Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
October 26, 2023

Administrator
Woodbury Health Care Center
7012 Lake Road
Woodbury, MN 55125

RE: CCN: 245235
Cycle Start Date: August 10, 2023

Dear Administrator:

On September 21, 2023, we notified you a remedy was imposed. On October 17, 2023 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 October 13, 2023.

As authorized by CMS the remedy of:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective November 10, 2023 did not go into effect. (42 CFR 488.417 (b))

In our letter of September 6, 2023, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from November 10, 2023 due to denial of payment for new admissions. Since your facility attained substantial compliance on October 13, 2023, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

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

Feel free to contact me if you have questions.

Sincerely,

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

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October 26, 2023

Administrator
Woodbury Health Care Center
7012 Lake Road
Woodbury, MN 55125

Re: Reinspection Results
Event ID: UL5Z12

Dear Administrator:

On October 3, 2023 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on August 10, 2023. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

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

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
September 6, 2023

Administrator
Woodbury Health Care Center
7012 Lake Road
Woodbury, MN 55125

RE: CCN: 245235
Cycle Start Date: August 10, 2023

Dear Administrator:

On August 10, 2023, 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 a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

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

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

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

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

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

DEPARTMENT CONTACT

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

Renee McClellan, Unit Supervisor
Metro A District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: renee.mcclellan@state.mn.us
Office: 651-201-4391 Mobile: 651-328-9282

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

If substantial compliance has been achieved, certification of your facility in the Medicare and/or

Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

If substantial compliance with the regulations is not verified by November 10, 2023 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by February 10, 2024 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

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

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

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

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

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

Please note that the failure to complete the informal dispute resolution process will not delay the

dates specified for compliance or the imposition of remedies.

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

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

Feel free to contact me if you have questions.

Sincerely,

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245235	A. BUILDING _____ B. WING _____	C 08/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODBURY HEALTH CARE CENTER	7012 LAKE ROAD WOODBURY, MN 55125

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments On 8/7/23 through 8/10/23, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) was conducted during a standard recertification survey. The facility was in compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On 8/7/23 through 8/10/23, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was not in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. In addition to the recertification survey, the following complaints were reviewed with no deficiencies cited: H52354231C (MN00095599) H52354229C (MN00094638) H52354227C (MN00093340) H52354228C (MN00089563) H5235142C (MN00076036) AND The following complaints were reviewed: H52354230C (MN00090518) with a deficiency issued at F584.	F 000		

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

Electronically Signed | 09/13/2023

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 000	Continued From page 1 The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure a self-administration of medications assessment was completed to allow residents to safely administer their own medications for 1 of 1 resident (R25) observed with medications at bedside. Findings include: R25's quarterly MInimum Data Set (MDS) dated 6/29/23, indicated R25 had intact cognition and diagnoses of congenital malformations of intestinal fixation (the intestines are not in the correct position in the abdomen), right upper quadrant pain, and unspecified abdominal pain. It further indicated, R2 was independent with all	F 554	The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing statement, the facility states that: 1.R25 had a self-administration of medication assessment completed and an order to self-administer tube feeding was obtained.	9/29/23

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F 554	Continued From page 2 activities of daily living (ADL) except eating which required supervision, had a feeding tube, received 26-50% of calories and 501 cubic centimeters (cc) or more fluids through TF. R25's physician's orders dated 8/5/23, indicated tube feeding Osmolite 1.5 at 50 millileters (ml)/hour (hr). If patient is able to eat small meals frequently throughout the day, then infuse TF overnight only from 8:00 p.m.-8:00 a.m. If ongoing nausea/abdominal discomfort with inability to take adequate food by mouth, then infuse 24 hours per day. Initiate at 10 ml/hr and advance by 10 ml every 6 hr. as tolerated to goal at 50 ml/hr. Do not advance TF rate unless potassium is equal to or greater than 3.0, Magnesium is equal to or greater than 1, every shift. It further lacked a doctor's order to be able to self administer her medication. R25's care plan dated 7/5/23, indicated R25 was able to perform ADL's with minimal assistance from staff and had a tube feeding and nausea. She had been noted to take food and drinks (mostly soda, bread and cheese) to her room and eat/drink it. It further indicated the following interventions: eats independently by mouth, but receives most of her nutrition by feeding tube. Per gastrointestinal (GI) clinic recommendations: continue TFs as per your dietician, if you do eat or drink anything, please remain upright for an hour or so afterwards. Ok to take "non-crushable" medications by mouth. She is able to manage her tube feeding with set up and supervision from nursing staff. Assist as needed. During interview on 8/07/23 at 5:21 p.m., R25	F 554	2.All residents who prefer to self-administer medications were reviewed to ensure provider orders and self-administration of medication assessments are completed. The self-administration of medication guideline was reviewed. 3.All licensed staff will receive education on self-administration of medication policy by 9/29/23. 4.The Director of Nursing and/or designee will complete medication administration audits focusing on self-administration of medications on two licensed nurses or trained medication assistants weekly for two months to ensure self-administration of medication policy is followed. The data collected will be presented to the QA committee by the Director of Nursing and/or designee. The data will be reviewed/discussed at the monthly Quality Committee. At this time the committee will make the decision/recommendation regarding any necessary follow-up studies.	

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F 554	Continued From page 3 stated she administerd her own TF and flushes but her doctor was trying to convince her to let the nurses administer it. During observtion/interview on 8/9/23 at 8:00 a.m., R25 was sitting in her room working on some paperwork. The TF pole was in her room but their wasn't any Osmolite hanging and the TF wasn't running. R25 stated she started her TF at approximately 9:00 p.m. on (8/8/23) and stopped it at approximately 7:00 a.m., stating "thought I'd had enough already." R25 further stated she "had everything in her room to do it herself." During an interview on 8/9/23 at 8:49 a.m., registered nurse (RN)-E stated R25 usually administerd her own tube feeding because she won't allow staff to do it. She further stated the doctor's order wasn't clear and the notes from the hospital say she manages her own TF. The doctor needs to give us an order that's clear. RN-E verified R25 had Osmolite and TF supplies in her room. During an interview on 8/9/23 at 10:57 a.m., LPN-D stated R25 administerd her TF "without telling anyone, staff offer to help but she won't let us or says she already did it. We are trying to get a doctor's order for staff to do it." LPN-D further stated R25 "get's the supplies from the supply room and keeps them in her closet." During observation on 8/9/23 at 1:15 p.m., a full bottle of unopened Osmolite was sitting on R25's dresser and there was an unopened package of tubing next to it. During an interview on 8/9/23 at 1:25 p.m., nursing assistannt (NA)-L verified there was a	F 554		

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F 554	Continued From page 4 bottle of Osmolite sitting on the dresser in R25's room and stated all of the supplies for R25's TF are stored in the supply closet and the Osmolite was stored in the medication room both of which were locked. During an interview on 8/9/23 at 1:28 p.m., nurse manager RN-C stated R25 was administering her own TF and verified R25 had not been assessed (SAM) and didn't have a doctor's order to be self-administering her own medications. RN-C further stated R25 should not have Osmolite or TF feeding supplies in her room and she did not have access to the supply closet or medication room and would have to be let in by a nurse. During interview on 8/10/23 at 12:48 p.m., the director of nursing (DON) stated in order for a resident to be able to administer their own medications, they need to be assessed, reviewed in IDT, and have a doctor's order. The DON further stated the nurses were responsible for administering R25's TF and flushes and verified R25 did not have a self administration of medications assessment (SAM), and the supplies for her TF were locked up in the medication room and a nurse would have to access it for her. A facility policy on medication administration was received, however it did not address self adminstration of medication.	F 554		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would	F 558		9/29/23

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F 558	Continued From page 5 endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure resident's needs were assessed appropriately for 1 of 1 resident (R58) when a staff answered a call light and immediately turned it off without assessing or addressing the resident's needs. Findings include: R58's quarterly Minimum Data Set (MDS) dated 6/5/23, indicated R58 was cognitively impaired, required 2-person physical assist for bed mobility, transfers, and toilet use. R58 required 1-person physical assist with all other activities of daily living (ADLs) and could always make self understood with verbal and non-verbal expression. R58's diagnoses included dementia, dysphagia, and anxiety. R58's communication care area assessment (CAA) dated 3/7/23, indicated R58 had difficulty putting sentences together. R58's care plan (CP) dated 6/14/23, indicated R58 had cognitive loss and directed staff to use communication techniques that facilitate optimal interaction and to identify self, face when speaking, and make eye contact. The CP further directed staff to anticipate needs, and observe physical, nonverbal indicators of discomfort or distress. During observation on 8/8/23 at 1:51 p.m., R58 was in bed fidgeting with the bed control pointed to the other side of the room where there was a	F 558	The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing statement, the facility states that: 1.R58 has had her needs met by staff. 2.Residents with severe cognitive impairment (BIMS less than 7) or are unable to communicate were reviewed to ensure the call light was in place. The Standards of Care guideline was reviewed. 3.All staff will receive education on determining needs for residents with cognitive impairments including communication strategies and observation of non-verbal communication by 9/29/23. 4.The Director of Nursing and/or designee will complete resident care audits focusing on staff interactions with residents with cognitive impairments weekly for two months. The data collected will be presented to the QA committee by the	

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F 558	Continued From page 6 TV, a water pitcher, a wheelchair, and blanket. R58's legs were moving as if attempting to get out of bed. R58 was provided her call light which was within reach, and she activated it independently. During observation on 8/8/23 at 1:54 p.m., nursing assistant (NA)-E walked into R58's room, reset the call light and left R58's room without addressing what the call light was on for. NA-E was in R58's room for 10 seconds. NA-E entered a different resident's room. During observation on 8/8/23 at 1:56 p.m., R58 continued to fidget with the bed control, appeared restless in bed, and pointed toward the other side of the room. Surveyor pointed to several items and R58 nodded when the water pitcher was offered. During observation on 8/8/23 at 2:07 p.m., NA-E exited the other room and walked away from R58's room toward the common area and did not return to R58's room. When interviewed on 8/8/23 at 2:08 p.m., NA-E stated R58 did not want anything and she "must have pulled the call light off the wall and hit it accidentally." NA-E further stated to understand R58, staff should get close to her and listen carefully. When interviewed on 8/9/23 at 9:09 a.m., NA-G stated R58 did not communicate well and required staff to get down close to her and speak slowly. NA-G further stated when R58 activated her call light, staff should look for signs of grimacing or pain, check her brief, offer drinks or snacks and allow her time to try to express her	F 558	Director of Nursing and/or designee. The data will be reviewed/discussed at the monthly Quality Committee. At this time the committee will make the decision/recommendation regarding any necessary follow-up studies.	

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F 558	Continued From page 7 needs. NA-G stated this interaction should take at least a few minutes and may take up to 5 minutes to determine what her need was or if she had activated the call light on accident. When interviewed on 8/9/23 at 12:42 p.m., registered nurse (RN)-C stated R58 had cognitive loss and staff should always attempt to figure out and address needs when R58's call light was activated. RN-C stated staff should take their time with all residents but particularly with those who had communication barriers. When interviewed on 8/10/23 at 10:14 a.m., director of nursing (DON) stated the expectation was staff should not just reset a call light, but should take a few minutes to attempt to understand and address resident's needs when answering call lights. Facility policy Standards of Care Guidelines dated 3/24/15, identified, "All staff will care for residents in a manner that promotes maintenance, dignity, or enhancement of each resident's quality of life."	F 558		
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.	F 584		9/29/23

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WOODBURY HEALTH CARE CENTER	7012 LAKE ROAD WOODBURY, MN 55125

(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 584	Continued From page 8 (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure the west hallway shower room was kept clean, sanitary and in good repair, which had the potential to affect all 22 residents who utilized the west shower room. Additionally, the facility failed to provide maintenance services for 2 of 2 (R11, R295) residents whom had broken door handles and latches.	F 584	The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions	

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F 584	Continued From page 9 Findings include: R11's significant change Minimum Data Set (MDS) dated 5/6/23, identified intact cognition, a diagnosis of medically complex conditions related to colon cancer, rejection of care 1-3 days in the seven day look back period, and one-person physical assist was provided for bathing along with extensive staff assistance provided for transfers, hygiene and dressing. During an interview on 8/7/23 at 12:50 p.m., R24 stated the common shower room she used in the hallway was "disgusting". During an observation on 8/7/23 at 12:52 p.m., the shower room was observed to have an approximate four by four-foot area for showering with white tile and grout on the floors and wall. The grout alongside the floor of the shower where it met with the wall was discolored brown and orange. The grout in the two back corners was spotted black extending up the walls approximately two inches. The shower had no curtain. There was a tattered clear plastic bag taped and tied onto the shower grab bar. During an interview on 8/7/23 at 3:01 p.m., nursing assistant (NA)-J stated showers were disinfected between residents. NA-J stated the cleaning solution needed to be obtained from housekeeping and was not kept in the shower room. During an interview on 8/7/23 at 3:03 p.m., NA-K stated she was not sure what cleaners were used between resident uses of the shower and would have to ask the nurse.	F 584	of State and Federal law. Without waiving the foregoing statement, the facility states that: The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing statement, the facility states that: 1.R295 in room 112 had new door ordered on 8/11/2023. R11 in room 223 door was removed and replaced on 8/9/2023. Quote for second floor west hall shower room remodel received on 9/13/2023. Plastic bag removed from shower room and privacy curtain was present in shower at time of survey. 2. All resident room doors inspected to ensure they are free of malfunctioning door handles or latches. All resident shower rooms were inspected to ensure kept clean, sanitary, and in good repair. 3. All staff will receive education on submitting maintenance work order requests through the online maintenance logging system TELS and education on disinfecting shower rooms between residents by 9/29/23.	

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F 584	Continued From page 10 During an observation and interview on 8/8/23 at 10:14 a.m., the housekeeper (H)-A cleaned the shower room floor with bleach. H-A stated nursing could call housekeeping for assistance. During an observation and interview on 8/9/23 at 9:32 a.m., maintenance (MA) confirmed the above findings in the shower room and stated grout was maintained by maintenance, and shower curtains would be maintained by housekeeping. MA stated he was unsure what the clear plastic bag tied to the grab bar was for and wondered if it was a make-shift shower curtain. MA stated the grout should be fixed by maintenance and needed to be cleaned well. MA stated maintenance periodically inspected the showers,and had not noticed nor been informed by staff of the discolored grout or lack of shower curtain. During an interview on 8/9/23 at 9:43 a.m., the housekeeping manager (HM) stated a shower curtain should been in place in resident shower rooms. The HM stated any cleaning needs could be submitted to housekeeping via the TELS system (an online system of logging maintenance or housekeeping requests). The HM reviewed the TELS reports and verified no request had been submitted for a west shower curtain or grout concerns. During an interview on 8/9/23 at 2:27 p.m., the director of plant operations (DPO) stated housekeeping was responsible to clean bathrooms and grout and maintenance would be responsible for grout repairs. The undated facility document titled	F 584	4. The NHA and/or designee will complete annual door inspections to ensure free of chipped wood and proper door handle latching. Environmental Services Director and/or designee to complete shower audits to ensure showers are clean, sanitary, and in good repair once a week for two months. The data collected will be presented to the QA committee by Director of Plant Operations and/or designee. The data will be reviewed/discussed at the monthly Quality Committee. At this time the committee will make the decision/recommendation regarding any necessary follow-up studies.	

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F 584	Continued From page 11 Housekeeping In-Service identified mops and germicide solutions were used to disinfect washroom floors. Additionally, the mop should run alongside the edges and never push dirt into the corners. A policy for shower room maintenance was requested and not provided. R295's Clinical Census Form in the electronic medical record (EMR) indicated R295 was admitted to the facility on 1/20/23, to room 112. R295's nursing progress notes dated 1/20/23, indicated R295 was discharged with family member (FM)-C. However, did not indicated any reasoning for the discharge. During interview on 8/9/23, at 1:35 p.m., FM-C stated R295's room was located on the main floor and the door knob looked like someone tried to pry it with a screw driver. During interview and observation on 8/9/23, between 1:43 p.m., and 1:45 p.m., the door handle to room 112 was pulled down and stuck in the downward position. At 1:45 p.m., housekeeper (H)-C verified the latch parts were loose and there was a loose screw and the latch was stuck inside when the door handle was pushed downward. Part of the door next to the latch had what appeared to be chipped wood measuring approximately 2.5 inches long by .75 inches wide. H-C did not know how long the door had been in this condition. Facility work orders were reviewed from 1/1/23	F 584		

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F 584	Continued From page 12 through 8/9/23, and no orders were located for room 112's door. During interview on 8/9/23 at 1:52 p.m. maintenance (MA) verified the latch was stuck and wood was missing on the side of the door latch and stated he requestesd more door handles be ordered as room 223 also had a bad bathroom handle and would see what he had for doors and also had wood putty. During interview on 8/9/23 at 2:03 p.m., FM-C stated he notified staff of the condition of the door and stated he asked for the person in charge. Provided the surveyor with pictures of the door latch/handle. During interview on 8/9/23 at 2:27 p.m., the director of plant operations (DP) stated they completed latch and gap inspections once a month and if anything needed to be done, they repaired them. During interview on 8/10/23 at 9:54 a.m., MA verified the latch in the photograph and the door latch for room 112 were absolutely the same latch, adding you could tell because the same wood was missing in the picture as was identified on the door for room 112. MA verified latches were checked and inspected monthly and stated a new door was ready to be installed. A policy was requested, but not received.	F 584		
F 676 SS=D	Activities Daily Living (ADLs)/Mntn Abilities CFR(s): 483.24(a)(1)(b)(1)-(5)(i)-(iii) §483.24(a) Based on the comprehensive assessment of a resident and consistent with the	F 676		9/29/23

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F 676	Continued From page 13 resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that: §483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section ... §483.24(b) Activities of daily living. The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living: §483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care, §483.24(b)(2) Mobility-transfer and ambulation, including walking, §483.24(b)(3) Elimination-toileting, §483.24(b)(4) Dining-eating, including meals and snacks, §483.24(b)(5) Communication, including (i) Speech, (ii) Language, (iii) Other functional communication systems. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure assistive devices were maintained and provided for 1 of 1	F 676	The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted	

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F 676	Continued From page 14 resident (R24) reviewed for hearing aid assistance. Findings include: R24's quarterly Minimum Data Set (MDS) dated 6/22/23, identified adequate hearing, moderately impaired cognition, diagnoses of medical complex condition related to diabetes mellitus, and staff provided supervision for hygiene and dressing. R24's hearing evaluation clinical note dated 5/31/23, identified R24 reported difficulty hearing and was a good candidate for amplification. Bilateral rechargeable hearing aids for both ears were recommended/chosen and both R24 and her family member approved to proceed. R24's Annual Comprehensive Nursing Home visit notes dated 8/4/23, identified R24 received hearing aids today and reported they helped with hearing. R24's care plan dated 7/2/23, identified deficits in memory/recall ability, judgement and decision making related to dementia. Interventions included consistent routine and face when speaking and make eye contact. The care plan lacked interventions related to hearing aid assistive devices. R24's medication administration record (MAR) dated 8/1/23 through 8/31/23, identified an order with a start date of 8/4/23, for staff to place hearing aids in R24's ears in the morning and put on the charger once removed. During an observation and interview on 8/8/23 at	F 676	as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing statement, the facility states that: 1.R24's care plan and NAR care sheets were updated to include interventions related to hearing aid assistive devices. 2.All residents with hearing aid assistive devices were reviewed to ensure interventions for placement and charging are included in the care plan and NAR care sheets. 3.All staff will receive education on placement and general care of assistive hearing devices by 9/29/23. 4.The Director of Nursing and/or designee will complete resident care audits focusing proper placement and care of assistive hearing devices weekly for two months. The data collected will be presented to the QA committee by the Director of Nursing and/or designee. The data will be reviewed/discussed at the monthly Quality Committee. At this time the committee will make the decision/recommendation regarding any necessary follow-up studies.	

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F 676	Continued From page 15 8:59 a.m., R24 was in her wheelchair in the hallway without hearing aids in. R24 stated she wanted to wear them but could not put her own hearing aids in and sometimes her family helped her. R24's charger was seen on her bedside table but not plugged into the wall, the hearing aids had no charge to them. R24's hearing aides were not placed in the charger properly as ordered. During an interview on 8/8/23 at 2:25 p.m., nursing assistant (NA)-B stated R24 did not have hearing aids identified on her nursing assistant task sheet and therefore had not assisted with placing them. During an interview and observation on 8/8/23 at 2:30 p.m., registered nurse (RN)-B stated R24 had refused to wear hearing aids today and had not identified why. RN-B was asked if he checked the charger, and he said no. RN-B entered R24's room and verified the charger was unplugged and the hearing aids had no charge. RN-B stated he should have checked this at the beginning of his shift so the hearing aids could be charged. During an interview on 8/9/23 at 12:53 p.m., RN-C stated according to the order, R24's hearing aids should be checked to make sure they are charging in the evening once removed and nursing should complete this task. During an interview on 8/10/23 at 9:04 a.m., the director of nursing (DON) stated assistive devices should be placed as ordered. A policy for hearing aids or applying assistive devices was requested during survey but not provided.	F 676		

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F 686	Continued From page 16	F 686		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure interventions were used consistently for 1 of 2 residents (R36) at risk for pressure ulcers (PU) when an air mattress was unplugged for several days and not used. Findings include: R36's quarterly Minimum Data Set (MDS) dated 6/27/23, indicated R36 was cognitively impaired and required 1-person physical assistance with bed mobility and most activities of daily living (ADLs). The MDS indicated R36 was at risk for developing PUs and had a stage II PU (partial-thickness skin loss with exposed dermis) upon admission to the facility. R36's diagnoses included fractured vertebra, dementia, and muscle weakness.	F 686	The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing statement, the facility states that: 1.The alternating air mattress in place for R36 was evaluated and the outlet was repaired. The care plan, NAR care sheets and eMAR were updated to include observation of the mattress to ensure proper inflation.	9/29/23

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F 686	Continued From page 17 R36's skin care area assessment (CAA) dated 3/30/23, indicated R36 was at risk for developing PU's and interventions would be added to R36's care plan (CP) to minimize risk and avoid complications. R36's CP dated 7/6/23, indicated R36 had potential for impairment to skin integrity related to decreased mobility, incontinence, and a stage II PU. The CP interventions included, "Mattress replacement system Air mattress." R36's wound assessment dated 6/5/23, indicated a new in-house acquired stage II left gluteus PU with treatments listed and additional care noted as mattress with pump, "air mattress ordered." R36's wound assessment dated 6/13/23, indicated a stage II left gluteus PU as improving. R36's wound assessment dated 6/22/23, indicated a stage II left gluteus PU as improving and additional care listed as mattress with pump. R36's wound assessment dated 6/28/23, indicated a stage II left gluteus PU as improving and additional care listed as mattress with pump. R36's wound assessment dated 7/14/23, indicated a stage II left gluteus PU as resolved. During observation on 8/7/23 at 12:35 p.m., R36 was in bed with an air mattress not on and the plug approximately 12 inches from the wall socket wedged between the bed mattress and frame. During interview on 8/7/23 at 2:51 p.m., family member (FM)-A stated R36 had a sore on her bottom but it has since resolved. FM-A stated he	F 686	2.All residents with air mattress equipment were reviewed to ensure care plan, NAR care sheets and eMAR include observation of mattress to ensure proper inflation. The Skin Management Program was reviewed. 3.All staff will receive education on observing air mattresses to ensure they are properly inflated by 9/29/23. 4.The Director of Nursing and/or designee will complete audits focusing on verification of proper inflation of two air mattresses weekly for two months. The data collected will be presented to the QA committee by the Director of Nursing and/or designee. The data will be reviewed/discussed at the monthly Quality Committee. At this time the committee will make the decision/recommendation regarding any necessary follow-up studies.	

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F 686	Continued From page 18 visited almost daily and had noticed the air mattress turned on sometimes and sometimes turned off, but lately had not been on while R36 was in bed. During observation on 8/8/23 at 8:30 a.m., R36's air mattress was still unplugged with the plug trapped in the same position between the bed mattress and the bed frame. R36 was resting in bed. During observation on 8/9/23 at 7:22 a.m., R36's air mattress was still unplugged with the plug trapped in the same position between the bed mattress and the bed frame. R36 was resting in bed. During observation on 8/9/23 at 8:37 a.m., nursing assistant (NA)-H assisted R36 onto the toilet and with morning cares. NA-H made R36's bed and did not notice the air mattress was not on and did not plug it in. During interview on 8/9/23 at 8:57 a.m., NA-H stated R36's PU was resolved but they still had PU prevention measures in place including barrier cream, offloading and toileting every 2 hours and air mattress for the bed. During interview on 8/9/23 at 9:00 a.m., NA-G stated R36 had a PU on her bottom but it had resolved a few weeks ago. NA-G stated they still provided intervention to prevent PU due to R36 still being at risk for developing PU's. NA-G stated R36 had barrier cream, repositioning and toileting schedule, cushion on wheelchair, and air mattress on bed since R36 preferred to sleep on her back.	F 686		

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F 686	Continued From page 19 During interview on 8/9/23 at 9:29 a.m., NA-H confirmed R36's air mattress was not on, and the plug was trapped between the mattress and the frame. NA-H stated it was the NA's responsibility to check that the air mattress was turned on and working whenever the resident was in bed. NA-H plugged the air mattress in and confirmed it was working properly. During interview on 8/9/23 at 9:56 a.m., registered nurse (RN)-C stated resident's with PU or at risk for developing PUs have interventions in place such as repositioning every 2 hours, barrier cream, cushion on wheelchair and air mattress on bed. RN-C stated the expectation was for NA's to check that the air mattress was on and working. RN-C further stated R36 should have an air mattress on and working all the time due to her history of PU and at risk status for developing one again. RN-C stated R36 did not have the cognitive ability to know that the air mattress was not on when it should have been and not able to tell staff. RN-C stated she would have maintenance look at R36's bed to determine why the plug was stuck in the bed. During observation on 8/10/23 at 9:16 a.m., R36 was in bed and the air mattress was not on. The plug was not seated fully into the wall outlet. During interview on 8/10/23 at 9:19 a.m., NA-G stated R36's air mattress should be on and working and confirmed it was not on or plugged in completely into the outlet. NA-G could not explain why it kept dislodging but stated it should be checked anytime R36 was assisted back to bed. NA-G called maintenance and requested they look at it and provide a long-term solution.	F 686		

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F 686	Continued From page 20 During interview on 8/10/23 at 10:10 a.m., director of nursing (DON) stated when air mattresses were in place they should be turned on and in working condition. DON stated the expectation was NA's should check to make sure PU precautions were in place and air mattresses were plugged in and turned on. DON stated R36 not using an air mattress could potentially reopen the previous stage II PU on her bottom. Facility policy Skin Management Program dated 9/2022, indicated purpose to "promote the prevention of alterations in skin integrity: promote healing of current skin alteration and to prevent further loss of skin integrity." The policy further indicated interventions may include "pressure reducing mattress and/or wc [wheelchair] cushion for all residents at risk."	F 686		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed	F 755		9/29/23

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F 755	Continued From page 21 pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure an expired medication was discarded and replaced before administration for 1 of 2 residents (R30) reviewed for insulin administration. Findings include: R30's quarterly Minimum Data Set (MDS) dated 6/16/23, identified Intact cognition, extensive assist of one staff provided for hygiene, a diagnosis of diabetes mellitus, and insulin given seven out of seven days in the lookback period. R30's care plan identified he had diabetes mellitus type II with a history of complications and a goal for insulin daily. R30's Medication Administration Record (MAR) dated 8/1/23 through 8/9/23, identified an order for Humalog (insulin lispro) inject five units subcutaneously before meals for diabetes (three times daily).	F 755	The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing statement, the facility states that: 1.The insulin pen for R30 was replaced with a new pen and dated. 2.All residents receiving insulin were reviewed to ensure they are administered within 28 days of opening or per manufacturer instructions. The Medication Management guideline was reviewed. 3.All licensed staff will receive education	

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F 755	Continued From page 22 Humalog (lispro insulin) manufacturer's instructions dated 2012, identified used cartridges or prefilled pens should be discarded after 28 days, even if insulin remained. During an observation on 8/9/23 at 10:57 a.m., trained medication aide (TMA)-A checked R30's blood glucose with a result of 132 and updated licensed practical nurse (LPN)-A on the results. During an observation and interview on 8/9/23 at 11:35 a.m., LPN-A returned to the medication cart and put R30's Humalog insulin pen with insulin remaining into the medication cart. LPN-A stated she had just administered R30's insulin. The insulin pen was dated as opened on 7/9/23, which placed the insulin expired by three days. LPN-A stated she thought insulin was good for 30 days after opening, instead of 28 days in accordance with the manufacturer's instructions. LPN-A then went to call the pharmacy who she said verified the insulin should have been disposed of on the 28th day. LPN-A stated she would discard the expired insulin and put a new one in the medication cart. During an interview on 8/9/23 at 2:31 p.m., registered nurse (RN)-D stated insulin expired 28 days after opening. During an interview on 8/9/23 at 2:46 p.m., the director of nursing (DON) stated insulin should be used within 28 days once opened, then removed from the cart and replaced. The DON stated the efficacy of the medication would be reduced after it expired. During an interview on 8/10/23 at 12:29 p.m., the	F 755	on expiration dates for opened insulins by 9/29/23. 4.The Director of Nursing and/or designee will complete audits focusing on ensuring insulin is dated and not administered after their expiration date weekly for two months. The data collected will be presented to the QA committee by the Director of Nursing and/or designee. The data will be reviewed/discussed at the monthly Quality Committee. At this time the committee will make the decision/recommendation regarding any necessary follow-up studies.	

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F 755	Continued From page 23 consultant pharmacist (CP) stated R30's insulin was good for 28 days after opening. The CP stated once insulin was out of the fridge and opened the efficacy reduced after 28 days. The CP stated insulin should be used per the manufacturer's instructions to ensure efficacy. The facility policy Medications Management dated 6/2023, identified once opened, an insulin vial/pen expired 28 days per the manufacturer's date.	F 755		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can	F 761		9/29/23

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F 761	Continued From page 24 be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure insulin stored in the medication cart was labeled with an expiration date for 2 of 4 residents (R57 and R145) reviewed for medication storage. Findings include: R57's admission Minimum Data Set (MDS) dated 6/29/23, identified moderately impaired cognition, extensive assist of one staff was provided for hygiene, a diagnosis of diabetes mellitus and insulin was given seven out of seven days in the look back period. R57's Medication Administration Record (MAR) dated 8/1/23 through 8/31/23, identified an order for Novolog (insulin aspart) inject 15 units subcutaneously at bedtime for diabetes. R145's admission MDS was not yet completed due to being a new admission. R145's face sheet identified an admission date of 8/8/23, and a diagnosis of diabetes mellitus type II. R145's MAR dated 8/1/23 through 8/31/23, identified an order for insulin Lantus inject 15 units subcutaneously at bedtime for diabetes. During an observation and interview on 8/9/23 at 1:07 p.m., licensed practical nurse (LPN)-A reviewed the insulin pens in the medication cart. LPN-A stated R57's Novolog and R145's Lantus insulin pens had been opened before today and	F 761	The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing statement, the facility states that: 1.Insulin for R57 and R145 were replaced and dated. 2.All residents receiving insulin were reviewed to ensure they were dated upon opening. The Medication Management guideline was reviewed. 3.All licensed staff will receive education on dating insulin upon opening by 9/29/23. 4.The Director of Nursing and/or designee will complete audits focusing on ensuring insulin is dated and not administered after their expiration date weekly for two months. The data collected will be presented to the QA committee by the Director of Nursing and/or designee. The data will be reviewed/discussed at the monthly Quality Committee. At this time the committee will make the decision/recommendation regarding any necessary follow-up studies.	

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F 761	Continued From page 25 lacked a label with the opened date or the expiration date. During an interview on 8/9/23 at 2:46 p.m., the director of nursing (DON) stated insulin should be labeled with an opened date to ensure it was used before the 28-day expiration. During an interview on 8/10/23 at 12:29 p.m., the consultant pharmacist (CP) stated R57 and R145's insulin should have been labeled once opened so the expiration date could be tracked. The CP stated insulin expired after 28 days of opening and the efficacy was reduced after 28 days. The facility policy Medications Management dated 6/2023, identified once opened medication should be labeled with the specific date of first use.	F 761		
F 791 SS=D	Routine/Emergency Dental Srvcs in NFs CFR(s): 483.55(b)(1)-(5) §483.55 Dental Services The facility must assist residents in obtaining routine and 24-hour emergency dental care. §483.55(b) Nursing Facilities. The facility- §483.55(b)(1) Must provide or obtain from an outside resource, in accordance with §483.70(g) of this part, the following dental services to meet the needs of each resident: (i) Routine dental services (to the extent covered under the State plan); and (ii) Emergency dental services; §483.55(b)(2) Must, if necessary or if requested,	F 791		9/29/23

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F 791	Continued From page 26 assist the resident- (i) In making appointments; and (ii) By arranging for transportation to and from the dental services locations; §483.55(b)(3) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay; §483.55(b)(4) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; and §483.55(b)(5) Must assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State plan. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure dental services were provided for 1 of 1 resident (R50) reviewed for dental services. Findings include: R50's quarterly Minimum Data Set (MDS) dated 5/23/23, indicated R50 had moderate cognitive impairment and required 2-person physical assistance for most activities of daily living (ADLs). R50's diagnoses included dementia,	F 791	The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing statement, the facility states that:	

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F 791	Continued From page 27 schizophrenia, and abnormal weight loss. R50's care plan (CP) dated 6/6/23, indicated R50 had oral/dental health problem related to partial dentures with an intervention of "coordinate arrangements for dental care, transportation as needed/as ordered." R50's Oral/Dental Assessment Form (O/DAF) dated 5/24/23, indicated R50 had obvious missing teeth, no teeth/dentures on upper and missing posterior teeth on lower. The O/DAF indicated, recommended treatment included routine, non-urgent dental care to replace upper denture and provide new lower partial. R50's provider order dated 1/25/23, indicated R50 could be seen by dental per facility policy. R50's Oral Health Plan and Consent Form signed 3/23/21, indicated R50 authorized Apple Tree Dental (ATD) to provide comprehensive and periodic oral evaluations, x-rays, preventive care and a house call/facility visit. During interview on 8/7/23 at 3:18 p.m., R50 stated needed new dentures and was not aware of any plan and did not think the facility was working on it. R50 stated she had not had any dental appointments since admitting to the facility. During interview on 8/9/23 at 10:38 a.m., licensed social worker (SS)-A stated dental services were reviewed during quarterly care conferences and ATD came to the facility every 3 to 6 months. SS-A was not sure how the residents were selected to be seen during the next ATD visit. During interview on 8/9/23 at 10:46 a.m., health	F 791	1.R50 is scheduled to receive dental services as ordered. 2.All residents will be reviewed to ensure dental referrals and services are provided as indicated on their dental consent for services. 3.All staff will receive education on dental services by 9/29/23. 4.The Director of Nursing and/or designee will complete audits focusing on ensuring dental services are provided as indicated twice monthly for two months. The data collected will be presented to the QA committee by the Director of Nursing and/or designee. The data will be reviewed/discussed at the monthly Quality Committee. At this time the committee will make the decision/recommendation regarding any necessary follow-up studies.	

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F 791	Continued From page 28 unit coordinator (HUC) stated ATD triages and creates the list for who they will see and perform services for during their next visit. HUC confirmed R50 was not on the list to be seen on the upcoming visit on 8/19/23. During interview on 8/9/23 at 11:30 a.m., Apple Tree Dental Community Care Coordinator (ATDCCC) stated ATD, and the facility had 2 different contracts -one that provided an annual evaluation and recommendation and another that provided dental services. ATDCCC stated R50 was not in their system and therefore, did not have a contract for ATD to complete dental services. ATDCCC further stated upon admission to the facility, a resident was provided a choice to utilize ATD, their own dentist or decline all dental services. ATDCCC stated that since R50 was not in their system, ATD never received a consent to provide R50 dental services. During interview on 8/9/23 at 12:24 p.m., SS-A confirmed R50 had a signed consent for ATD services in her electronic medical record (EMR). SS-A stated R50 should have been receiving ATD services for the last 2 years. SS-A stated the process upon admission was to review the consent with the resident and/or representative and assist them in completing the form. SS-A would then scan and send the completed form to the HUC and the HUC would forward to ATD or other appropriate service. SS-A stated not sure how this was missed, "someone dropped the ball." SS-A confirmed no dental visits were documented in R50's EMR since admission. During interview on 8/9/23 at 12:37 p.m., registered nurse (RN)-C stated completed consents should be sent to the appropriate	F 791		

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F 791	Continued From page 29 services and could not explain why R50's dental consent was never sent to ATD nor why it had been missed for the last 2 years. RN-C stated expectation was for R50 to have received necessary services from ATD. During interview on 8/10/23 at 10:07 a.m., director of nursing (DON) stated the process upon admission was for consent completion and HUC to forward to appropriate service. DON stated expectation was that ATD provided dental services for R50 and the lack of services in the last 2 years should have been caught and resolved. Facility policy on dental services requested but not received.	F 791		
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	F 880		9/29/23

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F 880	Continued From page 30 providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable 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.	F 880		

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F 880	Continued From page 31 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 contact precautions (measures intended to prevent transmission of infectious agents which are spread by direct or indirect contact with the resident or the resident's environment) for clostridioides difficile (C. diff), (a germ that can cause symptoms ranging from diarrhea to life-threatening colon inflammation) were implemented for 3 of 3 residents (R81, R106, R20). Findings include: R81's admission Minimum Data Set (MDS) dated 7/12/23, indicated moderate cognitive impairment, required extensive assistance with most activities of daily living (ADLs) including toileting, and was frequently incontinent of stool. R81's Medical Diagnosis form in the electronic medical record (EMR), indicated the following diagnoses: arthritis due to other bacteria to right knee, sepsis, bacterial infection unspecified. R81's medication administration record (MAR) dated August 2023, indicated R81 finished vancomycin (an antibiotic) 125 milligram capsule, 1 capsule by mouth four times a day for C. diff on 8/2/23.	F 880	The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing statement, the facility states that: 1.R81, R106 and R20 had enteric contact precautions put in place per facility guideline. 2.All residents with new onset of loose stools have been reviewed to ensure enteric contact precautions and testing for C. diff infection are in place if indicated. The facility C. diff infection and PPE guidelines were reviewed. 3.All staff will receive education on initiating enteric contact precautions when C. diff infection is suspected and donning and doffing PPE by 9/29/23. 4.The Director of Nursing and/or designee	

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F 880	Continued From page 32 R81's Bowel Continence and BM (bowel movement) form for August 2023, indicated R81 had loose diarrhea once on 8/4/23, once on 8/5/23, two times on 8/6/23, once on 8/7/23, and once on 8/8/23. R81's C. Diff laboratory report dated 7/19/23, identified R81 had a positive C. difficile GDH antigen and C. Difficile toxin. The report further indicated the results must be interpreted based on clinical findings and were supportive of C. Diff infection. R81's care plan dated 7/17/23, indicated R81 had incontinence of bowel and bladder. During interview and observation on 8/7/23 at 1:10 p.m., R81 had a cart that contained gowns and gloves located outside the room. There was no sign located on the door or the wall that identified whether R81 was on any type of precautions. Nursing assistant (NA)-C stated R81 had C. Diff and verified there was no signage posted regarding precautions. During observation on 8/7/23 at 1:21 p.m., NA-C placed a sign on the wall next to R81's room that identified R81 was on contact precautions. During interview on 8/8/23, at 10:16 a.m., R81 stated he still had looser stools than normal. During interview on 8/8/23 at 10:38 a.m., licensed practical nurse (LPN)-B stated R81 still had symptoms of C. Diff. LPN-B further stated staff could go into R81's room with out a gown if just administering medications and would not need to donn a gown if she wasn't changing a brief,	F 880	will complete audits focusing on donning and doffing PPE and precaution signage is in place weekly for two months. The data collected will be presented to the QA committee by the Director of Nursing and/or designee. The data will be reviewed/discussed at the monthly Quality Committee. At this time the committee will make the decision/recommendation regarding any necessary follow-up studies.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245235	A. BUILDING _____ B. WING _____	C 08/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 880	Continued From page 33 dressing, or bathing R81. During observation on 8/9/23 at 7:09 a.m., R81's contact precautions sign posted on the wall outside the door indicated everyone had to clean their hands prior to entering and when leaving, put on gloves before room entry and discard before room exit, put on a gown before room entry, and discard the gown before room exit. During interview and observation on 8/9/23 between 7:49 a.m. and 7:50 a.m., NA-C walked into R81's room without a gown or gloves donned and delivered R81's breakfast tray. NA-C was observed touching the bedside table. NA-C stated gowns and gloves needed to be worn only when providing cares. During observation on 8/9/23 at 9:19 a.m., NA-C walked into R81's room without a gown or gloves donned and asked R81 if he wanted to get up. When R81 stated he wanted to get up, NA-C sanitized hands, walked out of the room donned a gown and gloves and LPN-B donned a gown and gloves and entered the room. R106's admission MDS dated 7/28/23, indicated severe cognitive impairment, required extensive assist for most ADL's including toileting, and was frequently incontinent of stool. R106's Medical Diagnosis form in the EMR indicated the following diagnoses: nondisplaced intertrochanteric fracture of the right femur, paroxysmal atrial fibrillation, congestive heart failure, chronic kidney disease, and Alzheimer's disease. R106's clinical physician orders dated 8/7/23,	F 880		

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F 880	Continued From page 34 indicated obtain stool sample for salmonella, shigella, campylobacter, Y Enterocolitica, C. Diff, stool anion gap. R106's care plan dated 8/4/23, indicated R106 had bowel incontinence. R106's Bowel Continence and BM form for July-August 2023, indicated R106 had loose diarrhea one time on 7/29/23, 7/31/23, 8/2/23, 8/4/23, 8/5/23, 8/6/23, and 8/7/23. R106's C. Diff laboratory result dated 8/8/23 at 7:15 p.m., indicated a negative result. During interview 8/7/23 at 2:54 p.m., family member (FM)-B stated R106 had chronic diarrhea. During observation 8/8/23 at 8:30 a.m., R106 did not have an isolation cart located outside the door and no precautions sign was located on the door. During observation 8/8/23 at 1:32 p.m., R106's door was closed and there was no isolation cart located outside the door and no precautions sign on the wall or door indicating any type of contact precautions. During observation 8/9/23 at 8:22 a.m., R106's door was closed and there was no isolation cart located outside the door and no contact precautions sign. R106's paper chart was reviewed along with the EMR and did not locate C. Diff laboratory results. During interview and observation on 8/9/23 at 9:46 a.m., NA-F stated she worked at the facility for four years and mainly worked on R106's side.	F 880		

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F 880	Continued From page 35 NA-F stated R106 always had loose stools and stated R106 was not on any kind of precautions. During interview on 8/9/23 at 10:10 a.m., LPN-A initially stated she was not aware if a stool sample had been obtained for R106 yet, then added the stool had been sent the day prior for C. Diff. When asked if R106 was on contact precautions for potential C. Diff, LPN-A stated they always do standard precautions (infection prevention practices that apply to all residents, regardless of suspected or confirmed diagnosis or presumed infection status. Standard precautions is based on the principle that all blood, body fluids, secretions, excretions except sweat, regardless of whether they contain visible blood, non-intact skin, and mucous membranes may contain transmissible infectious agents) but had just obtained the specimen and everyone was on standard precautions until the test results were received. During interview on 8/9/23 at 12:44 p.m., the infection preventionist-(IP)-E stated she was alerted to new infections through staff notification, and if a resident was placed on an antibiotic, it would appear on the dashboard. If there was suspected C. Diff, staff would notify the physician and wait for a culture and staff would put out a cart with gowns and gloves. A resident comes off contact precautions if they are finished with the antibiotic and are no longer having symptoms for 48 hours. Staff are notified when a patient is no longer on precautions and the cart would be removed. IP-E stated she heard R81 did not have a sign posted and verified he was still on contact precautions because he was still having loose stools. IP-E further stated she expected staff to wear a gown and gloves if providing	F 880		

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F 880	Continued From page 36 cares, and added the use of gloves depended on the situation. IP-E stated if a test for C. Diff was ordered, she expected contact precautions to be initiated because if a resident was found to be positive for C. Diff, staff could spread the infection to multiple residents. During interview on 8/10/23 at 10:04 a.m., the director of nursing (DON) stated their policy indicated if touching surfaces gloves should be worn and expected gloves and gowns for contact precautions and staff should wash hands before exiting room. DON further stated he expected contact precautions to be put in place preemptively while awaiting test results. R20's 5-day Minimum Data Set (MDS) dated 6/23/23, indicated R20 was cognitively intact, required 2-person physical assistance with transfers and bed mobility and 1-person physical assistance with toileting and personal hygiene. R20's diagnoses included osteomyelitis of vertebra (infection in the bone), enterocolitis due to clostridium difficile (C-diff), recurrent, and need for assistance with personal care. R20's care plan (CP) dated 7/26/23, indicated R20 had incontinence of bowel and bladder related to stress incontinence, history of recurrent urinary tract infection, and colitis related to C-diff. Interventions included perineal care after incontinent episode and record bowel movements daily.	F 880		

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F 880	Continued From page 37 R20's August treatment administration record (TAR) indicated an order dated 8/7/23, to check stool for C-diff every shift for 3 days. Discontinue when completed. R20's progress note dated 8/8/23 at 5:03 p.m., indicated, "Room Change: Reason: C-Diff precautions-resident has had loose stool..." During interview on 8/8/23 at 3:56 p.m., registered nurse (RN)-C stated she thought R20 had a stool sample collected per the provider's order but had not been placed on precautions. During observation on 8/9/23 at 7:40 a.m., R20 and R20's bed was not in her room. When interviewed on 8/9/23 at 7:44 a.m., nursing assistant (NA)-I stated R20 was transferred yesterday (8/8/23) around dinner time. NA-I did not know the reason for the R20's transfer and was not aware of an order to collect a stool sample. When interviewed on 8/9/23 at 7:56 a.m., NA-G stated the infection preventionist (IP) and director of nursing (DON) informed her yesterday (8/8/23) that R20 had an order for stool sample collection to check for C-diff. NA-G stated the facility policy was for residents to be placed on contact precautions anytime C-diff was suspected, and a stool sample ordered so that C-diff would not inadvertently be spread to other residents. NA-G stated contact precautions for C-diff would include bleach wipes for surfaces, soap and water hand hygiene, gowns and gloves for any cares. NA-G stated an isolation cart with all the appropriate items for precautions would immediately be placed outside a resident's room	F 880		

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F 880	Continued From page 38 while waiting for C-diff results. When interviewed on 8/9/23 at 9:52 a.m. RN-C stated R20 was transferred to a private room and contact precautions initiated only after she was alerted that a stool sample for C-diff had been ordered. RN-C stated precautions should have been started as soon as the order for the sample was placed but there was a breakdown in communication. RN-C stated R20 was on an antibiotic prophylactically for C-diff, however, with her recent episodes of diarrhea and her history of recurrent C-diff, they were collecting a stool sample to test for it. When interviewed on 8/10/23 at 10:20 a.m., DON stated contact precautions should be initiated immediately upon receiving an order for a stool sample to test for C-diff. DON stated there was a breakdown in communication in R20's case. A policy, Clostridium Difficile (Based on the MDH Clostridium difficile Algorithms for LTC) dated 7/2018, indicated risk factors for C. Diff infections included recent antibiotic use, over age 65, and other serious illness. Contact precautions are used with any resident with C. Diff infection or those who may be suspected of having C. Diff. Gloves and gowns are always worn when providing direct cares with the resident. Under the heading, Early Recognition, the provider is contacted to obtain an order for a lab test for C. Diff and while the test was pending, pre-emptive contact precautions is initiated. Further indicated under the heading Contact Precautions, a contact precautions symbol was placed on the door of resident's room to alert staff of contact precautions along with an isolation cart with adequate supplies for resident care. Gloves were	F 880		

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F 880	Continued From page 39 worn whenever entering room and gowns were worn for direct care of the resident or any environmental contact.	F 880		

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	245235	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/09/2023**

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K 000	INITIAL COMMENTS The Minnesota Department of Public Safety conducted an annual Life Safety recertification survey, State Fire Marshal Division on 08/09//2023. At the time of this survey, Woodbury Healthcare Center 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. Woodbury Health Care Center is a 3-story building with a lower level. The building was constructed at 2 different times. The original 2 story building with the lower level was constructed in 1979 and was determined to be of Type II(222) construction. In 1986, the third floor addition was constructed and determined to be of Type II(222) construction. Because the original building and the 1 addition are of the same type of construction, the facility was surveyed as one building. The building is protected by a full fire sprinkler system. The facility has a fire alarm system with full corridor smoke detection, resident rooms and spaces open to the corridors that are monitored for automatic fire department notification. The facility has a capacity of 155 beds and had a census of 94 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is MET.	K 000		

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

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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Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
September 6, 2023

Administrator
Woodbury Health Care Center
7012 Lake Road
Woodbury, MN 55125

Re: State Nursing Home Licensing Orders
Event ID: UL5Z11

Dear Administrator:

The above facility was surveyed on August 7, 2023 through August 10, 2023 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

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

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

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

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

Renee McClellan, Unit Supervisor
Metro A District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: renee.mcclellan@state.mn.us
Office: 651-201-4391 Mobile: 651-328-9282

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

Please feel free to call me with any questions.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00803	A. BUILDING: _____ B. WING _____	C 08/10/2023

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 8/7/23 - 8/10/23, a licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was not in compliance with the MN State Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you have reviewed these orders and	2 000		

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2 000	Continued From page 1 identify the date when they will be completed. The following complaints were reviewed during the survey: H52354231C (MN00095599) H52354229C (MN00094638) H52354227C (MN00093340) H52354228C (MN00089563) H5235142C (MN00076036) with no licensing orders issued. The following complaint was reviewed during the survey: H52354230C (MN00090518) with licensing order issued at 1695. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled " ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin <https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html> The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please	2 000		

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2 000	Continued From page 2 enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES. http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm. The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form.	2 000		
21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment.	21375		9/29/23

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	00803	A. BUILDING: _____ B. WING _____	C 08/10/2023

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21375	Continued From page 3 This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure contact precautions (measures intended to prevent transmission of infectious agents which are spread by direct or indirect contact with the resident or the resident's environment) for clostridioides difficile (C. diff), (a germ that can cause symptoms ranging from diarrhea to life-threatening colon inflammation) were implemented for 3 of 3 residents (R81, R106, R20). Findings include: R81's admission Minimum Data Set (MDS) dated 7/12/23, indicated moderate cognitive impairment, required extensive assistance with most activities of daily living (ADLs) including toileting, and was frequently incontinent of stool. R81's Medical Diagnosis form in the electronic medical record (EMR), indicated the following diagnoses: arthritis due to other bacteria to right knee, sepsis, bacterial infection unspecified. R81's medication administration record (MAR) dated August 2023, indicated R81 finished vancomycin (an antibiotic) 125 milligram capsule, 1 capsule by mouth four times a day for C. diff on 8/2/23. R81's Bowel Continence and BM (bowel movement) form for August 2023, indicated R81 had loose diarrhea once on 8/4/23, once on 8/5/23, two times on 8/6/23, once on 8/7/23, and once on 8/8/23.	21375	Corrected	

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21375	Continued From page 4 R81's C. Diff laboratory report dated 7/19/23, identified R81 had a positive C. difficile GDH antigen and C. Difficile toxin. The report further indicated the results must be interpreted based on clinical findings and were supportive of C. Diff infection. R81's care plan dated 7/17/23, indicated R81 had incontinence of bowel and bladder. During interview and observation on 8/7/23 at 1:10 p.m., R81 had a cart that contained gowns and gloves located outside the room. There was no sign located on the door or the wall that identified whether R81 was on any type of precautions. Nursing assistant (NA)-C stated R81 had C. Diff and verified there was no signage posted regarding precautions. During observation on 8/7/23 at 1:21 p.m., NA-C placed a sign on the wall next to R81's room that identified R81 was on contact precautions. During interview on 8/8/23, at 10:16 a.m., R81 stated he still had looser stools than normal. During interview on 8/8/23 at 10:38 a.m., licensed practical nurse (LPN)-B stated R81 still had symptoms of C. Diff. LPN-B further stated staff could go into R81's room with out a gown if just administering medications and would not need to donn a gown if she wasn't changing a brief, dressing, or bathing R81. During observation on 8/9/23 at 7:09 a.m., R81's contact precautions sign posted on the wall outside the door indicated everyone had to clean their hands prior to entering and when leaving, put on gloves before room entry and discard before room exit, put on a gown before room	21375		

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21375	Continued From page 5 entry, and discard the gown before room exit. During interview and observation on 8/9/23 between 7:49 a.m. and 7:50 a.m., NA-C walked into R81's room without a gown or gloves donned and delivered R81's breakfast tray. NA-C was observed touching the bedside table. NA-C stated gowns and gloves needed to be worn only when providing cares. During observation on 8/9/23 at 9:19 a.m., NA-C walked into R81's room without a gown or gloves donned and asked R81 if he wanted to get up. When R81 stated he wanted to get up, NA-C sanitized hands, walked out of the room donned a gown and gloves and LPN-B donned a gown and gloves and entered the room. R106's admission MDS dated 7/28/23, indicated severe cognitive impairment, required extensive assist for most ADL's including toileting, and was frequently incontinent of stool. R106's Medical Diagnosis form in the EMR indicated the following diagnoses: nondisplaced intertrochanteric fracture of the right femur, paroxysmal atrial fibrillation, congestive heart failure, chronic kidney disease, and Alzheimer's disease. R106's clinical physician orders dated 8/7/23, indicated obtain stool sample for salmonella, shigella, campylobacter, Y Enterocolitica, C. Diff, stool anion gap. R106's care plan dated 8/4/23, indicated R106 had bowel incontinence. R106's Bowel Continence and BM form for July-August 2023, indicated R106 had loose	21375		

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21375	Continued From page 6 diarrhea one time on 7/29/23, 7/31/23, 8/2/23, 8/4/23, 8/5/23, 8/6/23, and 8/7/23. R106's C. Diff laboratory result dated 8/8/23 at 7:15 p.m., indicated a negative result. During interview 8/7/23 at 2:54 p.m., family member (FM)-B stated R106 had chronic diarrhea. During observation 8/8/23 at 8:30 a.m., R106 did not have an isolation cart located outside the door and no precautions sign was located on the door. During observation 8/8/23 at 1:32 p.m., R106's door was closed and there was no isolation cart located outside the door and no precautions sign on the wall or door indicating any type of contact precautions. During observation 8/9/23 at 8:22 a.m., R106's door was closed and there was no isolation cart located outside the door and no contact precautions sign. R106's paper chart was reviewed along with the EMR and did not locate C. Diff laboratory results. During interview and observation on 8/9/23 at 9:46 a.m., NA-F stated she worked at the facility for four years and mainly worked on R106's side. NA-F stated R106 always had loose stools and stated R106 was not on any kind of precautions. During interview on 8/9/23 at 10:10 a.m., LPN-A initially stated she was not aware if a stool sample had been obtained for R106 yet, then added the stool had been sent the day prior for C. Diff. When asked if R106 was on contact precautions for potential C. Diff, LPN-A stated they always do standard precautions (infection prevention	21375		

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21375	Continued From page 7 practices that apply to all residents, regardless of suspected or confirmed diagnosis or presumed infection status. Standard precautions is based on the principle that all blood, body fluids, secretions, excretions except sweat, regardless of whether they contain visible blood, non-intact skin, and mucous membranes may contain transmissible infectious agents) but had just obtained the specimen and everyone was on standard precautions until the test results were received. During interview on 8/9/23 at 12:44 p.m., the infection preventionist-(IP)-E stated she was alerted to new infections through staff notification, and if a resident was placed on an antibiotic, it would appear on the dashboard. If there was suspected C. Diff, staff would notify the physician and wait for a culture and staff would put out a cart with gowns and gloves. A resident comes off contact precautions if they are finished with the antibiotic and are no longer having symptoms for 48 hours. Staff are notified when a patient is no longer on precautions and the cart would be removed. IP-E stated she heard R81 did not have a sign posted and verified he was still on contact precautions because he was still having loose stools. IP-E further stated she expected staff to wear a gown and gloves if providing cares, and added the use of gloves depended on the situation. IP-E stated if a test for C. Diff was ordered, she expected contact precautions to be initiated because if a resident was found to be positive for C. Diff, staff could spread the infection to multiple residents. During interview on 8/10/23 at 10:04 a.m., the director of nursing (DON) stated their policy indicated if touching surfaces gloves should be worn and expected gloves and gowns for contact	21375		

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21375	Continued From page 8 precautions and staff should wash hands before exiting room. DON further stated he expected contact precautions to be put in place preemptively while awaiting test results. R20's 5-day Minimum Data Set (MDS) dated 6/23/23, indicated R20 was cognitively intact, required 2-person physical assistance with transfers and bed mobility and 1-person physical assistance with toileting and personal hygiene. R20's diagnoses included osteomyelitis of vertebra (infection in the bone), enterocolitis due to clostridium difficile (C-diff), recurrent, and need for assistance with personal care. R20's care plan (CP) dated 7/26/23, indicated R20 had incontinence of bowel and bladder related to stress incontinence, history of recurrent urinary tract infection, and colitis related to C-diff. Interventions included perineal care after incontinent episode and record bowel movements daily. R20's August treatment administration record (TAR) indicated an order dated 8/7/23, to check stool for C-diff every shift for 3 days. Discontinue when completed. R20's progress note dated 8/8/23 at 5:03 p.m., indicated, "Room Change: Reason: C-Diff precautions-resident has had loose stool..." During interview on 8/8/23 at 3:56 p.m., registered nurse (RN)-C stated she thought R20 had a stool sample collected per the provider's order but had not been placed on precautions. During observation on 8/9/23 at 7:40 a.m., R20 and R20's bed was not in her room.	21375		

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21375	Continued From page 9 When interviewed on 8/9/23 at 7:44 a.m., nursing assistant (NA)-I stated R20 was transferred yesterday (8/8/23) around dinner time. NA-I did not know the reason for the R20's transfer and was not aware of an order to collect a stool sample. When interviewed on 8/9/23 at 7:56 a.m., NA-G stated the infection preventionist (IP) and director of nursing (DON) informed her yesterday (8/8/23) that R20 had an order for stool sample collection to check for C-diff. NA-G stated the facility policy was for residents to be placed on contact precautions anytime C-diff was suspected, and a stool sample ordered so that C-diff would not inadvertently be spread to other residents. NA-G stated contact precautions for C-diff would include bleach wipes for surfaces, soap and water hand hygiene, gowns and gloves for any cares. NA-G stated an isolation cart with all the appropriate items for precautions would immediately be placed outside a resident's room while waiting for C-diff results. When interviewed on 8/9/23 at 9:52 a.m. RN-C stated R20 was transferred to a private room and contact precautions initiated only after she was alerted that a stool sample for C-diff had been ordered. RN-C stated precautions should have been started as soon as the order for the sample was placed but there was a breakdown in communication. RN-C stated R20 was on an antibiotic prophylactically for C-diff, however, with her recent episodes of diarrhea and her history of recurrent C-diff, they were collecting a stool sample to test for it. When interviewed on 8/10/23 at 10:20 a.m., DON stated contact precautions should be initiated immediately upon receiving an order for a stool	21375		

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21375	Continued From page 10 sample to test for C-diff. DON stated there was a breakdown in communication in R20's case. A policy, Clostridium Difficile (Based on the MDH Clostridium difficile Algorithms for LTC) dated 7/2018, indicated risk factors for C. Diff infections included recent antibiotic use, over age 65, and other serious illness. Contact precautions are used with any resident with C. Diff infection or those who may be suspected of having C. Diff. Gloves and gowns are always worn when providing direct cares with the resident. Under the heading, Early Recognition, the provider is contacted to obtain an order for a lab test for C. Diff and while the test was pending, pre-emptive contact precautions is initiated. Further indicated under the heading Contact Precautions, a contact precautions symbol was placed on the door of resident's room to alert staff of contact precautions along with an isolation cart with adequate supplies for resident care. Gloves were worn whenever entering room and gowns were worn for direct care of the resident or SUGGESTED METHOD OF CORRECTION: The director of nursing (DON), or designee, could review applicable policies and procedures regarding PPE use with lab-results pending cases; then educate staff and audit to ensure ongoing compliance. TIME FRAME FOR CORRECTION: Twenty-one (21) days	21375		
21565	MN Rule 4658.1325 Subp. 4 Administration of Medications Self Admin	21565		9/29/23

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21565	Continued From page 11 Subp. 4. Self-administration. A resident may self-administer medications if the comprehensive resident assessment and comprehensive plan of care as required in parts 4658.0400 and 4658.0405 indicate this practice is safe and there is a written order from the attending physician. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure a self-administration of medications assessment was completed to allow residents to safely administer their own medications for 1 of 1 resident (R25) observed with medications at bedside. Findings include: R25's quarterly MInimum Data Set (MDS) dated 6/29/23, indicated R25 had intact cognition and diagnoses of congenital malformations of intestinal fixation (the intestines are not in the correct position in the abdomen), right upper quadrant pain, and unspecified abdominal pain. It further indicated, R2 was independent with all activities of daily living (ADL) except eating which required supervision, had a feeding tube, received 26-50% of calories and 501 cubic centimeters (cc) or more fluids through TF. R25's physician's orders dated 8/5/23, indicated tube feeding Osmolite 1.5 at 50 millileters (ml)/hour (hr). If patient is able to eat small meals frequently throughout the day, then infuse TF overnight only from 8:00 p.m.-8:00 a.m. If ongoing nausea/abdominal discomfort with inability to take adequate food by mouth, then infuse 24 hours per day. Initiate at 10 ml/hr and advance by 10 ml every 6 hr. as tolerated to goal	21565	Corrected	

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21565	Continued From page 12 at 50 ml/hr. Do not advance TF rate unless potassium is equal to or greater than 3.0, Magnesium is equal to or greater than 1, every shift. It further lacked a doctor's order to be able to self administer her medication. R25's care plan dated 7/5/23, indicated R25 was able to perform ADL's with minimal assistance from staff and had a tube feeding and nausea. She had been noted to take food and drinks (mostly soda, bread and cheese) to her room and eat/drink it. It further indicated the following interventions: eats independently by mouth, but receives most of her nutrition by feeding tube. Per gastrointestinal (GI) clinic recommendations: continue TFs as per your dietician, if you do eat or drink anything, please remain upright for an hour or so afterwards. Ok to take "non-crushable" medications by mouth. She is able to manage her tube feeding with set up and supervision from nursing staff. Assist as needed. During interview on 8/07/23 at 5:21 p.m., R25 stated she administerd her own TF and flushes but her doctor was trying to convince her to let the nurses administer it. During observtion/interview on 8/9/23 at 8:00 a.m., R25 was sitting in her room working on some paperwork. The TF pole was in her room but their wasn't any Osmolite hanging and the TF wasn't running. R25 stated she started her TF at approximately 9:00 p.m. on (8/8/23) and stopped it at approximately 7:00 a.m., stating "thought I'd had enough already." R25 further stated she "had everything in her room to do it herself." During an interview on 8/9/23 at 8:49 a.m.,	21565		

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21565	Continued From page 13 registered nurse (RN)-E stated R25 usually administerd her own tube feeding because she won't allow staff to do it. She further stated the doctor's order wasn't clear and the notes from the hospital say she manages her own TF. The doctor needs to give us an order that's clear. RN-E verified R25 had Osmolite and TF supplies in her room. During an interview on 8/9/23 at 10:57 a.m., LPN-D stated R25 administerd her TF "without telling anyone, staff offer to help but she won't let us or says she already did it. We are trying to get a doctor's order for staff to do it." LPN-D further stated R25 "get's the supplies from the supply room and keeps them in her closet." During observation on 8/9/23 at 1:15 p.m., a full bottle of unopened Osmolite was sitting on R25's dresser and there was an unopened package of tubing next to it. During an interview on 8/9/23 at 1:25 p.m., nursing assistannt (NA)-L verified there was a bottle of Osmolite sitting on the dresser in R25's room and stated all of the supplies for R25's TF are stored in the supply closet and the Osmolite was stored in the medication room both of which were locked. During an interview on 8/9/23 at 1:28 p.m., nurse manager RN-C stated R25 was administering her own TF and verified R25 had not been assessed (SAM) and didn't have a doctor's order to be self-administering her own medications. RN-C further stated R25 should not have Osmolite or TF feeding supplies in her room and she did not have access to the supply closet or medication room and would have to be let in by a nurse.	21565		

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21565	Continued From page 14 During interview on 8/10/23 at 12:48 p.m., the director of nursing (DON) stated in order for a resident to be able to administer their own medications, they need to be assessed, reviewed in IDT, and have a doctor's order. The DON further stated the nurses were responsible for administering R25's TF and flushes and verified R25 did not have a self administration of medications assessment (SAM), and the supplies for her TF were locked up in the medication room and a nurse would have to access it for her. A facility policy on medication administration was received, however it did not address self adminstration of medication. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review applicable policies and procedures to ensure residents' are assessed timely with self administration of medications; then provide staff education. The quality assurance committe could monitor for compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21565		
21695	MN Rule 4658.1415 Subp. 4 Plant Housekeeping, Operation, & Maintenance Subp. 4. Housekeeping. A nursing home must provide housekeeping and maintenance services necessary to maintain a clean, orderly, and comfortable interior, including walls, floors, ceilings, registers, fixtures, equipment, lighting, and furnishings.	21695		9/29/23

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21695	Continued From page 15 This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure the west hallway shower room was kept clean, sanitary and in good repair, which had the potential to affect all 22 residents who utilized the west shower room. Additionally, the facility failed to provide maintenance services for 2 of 2 (R11, R295) residents whom had broken door handles and latches. Findings include: R11's significant change Minimum Data Set (MDS) dated 5/6/23, identified intact cognition, a diagnosis of medically complex conditions related to colon cancer, rejection of care 1-3 days in the seven day look back period, and one-person physical assist was provided for bathing along with extensive staff assistance provided for transfers, hygiene and dressing. During an interview on 8/7/23 at 12:50 p.m., R24 stated the common shower room she used in the hallway was "disgusting". During an observation on 8/7/23 at 12:52 p.m., the shower room was observed to have an approximate four by four-foot area for showering with white tile and grout on the floors and wall. The grout alongside the floor of the shower where it met with the wall was discolored brown and orange. The grout in the two back corners was spotted black extending up the walls approximately two inches. The shower had no curtain. There was a tattered clear plastic bag taped and tied onto the shower grab bar. During an interview on 8/7/23 at 3:01 p.m.,	21695	Corrected	

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21695	Continued From page 16 nursing assistant (NA)-J stated showers were disinfected between residents. NA-J stated the cleaning solution needed to be obtained from housekeeping and was not kept in the shower room. During an interview on 8/7/23 at 3:03 p.m., NA-K stated she was not sure what cleaners were used between resident uses of the shower and would have to ask the nurse. During an observation and interview on 8/8/23 at 10:14 a.m., the housekeeper (H)-A cleaned the shower room floor with bleach. H-A stated nursing could call housekeeping for assistance. During an observation and interview on 8/9/23 at 9:32 a.m., maintenance (MA) confirmed the above findings in the shower room and stated grout was maintained by maintenance, and shower curtains would be maintained by housekeeping. MA stated he was unsure what the clear plastic bag tied to the grab bar was for and wondered if it was a make-shift shower curtain. MA stated the grout should be fixed by maintenance and needed to be cleaned well. MA stated maintenance periodically inspected the showers,and had not noticed nor been informed by staff of the discolored grout or lack of shower curtain. During an interview on 8/9/23 at 9:43 a.m., the housekeeping manager (HM) stated a shower curtain should been in place in resident shower rooms. The HM stated any cleaning needs could be submitted to housekeeping via the TELS system (an online system of logging maintenance or housekeeping requests). The HM reviewed the TELS reports and verified no request had been submitted for a west shower curtain or grout	21695		

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21695	Continued From page 17 concerns. During an interview on 8/9/23 at 2:27 p.m., the director of plant operations (DPO) stated housekeeping was responsible to clean bathrooms and grout and maintenance would be responsible for grout repairs. The undated facility document titled Housekeeping In-Service identified mops and germicide solutions were used to disinfect washroom floors. Additionally, the mop should run alongside the edges and never push dirt into the corners. R295's Clinical Census Form in the electronic medical record (EMR) indicated R295 was admitted to the facility on 1/20/23, to room 112. R295's nursing progress notes dated 1/20/23, indicated R295 was discharged with family member (FM)-C. However, did not indicated any reasoning for the discharge. During interview on 8/9/23, at 1:35 p.m., FM-C stated R295's room was located on the main floor and the door knob looked like someone tried to pry it with a screw driver. During interview and observation on 8/9/23, between 1:43 p.m., and 1:45 p.m., the door handle to room 112 was pulled down and stuck in the downward position. At 1:45 p.m., housekeeper (H)-C verified the latch parts were loose and there was a loose screw and the latch was stuck inside when the door handle was pushed downward. Part of the door next to the latch had what appeared to be chipped wood measuring approximately 2.5 inches long by .75 inches wide. H-C did not know how long the door	21695		

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21695	Continued From page 18 had been in this condition. Facility work orders were reviewed from 1/1/23 through 8/9/23, and no orders were located for room 112's door. During interview on 8/9/23 at 1:52 p.m. maintenance (MA) verified the latch was stuck and wood was missing on the side of the door latch and stated he requestesd more door handles be ordered as room 223 also had a bad bathroom handle and would see what he had for doors and also had wood putty. During interview on 8/9/23 at 2:03 p.m., FM-C stated he notified staff of the condition of the door and stated he asked for the person in charge. Provided the surveyor with pictures of the door latch/handle. During interview on 8/9/23 at 2:27 p.m., the director of plant operations (DP) stated they completed latch and gap inspections once a month and if anything needed to be done, they repaired them. During interview on 8/10/23 at 9:54 a.m., MA verified the latch in the photograph and the door latch for room 112 were absolutely the same latch, adding you could tell because the same wood was missing in the picture as was identified on the door for room 112. MA verified latches were checked and inspected monthly and stated a new door was ready to be installed. A policy for shower room maintenance and other maintenance was requested and not provided. SUGGESTED METHOD FOR CORRECTION:	21695		

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21695	Continued From page 19 The Administrator or designee could review the current policies and procedures to ensure all resident environments and equipment are clean and in good repair. The Administrator could educate staff on those policies and procedures and designate someone to monitor for compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21695		
21810	MN St. Statute 144.651 Subd. 6 Patients & Residents of HC Fac.Bill of Rights Subd. 6. Appropriate health care. Patients and residents shall have the right to appropriate medical and personal care based on individual needs. Appropriate care for residents means care designed to enable residents to achieve their highest level of physical and mental functioning. This right is limited where the service is not reimbursable by public or private resources. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure resident's needs were assessed appropriately for 1 of 1 resident (R58) when a staff answered a call light and immediately turned it off without assessing or addressing the resident's needs. Findings include: R58's quarterly Minimum Data Set (MDS) dated 6/5/23, indicated R58 was cognitively impaired, required 2-person physical assist for bed mobility,	21810	Corrected	9/29/23

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21810	Continued From page 20 transfers, and toilet use. R58 required 1-person physical assist with all other activities of daily living (ADLs) and could always make self understood with verbal and non-verbal expression. R58's diagnoses included dementia, dysphagia, and anxiety. R58's communication care area assessment (CAA) dated 3/7/23, indicated R58 had difficulty putting sentences together. R58's care plan (CP) dated 6/14/23, indicated R58 had cognitive loss and directed staff to use communication techniques that facilitate optimal interaction and to identify self, face when speaking, and make eye contact. The CP further directed staff to anticipate needs, and observe physical, nonverbal indicators of discomfort or distress. During observation on 8/8/23 at 1:51 p.m., R58 was in bed fidgeting with the bed control pointed to the other side of the room where there was a TV, a water pitcher, a wheelchair, and blanket. R58's legs were moving as if attempting to get out of bed. R58 was provided her call light which was within reach, and she activated it independently. During observation on 8/8/23 at 1:54 p.m., nursing assistant (NA)-E walked into R58's room, reset the call light and left R58's room without addressing what the call light was on for. NA-E was in R58's room for 10 seconds. NA-E entered a different resident's room. During observation on 8/8/23 at 1:56 p.m., R58 continued to fidget with the bed control, appeared restless in bed, and pointed toward the other side of the room. Surveyor pointed to several items	21810		

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21810	Continued From page 21 and R58 nodded when the water pitcher was offered. During observation on 8/8/23 at 2:07 p.m., NA-E exited the other room and walked away from R58's room toward the common area and did not return to R58's room. When interviewed on 8/8/23 at 2:08 p.m., NA-E stated R58 did not want anything and she "must have pulled the call light off the wall and hit it accidentally." NA-E further stated to understand R58, staff should get close to her and listen carefully. When interviewed on 8/9/23 at 9:09 a.m., NA-G stated R58 did not communicate well and required staff to get down close to her and speak slowly. NA-G further stated when R58 activated her call light, staff should look for signs of grimacing or pain, check her brief, offer drinks or snacks and allow her time to try to express her needs. NA-G stated this interaction should take at least a few minutes and may take up to 5 minutes to determine what her need was or if she had activated the call light on accident. When interviewed on 8/9/23 at 12:42 p.m., registered nurse (RN)-C stated R58 had cognitive loss and staff should always attempt to figure out and address needs when R58's call light was activated. RN-C stated staff should take their time with all residents but particularly with those who had communication barriers. When interviewed on 8/10/23 at 10:14 a.m., director of nursing (DON) stated the expectation was staff should not just reset a call light, but should take a few minutes to attempt to understand and address resident's needs when	21810		

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21810	Continued From page 22 answering call lights. Facility policy Standards of Care Guidelines dated 3/24/15, identified, "All staff will care for residents in a manner that promotes maintenance, dignity, or enhancement of each resident's quality of life." SUGGESTED METHODS OF CORRECTION: The director of nursing (DON) or designee could develop, review, and /or revise policies and procedures to ensure all residents have their call lights answered appropriately. The DON or designee could educate all appropriate staff. The DON or designee could develop monitoring systems to ensure ongoing compliance and report those results to the quality assurance committee. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21810		