. Title of the person responsible for implementing this plan: " The administrator is responsible for compliance of this corrective action. It will be fully implemented on 1/30/2025	

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F 640	Continued From page 33 During interview on 12/20/24 at 2:23 p.m., director of nursing (DON) stated she had not had a lot to do with MDS completion and submission since she started in October. She stated there was a leadership email group that should be updated whenever someone was admitted, transferred to the hospital or discharged. The MDS nurse should have been on this email group and should have received updates. The DON stated it was important to submit complete and accurate MDS data in a timely manner to document and bill correctly. Policy for MDS submissions requested and not provided.	F 640		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the	F 657		1/30/25

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F 657	Continued From page 34 resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to revise the comprehensive care plan for 2 of 2 residents (R33, R43) reviewed for heart failure. Findings include: R33's significant change Minimum Data Set (MDS) dated 10/30/24, indicated R33 was admitted to facility on 9/15/23 and had the following diagnoses: chronic diastolic congestive heart failure (CHF), atrial fibrillation (A-Fib), chronic obstructive pulmonary disease (COPD), and diabetes. The MDS further indicated R33 was cognitively intact. R33's care plan with a last review date of 6/19/24, indicated a focus area of alteration in respiratory status related to diagnoses of COPD, sleep apnea, CHF, chronic bronchitis, and resident experienced shortness of breath (SOB) with exertion. Interventions were listed to administer medications/nebulizers as ordered and observe for effectiveness/side effects; observe for SOB, dyspnea (labored breathing), cyanosis (blue skin), change in mentation (mental function), anxiety, restlessness, air hunger, and document if these occurred; utilize CPAP per physician order. The care plan also listed an intervention of licensed	F 657	F657 Care Plan Timing and Revision The facility does revise resident Care Plans for individual needs and conditions. 1. Corrective Action to be taken for residents found to have been affected by the deficient practice: R33 & R43 have revised Care Plans to include orders, treatments and diagnosis. Care plans personalized to reflect orders, treatments, diagnosis and plan of care. 2. How the center will identify other residents having the potential to be affected by the same deficient practice? All residents in the facility have the potential to be affected by this deficient practice. 3. What systemic changes will be implemented to prevent recurrence? Staff were re-educated on initial and comprehensive Care Plans. Resident changes will be discussed in morning meetings and care plans will be adjusted accordingly. Residents care plans will be discussed upon admission, quarterly & with change of condition to ensure accuracy. Nurse managers educated on expectations of care planning. 4. How will facility monitor the corrective	

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F 657	Continued From page 35 nurse to observe skin weekly. Additionally, an intervention of daily weights was added on 12/12/24. R33's cardiology clinic note dated 2/28/24, indicated R33 presented with her family member (FM)-B for a cardiology provider visit on 2/26/24. R33 had CHF with noted congestion in lungs and reported occasional shortness of breath and lower extremity edema. The cardiologist ordered furosemide (Lasix - a diuretic) 20mg daily as needed (PRN) for lung congestion and/or lower extremity (LE) edema related to CHF. However, R33's record lacked evidence a nurse had contacted the cardiologist to obtain more specific parameters for the administration of a PRN diuretic. Additionally, R33's record lacked evidence measures were initiated to monitor R33 for lung congestion and LE edema. R33's order history, printed 12/18/24, indicated R33 had an order for furosemide oral tablet 20mg daily as needed for lung congestion and/or lower extremity edema was started on 2/28/24. However, R33's care plan had not been updated to include interventions to monitor for lung congestion and LE edema. R33's Hospital Orders Discharge Report dated 8/20/24, indicated R33 was hospitalized from 8/14/24 to 8/20/24. The discharge orders instructed facility staff to call the physician for weight gain of 3 pounds or more over night or gain 5 pounds in a week. However, R33's record lacked evidence the weight monitoring order had been transcribed and implemented. Additionally, R33's care plan had not been updated to include interventions to monitor for weight gain.	F 657	actions: Nurse managers or designee will conduct 2 random audits per week for 4 weeks to ensure all Care Plans accurate,, than 1x a week for 12 weeks. Care Plans will be individualized. Nurse managers will not audit their own care plan. Each nurse manager will conduct peer audits of care plan per designated schedule. 5. Results of the audits will be reviewed in QAPI. Identified concerns shall be reviewed by the facilities QAPI team and a plan will be implemented for correction. Recommendations for further corrective action will be discussed and implemented as needed.	

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F 657	Continued From page 36 R33's progress note dated 9/3/24 at 11:57 a.m., indicated R33 was seen on provider rounds and "weights x 1 week" was ordered. However, R33's care plan had not been updated to include interventions to monitor weights. R33's PCP progress notes for 9/3/24, dated 9/4/24 at 8:10 a.m., indicated R33's Jardiance was to be discontinued to help with R33's urinary concerns, and because CHF was a chronic concern, nursing staff would monitor weights 3 times weekly, and if weight increased the provider would consider ordering a diuretic or restart a lower dose of Jardiance. However, R33's care plan had not been updated to include interventions to monitor weights or signs/symptoms of CHF exacerbation. R43's quarterly minimum data set (MDS) dated 10/16/24 indicated R43 was admitted to facility on 8/8/23 and had the following diagnoses: acute on chronic congestive heart failure, hypertensive heart disease with heart failure, history of transient ischemic attack and cerebral infarct. The MDS further indicated R43 was cognitively intact. R43's care plan with a last review date of 6/19/24 indicated a focus area of alteration in cardiac status related to diagnosis of hypertension (high pressure in the arteries that carry blood from the heart to the rest of the body), congestive heart failure (CHF) (a progressive disease that affects pumping action of the heart muscles), angina (a condition characterized by chest pain due to insufficient oxygen-rich blood reaching the heart muscle), atrial fibrillation (an irregular and often fast heartbeat) and deep vein thrombosis (a blood clot in a deep vein). Interventions were listed as	F 657		

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F 657	Continued From page 37 administer oxygen as ordered; appointments with cardiology as directed; observe for signs and symptoms of CHF exacerbation including but not limited to edema, shortness of breath, weight gain, adventitious lung sounds, cough, decreased oxygen saturations, weakness, increased heart rate, distended neck veins. The care plan also listed an intervention of obtaining weights as directed and update MD as ordered. An order summary dated 11/20/24, indicated R43 had an order for furosemide oral tablet 20 mg twice daily related to acute on chronic congestive heart failure. The bottom of the document had a handwritten provider note indicating the following: D/C Lasix(furosemide); Bumex 1mg BID; Labs-TSH, BNP, BMP in 1.5 weeks. Weights MWF. DX: CHF. R43 physician note dated 11/21/24, indicated resident had 'a history of heart failure and had been seen a few times earlier this year for the same issue. Resident baseline weight was around 245 to 250 pounds, but she has been experiencing a gradual increase over the past few months. Her most recent weight, recorded three days ago, was 268 pounds. This morning, her weight was recorded as 265.5 pounds. Resident believed her weight gain is due to fluid retention, as her legs feel tight'. R43 physician note dated 12/3/24, indicated resident reported her weight was recorded once during week, despite being scheduled for weigh-in on Monday, Wednesday, and Friday. The provider indicated ongoing concerns and despite orders for weights 3 times weekly, nursing staff had only completed once weekly and weight was up to 268.	F 657		

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F 657	Continued From page 38 During interview on 12/20/2024, at 4:11 p.m., director of nursing (DON) confirmed R33 had a history of CHF exacerbation and expected nurses to implement interventions to monitor weights and edema. Additionally, nurses were expected to review and update resident care plans when they review orders, provider notes, and hospital discharge orders. Further, DON stated R43 had an order for weights three times weekly on Monday, Wednesday, and Friday. DON also confirmed the order was not carried over to the care plan as written. DON stated nursing staff is responsible for creating the care plan based on assessments of each resident and physician's orders. DON stated this process was important for maintaining resident health and for staff to have a clear directive and plan to prevent an acute exacerbation of heart failure. During interview on 12/20/24 at 4:18 p.m., director of nursing (DON) A policy was requested, but not provided.	F 657		
F 684 SS=G	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the	F 684	Plan of Correction for F684	1/30/25

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F 684	Continued From page 39 facility failed to monitor and implement interventions for heart failure for 2 of 2 residents (R33, R43) reviewed. This resulted in actual harm to R33 who was re-hospitalized for exacerbation of heart failure. Findings include: R33's significant change Minimum Data Set (MDS) dated 10/30/24, indicated R33's diagnoses included dementia, chronic diastolic congestive heart failure (CHF), diabetes, phantom limb pain (from below knee amputation), and cellulitis (bacterial infection) of left lower limb. R33's cardiology clinic note dated 2/28/24, indicated R33 presented with her family member (FM)-B for a cardiology provider visit on 2/26/24. R33 had CHF with noted congestion in lungs and reported occasional shortness of breath and lower extremity edema. The cardiologist ordered furosemide (Lasix - a diuretic) 20mg daily as needed (PRN) for lung congestion and/or lower extremity (LE) edema related to CHF. However, R33's record lacked evidence a nurse had contacted the cardiologist to obtain more specific parameters for the administration of a PRN diuretic. Additionally, R33's record lacked evidence measures were initiated to monitor R33 for lung congestion and LE edema. During interview on 12/20/24 at 4:18 p.m., director of nursing (DON) stated the nurse was expected to update R33's care plan to ensure R33 was monitored for lung congestion and edema to trigger the nurse to administer the PRN Lasix as ordered. Additionally, because R33 had a diagnosis of CHF, the nurse was expected to ensure R33 was monitored for edema and weight	F 684	1. What corrective actions will be accomplished for those residents found to have been affected by the deficient practice: • R33 & R43 monitored for signs and symptoms of CHF. • Care plan and Kardex updated to include interventions. • Signs and symptoms of CHF added to the EMAR. • Staff licensed staff educated on diagnosis of CHF/heart failure and required monitoring and interventions to be incited. 2. How other residents having the potential having the potential to be affected by the same deficient practice: • Any resident who has a diagnosis of heart failure is at risk to be affected by deficient practice. 3. What measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur: • The Director of Nursing/designee educated all licensed nurses on the diagnosis of CHF and the requirements of monitoring including but not limited to edema, shortness of breath, weight gain, lung sounds, cough. Decrease oxygen saturations. • Provider needs to be updated with change in condition. • Educated licensed staff on the	

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F 684	Continued From page 40 gain to prevent CHF exacerbation. R33's progress note, dated 3/13/24 at 12:35 a.m., indicated R33 had left lower extremity (LLE) 2+ edema (moderate pitting), and the area below and behind the knee was taut. However, R33's record lacked evidence the nurse administered Lasix 20mg daily PRN for LE edema as ordered. Additionally, the record lacked evidence the provider had been notified. R33's weight summary, printed 12/18/24, indicated R33's weight was 199 pounds (lb) on 3/15/24, and 205 lb on 3/22/24, which indicated a weight gain of 6 pounds in a week. However, R33's record lacked evidence R33 had been assessed for lung congestion and/or LE edema to determine if PRN Lasix was indicated. Additionally, the record lacked evidence the provider had been notified of the weight gain. R33's pharmacist (PharmD) recommendations to providers dated 3/21/24, indicated an order for 'PRN Lasix 20mg to give for lung congestion or edema' had vague parameters that could lead to inconsistencies in administration. PharmD indicated the PRN Lasix had not been used since ordered on 2/26/24, and suggested the provider consider either discontinuing the PRN Lasix; or if the provider wished to continue the PRN Lasix, the order needed to include specific parameters for when to administer (e.g. Give for 5-lb weight gain in a week, 3-lb weight gain in a day). Subsequently, on 3/26/24, R33's primary care provider (PCP) placed a check mark in the "agree" box and signed the document, but the provider had not indicated if the PRN Lasix was to be discontinued or if it was to be continued with specific parameters. Further, R33's record lacked	F 684	importance of following provider orders and up dating provider if unable to follow provider orders, Example refusal of care. 4. How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. • Complete audit of all residents with a diagnosis of heart failure to include care plan, Kardex, MAR/TAR. • Facility will audit 5x a week all residents with a diagnosis of heart failure to ensure provider orders are followed and provider notification and plan of care is followed. Audits will continue for 4 weeks. Than 2x a week for 8 weeks. • The facility will review results of the audits and review with the QAPI committee. • QAPI committee will determine if Audits need to continue.	

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F 684	Continued From page 41 evidence the nurse had contacted the PCP and/or the cardiologist to clarify the PharmD recommendations. During interview on 12/20/24 at 4:18 p.m., DON acknowledged the provider's response to the PharmD recommendations dated 3/21/24 was unclear. DON verified PRN Lasix order had been discontinued by the nurse on 3/26/24. DON stated the PRN Lasix should not have been discontinued and the nurse should have contacted the provider to clarify the order. R33's medication administration record (MAR) dated March 2024, indicated R33's furosemide [Lasix] 20mg daily PRN for lung congestion and/or lower extremity edema was discontinued on 3/26/24. However, R33's chart lacked evidence of a signed physician order to discontinue Lasix 20mg daily PRN. R33's progress note dated 3/31/24 at 10:15 p.m., indicated R33's LLE had 3+ edema (deep pitting) and "cracks" on foot where swelling increased pressure. However, the nurse indicated "will update provider on next doctor rounds". R33's record indicated the provider saw R33 on 4/4/24. R33's progress note dated "late entry" 4/12/24 at 10:05 a.m., indicated upon skin assessment resident found to have a few blood blisters on left shin. Current interventions included inspect skin PRN with cares, nurse to observe skin weekly, lift/do not slide resident, use assistive devices, and observe for signs/symptoms of infection and updated provider PRN. New intervention of "lotion body daily PRN". However, R33's record lacked evidence the provider had been notified.	F 684		

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F 684	Continued From page 42 R33's progress note dated 4/12/24 at 4:30 p.m., indicated two small "blood blisters" and two small "opened" blisters were found on R33's left calf, and occasional blistering of skin was "related to edema". However, R33's record lacked evidence the provider had been notified. R33's progress note dated 4/16/24 at 3:30 p.m., indicated R33 was seen by the provider during rounds, and ordered increased bedtime (HS) dose of gabapentin (for pain), increase HS dose of Lyrica (for pain), and continue to monitor blood blisters on LLE. R33's weight summary for April 2024 through August 2024, indicated R33's weights were obtained 4/5/24, 4/12/24, 4/19/24, 5/10/24, 5/17/24, 6/1/24, 6/7/24, 6/14/24, 6/28/24, 7/5/24, 7/12/24, 7/19/24, 8/2/24, 8/9/24, and 8/26/24, with no significant weight gain noted. R33's order history, printed 12/18/24, indicated R33 received wound care for a right lower extremity (RLE) ulcer from 4/23/24 through 6/19/24, and an order for a wound clinic referral was placed 4/30/24. R33's progress note dated 8/12/24 at 5:21 a.m., indicated R33's 2nd, 3rd, and 4th toes on left foot were very red, not warm to touch, swollen, and R33 denied pain. However, R33's record lacked evidence the provider had been notified. R33's progress note dated 8/13/24 at 12:37 a.m., indicated R33 was noted to have bled through her sock and all R33's toes on left foot were swollen with dark purple discoloration extending to the top of R33's foot, with redness across top of foot. R33's 1st toe was largely swollen with the 2nd toe	F 684		

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F 684	Continued From page 43 resting tightly against it. R33's 3rd toe was "swollen to the point of skin breaking open" on top of toe with peeling skin and "resident cannot feel toes and cannot detect pain". The nurse indicated the unit manager was notified and R33 was added to provider rounds later that day. R33's progress note dated 8/13/24 at 12:58 a.m., indicated R33 had a 3cm x 3cm wound on the front of left calf and noted to have thick, purulent drainage (pus). R33's progress note dated 8/13/24 at 12:56 p.m., indicated R33 was seen by the provider for her LLE. The provider ordered Keflex (antibiotic) 500mg three times a day (TID) for 7 days, MRI for left foot to check for deeper infection, and labs drawn 8/15/24. R33's progress note dated 8/14/24 at 12:52 p.m., indicated R33 was transferred to the ED for increased redness and swelling in left foot. A subsequent progress note dated 8/14/24 at 6:20 p.m., indicated R33 was admitted to the hospital. R33's Hospital Orders Discharge Report dated 8/20/24, indicated R33 was hospitalized from 8/14/24 to 8/20/24 for multiple open wounds of LLE. The discharge orders instructed facility staff to call the physician for weight gain of 3 pounds or more over night or gain 5 pounds in a week. However, R33's record lacked evidence the weight monitoring order had been transcribed and implemented. During interview on 12/20/24 at 4:18 p.m., DON verified the 8/20/24 hospital discharge order to monitor R33's weight had not been completed. DON stated the nurse was expected to identify	F 684		

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F 684	Continued From page 44 and follow the hospital weight monitoring order. R33's primary care provider (PCP) progress notes, dated 8/22/24, indicated R33 had a history of right partial lower extremity amputation below the knee in 2020 due to osteomyelitis, and had recently been hospitalized due to a wound on R33's left lower leg. R33's progress note dated 9/3/24 at 11:57 a.m., indicated R33 was seen on provider rounds and "weights x1 week" was ordered. However, R33's record lacked evidence the nurse clarified the order to obtain specific parameters for when to notify the physician. R33's subsequent PCP progress notes for 9/3/24, dated 9/4/24 at 8:10 a.m., indicated nursing staff were to monitor R33's "weights 3 times weekly, and if weight increased the PCP would look at as needed dosing of diuretics or reinstitution of lower dose of Jardiance". However, R33's record lacked evidence the nurse identified the conflicting weight orders of "weights x1 week" and "weights 3 times weekly", and R33's record lacked evidence the conflicting weight orders were clarified with the provider. During interview on 12/20/24 at 4:18 p.m., DON acknowledged the PCP progress notes for 9/3/24 directing the nursing staff to monitor weights 3 times weekly had not been completed. DON stated the nurse was expected to review the PCP progress notes and to have entered the order to monitor R33's weights 3 times weekly. Additionally, DON stated the nurse was expected to contact the provider to clarify any order discrepancies and ensure specific parameters were in place.	F 684		

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F 684	Continued From page 45 R33's order history indicated an order for daily weights one time a day for 1 week was started 9/4/24 and ended on 9/11/24. R33's weight summary indicated the following weights for 9/4/24 through 9/11/24: 9/4 - no documented weight 9/5 - 201 lb 9/6 - no documented weight 9/7 - 200 lb 9/8 - 199 lb 9/9 - no documented weight 9/10 - 206.5 lb - gain of 7.5 lb in 2 days 9/11 - no documented weight However, R33's record lacked evidence the provider was notified of the weight gain of 7.5 lb from 9/8/24 through 9/10/24. Additionally, the record lacked evidence the nurse notified the provider, weights had not been obtained on 9/4/24, 9/6/24, 9/9/24, and 9/11/24. R33's record lacked evidence the order for "weights 3 times weekly", as indicated on the 9/3/24 PCP progress notes were entered and implemented. R33's weight summary indicated R33's weight was 204 lb on 9/23/24, and 209 lb on 9/27/24, which indicated a weight gain of 5 lb in 4 days. R33's record lacked evidence the provider had been notified. R33's weight summary indicated R33's weight was 206 lb on 10/22/24, and 213 lb on 10/24/24, which indicated a weight gain of 7 lb in 2 days. R33's record lacked evidence the provider had been notified.	F 684		

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F 684	Continued From page 46 R33's weight summary indicated R33's weight was 206.5 lb on 10/28/24, and 209.5 lb on 10/29/24, which indicated a weight gain of 3 lb in 1 day. R33's record lacked evidence the provider had been notified. R33's PCP progress notes, dated 10/30/24, indicated R33's continued to have LLE sores that were secondary to chronic edema of the area. R33's PCP progress notes, dated 11/5/24, indicated R33's active diagnoses included CHF, and cellulitis of the LLE. The PCP progress note further indicated, "Cardiology has recommended Lasix 20 mg if she experiences a 2-pound weight gain". However, R33's record lacked evidence a nurse notified the provider that R33 did not have a current order for Lasix. R33's orthopedic visit note, dated 11/7/24, indicated the lesion at the front of R33's left leg was a result of swelling into the leg. R33's weight summary indicated R33's weight was 206.5 lb on 11/18/24, and 211 lb on 11/19/24, which indicated a weight gain of 4.5 lb in 1 day. R33's record lacked evidence the provider had been notified. During interview on 12/18/24 at 9:46 a.m., R33's family member (FM)-B stated "a few weeks ago" she spoke with the DON why R33 was not getting her PRN Lasix because she was concerned about the swelling in R33's legs. FM-B stated the DON told her the PRN Lasix had been discontinued on 3/26/24, and the DON later found the order had been discontinued based on a pharmacy recommendation. FM-B stated she had	F 684		

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F 684	Continued From page 47 asked the cardiologist in February 2024 to prescribe something for R33's edema and thought R33 had been receiving the PRN Lasix since then. FM-B stated R33's family was concerned because R33 already had a leg amputated after her edema led to blisters and sores that became infected. FM-B stated she was concerned the same could happen to R33's LLE because the facility was not following physician orders. R33's Physician Fax Order, dated 12/4/24, indicated registered nurse (RN)-E requested an order for PRN Lasix as indicated on the cardiology clinic note dated 2/26/24, as R33 did not have the medication available, and family wanted it available. However, RN-E failed to provide any assessment information to support the request. On 12/5/24, R33's PCP subsequently wrote an order for Lasix 20mg daily PRN for 3 lb gain in a day or 5 lb gain in a week. During interview on 12/20/24 at 4:18 p.m., DON stated the 12/4/24 request to the provider for PRN Lasix was prompted after FM-B stated concern regarding R33's edema and asking why R33 was not receiving the PRN Lasix. DON stated after she determined the PRN Lasix had been discontinued on 3/26/24 and subsequently requested on order for PRN Lasix. Additionally, DON stated prior to FM-B bringing the concern to her, she "absolutely would have expected a nurse to have identified the changes". R33's order history indicated an order for "weight daily AM" was started 11/28/24 and on 12/5/24, an order for Lasix 20mg every 24 hours as needed for edema; weight gain "give if 3 lb gain in a day or 5 lb gain in a week" was started.	F 684		

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F 684	Continued From page 48 However, the nurse failed to ensure the "weight daily AM" order alerted the nurse of the specific parameters and PRN Lasix order. During interview on 12/20/24 at 4:18 p.m., DON stated the nurse was expected to have transcribed the order and/or verify the order to ensure the weight order was connected to the PRN Lasix order. R33's weight summary indicated the following weights for 12/5/24 to 12/18/24: 12/5 - 210.5 12/6 - 211 lb 12/7 - 211 lb 12/8 - 208 lb 12/9 - 212 lb 12/10 - no documented weight 12/11 - 212 lb 12/12 - 211 lb 12/13 - 211.5 lb 12/14 - 211 lb 12/15 - no documented weight 12/16 - 214.5 lb 12/17 - no documented weight 12/18 - 212 lb R33's weight summary indicated R33's weight was 208 lb on 12/8/24, and 212 lb on 12/9/24, which indicated a weight gain of 4 lb in 1 day. However, R33's MAR, dated December 2024, indicated PRN Lasix was not administered on 12/9/24 as ordered by the provider. During interview on 12/20/24 at 4:18 p.m., DON verified Lasix 20mg PRN had not been administered on 12/9/24. Additionally, DON verified R33 had a weight gain of 4 lbs in 1 day,	F 684		

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F 684	Continued From page 49	F 684		

from 12/8/24 to 12/9/24. DON stated the nurse was expected to administer the PRN Lasix because R33's weight gain met the parameters.

R33's care plan, printed 12/18/24, indicated "daily weight" was initiated on 12/12/24. However, no information regarding the PRN Lasix was added to R33's care plan.

R33's weight summary indicated R33's weight was 211 lb on 12/14/24, and 214.5 lb on 12/16/24, which indicated a weight gain of 3.5 lb in 2 days. However, R33's lacked evidence the nurse notified the provider R33's weight was not obtained on 12/15/24.

During interview on 12/20/24 at 2:35 p.m., registered nurse (RN)-A verified she administered R33's medications on 12/16/24. RN-A stated R33's weight had not been taken on 12/15/24, so she looked at the weight from one week prior, and R33's weight on 12/9/24 was 212. RN-A stated she did not administer PRN Lasix to R33 on 12/16/24 because there was only a 2.5 lb gain in a week. RN-A stated the provider was not contacted for direction and the provider was not notified of the missed weight.

Additionally, R33's record lacked evidence the nurse notified the provider R33's weights had not been obtained on 12/10/24 and 12/17/24.

During interview on 12/20/24 at 4:18 p.m., DON stated the nurse was expected to reach out to the provider to notify weight missed and request advice. DON expected the nurse on the cart to ensure the daily weight was obtained.

R33's progress note dated 12/19/24 at 12:18

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F 684	Continued From page 50	F 684		

a.m., indicated R33 had been admitted to the hospital telemetry unit for CHF, it was unclear if R33 had a hip fracture, but the hospital was dealing with the CHF at that time.

R33's Hospital Emergency Department (ED) to Admission Notes, dated 12/19/24, indicated R33 presented to the ED on 12/18/24 with acute on chronic heart failure exacerbation, coming in for dieresis, and a fall injury. R33 was started on Lasix 40 mg intravenous (IV), with plan to increase as needed.

On 12/19/24 at 8:23 a.m., FM-B stated she was with R33 in the ED on 12/18/24. In the ED, R33's LLE was "really swollen", red, and R33 was unable to straighten her leg. FM-B stated R33 was given Lasix IV in the ED and R33's weight went down as a result. On 12/20/24 at 9:10 a.m., FM-B stated R33's weight was down and it was visible in R33's face, legs, and belly. FM-B stated R33 was given scheduled Lasix and would discharge from the hospital with an order for scheduled Lasix.

On 12/19/24 at 12:20 p.m., the provider stated Lasix 20mg daily PRN for 3 lb gain in a day or 5 lb gain in a week was ordered for R33, and the facility was expected to obtain daily weights for such an order. R33 should have received PRN Lasix on 12/9/24 because of a one-day 4 lb increase, and the provider should have been notified. The provider expected to be notified if a daily weight was missed, and he was not aware daily weights were missed on 12/10, 12/15, and 12/17. The provider stated if the order was not followed, it could cause fluid retention leading to heart failure, shortness of breath, and possible hospitalization. Provider acknowledged R33 was

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F 684	Continued From page 51 currently hospitalized and stated if the PRN Lasix was administered per the specific parameters, the need for dieresis could have been avoided. On 12/19/24 at 3:01 p.m., nursing assistant (NA)-B stated R33 had LE swelling that varied in severity, "they are normal, then big, then in between", and NA-B notified the nurse whenever R33's legs were bigger than the prior day. On 12/20/24 at 4:18 p.m., DON verified R33 was currently hospitalized and was admitted with diagnosis of acute exacerbation of CHF and fracture of the femur. DON acknowledged the facility failed to monitor R33's weights and administer PRN Lasix as ordered, and stated "Absolutely, the need to admit for exacerbation could have been avoided". R43's quarterly minimum data set (MDS) dated 10/16/24 indicated R43 was admitted to facility on 8/8/23 and had the following diagnoses: acute on chronic congestive heart failure, hypertensive heart disease with heart failure, history of transient ischemic attack and cerebral infarct. The MDS further indicated R43 was cognitively intact. An order summary dated 11/20/24 indicated R43 had an order for furosemide oral tablet 20 mg twice daily related to acute on chronic congestive heart failure. The bottom of the document had a handwritten provider note indicating the following: D/C Lasix (furosemide); Bumex 1mg BID; Labs-TSH, BNP, BMP in 1.5 weeks. Weights MWF. DX: CHF. An unsigned order summary dated 12/20/24 indicated an order for Bumex 1mg tablet -give Bumex 1mg by mouth in the afternoon related to acute on chronic congestive	F 684		

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F 684	Continued From page 52 heart failure, and Bumex 1mg tablet-give Bumex 2 mg by mouth in the morning for acute on chronic congestive heart failure. The order summary lacked a documented order for weights to be obtained on Monday, Wednesday and Friday as ordered on 11/20/24. R43's care plan with a last review date of 6/19/24 indicated a focus area of alteration in cardiac status related to diagnosis of hypertension (high pressure in the arteries that carry blood from the heart to the rest of the body), congestive heart failure (CHF) (a progressive disease that affects pumping action of the heart muscles), angina (a condition characterized by chest pain due to insufficient oxygen-rich blood reaching the heart muscle), atrial fibrillation (an irregular and often fast heartbeat) and deep vein thrombosis (a blood clot in a deep vein). Interventions included: administer oxygen as ordered; appointments with cardiology as directed; observe for signs and symptoms of CHF exacerbation including not limited to edema, shortness of breath, weight gain, adventitious lung sounds, cough, decreased oxygen saturations, weakness, increased heart rate, distended neck veins. The care plan also listed an intervention of obtaining weights as directed and update MD as ordered. Review of R43's documented weights indicated between 8/2/2024 through 8/30/24 seven out of thirteen opportunities for weight were missed. The record lacked evidence of provider notification of the missed weights. Review of R43's documented weights indicated between 9/2/24 through 9/30/24 eight of thirteen opportunities for weight were missed. The record lacked evidence of provider notification of the	F 684		

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	245339	A. BUILDING _____ B. WING _____	C 12/20/2024

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F 684	Continued From page 53 missed weights. Review of R43's documented weights indicated between 10/2/24 through 10/30/24 seven of thirteen opportunities for weight were missed. The record lacked evidence of provider notification of the missed weights. Review of R43's documented weights indicated between 11/1/24 through 11/29/24 nine of thirteen opportunities for weight were missed. The record lacked evidence of provider notification of the missed weights. Physician progress note dated 11/18/24 indicated R43 told provider she felt like she was gaining water weight and her legs felt tighter than usual. The note went on to indicate the R43's weight had increased from 261.5 on 11/1 to 265.5 on 11/11 to 268.5 on 11/18. The progress note confirmed R43's order to check weights MWF but were not getting done consistently. Physician progress note dated 11/24/24 indicated resident had a history of heart failure and had been seen a few times earlier in 2024 for the same issue. The note indicated R43's baseline weight was around 245 to 250 pounds, but she had been experiencing a gradual increase over the past few months. Review of R43's documented weights indicated between 12/2/24 through 12/16/24 three of seven opportunities for weight were missed. The record lacked evidence of provider notification of the missed weights. Physician progress note dated 12/3/24 indicated R43 reported to the provider her weight was recorded once during week, despite being	F 684		

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F 684	Continued From page 54 scheduled for weigh-in on Monday, Wednesday, and Friday. The provider indicated ongoing concerns and despite orders for weights 3 times weekly, nursing staff had only completed once weekly. During observation and interview on 12/16/24 at 09:57 a.m., R43 had pitting edema (swelling caused by excess fluid in the body's tissues that leaves an indentation when pressed) in both lower extremities. R43 stated she took diuretics (a medication to help move excess fluid and salt out of the body) daily and was supposed to be weighed three times weekly on Monday, Wednesday, and Friday before breakfast. R43 stated she was frequently weighed only once per week despite orders from her physician to be weighed three times. During interview on 12/20/24 at 3:15 p.m., licensed practical nurse (LPN)A stated residents with CHF should be monitored closely for weight increases as this could be a sign of fluid overload. LPN-A stated this would be completed by the certified nursing assistants (CNA) with morning cares. LPN-A went on to say she did not routinely follow up with CNAs to confirm scheduled weights were completed. During interview on 12/20/2024 at 4:11 p.m., director of nursing (DON) confirmed R43 had an order for weights three times weekly on Monday, Wednesday, and Friday and was missing documentation for more than half of scheduled weights over the past 5 months. DON stated when a physician orders scheduled weights, she expects nursing staff to follow the order, obtain the weight and if it is not completed staff should document the reason why and communicate any	F 684		

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F 684	Continued From page 55 missed weights to the provider. DON stated this process was important for monitoring for signs/symptoms of heart failure and the purpose of the scheduled weights was to avoid an acute episode of heart failure. A policy was requested. However, not provided.	F 684		
F 732 SS=F	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data	F 732		1/30/25

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F 732	Continued From page 56 available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on record review and interviews the facility failed to ensure the required staffing information was posted daily. This had the potential to affect all 57 residents residing in the facility and their visitors who may wish to view the information. Findings include: On 12/16/24 upon entrance the staff posting was observed to include liscensed staff and total hours worked. On 12/17/24 the staff posting included liscensed staff and total hours worked. Staff postings dated 11/17/24 through 12/20/24, lacked evidence of accurate postinging information as evidenced by lack of information regarding how many liscensed staff were working in the facility each day, how many hours worked, and the total hours of all liscensed staff working on the days listed above. On 12/20/24 at 2:01 p.m., the director of nursing stated the information on the staff postings was incorrect and there had been miscommunication. The "information had been lost".	F 732	F732 Posted nurse staffing 1. What specific corrective actions will be taken for affected residents: For the Residents affected, the employee responsible for maintaining staffing sheets was in-serviced on 12/27/2024 on making sure the facility name, date, the total number of actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift are RNs, LPNs, and CNAs, and resident census. 2. How will other potentially impacted residents be identified: Deficient practice had the potential to affect all residents. 3. What systemic changes will be implemented to prevent recurrence: Staff scheduler is responsible for printing and posting staffing information daily. Human Resources will be the back up person in the event the Staff Scheduler is not available. New scheduler hired on 1/9/2025 and educated on the responsibility of printing and posting the nursing staffing hours. 4. How will the facility monitor the corrective action: The facility Administrator or designee will	

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F 732	Continued From page 57 On 12/20/24 at 2:08 p.m., the director of nursing and the HR manager (O)-F stated they would run a report through their charting system and then post the posting for Monday through Friday daily and would pre-post it for the weekend. Both the DON and O-F confirmed the information on the daily staffing sheets was incorrect and/or not there. It was not updated in person on the weekends, and they had not kept the information for the time frame requested. On 12/20/24 at 2:28 p.m., the DON stated their expectation was the staff posting to be updated and posted with correct information and was important to know how many licensed staff and residents are in the building, however did not indicate daily posting as required. The facility policy was requested and none was provided.	F 732	be review the daily staffing postings 5 days a week for 4 weeks; then will review 2x a week for a 4 weeks ; 1x a week for 8 weeks to ensure the staffing sheets have the accurate staffing information documented on the staffing sheets. This plan of correction and the quality improvement monitoring will be followed by the facility's Quality Assurance Performance Improvement Committee and any areas of concern will be addressed timely and appropriately.	
F 838 SS=F	Facility Assessment CFR(s): 483.71(a)(1)(3)(b)(1)(c)(1)-(5) §483.71 Facility assessment. The facility must conduct and document a facility-wide assessment to determine what resources are necessary to care for its residents competently during both day-to-day operations (including nights and weekends) and emergencies. The facility must review and update that assessment, as necessary, and at least annually. The facility must also review and update this assessment whenever there is, or the facility plans for, any change that would require a substantial modification to any part of this assessment. §483.71(a) The facility assessment must address	F 838		1/30/25

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F 838	Continued From page 58 or include the following: §483.71(a)(1) The facility's resident population, including, but not limited to: (i) Both the number of residents and the facility's resident capacity; (ii) The care required by the resident population, using evidence-based, data-driven "methods" that considering the types of diseases, conditions, physical and behavioral health needs, cognitive disabilities, overall acuity, and other pertinent facts that are present within that population, consistent with and informed by individual resident assessments as required under § 483.20; (iii) The staff competencies and skill sets that are necessary to provide the level and types of care needed for the resident population; (iv)The physical environment, equipment, services, and other physical plant considerations that are necessary to care for this population; and (v) Any ethnic, cultural, or religious factors that may potentially affect the care provided by the facility, including, but not limited to, activities and food and nutrition services. §483.71(a)(2) The facility's resources, including but not limited to the following: (i) All buildings and/or other physical structures and vehicles; (ii) Equipment (medical and non- medical); (iii) Services provided, such as physical therapy, pharmacy, behavioral health, and specific rehabilitation therapies; (iv) All personnel, including managers, nursing and other direct care staff (both employees and those who provide services under contract), and volunteers, as well as their education and/or training and any competencies related to resident	F 838		

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F 838	Continued From page 59 care; (v) Contracts, memorandums of understanding, or other agreements with third parties to provide services or equipment to the facility during both normal operations and emergencies; and (vi) Health information technology resources, such as systems for electronically managing patient records and electronically sharing information with other organizations. §483.71(a)(3) A facility-based and community-based risk assessment, utilizing an all-hazards approach as required in §483.73(a)(1). § 483.71(b) In conducting the facility assessment, the facility must ensure: § 483.71(b)(1) Active involvement of the following participants in the process: (i) Nursing home leadership and management, including but not limited to, a member of the governing body, the medical director, an administrator, and the director of nursing; and (ii) Direct care staff, including but not limited to, RNs, LPNs/LVNs, NAs, and representatives of the direct care staff, if applicable. (iii) The facility must also solicit and consider input received from residents, resident representatives, and family members. §483.71(c) The facility must use this facility assessment to: §483.71(c)(1) Inform staffing decisions to ensure that there are a sufficient number of staff with the appropriate competencies and skill sets necessary to care for its residents' needs as identified through resident assessments and plans of care as required in § 483.35(a)(3).	F 838		

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F 838	Continued From page 60 §483.71(c)(2) Consider specific staffing needs for each resident unit in the facility and adjust as necessary based on changes to its resident population. §483.71(c)(3) Consider specific staffing needs for each shift, such as day, evening, night, and adjust as necessary based on any changes to its resident population. §483.71(c)(4) Develop and maintain a plan to maximize recruitment and retention of direct care staff. §483.71(c)(5) Inform contingency planning for events that do not require activation of the facility's emergency plan, but do have the potential to affect resident care, such as, but not limited to, the availability of direct care nurse staffing or other resources needed for resident care. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to conduct and document a comprehensive facility-wide assessment which included all of the necessary components to provide adequate care and services to the residents in the facility. The deficient practice had the potential to affect all 57 residents in the facility. Findings include: During the entrance conference on 12/16/24 at 9:19 a.m., the team leader requested the facility assessment to be provided within four hours of entrance. Subsequent requests were made on 12/19/24 and 12/20/24.	F 838	F838 Facility Assessment 1. What specific corrective action taken for affected residents: The Facility Assessment has been updated to reflect current average census, bed capacity, staffing, and changes in leadership. 2. Identify other residents that maybe affected by deficient practice: All residents could have been affected. 3. What Systemic changes will be implemented to prevent recurrence? The leadership team has been educated on the importance of ensuring that the Facility Assessment is accurate and kept updated as facility characteristics change.	

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F 838	Continued From page 61 On 12/20/24 at 6:11 p.m., the administrator sent an email to the survey team containing the document titled Facility Assessment Tool 12-2024. Review of the entire document with an assessment date of 9/5/2024, indicated the assessment lacked important components to ensure the facility identified all the resources necessary to care for and provide services to their residents. The provided document had some sections filled out and others left blank. The missing components included but were not limited to: 1) The facility's information such as name of the facility, names of current leadership and management, medical director. 2) The quality assurance teams input or participation in the facility assessment formation or update. 3) List of personal or person from whom the information was gathered, or if resident or family member input was taken into account when the assessment was created. 4) A contingency staffing plan. 5) Staff Competencies and skill sets. 6) Health information technology resources. On 12/20/24 at 5:54 p.m., the administrator confirmed they were responsible for writing and creating the facility assessment. Their expectation was its completion should have been verified while they worked on their emergency preparedness program. It was important to complete a facility assessment to help guide staffing needs, equipment, and resident care needs. A facility assessment Policy was request and	F 838	The Administrator will be responsible for ensuring that the Facility Assessment is updated. 4. Monitor corrective actions The Administrator/Designee will complete monthly audits of the Facility Assessment to ensure that it is accurate. The results will be reported to the QAPI Committee monthly x 3 months for review and recommendations. The QAPI Committee is responsible for the ongoing monitoring for compliance.	

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F 838	Continued From page 62 none was provided.	F 838		
F 865 SS=F	QAPI Prgm/Plan, Disclosure/Good Faith Attmpt CFR(s): 483.75(a)(1)-(4)(b)(1)-(4)(f)(1)-(6)(h)(i) §483.75(a) Quality assurance and performance improvement (QAPI) program. Each LTC facility, including a facility that is part of a multiunit chain, must develop, implement, and maintain an effective, comprehensive, data-driven QAPI program that focuses on indicators of the outcomes of care and quality of life. The facility must: §483.75(a)(1) Maintain documentation and demonstrate evidence of its ongoing QAPI program that meets the requirements of this section. This may include but is not limited to systems and reports demonstrating systematic identification, reporting, investigation, analysis, and prevention of adverse events; and documentation demonstrating the development, implementation, and evaluation of corrective actions or performance improvement activities; §483.75(a)(2) Present its QAPI plan to the State Survey Agency no later than 1 year after the promulgation of this regulation; §483.75(a)(3) Present its QAPI plan to a State Survey Agency or Federal surveyor at each annual recertification survey and upon request during any other survey and to CMS upon request; and §483.75(a)(4) Present documentation and evidence of its ongoing QAPI program's implementation and the facility's compliance with requirements to a State Survey Agency, Federal	F 865		1/30/25

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F 865	Continued From page 63 surveyor or CMS upon request. §483.75(b) Program design and scope. A facility must design its QAPI program to be ongoing, comprehensive, and to address the full range of care and services provided by the facility. It must: §483.75(b)(1) Address all systems of care and management practices; §483.75(b)(2) Include clinical care, quality of life, and resident choice; §483.75(b)(3) Utilize the best available evidence to define and measure indicators of quality and facility goals that reflect processes of care and facility operations that have been shown to be predictive of desired outcomes for residents of a SNF or NF. §483.75(b) (4) Reflect the complexities, unique care, and services that the facility provides. §483.75(f) Governance and leadership. The governing body and/or executive leadership (or organized group or individual who assumes full legal authority and responsibility for operation of the facility) is responsible and accountable for ensuring that: §483.75(f)(1) An ongoing QAPI program is defined, implemented, and maintained and addresses identified priorities. §483.75(f)(2) The QAPI program is sustained during transitions in leadership and staffing; §483.75(f)(3) The QAPI program is adequately	F 865		

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F 865	Continued From page 64 resourced, including ensuring staff time, equipment, and technical training as needed; §483.75(f)(4) The QAPI program identifies and prioritizes problems and opportunities that reflect organizational process, functions, and services provided to residents based on performance indicator data, and resident and staff input, and other information. §483.75(f)(5) Corrective actions address gaps in systems, and are evaluated for effectiveness; and §483.75(f)(6) Clear expectations are set around safety, quality, rights, choice, and respect. §483.75(h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. §483.75(i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to maintain a Quality Assurance Assessment/ Quality Assurance and Performance Improvement (QAA/QAPI) program that was effective in identifying, assessing, performing, developing and implementing appropriate plans of action to assure clinical care, quality of care, resident rights and services were identified to maintain acceptable levels of performance. Furthermore, the facility failed to conduct ongoing	F 865	F865 QAPI 1. What specific corrective actions will be taken for affected residents: All residents have the potential to be affected. The plan of correcting cited deficiency of F865 and the process that lead to the citation; The facility will ensure that it has an effective QAPI Committee. The plan for correcting the cited	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 865	Continued From page 65 quality assessment and assurance activities, develop, and implement appropriate plans of action to correct repeated quality deficiencies identified during the survey the facility was aware of or should have been aware of which had the potential to adversely affect all 57 residents which resided in the facility. Findings include: See F552: The facility failed to ensure changes in medication were communicated to residents (R33) and or resident representative infringing on the resident's right to be informed. See F625: The facility failed to provide a written notice of a bed-hold at the time of transfer for hospitalizations as required. See F684: The facility failed to monitor and implement interventions for heart failure. This resulted in actual harm to R33 who was re-hospitalized for exacerbation of heart failure. See F838: The facility failed to conduct and document a comprehensive facility-wide assessment which included all of the necessary components to provide adequate care and services to the residents in the facility. See F880: The facility failed to ensure appropriate hand hygiene during medication pass and while handling soiled clothing to reduce the risk of infection. The facility's QAPI meeting minutes for the past 12 months were requested, however the facility only provided Quality Assurance and Assessment (QAA)/Quality Assessment and Performance	F 865	deficiency is that the facility has scheduled monthly QAPI meetings to include review of plan of correction audits. Facility will review audits from survey to ensure compliance. 2. How will other potentially impacted residents be identified: All residents in this facility have the potential of being impacted by this deficient practice. 3. What systemic changes will be implemented to prevent recurrence: The Administrator and the interim Director of Nursing will update the QAPI process to includes: plan of action to maintain quality of care, audits, OHFC reports, discussing facility wide assessment, emergency preparedness plan, facility risk assessment, Emergency preparedness drills. Current performance improvement projects, QIIP projects. Current action items and resolved action items will be reflected in QAPI minutes. • QAPI is scheduled the third Thursday of every month at 2:00pm • Facility medical director attends QAPI quarterly. • Pharmacy rep. Attends QAPI monthly. • Facility uses QAPI template provided by Superior Health. • QAPI is open to all employees and steak holders. • 4. Results will be discussed during the monthly QAPI meetings, any negative concerns will be addressed promptly. Plan of correction audits will be reviewed in QAPI to ensure compliance and quality of	

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	245339	A. BUILDING _____ B. WING _____	C 12/20/2024

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F 865	Continued From page 66 Improvement meeting agenda dated October 17th, 2024. The meeting agenda did not identify previous recertification survey results. The meeting agenda identified the current performance improvement project (PIP) as meds not available on electronic medication administration record (EMAR). During interview on 12/20/24 at 4:11 p.m., the director of nursing (DON) stated she was aware of ongoing issues of quality of care and specifically concerns of staff obtaining and documenting resident weights. DON stated she had identified the issue in October 2024, however failed to provide staff education or training until two months later on 12/20/24. During interview on 12/20/24 at 5:42 p.m. the administrator stated the facility held monthly QAA meetings and quarterly QAPI meetings, however no monthly QAA meeting minutes were provided, and only one QAPI meeting agenda dated 10/17/24 was provided. The administrator stated the facilities current PIP included weights, skin audits, staffing and medication administration, however the provided QAPI agenda lacked evidence of the reported PIP projects. Undated facility policy titled Quality Assurance and Performance Improvement (QAPI) Program identified the objections of the QAPI program as: 1. Provide a means to measure current and potential indicators for outcomes of care and quality of life. 2. Provide a means to establish and implement performance improvement projects to correct identified negative or problematic indicators. 3. Reinforce and build upon effective systems and processes related to the delivery of quality	F 865	care. 5. How will the facility monitor the corrective action: Administrator and Director of Nursing will review QAPI monthly to ensure the 'new" QAPI format meets QAPI requirements. Next QAPI meeting scheduled for February 20th 2025.	

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F 865	Continued From page 67 care and services. 4. Establish systems through which to monitor and evaluate corrective actions.	F 865		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, 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 §483.71 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	F 880		1/30/25

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F 880	Continued From page 68 reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure appropriate hand hygiene for 2 of 4 staff observed for medication pass. Further, the facility failed to ensure 1 of 1 staff consistently followed infection control standards of practice for handling soiled	F 880	F880 1. What corrective actions will be taken for affected residents? No residents identified. Staff identified was reeducated immediately on hand hygiene and handling solid lien in accordance with the	

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F 880	Continued From page 69 clothing to reduce the risk of infection. This practice had the potential to affect all 57 residents, staff, and visitors. Findings include: During observation on 12/19/24 at 7:51 a.m., registered nurse (RN)-C was preparing and administering medications for a resident. RN-C prepared medication in medication cup, locked the medication cart, went to resident in common area and handed medication cup to the resident who took medications independently. RN-C returned to the cart, picked up a new medication cup off of a stack of medication cups, pulled up information for a new resident on computer and unlocked medication cart to retrieve medications. RN-C did not wash hands with soap and water or utilize alcohol-based hand sanitizer during this process. During interview on 12/19/24 at 7:54 a.m., RN-C stated she always utilized alcohol-based hand sanitizer when passing medications. She stated she was going to throw away the medication cups and utilize alcohol-based hand sanitizer before preparing the next resident's medications. During observation on 12/19/24 at 11:49 a.m., licensed practical nurse (LPN)-A completed a blood sugar check utilizing a glucometer stored in the resident's room. LPN-A utilized alcohol-based hand sanitizer, applied gloves, cleansed resident's finger, and completed blood sugar check appropriately. LPN-A disposed of supplies and removed gloves. LPN-A did not wash hands with soap and water or utilize alcohol-based hand sanitizer after removing gloves. LPN-A then drew up insulin, applied gloves, cleansed	F 880	CDC guidelines. 2. How will other potentially impacted residents be identified? All residents could potentially be affected by deficient practice. 3. What systemic changes will be implemented to prevent recurrence? All Staff will be reeducated on hand hygiene and handling of solid lien in accordance with the CDC guidelines and staff competencies will be assessed. Staff Educator of designee will complete hand washing and solid lien competencies on staff upon hire, annually and as needed. 4. How will the facility monitor the corrective actions? Infection Control preventionist and/or designee will randomly audit 5 staff members weekly to ensure compliance with hand hygiene and solid linen for 4 weeks . Audits will be completed by Infection Control preventionist and/or designee weekly for 4 weeks. 2 staff members weekly for 8 weeks. Findings of audits will be reviewed and presented to the Administrator and to the Quality Assurance Performance and Improvement committee monthly until 100% compliance	

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F 880	Continued From page 70 administration site, and gave insulin correctly. LPN-A disposed of supplies and removed gloves. LPN-A did not wash hands with soap and water or utilize alcohol-based hand sanitizer after removing gloves. LPN-A then picked up a new medication up and pulled up information to administer medication to a different resident without washing hands. During interview on 12/19/24 at 11:50 a.m., LPN-A stated she should have utilized alcohol-based hand sanitizer between residents and after completing tasks, but she forgot. During interview on 12/20/24 at 11:32 a.m., director of nursing (DON) stated she expected staff to utilize alcohol-based hand sanitizer between each resident and before and after tasks while passing medications. She stated this was important to reduce infection. Facility policy titled Medication Administration dated April 2019, included staff will follow established infection control procedures, including handwashing, for medication administration. On 12/19/24 at 8:06 a.m., nursing assistant (NA)-A was observed holding a pair of dark blue, plaid, flannel pants as she walked down the 2nd floor hallway, past the nurse station, and into the tub room. However, NA-A was observed to to be wearing gloves and the clothing was not secured in a bag. On 12/19/24 at 8:07 a.m., NA-A confirmed the soiled clothing should have been placed in a bag before the item was removed from the resident's room and brought to the tub room. NA-A did not	F 880		

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F 880	Continued From page 71 confirm nor deny wearing gloves. On 12/20/24 at 1:25 p.m., infection preventionist (IP) stated staff were expected to have soiled items bagged and gloves on when handling soiled clothing/linens. IP stated soiled items needed to be contained, and gloves worn as a protective barrier, to prevent the spread of infection. Policy requested, but not provided by facility.	F 880		
F 883 SS=D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or	F 883		1/30/25

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F 883	Continued From page 72 refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to provide pneumococcal vaccine in a timely manner to 1 of 5 residents (R45) reviewed for immunizations. Findings include: R45's admission Minimum Data Set (MDS) dated 11/12/24, included an admission date of 11/5/24. R45's MDS indicated he was not up to date with	F 883	F883 Influenza and Pneumoccal Immunizations 1. What specific corrective actions will be taken for affected residents: R45 offered the Pneumonia vaccine and vaccine have been administered 1/28/2025. 2. How will other potentially impacted residents be identified: An audit of all	

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F 883	Continued From page 73 the Pneumococcal vaccinations. Undated facility document titled Pneumococcal Vaccination Consent/Declination was marked "yes" next to the question asking if R45 would have been interested in receiving the recommended pneumococcal vaccination. Form was signed by R45 and uploaded to the electronic medical record (EMR) within the same week as admission. During an interview on 12/20/24 at 11:39 a.m., director of nursing (DON) stated she was unsure of the process of reviewing for and giving immunizations and would have to defer to the infection preventionist. During an interview on 12/20/24 at 1:20 p.m., infection preventionist (IP) stated she reviewed immunization status when a resident was admitted utilizing the Minnesota Immunization Information Connection (MIIC). The IP utilized an app on her phone recommended by the facility pharmacy to find out which pneumococcal vaccinations a resident was eligible for and had residents sign a consent to show if they were interested in receiving an immunization or not. The immunization would be ordered from the pharmacy after review and consent. IP stated she would follow up with the pharmacy if she had not received the immunization within a few days. IP confirmed the immunization should have been received and given by 12/20/24. Facility policy on pneumococcal vaccination requested and not received.	F 883	current residents has been completed. There were no additional findings related to this citation. 3. What systemic changes will be implemented to prevent recurrence: Systemic changes Nursing staff have been educated on the importance of ensuring that residents are offered vaccines and ensuring that the residents and/or their responsible party are given information/education regarding the benefits and risks of immunization. The Infection Control Nurse will be responsible for ensuring that vaccines are offered with information/education regarding the benefits and risks of immunization. 4. How will the facility monitor the corrective actions: Medical Records or Designee will complete weekly audits of vaccination reports to ensure that vaccines are being offered and the medical records of residents with new vaccinations to ensure that information/education regarding the benefits and risks of immunization. The results will be reported to the QAPI Committee monthly x 3 months for review and recommendations. The QAPI Committee is responsible for the ongoing monitoring for compliance.	

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 12/18/2024. At the time of this survey, Mother of Mercy Senior Living Building 01 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		01/27/2025

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. Building 01 Main Building: Mother of Mercy Senior Living is a 3 story building with no basement. The building was constructed at 3 different times. The original building is a 2 story building without basement that was constructed in 1983 and is determined to be of Type II(222) construction. In 1999, a 1 story addition (Welcome Center) was added to the east that was determined to be of Type V(111) construction. In 2009 the 3rd floor addition was added to the facility above the existing 1983	K 000		

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K 000	Continued From page 2 building and was determined to be of Type II (111) construction. The facility was surveyed as two facilities. The facility has 2 hour fire separations between the 1983, 1999, and 2009 buildings and additions. The facility has been divided and inspected as 2 separate buildings. Building 01 consists of the 1st, 2nd and the 3rd floors of the facility has two separate building construction types and is being downgraded to Type II(111), which is separated from building 02 by a 2 hour vertical fire barrier. The facility has a capacity of 65 beds and had a census of 57 at the time of the survey. The requirements at 42 CFR, Subpart 483.70(a), are NOT MET as evidenced by:	K 000		
K 223 SS=D	Doors with Self-Closing Devices CFR(s): NFPA 101 Doors with Self-Closing Devices Doors in an exit passageway, stairway enclosure, or horizontal exit, smoke barrier, or hazardous area enclosure are self-closing and kept in the closed position, unless held open by a release device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke compartment or entire facility upon activation of: * Required manual fire alarm system; and * Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and * Automatic sprinkler system, if installed; and * Loss of power. 18.2.2.2.7, 18.2.2.2.8, 19.2.2.2.7, 19.2.2.2.8 This REQUIREMENT is not met as evidenced by:	K 223		1/31/25

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K 223	Continued From page 3 Based on observation and staff interview, the facility failed to maintain doors with self-closing devices per NFPA 101 (2012 edition), Life Safety Code, sections 19.2.2.2.7, 7.2.13.4, and 7.2.1.8.1. This deficient finding could have an isolated impact on residents within the facility. Findings include: On 12/18/2024 between 9:15 and 11:45 AM, it was revealed by observation that the self-closing fire door separating the main kitchen from the elevator was being blocked with buckets in the open position. An interview with the Administrator and Director of Environmental Services verified this deficient finding at the time of discovery.	K 223	K223 1. Self-closing fire door separating the main kitchen from the elevator was being blocked with buckets in the open position. Buckets were removed. Kitchen staff educated on not to prop open fire doors. Sign placed on door to remind staff not to prop door open. Sign reads: “Please Do Not Prop Door Open, Keep door closed.” 2. Kitchen Manager/ Maintenance Director or Designee will conduct audits 2x a week for 4 weeks and then monthly for 4 weeks to ensure self-closing doors are not being propped open. 3. Administrator/designee will monitor for compliance. Any issues will be addressed immediately. The audits will be discussed during monthly QA meeting. QA committee will determine if continued auditing is necessary once 100% compliance threshold is achieved for two consecutive months. 4. Systematic changes completed on 1/20/2025	
K 321 SS=E	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied	K 321		1/31/25

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	245339	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**12/18/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOTHER OF MERCY SENIOR LIVING	**230 CHURCH AVENUE, BOX 676 ALBANY, MN 56307**

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K 321	Continued From page 4 protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain hazardous area enclosures per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.2.1, 19.3.2.1.3, and 19.3.6.3.5. These deficient findings could have a patterned impact on the residents within the facility. Findings include: 1. On 12/18/2024 between 9:15 and 11:45 AM, it was revealed by observation that the following doors to hazardous areas with self-closing devices did not properly latch: Room 229 Soiled Utility, Room 231 Clean Linen, and the Basement Storage Room. 2. On 12/18/2024 between 9:15 and 11:45 AM, it was revealed by observation that the	K 321	K 321 1. Self-closing device did not properly latch: room 229 solid utility room; room 231 clean linen room, and the basement storage room. The house keeping storage room 230 door was blocked open with a brick. The Maintanence Director adjusted the self-closing doors to latch correctly on 1/20/2025. 2. Maintenance Director or Designee will conduct audits 2x a week for 4 weeks and then monthly for 4 weeks to ensure self-closing doors latch properly. 3. Administrator/designee will monitor for compliance. Any issues will be addressed immediately. The audits will be discussed during monthly QA meeting. QA committee will determine if continued	

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	245339	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**12/18/2024**

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K 321	Continued From page 5 Housekeeping Storage Room 230 door was blocked open with a brick. This violation was corrected at the time of discovery. An interview with the Administrator and Director of Environmental Services verified these deficient findings at the time of discovery.	K 321	auditing is necessary once 100% compliance threshold is achieved for two consecutive months. 4. Systematic changes completed on 1/20/2025	
K 353 SS=E	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to inspect the fire sprinkler system per NFPA 101 (2012 edition), Life Saftey Code, section 9.7.5, and NFPA 25 (2011 edition), Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, sections 5.2.1.1.2(5), and 5.2.2.2.	K 353	K353 1. Sprinkler heads in the main kitchen dish area by the cooking equipment were covered with lint and dust. Sprinkler pipe in the plant maintenance office has a wire zip tied to the pipe.	1/31/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245339	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**12/18/2024**

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K 353	Continued From page 6 These deficient findings could have a patterned impact on residents within the facility. Findings include: 1. On 12/18/2024 between 9:15 and 11:45 AM, it was revealed by observation that sprinkler heads in the main kitchen dish area and by the cooking equipment were covered with lint and dust. 2. On 12/18/2024 between 9:15 and 11:45 AM, it was revealed by observation that a white wire was zip tied to the sprinkler pipe in the Plant Maintenance Office. An interview with the Administrator and the Director of Enviornmental Services verified these deficient findings at the time of discovery.	K 353	2. Sprinkler heads in the main kitchen dust and lint cleaned off sprinkler heads. Zip tie removed from sprinkler pipe in maintenance office. 3. Maintenance department educated on keeping sprinkler heads clean and free from debris. Maintenance department also educated not to tie things to the sprinkler pipes. 4. Maintenance Director or Designee will conduct audits 2x a week for 4 weeks and then monthly for 4 weeks to ensure sprinkler system is free from dust and debris. 5. Administrator/designee will monitor for compliance. Any issues will be addressed immediately. The audits will be discussed during monthly QA meeting. QA committee will determine if continued auditing is necessary once 100% compliance threshold is achieved for two consecutive months. 6. Systematic changes completed on 1/20/2025	
K 363 SS=D	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible	K 363		1/31/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245339	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**12/18/2024**

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K 363	Continued From page 7 materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain corridor doors per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.6.3 and 19.3.6.3.5. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 12/18/2024 between 9:15 and 11:45 AM, it	K 363	K 363 1. Self-closing magnetic device did not properly latch in the main hallway between the care center and the assisted living. Magnetic hold device replaced by maintenance department on 1/20/2025. 2. Maintenance Director or Designee will conduct audits 2x a week for 4 weeks and then monthly for 4 weeks to ensure self-closing doors latch properly.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245339	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**12/18/2024**

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K 363	Continued From page 8 was revealed by observation that the doors separating the nursing home from the assisted living facilty in the main level hallway did not close and latch when released from the magnetic hold-open device. An interview with the Administrator and Director of Environmental Services verified this deficient finding at the time of discovery.	K 363	3. Administrator/designee will monitor for compliance. Any issues will be addressed immediately. The audits will be discussed during monthly QA meeting. QA committee will determine if continued auditing is necessary once 100% compliance threshold is achieved for two consecutive months. 4. Systematic changes completed on 1/20/2025	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245339	A. BUILDING **02 - 3RD FLOOR ADDITION** B. WING _____	**12/18/2024**

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 12/18/2024. At the time of this survey, Mother of Mercy Senior Living Building 02 was found in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, the Health Care Facilities Code. Building 02 (Welcome Center): Mother of Mercy Senior Living is a 3 story building with no basement. The building was constructed at 3 different times. The original building is a 2 story building without basement that was constructed in 1983 and is determined to be of Type II(222) construction. In 1999, a 1 story addition (Welcome Center) was added to the east that was determined to be of Type V(111) construction. In 2009 the 3rd floor addition was added to the facility above the existing 1983 building and was was determined to be of Type II (111) construction. The facility was surveyed as two facilities. The facility has 2 hour fire separations between the 1983, 1999, and 2009 buildings and additions. The facility has been divided and inspected as 2 separate buildings. Building 02 consists of the 1999 Welcome Center addition, located on the east wall of the 2nd floor and is determined to be of type V(111).	K 000		

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

Electronically Signed | 01/27/2025

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 The facility has a capacity of 65 beds and had a census of 57 at the time of the survey. The requirements at 42 CFR, Subpart 483.70(a), is MET.	K 000		

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER #	MULTIPLE CONSTRUCTION	DATE SURVEY COMPLETE:
	245339	A. BUILDING: **01 - MAIN BUILDING 01** B. WING _____	**12/18/2024**

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ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
K 920	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the usage of electrical adaptive devices per NFPA 99 (2012 edition), Health Care Facilities Code, sections 10.5.2.3.1 and 10.2.4.2.1, NFPA 101 (2012 edition), Life Safety Code, section 9.1.2, NFPA 70, (2011 edition), National Electrical Code, section 400.8. These deficient findings could have a patterned impact on the residents within the facility. Findings include: On 12/18/2024 between 9:15 and 11:45 AM, it was revealed by observation that there was a green extension cord in Room 224 plugged into a Christmas tree. Violation was corrected at the time of discovery. An interview with the Administrator and Director of Environmental Services verified these deficient findings at the time of discovery.

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The above isolated deficiencies pose no actual harm to the residents