Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
November 7, 2024

Administrator
The Terrace At Crystal LLC
3245 Vera Cruz Avenue North
Crystal, MN 55422

RE: CCN: 245289
Cycle Start Date: August 30, 2024

Dear Administrator:

On September 13, 2024, we notified you a remedy was imposed. On November 5, 2024 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 29, 2024.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective September 28, 2024 be discontinued as of October 29, 2024. (42 CFR 488.417 (b))

In our letter of September 13, 2024, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from September 28, 2024. This does not apply to or affect any previously imposed NATCEP loss.

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

Feel free to contact me if you have questions.

Sincerely,

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

An equal opportunity employer.

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

NOTICE OF TOTAL AMOUNT OF ASSESSMENT
FOR NURSING HOMES

November 7, 2024

Administrator
The Terrace At Crystal LLC
3245 Vera Cruz Avenue North
Crystal, MN 55422

RE: UQ8R13

Dear Administrator:

On November 5, 2024, a Notice of Assessment for Noncompliance with Correction Orders with an imposed a daily fine in the amount of $350.00 was electronically issued to the above facility. An acknowledgement was electronically received by the Department stating that the violation(s) had been corrected. A reinspection was held on November 5, 2024 and it was determined that compliance with the licensing rules was attained.

Therefore, the total amount of the assessment is $350.00. In accordance with Minnesota Statutes, § 144A.10, subdivision 7, the costs of the reinspection, totaling $487.20, are to be added to the total amount of the assessment. You are required to submit a check, made payable to the Commissioner of Finance, Treasury Division, in the amount of $837.20 within 15 days of the receipt of this notice. That check should be forwarded to:

Department of Health
Health Regulation Division,
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900

Sincerely,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health

An equal opportunity employer.

P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

cc: Joanne Simon, Program Assurance Superviosr
Kami Fiske-Downing, Licensing and Certification Program
Penalty Assessment Deposit Staff

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF ASSESSMENT FOR NONCOMPLIANCE WITH CORRECTION ORDERS FOR NURSING HOMES

Electronically delivered

November 5, 2024

Administrator
The Terrace At Crystal LLC
3245 Vera Cruz Avenue North
Crystal, MN 55422

Re: CCN: 245289
Cycle Start Date: August 30, 2024

Dear Administrator:

On October 7, 2024, survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on August 30, 2024 with orders received by you electronically on September 13, 2024.

State licensing orders issued pursuant to the last survey completed on August 30, 2024, found not corrected at the time of this October 7, 2024 revisit and subject to penalty assessment are as follows:

20830 -- S/S: -- MN Rule 4658.0520 Subp. 1 -- Adequate And Proper Nursing Care; General $350.00

The details of the violations noted at the time of this revisit completed on October 7, 2024 (listed above) are on the attached Minnesota Department of Health Statement of Deficiencies-Licensing Orders Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags. It is not necessary to develop a plan of correction, electronically acknowledge and date this form and submit to the Minnesota Department of Health if there are no new orders issued.

Therefore, in accordance with Minnesota Statutes, § 144A.10, you will be assessed an amount of $350.00 per day beginning on the day you receive this notice.

The fines shall accumulate daily until notification from the nursing home is received by the Department stating that the orders have been corrected. This written notification shall be mailed or delivered:

Pete Cole, RN Regional Operations Supervisor
Metro Team C District Office

Health Regulation Division
Minnesota Department of Health
625 Robert Street N
P.O. Box 64975
Saint Paul, Minnesota 55164-0975
Email: peter.cole@state.mn.us
Office/Mobile: (651) 249-1724

When the Department receives notification that the orders are corrected, a reinspection will be conducted to verify that acceptable corrections have been made. If it is determined that acceptable corrections have not been made, the daily accumulation of the fines shall resume and the amount of the fines which otherwise would have accrued during the period prior to resumption shall be added to the total assessment. The resumption of the fine can be challenged by requesting a hearing within 15 days of the receipt of the notice of the resumption of the fine.

If the accumulation of the fine is resumed, the fines will continue to accrue in the manner described above until a written notification stating that the orders have been corrected is verified by the Department.

The costs of all reinspections required to verify whether acceptable corrections have been made will be added to the total amount of the assessment.

You may request a hearing of any of the above noted penalty assessments provided that a written request is made within 15 days of the receipt of this Notice. Any request for a hearing shall be sent to:

Shellae Dietrich, Health Program Manager
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
St. Paul, Minnesota 55164-0900

Once the penalty assessments have been verified as corrected the facility will receive a notice of the total amount of the penalty assessment including the costs of any reinspections.

Also, at the time of this reinspection completed on October 7, 2024 additional violations were cited as follows:

20130 -- S/S: -- MN Rule 4658.0050 Subp. 1 -- Licensee;general Duties
21705 -- S/S: -- MN Rule 4658.1415 Subp. 6 -- Plant Housekeeping, Operation, & Maintenance

They are delineated on the electronically delivered Minnesota Department of Health Statement of Deficiencies-Licensing Orders Form. Only the ID Prefix Tag in the left hand column without brackets will identify these licensing orders. It is not necessary to develop a plan of correction, however, you will need to acknowledge when all orders will be corrected, and electronically submit.

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

Enclosure

cc: Licensing and Certification File
Kami Fiske-Downing, Licensing and Certification Program
Penalty Assessment Deposit Staff

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
October 16, 2024

Administrator
The Terrace At Crystal LLC
3245 Vera Cruz Avenue North
Crystal, MN 55422

RE: CCN: 245289
Cycle Start Date: August 30, 2024

Dear Administrator:

Please note that this facility has been chosen as a Special Focus Facility (SFF). CMS' policy of progressive enforcement means that any SFF nursing home that reveals a pattern of persistent poor quality is subject to increasingly stringent enforcement action, including stronger civil monetary penalties, denial of payment for new admissions and/or termination of the Medicare provider agreement.

On September 13, 2024, we informed you of imposed enforcement remedies.

On October 8, 2024, the Minnesota Departments of Health and Public Safety completed a revisit and it has been determined that your facility continues to not to be in substantial compliance. The most serious deficiencies in your facility were found to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

The deficiencies not corrected are as follows:

E0007 -- S/S: C -- 483.73(a)(3) -- Ep Program Patient Population
F0689 -- S/S: D -- 483.25(d)(1)(2) -- Free Of Accident Hazards/supervision/devices
K0363 -- S/S: E -- NFPA 101 -- Corridor - Doors Bld: 01
K0374 -- S/S: D -- NFPA 101 -- Subdivision Of Building Spaces - Smoke Barrie Bld: 01
20830 -- MN Rule 4658.0520 Subp. 1 -- Adequate And Proper Nursing Care; General

In addition, at the time of this revisit, we identified the following deficiencies:

F0584 -- S/S: E -- 483.10(i)(1)-(7) -- Safe/clean/comfortable/homelike Environment
F0835 -- S/S: F -- 483.70 -- Administration
20130 -- MN Rule 4658.0050 Subp. 1 -- Licensee;general Duties
21705 -- MN Rule 4658.1415 Subp. 6 -- Plant Housekeeping, Operation, & Maintenance

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

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective September 28, 2024, will remain in effect.

This Department continues to recommend that CMS impose a civil money penalty. (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS location only if CMS agrees with our recommendation.

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective September 28, 2024. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective September 28, 2024.

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

As we notified you in our letter of September 13, 2024, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from September 28, 2024.

ELECTRONIC PLAN OF CORRECTION (ePOC)

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

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

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

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:

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

- Per day civil money penalty (42 CFR 488.430 through 488.444).

DEPARTMENT CONTACT

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

Pete Cole, RN Regional Operations Supervisor
Metro Team C District Office
Health Regulation Division
Minnesota Department of Health
625 Robert Street N
P.O. Box 64975
Saint Paul, Minnesota 55164-0975
Email: peter.cole@state.mn.us
Office/Mobile: (651) 249-1724

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by November 30, 2024 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at 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.

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing

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

Steven.Delich@cms.hhs.gov

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

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

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

INFORMAL DISPUTE RESOLUTION/ 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://forms.web.health.state.mn.us/form/NHDisputeResolution

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

Feel free to contact me if you have questions.

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 13, 2024

Administrator
The Terrace At Crystal LLC
3245 Vera Cruz Avenue North
Crystal, MN 55422

RE: CCN: 245289
Cycle Start Date: August 30, 2024

Dear Administrator:

Please note that this facility has been chosen as a Special Focus Facility (SFF). CMS' policy of progressive enforcement means that any SFF nursing home that reveals a pattern of persistent poor quality is subject to increasingly stringent enforcement action, including stronger civil monetary penalties, denial of payment for new admissions and/or termination of the Medicare provider agreement.

On August 30, 2024, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

REMEDIES

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

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective September 28, 2024.

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective September 28, 2024. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective September 28, 2024.

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

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

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $12,924; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by September 28, 2024, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, The Terrace At Crystal Llc will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from September 28, 2024. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions.

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

ELECTRONIC PLAN OF CORRECTION (ePOC)

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

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

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

DEPARTMENT CONTACT

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

Pete Cole, RN Regional Operations Supervisor
Metro Team C District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
625 Robert Street N
P.O. Box 64975
Saint Paul, Minnesota 55164-0975
Email: peter.cole@state.mn.us
Office/Mobile: (651) 249-1724

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by February 28, 2025 if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 488.412 and § 488.456.

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

APPEAL RIGHTS

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

file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Steven.Delich@cms.hhs.gov

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

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

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

INFORMAL DISPUTE RESOLUTION (IDR) / 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://forms.web.health.state.mn.us/form/NHDisputeResolution

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

Feel free to contact me if you have questions.

Sincerely,

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 13, 2024

Administrator
The Terrace At Crystal LLC
3245 Vera Cruz Avenue North
Crystal, MN 55422

Re: State Nursing Home Licensing Orders
Event ID: UQ8R11

Dear Administrator:

The above facility was surveyed on August 26, 2024 through August 30, 2024 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:

Pete Cole, RN Regional Operations Supervisor
Metro Team C District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
625 Robert Street N
P.O. Box 64975
Saint Paul, Minnesota 55164-0975
Email: peter.cole@state.mn.us
Office/Mobile: (651) 249-1724

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
	245289	A. BUILDING _____ B. WING _____	C 08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE TERRACE AT CRYSTAL LLC	3245 VERA CRUZ AVENUE NORTH CRYSTAL, MN 55422

(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 The Terrace of Crystal is a Special Focus Facility (SFF). On 8/26/24 - 8/30/24, a survey for compliance with CMS Appendix Z, the Emergency Preparedness Requirements, was conducted during a standard recertification survey. The facility was not in compliance. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulation has been attained.	E 000		
E 004 SS=C	Develop EP Plan, Review and Update Annually CFR(s): 483.73(a) §403.748(a), §416.54(a), §418.113(a), §441.184(a), §460.84(a), §482.15(a), §483.73(a), §483.475(a), §484.102(a), §485.68(a), §485.542(a), §485.625(a), §485.727(a), §485.920(a), §486.360(a), §491.12(a), §494.62(a). The [facility] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section. The emergency preparedness program must include, but not be limited to, the following elements:	E 004		10/4/24

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

Electronically Signed | 09/24/2024

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

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E 004	Continued From page 1 (a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be [reviewed], and updated at least every 2 years. The plan must do all of the following: * [For hospitals at §482.15 and CAHs at §485.625(a):] Emergency Plan. The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. * [For LTC Facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. * [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least every 2 years. . This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to develop, establish, and maintain, a comprehensive emergency preparedness program (EPP) which included a facility-based and community-based risk assessment . The facility failed to ensure their EPP included a facility risk assessment to identify hazards (e.g. natural, man-made, facility, geographic, etc.) and development of an EPP based off the needs of	E 004	E004 – develop EP plan, review and update annually 1.What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Facility risk assessment for external and internal was completed and inserted into the EP binder 2.How other residents having the potential	

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E 004	Continued From page 2 the population served and facility risk assessment. This had the potential to affect all 53 residing in the facility, as well as all staff who worked in the facility. Findings include: During document review on 8/29/24 at 8:00 a.m., the EPP was reviewed and did not contain a a facility-based and community-based risk assessment. On 8/29/24 at 8:08 a.m., director of maintenance (DOM) verified he oversaw emergency preparedness for the facility and he had been employed at the facility since June 2024. DOM stated he was not aware a facility risk assessment to identify hazards had been completed and verified the EPP was not based off the facility risk assessment. DOM verified the facility's risk for potential hazards (both external and internal hazards) had not been assessed. During interview on 8/29/24 at 2:04 p.m. the administrator verified, after review, that a risk assessment for the facility to identify hazards had not been completed that he was aware of. The administrator verified the facility assessment was completed on 6/10/24 and did not include a risk assessment for the facility. Review of the facility policy titled, Emergency Management Plan, reviewed 6/10/24, indicated, "The purpose of this emergency management plan is to provide an all-hazards approach to guide in the even of an emergency, a crisis, or a disaster scenario that would affect the safety and well-being of our resident and employees as well as community member stricken by the situation,"	E 004	to be affected by the same deficient practice will be identified and what corrective action will be taken? This deficient practice could affect all residents, staff and visitors. 3.What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? The assessment will be checked annually to ensure that assessments are up to date with the most current information 4.How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? The maintenance director is responsible for these actions in reviewing the assessment annually with the IDT team. The facility risk assessment will be reviewed by IDT during QAPI yearly to ensure EP plan is review and updated. 5.The systemic change be completed by 10/4/2024.	

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E 004	Continued From page 3 and further indicated "facility characteristics are determined through comprehensive facility, hazard vulnerability and security vulnerability assessments."	E 004		
E 007 SS=C	EP Program Patient Population CFR(s): 483.73(a)(3) §403.748(a)(3), §416.54(a)(3), §418.113(a)(3), §441.184(a)(3), §460.84(a)(3), §482.15(a)(3), §483.73(a)(3), §483.475(a)(3), §484.102(a)(3), §485.68(a)(3), §485.542(a)(3), §485.625(a)(3), §485.727(a)(3), §485.920(a)(3), §491.12(a)(3), §494.62(a)(3). [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following:] (3) Address [patient/client] population, including, but not limited to, persons at-risk; the type of services the [facility] has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans.** *[For LTC facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do all of the following: (3) Address resident population, including, but not limited to, persons at-risk; the type of services the LTC facility has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans.	E 007		10/4/24

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E 007	Continued From page 4 *NOTE: ["Persons at risk" does not apply to: ASC, hospice, PACE, HHA, CORF, CMCH, RHC/FQHC, or ESRD facilities.] This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to address the resident population including, but not limited to, residents most at-risk and the type of services the facility has the ability to provide in an emergency. This had the potential to affect all 53 residents residing in the facility. Findings include: Review of the facility Emergency Preparedness Plan (EPP) last revised on 6/10/24, lacked components regarding the resident populations: the persons at-risk and the type of services the facility has the ability to provide in an emergency. During interview on 8/29/24 at 8:14 a.m., director of maintenance (DOM) verified he oversaw emergency preparedness for the facility. DOM confirmed EPP does not what resident populations are most at risk during and emergency and did not specify how continuity of services would be maintained to such residents during an emergency. DOM verified they are continuing to update the EPP to ensure it up to compliance.	E 007	Citation: E007 Concern: Policy and process for identifying resident population needs and services for continuity of care in the event of an emergency. Identification of residents at risk All residents are at risk with the following citation. Corrective measures -Transfer agreement with Estates at Chateau has been established, this is a SNF with similar patient populations offering skilled nursing, psych services, rehab therapies, relocation services and chemical dependency treatments. Another transfer agreement with Gardens at Winsted, a skilled nursing facility, which has a similar patient population including skilled nursing, locked dementia unit, relocation services and rehab therapies. Our third transfer agreement is with Northridge, a SNF offering Skilled nursing, relocation, pysch services, and rehab therapies. -In the event of an emergency the Emergency Medical Record can be accessed on specific machines to refer appropriate residents to the appropriate	

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E 007	Continued From page 5	E 007	facilities. -All staff education will be provided to staff regarding use of the Emergency Medical Records system. -Emergency preparedness drills will follow the education Monitoring mechanism -Post-education quiz to evaluate staff knowledge -Conducting post-drill debriefing to identify weaknesses in the process and improve performance through practice. correction date 4PM 10-04-2024	
E 022 SS=C	Policies/Procedures for Sheltering in Place CFR(s): 483.73(b)(4) §403.748(b)(4), §416.54(b)(3), §418.113(b)(6)(i), §441.184(b)(4), §460.84(b)(5), §482.15(b)(4), §483.73(b)(4), §483.475(b)(4), §485.68(b)(2), §485.542(b)(4), §485.625(b)(4), §485.727(b)(2), §485.920(b)(3), §491.12(b)(2), §494.62(b)(3). (b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the	E 022		10/4/24

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E 022	Continued From page 6 following:] [(4) or (2),(3),(5),(6)] A means to shelter in place for patients, staff, and volunteers who remain in the [facility]. *[For Inpatient Hospices at §418.113(b):] Policies and procedures. (6) The following are additional requirements for hospice-operated inpatient care facilities only. The policies and procedures must address the following: (i) A means to shelter in place for patients, hospice employees who remain in the hospice. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to fully develop an emergency policy or procedure which outlined a means for sheltering for all residents, staff and volunteers who would remain in the facility if an evacuation could not be executed. This has the potential to affect all 53 residents currently residing within the facility and staff working at the facility. Findings include: During review of the facility's emergency preparedness plan (EPP) the plan included a Shelter-in Place policy. The policy lacked indication of identification of potential situations in which sheltering in place might be necessary and identification of locations within the facility that have been identified as suitable spaces that are structurally sound and away from potential exposure and did not include how continuity of care would be provided in the event residents and staff needed to shelter in place.	E 022	Citation 0020 What corrective action will be accomplished for those residents found to have been affected by the deficient practice? The shelter-in-place policy was updated to reflect all situations that would require a shelter in place as well as proper procedure as in continued care for residents, staff, volunteers and families in such situations. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken? This deficient practice could affect all residents, staff, volunteers, and visitors. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? The policy will be reviewed	

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E 022	Continued From page 7 During interview on 8/29/24 at 2:07 p.m., director of maintenance verified the policy lacked identification of potential situations in which sheltering in place might be necessary and for how it will provide a means to shelter in place for patients, staff and volunteers who remain in a facility.	E 022	annually to ensure that it is up to date with the most accurate information. A reminder will be placed into TELS to ensure completion. Staff will be educated about this change through education/training completed by the maintenance director. How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? The shelter-in-place procedure will be annually reviewed to ensure all information is up to date. Post-test will be given to employees to evaluate knowledge on the subject. Policy and procedures will be reviewed annually and discussed in QAPI to ensure everything is current. The systemic change be completed by 4pm 10/4/2024.	
E 025 SS=C	Arrangement with Other Facilities CFR(s): 483.73(b)(7) §403.748(b)(7), §418.113(b)(5), §441.184(b)(7), §460.84(b)(8), §482.15(b)(7), §483.73(b)(7), §483.475(b)(7), §485.625(b)(7), §485.920(b)(6), §494.62(b)(6). [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years [annually for LTC facilities]. At a minimum, the	E 025		10/4/24

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E 025	Continued From page 8 policies and procedures must address the following:] *[For Hospices at §418.113(b), PRFTs at §441.184,(b) Hospitals at §482.15(b), and LTC Facilities at §483.73(b):] Policies and procedures. (7) [or (5)] The development of arrangements with other [facilities] [and] other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of services to facility patients. *[For PACE at §460.84(b), ICF/IIDs at §483.475(b), CAHs at §486.625(b), CMHCs at §485.920(b) and ESRD Facilities at §494.62(b):] Policies and procedures. (7) [or (6), (8)] The development of arrangements with other [facilities] [or] other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of services to facility patients. *[For RNHCIs at §403.748(b):] Policies and procedures. (7) The development of arrangements with other RNHCIs and other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of non-medical services to RNHCI patients. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to develop and document written agreements with other providers that included pre-arranged written agreements with other facilities to receive residents in the event of limitations or cessation of operations to maintain the continuity of services to facility residents. This had the potential to affect all 53 residents who	E 025	0025 What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Facility, has a written transfer agreement in place with other skilled nursing facilities that offer the same	

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E 025	Continued From page 9 resided in the facility. Findings include: Upon review of the facility Emergency Preparedness Program (EPP) on 8/29/24 at 8:00 a.m., The EPP did not include any agreements with other facilities to receive residents in the event of limitations or cessation of operation. During interview on 8/29/24 at 8:27 a.m., director of maintenance (DOM) verified he developed and oversaw the facility's emergency preparedness program. DOM stated there were no prearranged transfer agreements in the EPP which he was aware of. During interview on 8/29/24 at 2:07 p.m., administrator stated there was an agreement with another facility, that was signed on 5/2/18, to receive residents but there was not an agreement for transportation and the agreement was with a facility which is now closed. Administrator verified there were no other agreements on file with any other facility to recieve residents in the event of limitations or cessation of operations to maintain the continuit of services to facility residents. No additional contracts of agreements provided.	E 025	services/amenities. Transportation agreement will have a signed agreement in place with MN Lakers Transporation LLC and or another transportation company. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken? This deficient practice could affect all residents, staff, and visitors. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? The agreement will be reviewed annually or if any changes occur to ensure that it is up to date. Staff will be educated on any revisions to the EPP by Maintenance Director. A reminder will be placed into TELS to ensure revisions/changes are updated. How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? The transfer facility and transportation agreement will be reviewed annually and discussed in QAPI to ensure changes are reflected as needed. A post-test will be given to staff to test their knowledge after education has been provided. The systemic change be completed by 4pm on 10/4/2024	
E 026 SS=C	Roles Under a Waiver Declared by Secretary	E 026		10/4/24

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E 026	Continued From page 10 CFR(s): 483.73(b)(8) §403.748(b)(8), §416.54(b)(6), §418.113(b)(6)(C)(iv), §441.184(b)(8), §460.84(b)(9), §482.15(b)(8), §483.73(b)(8), §483.475(b)(8), §485.542(b)(7), §485.625(b)(8), §485.920(b)(7), §494.62(b)(7). [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:] (8) [(6), (6)(C)(iv), (7), or (9)] The role of the [facility] under a waiver declared by the Secretary, in accordance with section 1135 of the Act, in the provision of care and treatment at an alternate care site identified by emergency management officials. *[For RNHCIs at §403.748(b):] Policies and procedures. (8) The role of the RNHCI under a waiver declared by the Secretary, in accordance with section 1135 of Act, in the provision of care at an alternative care site identified by emergency management officials. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure their emergency preparedness plan (EPP) included policies and procedures to address and identify the facility	E 026	0026 What corrective action will be accomplished for those residents found to	

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	245289	A. BUILDING _____ B. WING _____	C 08/30/2024

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E 026	Continued From page 11 under a waiver declared by the Secretary, in accordance with section 1135 of the Act, (a waiver designed to waive specific regulatory requirements in order to more easily provide needed care in an emergency situation) in the provision of care and treatment at an alternate care site identified by emergency management officials. This had the potential to affect all 53 residents currently residing in the facility. Findings include: The facility's EPP dated 6/10/24, was reviewed. The EPP lacked a policy or procedure for addressing the facility's role under a 1135 waiver declared by the Secretary during an emergency to provide services at an alternate site for their residents. During interview on 8/29/24 at 8:27 a.m., director of maintenance (DOM) verified he developed and oversaw the facility's emergency preparedness program. DOM stated he was unaware of anything pertaining to the procedures or policies relating to a 1135 waiver declaration. During interview on 8/29/24 at 2:12 p.m., administrator verified he was not aware of a policy or procedure pertaining to the facility's role in providing care under a 1135 waiver declaration.	E 026	have been affected by the deficient practice? The policy/plan was updated to reflect procedures and roles when a waiver is declared. The facility obtained an emergency transfer agreement in the event of an emergency with another facility. The facility has also obtained an emergency transportation agreement. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken? This deficient practice could affect all residents, staff, and visitors. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? The policy/plan will be reviewed annually to ensure that all information is up to date/reviewed. A reminder will be placed into TELS to ensure completion of the review. Maintenance Director will in-service staff of the changes to the EPP that have been identified. How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? The maintenance director will check TELS monthly to look at the tasks that need to be completed for that month to ensure compliance. The policy/plan will be annually reviewed by the IDT during QAPI to ensure all information is up to date. A post-test of the education will be given by the maintenance director to test their	

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E 026	Continued From page 12	E 026	knowledge after the education has been given. The systemic change be completed by 4pm on 10/4/2024	
E 034 SS=C	Information on Occupancy/Needs CFR(s): 483.73(c)(7) §403.748(c)(7), §416.54(c)(7), §418.113(c)(7) §441.184(c)(7), §482.15(c)(7), §460.84(c)(7), §483.73(c)(7), §483.475(c)(7), §484.102(c)(6), §485.68(c)(5), §485.68(c)(5), §485.727(c)(5), §485.542(c)(7), §485.625(c)(7), §485.920(c)(7), §491.12(c)(5), §494.62(c)(7). [(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities]. The communication plan must include all of the following: (7) [(5) or (6)] A means of providing information about the [facility's] occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee. *[For ASCs at 416.54(c)]: (7) A means of providing information about the ASC's needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee. *[For Inpatient Hospice at §418.113(c):] (7) A means of providing information about the hospice's inpatient occupancy, needs, and its	E 034		10/4/24

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E 034	Continued From page 13 ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to develop policies and procedures which addressed a means of providing information about the facility's occupancy needs, and its ability to provide assistance to the authority having jurisdiction, the Incident Command Center, or designee, policies and procedures which addressed a means of providing information about facility's occupancy needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee. This had the potential to affect all 53 residents who resided at the facility. Findings include: During review of the facilities emergency preparedness plan (EPP) on 8/29/24 at 8:00 a.m., the EPP lacked identification of how or whom in the facility would provide information about the facility's occupancy needs, and its ability to provide assistance to outside entities participating in emergency management in the event of an emergency. During interview on 8/29/24 at 8:30 a.m., director of maintenance (DOM) verified he developed and oversaw the facility's emergency preparedness program. DOM verified there is not a policy on how the facility would provide information regarding the facility's occupancy needs and ability to provide assistance in the event of an emergency.	E 034	0034 What corrective action will be accomplished for those residents found to have been affected by the deficient practice? The policy was updated to reflect procedures that provide information regarding facility occupant needs and assistance to the incident command center or designee. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken? This deficient practice could affect all residents, staff, and visitors. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? The policy will be reviewed annually to ensure that all information is up to date. A reminder will be placed into TELS to ensure completion by the maintenance director. Education will be completed by the maintenance director. How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? The policy will be annually reviewed to ensure all information is up to date. The	

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E 034	Continued From page 14 During interview on 8/29/24 at 2:24 p.m., administrator stated the EPP did not include identification of how or whom in the facility would provide information regarding the facility's occupancy needs and its ability to provide assistance to outside entities participating in emergency management in the event of an emergency.	E 034	maintenance director will check TELS monthly to look at the tasks that need to be completed for that month to ensure compliance. The policy will be annually reviewed by the IDT during QAPI to ensure all information is up to date. A post-test will be given after the in-service education to check knowledge competency. The systemic change be completed by 4pm on 10/4/2024	
E 036 SS=C	EP Training and Testing CFR(s): 483.73(d) §403.748(d), §416.54(d), §418.113(d), §441.184(d), §460.84(d), §482.15(d), §483.73(d), §483.475(d), §484.102(d), §485.68(d), §485.542(d), §485.625(d), §485.727(d), §485.920(d), §486.360(d), §491.12(d), §494.62(d). *[For RNCHIs at §403.748, ASCs at §416.54, Hospice at §418.113, PRTFs at §441.184, PACE at §460.84, Hospitals at §482.15, HHAs at §484.102, CORFs at §485.68, REHs at §485.542, CAHs at §486.625, "Organizations" under 485.727, CMHCs at §485.920, OPOs at §486.360, and RHC/FHQs at §491.12:] (d) Training and testing. The [facility] must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at	E 036		10/4/24

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E 036	Continued From page 15 least every 2 years. *[For LTC facilities at §483.73(d):] (d) Training and testing. The LTC facility must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually. *[For ICF/IIDs at §483.475(d):] Training and testing. The ICF/IID must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. The ICF/IID must meet the requirements for evacuation drills and training at §483.470(i). *[For ESRD Facilities at §494.62(d):] Training, testing, and orientation. The dialysis facility must develop and maintain an emergency preparedness training, testing and patient orientation program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training, testing	E 036		

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E 036	Continued From page 16 and orientation program must be evaluated and updated at every 2 years. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to develop and maintain an emergency preparedness training and testing program that is based on the emergency plan, risk assessment, policies, and procedures, and to ensure the communication plan is compliant with the requirements of this section. This had the potential to affect all 53 residents currently residing in the facility, as well as their families and/or representatives. Findings include: See E0037: The facility failed to provide staff emergency preparedness training at least annually which was based on the facility emergency preparedness plan (EPP). See E0039: The facility failed to provide staff emergency preparedness training at least annually which was based on the facility EPP.	E 036	E036 □ EP Training and testing 1.What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Facility-wide training on emergency preparedness was completed with all staff. 2.How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken? This deficient practice could affect all residents, staff, and visitors 3.What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? All training done with staff will be documented with the date and placed in EP binder. This training will be completed by the maintenance director and or designee. 4.How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? The training will be conducted by the maintenance director and all training will be signed by staff for documentation. Continual training will be completed as necessary and in accordance to life-safety standards. All results will be presented monthly to the Quality Assurance Committee until the committee determines that there is no necessity to continue based on findings of continued	

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E 036	Continued From page 17	E 036	compliance. 5.The systemic change be completed by 10/4/2024	
E 037 SS=C	EP Training Program CFR(s): 483.73(d)(1) §403.748(d)(1), §416.54(d)(1), §418.113(d)(1), §441.184(d)(1), §460.84(d)(1), §482.15(d)(1), §483.73(d)(1), §483.475(d)(1), §484.102(d)(1), §485.68(d)(1), §485.542(d)(1), §485.625(d)(1), §485.727(d)(1), §485.920(d)(1), §486.360(d)(1), §491.12(d)(1). *[For RNCHIs at §403.748, ASCs at §416.54, Hospitals at §482.15, ICF/IIDs at §483.475, HHAs at §484.102, REHs at §485.542, "Organizations" under §485.727, OPOs at §486.360, RHC/FQHCs at §491.12:] (1) Training program. The [facility] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the [facility] must conduct training on the updated policies and procedures. *[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following:	E 037		10/4/24

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E 037	Continued From page 18 (i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles. (ii) Demonstrate staff knowledge of emergency procedures. (iii) Provide emergency preparedness training at least every 2 years. (iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others. (v) Maintain documentation of all emergency preparedness training. (vi) If the emergency preparedness policies and procedures are significantly updated, the hospice must conduct training on the updated policies and procedures. *[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) After initial training, provide emergency preparedness training every 2 years. (iii) Demonstrate staff knowledge of emergency procedures. (iv) Maintain documentation of all emergency preparedness training. (v) If the emergency preparedness policies and procedures are significantly updated, the PRTF must conduct training on the updated policies and	E 037		

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E 037	Continued From page 19 procedures. *[For PACE at §460.84(d):] (1) The PACE organization must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, contractors, participants, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Demonstrate staff knowledge of emergency procedures, including informing participants of what to do, where to go, and whom to contact in case of an emergency. (iv) Maintain documentation of all training. (v) If the emergency preparedness policies and procedures are significantly updated, the PACE must conduct training on the updated policies and procedures. *[For LTC Facilities at §483.73(d):] (1) Training Program. The LTC facility must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. *[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following:	E 037		

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E 037	Continued From page 20 (i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment. (v) If the emergency preparedness policies and procedures are significantly updated, the CORF must conduct training on the updated policies and procedures. *[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following: (i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures.	E 037		

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E 037	Continued From page 21 (v) If the emergency preparedness policies and procedures are significantly updated, the CAH must conduct training on the updated policies and procedures. *[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least every 2 years. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to provide staff emergency preparedness training at least annually which was based on the facility emergency preparedness plan (EPP). This had the potential to affect all 53 residents, as well as staff, volunteers and visitors at the facility. Findings include: Employee training record review: LPN-D employee training record was reviewed and lacked evidence of emergency preparedness training through Educare or facility specific training based on EPP. TMA-A employee training record was reviewed and lacked evidence of emergency preparedness training through Educare or facility specific training based on EPP.	E 037	0037 What corrective action will be accomplished for those residents found to have been affected by the deficient practice? The Educare program was implemented for all staff with courses that needed to be in compliance. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken? This deficient practice could affect all residents, staff, and visitors What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? Courses will be monitored by Human Resources/Department Heads	

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E 037	Continued From page 22 LPN-E employee training record was reviewed and lacked evidence of emergency preparedness training through Educare or facility specific training based on EPP. NA-F employee training record was reviewed and lacked evidence of emergency preparedness training through Educare or facility specific training based on EPP. RN-C employee training record was reviewed and showed completion of some emergency preparedness training on Educare on 6/27/24. Record lacked evidence of facility specific training based on EPP. Employee training records for administrator, director of nursing and NA-G were requested and not received. Unable to review for any trainings. During interview on 8/28/24 at 12:11 p.m., nursing assistant (NA)-B stated she has not received any emergency preparedness training at the facility and had receieved no specific emergency preparedness training that was based on the facility EPP. During interview on 8/29/24 at 12:19 p.m., licensed practical nurse (LPN)-C stated they have worked in the facility for over a year. LPN-C did not recall initial or annual emergency preparedness that was based on the facility EPP. During interview on 8/29/24 at 10:27 a.m., director of human resources (DHR) verified she is responsible for assigning Educare (electronic learning management system) to all staff. DHR indicated when she started recently, she was	E 037	with staff reporting to them to ensure that staff are completing the courses for proper education. Maintenance director will conduct Emergency Preparedness training specific to the facility's individual emergency plan with staff. How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? Maintenance Director/Management team will be responsible for ensuring that their staff complete courses in a timely manner. Human Resource will audit completion regularly to ensure full compliance with compliance of EP training specific to the facility's individual emergency preparedness plan. All results will be presented monthly to the Quality Assurance Committee until the committee determines that there is no necessity to continue based on findings of continued compliance. The systemic change be completed by 4pm on 10/4/2024	

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E 037	Continued From page 23 made aware of issues with Educare and "recently got it up and running." DHR verified staff have been assigned Educare courses as of 8/21/24 which included emergency preparedness. DHR verified they are not in compliance with the training's and are working on getting into compliance. DHR stated she was going to look into the employee paper charts to see if she could find any more training's and provide them if she could. DHR stated she provided all the copies she printed to the ADON who will be providing them to surveyor. DHR did not provide any additional employee trainings. On 8/29/24 at 11:07 a.m., assistant director of nursing (ADON) provided a copy of the employee records that the facility had. ADON verified this was all the training's that have been completed that the facility has a record of. ADON stated, "we switched to a new system." ADON verified again, "this is all the records of the training's that we have," indicating, "if they aren't there, we don't have them." On 8/29/24 at 12:33 p.m., administrator verified there was no emergency preparedness trainings for the list of staff requested or for agency staff. A copy of the facility Educare module and any additional trainings were requested and not provided. Review of the facility Emergency Action Plan, dated 6/10/24, indicated training "will be performed every 6 months to ensure that employees: understand individual roles and responsibilities during an emergency; recognize types of emergencies that pose threats; understand communications procedures and	E 037		

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E 037	Continued From page 24 emergency response procedures; understand evacuation, shelter, and accountability procedures; understand emergency shutdown procedure; possess knowledge of location and use of common emergency equipment."	E 037		
E 039 SS=C	EP Testing Requirements CFR(s): 483.73(d)(2) §416.54(d)(2), §418.113(d)(2), §441.184(d)(2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2), §483.475(d)(2), §484.102(d)(2), §485.68(d)(2), §485.542(d)(2), §485.625(d)(2), §485.727(d)(2), §485.920(d)(2), §491.12(d)(2), §494.62(d)(2). *[For ASCs at §416.54, CORFs at §485.68, REHs at §485.542, OPO, "Organizations" under §485.727, CMHCs at §485.920, RHCs/FQHCs at §491.12, and ESRD Facilities at §494.62]: (2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following: (i) Participate in a full-scale exercise that is community-based every 2 years; or (A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or (B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event. (ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of	E 039		10/4/24

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E 039	Continued From page 25 this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed. *[For Hospices at 418.113(d):] (2) Testing for hospices that provide care in the patient's home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the following: (i) Participate in a full-scale exercise that is community based every 2 years; or (A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full scale community-based exercise or individual facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited	E 039		

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E 039	Continued From page 26 to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (3) Testing for hospices that provide inpatient care directly. The hospice must conduct exercises to test the emergency plan twice per year. The hospice must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual facility-based functional exercise; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospice is exempt from engaging in its next required full-scale community based or facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop led by a facilitator that includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to	E 039		

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E 039	Continued From page 27 challenge an emergency plan. (iii) Analyze the hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the hospice's emergency plan, as needed. *[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):] (2) Testing. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the [PRTF, Hospital, CAH] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency	E 039		

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E 039	Continued From page 28 plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the [facility's] emergency plan, as needed. *[For PACE at §460.84(d):] (2) Testing. The PACE organization must conduct exercises to test the emergency plan at least annually. The PACE organization must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the PACE experiences an actual natural or man-made emergency that requires activation of the emergency plan, the PACE is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.	E 039		

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E 039	Continued From page 29 (iii) Analyze the PACE's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the PACE's emergency plan, as needed. *[For LTC Facilities at §483.73(d):] (2) The [LTC facility] must conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The [LTC facility, ICF/IID] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. (B) If the [LTC facility] facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required a full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [LTC facility] facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the	E 039		

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E 039	Continued From page 30 [LTC facility] facility's emergency plan, as needed. *[For ICF/IIDs at §483.475(d)]: (2) Testing. The ICF/IID must conduct exercises to test the emergency plan at least twice per year. The ICF/IID must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or. (B) If the ICF/IID experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID is exempt from engaging in its next required full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the ICF/IID's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID's emergency plan, as needed. *[For HHAs at §484.102] (d)(2) Testing. The HHA must conduct exercises to test the emergency plan at	E 039		

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E 039	Continued From page 31 least annually. The HHA must do the following: (i) Participate in a full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise every 2 years; or. (B) If the HHA experiences an actual natural or man-made emergency that requires activation of the emergency plan, the HHA is exempt from engaging in its next required full-scale community-based or individual, facility based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the HHA's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the HHA's emergency plan, as needed. *[For OPOs at §486.360] (d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the	E 039		

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E 039	Continued From page 32 following: (i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. If the OPO experiences an actual natural or man-made emergency that requires activation of the emergency plan, the OPO is exempt from engaging in its next required testing exercise following the onset of the emergency event. (ii) Analyze the OPO's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. *[RNCHIs at §403.748]: (d)(2) Testing. The RNHCI must conduct exercises to test the emergency plan. The RNHCI must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the RNHCI's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the RNHCI's emergency plan, as needed. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to conduct a full-scale community exercise, a tabletop exercise, or a facility-based exercise with after action reports to test their	E 039	0039 What corrective action will be accomplished for those residents found to	

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E 039	Continued From page 33 emergency preparedness program twice per year or to document activation of their emergency preparedness plan or incident command system in response to an actual emergency event the facility experienced during the last year. This had the potential to affect all 53 residents who currently resided in the facility, along with staff who work in the facility. Findings include: Review of the facility's emergency preparedness plan (EPP) binder did not include documentation of full-scale community exercises, tabletop exercises, or facility-based exercises with after action reports performed from July 2023 through August 2024. During interview on 8/29/2 at 8:20 a.m., director of maintenance (DOM) verified he developed and oversaw the facility's emergency preparedness program. DOM verified that this requirement has not been met. DOM stated he has been in contact with the regional heatlh and medical preparedness coalition to set up a full-scale community exercise for September 2024. During interview on 8/29/24 at 2:24 p.m., administrator verified the requirements for the required exercises had not been met. Administrator stated they are working towards meeting the requirements. Facility policy titled Disaster Training, reviewed 6/10/24, identified "exercises, drills, and simulations are conducted on all levels of management within the organization and not just confined to routine fire or evacuation drill .....training exercises are conducted annually to	E 039	have been affected by the deficient practice? The coalition was re-contacted on 9/24 and we have secured a date. A coalition member will be out on 9/26 to provide resources on full scale exercise for facility. The full-scale exercise will be conducted on Friday 9/27/24 which includes full scale community based exercise (blizzard) and a full scale tornado drill exercise. Community based partners will be contacted to participate in the community exercise. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken? This deficient practice could affect all residents, staff, and visitors What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? Keeping in contact with the coalition for guidance as needed, as well as performing in-house disaster training with proper documentation and signatures. Maintenance director will schedule a task for the drills necessary using the TELS program to ensure compliance. Maintenance director will conduct all of the drills necessary using the guidance provided by the Coalition and in partnership with community partners. Education will be provided to staff by the Maintenance Director. How the corrective action will be monitored to ensure the deficient practice	

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E 039	Continued From page 34 test the emergency plan. Training exercises include all the following: a. Unannounced drills using emergency procedure. b. Community based, or facility based full-scale; and c. Community or facility based "tablet top" exercise that includes a group discussion led y a facilitator using a narrative scenario with problems and questions designed to challenge an emergency plan."	E 039	will not recur, i.e., what quality assurance program will be put into place? A full-scale scenario training will be done and documented with date and signatures to keep in compliance. All results will be presented monthly to the Quality Assurance Committee until the committee determines that there is no necessity to continue based on findings of continued compliance. A post-test will be done afterward to test knowledge comprehension. The systemic change be completed by 4pm on 10/4/2024	
F 000	INITIAL COMMENTS The Terrace at Crystal is a Special Focus Facility (SFF). On 8/26/24 - 8/30/24 a recertification survey was conducted. 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 The following complaints were reviewed with no deficiency issued: H52896512C (MN00105426) H52895949C (MN00101491) H52895950C (MN00098833) H52895951C (MN00097757) H52895791C (MN00097229) H52895953C (MN00096923) H52895953C (MN00096922)	F 000		

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	245289	A. BUILDING _____ B. WING _____	C 08/30/2024

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F 000	Continued From page 35 H52895953C (MN00096919) H52895865C (MN00096533) H52895867C (MN00095875) H52895869C (MN00092173) H52895870C (MN00092145) H52895871C (MN00091654) H52895873C (MN00091493) H52895873C (MN00091358) H52895874C (MN00091299) H52895875C (MN00090821) H52895875C (MN00090765) H52895876C (MN00090694) H52895877C (MN00090270) H52895794C (MN00087667) H52895795C (MN00087193) H52895796C (MN00086993) H52895797C (MN00086851) H52896003C (MN00086697) H52896004C (MN00086388) H52896005C (MN00086362) H52895956C (MN00085438) H52895872C (MN00091629) H52896000C (MN00089858) And The following complaints were reviewed: H52895741C (MN00104838) with a deficiency issued at F689. H52895961C (MN00101860) with a deficiency issued at F921. H52895866C (MN00095959) with a deficiency issued at F921. H52895868C (MN00095542) with a deficiency issued at F677. H52895878C (MN00090052) with a deficiency issued at F677. H52895879C (MN00089861) with deficiencies	F 000		

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F 000	Continued From page 36 issued at F677 and F921. H52896001C (MN00089652) with deficiencies issued at F686 and F689. H52895792C (MN00089548) with a deficiency issued at F686. H52895793C (MN00087927) with deficiencies issued at F677 and F686. H52896005C (MN00086361) with deficiencies issued at F677 and F686. 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 553 SS=D	Right to Participate in Planning Care CFR(s): 483.10(c)(2)(3) §483.10(c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the	F 553		10/4/24

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F 553	Continued From page 37 plan of care. (iii) The right to be informed, in advance, of changes to the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care. §483.10(c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must- (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the resident and/or resident representative participated in care conferences for the care planning process and development of care plan interventions for 2 of 4 residents (R53 and R406) reviewed for participation of care planning. Findings include: R53 R53's admission Minimum Data Set (MDS), dated 7/22/24, indicated R53 was admitted to the facility on 7/16/24 and had severe cognitive impairment. R53's Electronic Medical Record (EMR) lacked evidence a care conference had taken place for	F 553	F553-D Right to Participate in Planning Care//MN Rule 4658 .0405 Sub.1-2555 Concern: Participation in care conference, 48 hour/baseline care-plan, comprehensive care-planning participation. Identification of other residents at risk: All current facility residents are at risk Corrective Measures: "Nursing will meet with R406 & R53 to review plan of care and establish care conference with residents and/or resident representative.	

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F 553	Continued From page 38 R53 or that care needs were discussed with R53 and/or her representative. R53's EMR further lacked evidence of a baseline care plan to ensure staff were aware of her care needs within the first 48 hours of admission. During an interview on 8/29/24 at 9:50 a.m., R53's family member (FM)-A confirmed he had not been contacted about a care conference for his mom. FM-A stated he did not live near the care facility, but was able to be contacted via phone. FM-A further stated he wished he had more updates from the facility on how R53 was doing and what cares she was receiving from the facility. R406 R406's Face Sheet, printed 8/29/24, indicated R406 was admitted to the care facility on 7/25/24. R406's admission MDS, dated 7/31/24, was incomplete, with all sections except K "Swallowing/Nutritional Status" listed as "Incomplete." R406's EMR lacked evidence a care conference had taken place for R406 or that care needs were discussed with R406 and/or his representative. R406's EMR further lacked evidence of a baseline care plan to ensure staff were aware of his care needs within the first 48 hours of admission. During an interview on 8/29/24 at 9:08 a.m., R406 was in the main dining area eating breakfast. R406 stated he did not remember having a care conference since admission to the care facility and shrugged his shoulders when asked if he	F 553	"Care Conference will be scheduled for all facility residents to review plan of care "A new Baseline Care Plan template was created to address resident needs upon admission and/or within the first 48 hours. "Policy on Care Planning will be reviewed and revised as needed. "Current care plans will be reviewed with all residents with the ability to participate in their plan of care. Resident representatives will be contacted for all residents unable to participate in their plan of care. Residents unable to participate in their plan and/or do not need a patient representative will be referred to legal counsel and ombudsmen. "Education completed with nursing staff regarding baseline care plans "Education completed with IDT leadership team regarding care conferences schedules and timeliness. Monitoring Mechanisms: "Baseline Care Plans will be audited within 48 hours after admission x 90 days "The Care Conference Schedule will be audited every 3x per week to ensure timely scheduling, and attendance of care conferences x 90 days. Date of compliance 4PM on 10/04/2024	

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F 553	Continued From page 39 was receiving all the care he needed. R406 stated his daughter, listed as a contact in his EMR, lived out of town and that she did not visit. During an interview on 8/29/24 at 9:35 a.m., registered nurse and nurse manager (RN)-B stated social services had previously been responsible for setting up care conferences, but that the role had been open until recently, so she was unaware of who was currently responsible for setting up care conferences. RN-B confirmed she had not been involved in a care conference for R53 or R406 and that neither resident had had a care conference since admission to the care facility. RN-B stated administration has discussed the need for care conferences, stating it was important for residents and their families/representatives to be able to voice concerns, be informed on the resident's care and what has been going on for the resident since admission to the care facility. RN-B further stated it would be expected that an admission care conference had been already held for both R53 and R406. During an interview on 8/30/24 at 10:05 a.m., the director of nursing (DON) confirmed it would be expected that an admission care conference had been held for R53 and R406 to establish resident goals and plans of care. A facility policy titled Care Planning - Interdisciplinary Team, revised 11/28/16, indicated the resident and/or the resident representative was encouraged to participate in the development of the residents' care plan, indicating every effort would be made to schedule a care conference when it was convenient for the resident and/or their representative. The policy further indicated if	F 553		

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F 553	Continued From page 40 a resident was unable to make decision about their care or treatments, they would continue to be consulted on personal preferences.	F 553		
F 572 SS=D	Notice of Rights and Rules CFR(s): 483.10(g)(1)(16) §483.10(g) Information and Communication. §483.10(g)(1) The resident has the right to be informed of his or her rights and of all rules and regulations governing resident conduct and responsibilities during his or her stay in the facility. §483.10(g)(16) The facility must provide a notice of rights and services to the resident prior to or upon admission and during the resident's stay. (i) The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. (ii) The facility must also provide the resident with the State-developed notice of Medicaid rights and obligations, if any. (iii) Receipt of such information, and any amendments to it, must be acknowledged in writing; This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to inform residents of rules and regulations governing their rights and responsiblities as residents in a Long-Term Care facility affecting 2 of 2 residents (R49 and R406) reviewed for resident rights. Findings include:	F 572	F572-D Notice of Rights and Rules/MN Rule 4658.0145-2355 Concern: Notification of rights and responsibilities of residents at admission or during stay. Identification of other residents at risk: All current facility residents are at risk related to Notice of Right and Rules Corrective Measures:	10/4/24

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F 572	Continued From page 41 R49 R49's admission Minimum Data Set (MDS), dated 3/10/24, indicated R49 was admitted to the care facility on 3/4/24 and was cognitively intact. R49'S Electronic Medical Record (EMR) lacked any evidence of admission paperwork being completed with R49, including rights and responsibilities of being a resident of a long-term care facility. This information was confirmed by social services on 8/27/24. During an interview on 8/29/24 at 9:40 a.m., R49 stated he was unable to determine if he had signed an admission agreement or if his rights and responsibilities as a resident of the care facility were discussed with him prior to or at admission. R406 R406's Face Sheet, printed 8/29/24, indicated R406 was admitted to the care facility on 7/25/24. R406's Brief Interview for Mental Status (BIMS) assessment, dated 8/5/24 indicated R406 had mild cognitive impairment. R406's admission MDS, dated 7/31/24, was incomplete, with all sections except K "Swallowing/Nutritional Status" listed as "Incomplete." R406'S Electronic Medical Record (EMR) lacked any evidence of admission paperwork being completed with R406, including rights and responsibilities of being a resident of a long-term care facility. This information was confirmed by	F 572	"Social worker will meet with R49 & R406 to review resident rights and sign admission agreement "Residents who are their own representative or have a designated representative will sign admission agreements and review resident rights. "Residents who are unable to sign admission agreements or comprehend resident rights due to cognitive decline will be referred for legal counsel. "Review policy and procedure for admissions. "Educate staff on the admission process and timeliness of admission paperwork Monitoring Mechanisms: "New admissions will be audited within 48 hours of admission to ensure Resident Rights and Rules have been reviewed and signed by facility resident and/or resident representatives x 90 days. "The Admission Process and Admission paperwork will be added to QAPI x 180 days then reviewed to determine if ongoing monitoring is needed. Date of compliance 4pm 10/4/2024	

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F 572	Continued From page 42 social services on 8/27/24. During an interview on 8/29/24 at 9:08 a.m., R406 was in the main dining area eating breakfast. R406 stated he was not asked to sign any admission paperwork for the facility that would have included his rights and responsibilities as a resident of the care facility. R406 stated his daughter, listed as a contact in his EMR, lived out of state and did not visit or speak with him often. R406 shrugged his shoulders when asked if he was getting all the care he needed at the care facility. During an interview on 8/29/24 at 9:35 a.m., nurse manager and registered nurse (RN)-B stated the care facility used to have an admission nurse who would review all the admission paperwork with residents admitted to the facility, but the role had been open for about a month. Social services then took over the admission paperwork, but she is unaware of who does it now with social services being new in the role. During an interview on 8/30/24 at 10:05 a.m., the director of nursing (DON) confirmed R49 and R406 were missing admission paperwork and that going forward the social worker would be responsible for completing the admission paperwork, including reviewing the residents' rights and responsibilities while residing in the care facility. A facility policy on admission agreements was requested but not received.	F 572		
F 577 SS=C	Right to Survey Results/Advocate Agency Info CFR(s): 483.10(g)(10)(11)	F 577		10/4/24

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F 577	Continued From page 43 §483.10(g)(10) The resident has the right to- (i) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility; and (ii) Receive information from agencies acting as client advocates, and be afforded the opportunity to contact these agencies. §483.10(g)(11) The facility must-- (i) Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility. (ii) Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request; and (iii) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public. (iv) The facility shall not make available identifying information about complainants or residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the most recent State agency (SA) survey results were readily accessible at all times and post signage and/or notice of the inspection reports within the campus. This had potential to affect all 53 residents or visitors who could wish to review the information. Findings include: On 8/29/24 at 8:14 a.m., an interview was	F 577	Citation: F577-D: Right to Survey Results/Advocate Agency Info What corrective action will be accomplished for those residents found to have been affected by the deficient practice?: The right of residents and the public to review previous survey result inspections of both annual and complaint visits within the last three years was printed, placed in binders and posted	

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F 577	Continued From page 44 completed with R12 who was the acting Resident Council President. R12 verified he attended most of the meetings which were held on a monthly basis. R12 expressed staff at the care center often had poor, if at all, follow-up on issues and voiced none of the staff had ever discussed the facility' survey results at their meeting. R12 stated he was unsure even where the results were kept or located and reiterated nobody ever reviewed them with the Council adding aloud, "Nope." Immediately following, on 8/29/24 at 8:34 a.m., a tour of the care center main reception area was completed. The area had a doorway opening to the outside along with a reception desk and seating area present. The reception desk had multiple binders present on it which included a leave-of-absence (LOA) sign-out, visitor sign-in, and staff education handouts. However, there were no survey results present nor was any signage displayed anywhere on the first floor to explain where, if anywhere, the results were located or any availability of such results. When interviewed on 8/29/24 at 8:36 a.m., receptionist (RCP)-A explained the survey results were usually kept in a series of binders behind the reception desk (which opened to the left side) but "the DON grabbed them" when the survey team walked in days prior. RCP-A stated the binders had been kept there "since the last administrator was here" which was nearly a year and were just labeled on the spine with the respective years of completion. At 8:38 a.m., the assistant director of nursing (ADON) joined the interview and verified the survey results were in the DON office adding they thought the results may have log-in information for the CMS-671 (a form used on survey) on them. ADON verified	F 577	within the facility. Signage of where and what the binders with the survey results contain were posted visibly for anyone to see. Identification of other residents at risk: All current facility residents, family, vendors and visitors are affected. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?: Facility survey results over the last three years both with the annual survey and complaint visit surveys have been printed and made available on the first level lobby, second floor common area, and third floor common area for easy access. Signage of where and what the binders with the survey results contain were posted visibly for anyone to see. Staff will be educated about the location of the survey binders through education/training completed by the maintenance director. Monitoring Mechanisms: The administrative team will audit survey book placement twice weekly x 90 days to ensure survey result books are in place and current based on the most recent survey data going back three years. Results will be presented monthly to the Quality Assurance Committee until the committee determines that there is no necessity to continue based on findings of continued compliance.	

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F 577	Continued From page 45 they were removed from the reception desk, and subsequently from resident or visitor availability, earlier in the week and never put back. ADON placed two binders back behind the reception desk where they had been found. These were inspected and included a single white-colored binder labeled on the spine with black marker, "BBDZ12," and a printed label which read, "2022/2023 Survey." A red-colored binder had a printed label on the spine which read, "2024 Survey." These binders contained both the most recent full recertification survey along with multiple complaint survey CMS-2567's and their corresponding plan of correction (POC). However, there was no signage posted to direct anyone to these binders; nor signage posted saying results from surveys were available upon request. The lack of any signage or posting with such information was verified by RCP-A who expressed they had never seen any of the sort posted prior. On 8/29/24 at 12:46 p.m., the administrator verified no signage had been displayed which outlined the availability of the surveys results or their location within the care center so, as a result, the staff had just placed some. The administrator stated it was important to ensure survey results were readily available and the required signage was posted as the results were "supposed to be [available] to all family and anyone who wants to see it." A facility' provided Examination of Survey Results Policy, dated 11/2016, identified the resident has a right to examine the three most recent annual survey results and they would be placed in a readily accessible location with signage of their availability. The policy added, "Information	F 577	Date of Compliance 4pm at 10/04/2024	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 577	Continued From page 46 concerning the location of our facility's three most recent survey reports will be posted on the resident bulletin board and at each nurses' station."	F 577		
F 585 SS=D	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally	F 585		10/4/24

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	245289	A. BUILDING _____ B. WING _____	C 08/30/2024

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F 585	Continued From page 47 (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a	F 585		

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F 585	Continued From page 48 summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure a voiced and logged grievance concerning missing item(s) was addressed and resolved to satisfaction for 1 of 1 resident (R12) reviewed for grievances who reported missing items. Findings include: R12's quarterly Minimum Data Set (MDS) assessment, dated 7/18/24, identified R12 had intact cognition and demonstrated no delusions or other behavioral symptoms. During interview on 8/27/24 at 11:33 a.m., R12 stated he had several clothing items gone missing. R12 stated he reported missing items to	F 585	F585-D: Grievances/MN St. Statue 144.651 Subd.20 Concern: Policy and process for grievances filed for care, treatment, and lost or missing items from personal property log. Identification of other residents at risk: All current grievances will be reviewed for completion, including a signed resolution from the resident making the grievance and facility staff member. Corrective Measures: "A new grievance form will be completed with R-12 and resolution discussed and signed regarding missing clothing. "Grievance Policy reviewed and updated to reflect current practices	

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F 585	Continued From page 49 staff and completed a Personal Belongings Inventory log with staff, which he provided a signed copy. The log was signed by staff and R12 on 7/12/24 which included items R12 currently had and items R12 reported missing. The list included a total of 14 detailed clothing items that were reported missing. R12 stated he was told, "probably won't be able to refund your clothes .... don't know exactly what you had...would check lost and found but not sure if did it ... never had follow-up or grievance with them." R12's Personal Belonging Inventory document, signed and dated 7/12/24 by R12 and staff, included items reported missing. The document included a detailed list of 14 clothing items R12 reported to staff as missing. During an interview on 8/28/2024 at 11:18 a.m., registered nurse (RN)-C stated when a resident reports clothing items are missing, the facility tries to help the resident find the item and lets the housekeeper and their manager know about the missing item. RN-C stated they will then write it on a piece of paper to pass it along to the next staff or manager. RN-C stated she has not seen any form to fill out for reported missing items. RN-C stated all clothing items should be labeled, laundry takes care of that and was unsure of the process besides notifying laundry if she notices a piece of laundry needs to be labeled. During an interview on 8/29/24 at 12:00 p.m., laundry aid (LA)-A stated laundry labels all clothing. LA-A stated when a new resident moves in, nursing typically lets us know and will put all their clothing in a bag and bring it down to be labeled. LA-A stated usually only new residents have clothing that is not labeled. LA-A stated	F 585	"Grievance and Missing item forms are updated for better staff and resident clarity "Education completed with facility staff regarding the grievance policy, process and procedure Monitoring Mechanisms: "Administrative team will audit grievances for completion and resolution 3x per week x 30 days, then 2x per week x 60days. "Grievances will be added to QAPI x 180 days then reviewed to determine if ongoing monitoring is needed. Date of complaince 4pm on 10/04/2024	

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F 585	Continued From page 50 when they get clothing that is not labeled, they will keep it for a little while, "maybe 3 weeks" and then will put it in the lost and found. LA-A added, "sometimes we might bring upstairs and ask." During an interview on 8/29/2024 at 12:29 p.m., RN-A indicated that the social worker would be the person to follow up on missing clothing items. RN-A stated they would work on replacing items. RN-A indicated that nursing would fills out an Inventory Form and brings it to social services to follow up. During an interview on 8/29/24 at 3:25 p.m., social services designee (SSD)-A stated the process for a missing item is to fill out a grievance form, attempt to find the item and replace the item if needed. SSD-A reviewed R12's Personal Belongings Inventory document, verified that it was completed by R12 and a previous staff member and stated it had not been followed up on at this time. SSD-A indicated she was going to follow up regarding R12's reported missing items. During interview on 8/29/24 at 3:29 p.m., director of nursing (DON) indicated they are working on a new grievance process with new forms. A facility policy on grievances was requested and not provided.	F 585		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:	F 609		10/4/24

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F 609	Continued From page 51 §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to report to the State Agency (SA) an allegation of physical abuse for 1 of 1 resident (R45) reviewed for potential abuse. Findings include: R45's quarterly Minimum Data Set (MDS) dated 6/20/24, indicated R45 had moderate cognitive impairment, did not hallucinate, had no delusions, did not reject cares, and had no behaviors. The MDS indicated R45 was independent with all activities of daily living, including eating, transfers,	F 609	Citation: F609-D Reporting of Alleged Violations Concern: Reporting of alleged violations (Abuse, neglect, exploitation, mistreatment, injuries of unknown source, misappropriation of property/ funds) Identification of other residents at risk: All current residents will be interviewed regarding abuse and neglect Corrective Measures: "R45 was interviewed regarding allegations of Abuse	

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F 609	Continued From page 52 and ambulation. R45's Clinical Diagnosis form printed 8/30/24, indicated diagnoses of dementia without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety. The form also indicated R45 had diagnoses of failure to thrive, protein mal-nutrition, major depressive disorder with psychotic symptoms (include delusions, hallucinations, talking incoherently and agitation), chronic systolic congestive heart failure (a condition that occurs when the left ventricle of the heart is unable to pump blood efficiently), atrial fibrillation (irregular heart rhythm that can lead to blood clots in the heart), chronic kidney disease (means a gradual loss of kidney function), anxiety disorder, delusional disorder, and bilateral hearing loss. R45's care plan indicated a history of traumatic experience related to the death of her family during a war. R45's care plan goal indicated R45 will not experience any life threatening or traumatic events while at the facility. R45's safety care plan indicated a risk for abuse and the goal was to keep R45 safe and free from abuse until the next review. During interview on 8/28/24 at 9:26 a.m., R45 stated "two weeks ago a big African woman grab me [demonstrated woman grabbed her by her wrists] and threw me to the floor, across the room. I got bruises and was bleeding [pointed to her left upper arm]. The nurse manager called the hospital, she lied and said I fell." During interview on 8/28/24 at 10:56 a.m., nurse manager/ registered nurse (RN)-A stated "at one point, R45 said five staff members threw her from	F 609	"Education with all staff members regarding Abuse Policy, signs of abuse, and reporting abuse. Monitoring Mechanisms: "All grievances will be reviewed for signs of abuse, neglect, or misappropriation 5x per week x 30 days, 3x per week x 30 days, 2x per week x 30 days. "The IDT team will perform random audits to monitor for abuse and neglect 3x per week x 90 days to monitor for signs of abuse and neglect. "Reporting of alleged violations will be added to QAPI x 180 days then reviewed to determine if ongoing monitoring is needed. Date of complaince 4pm on 10/04/2024	

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F 609	Continued From page 53 one dining room to the next room. R45 said there were 4-5 big ladies but was unable to identify the staff members. R45 said one [staff] grabbed her by the wrists and had bruises." RN-A stated R45 refused a body check but allowed her to check her wrists. R45 had no bruises on her hands or wrists. RN-A stated, R45 told her "The bruises were not outside, they were inside her body." RN-A stated the incident occured on 6/4/24 and she subsequently recorded R45's statement and gave it to the previous director of nursing. RN-A stated the previous director of nursing completed an investigation, but she was not sure if it was reported to the SA. R45's progress notes lacked documentation of the alleged incident on 6/4/24. Facility's Incident Reports dated 8/31/24 lacked documentation of a report made to the SA regarding R45's allegation of abuse. During interview on 8/28/24 at 10:44 a.m., trained medication aid (TMA) stated "R45 makes up things. Once she said someone beat her up and said I was there. I informed the nurse manager, and she followed up with resident." During interview on 8/29/24 at 11:02 a.m., director of nursing (DON) stated R45 reported abuse, but it was not reported to the common entry point. DON stated all allegations of abuse needed to be reported. During interview on 8/29/24 at 1:19 p.m., administrator indicated previous the DON completed an investigation and said she had reported incident to the SA. The administrator verified the facility's Incident Report didn't include	F 609		

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F 609	Continued From page 54 R45's allegation of abuse was reported to the SA. Facility's undated policy titled Vulnerable Adult indicated "The resident has the right to be free from verbal, physical, sexual, or mental abuse, neglect, misappropriation of resident property, and exploitation as define in this policy. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's symptoms." The policy also indicated alleged violations and substantiated incidents needed to be reported immediately, but no later than 2 hours after the allegation is made.	F 609		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the	F 610	Citation:	10/4/24

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F 610	Continued From page 55 facility failed to thoroughly investigate an allegation of abuse for 1 of 1 resident (R45) reviewed for potential abuse. Findings include: R45's quarterly Minimum Data Set (MDS) dated 6/20/24, indicated R45 had moderate cognitive impairment, did not hallucinate, had no delusions, did not reject cares, and had no behaviors. The MDS indicated R45 was independent with all activities of daily living, including eating, transfers, and ambulation. R45's Clinical Diagnosis form printed 8/30/24, indicated diagnoses of dementia without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety. This form also indicated R45 had diagnosis of failure to thrive, protein mal-nutrition, major depressive disorder with psychotic symptoms (to include delusions, hallucinations, talking incoherently and agitation), chronic systolic congestive heart failure (a condition that occurs when the left ventricle of the heart is unable to pump blood efficiently), atrial fibrillation (irregular heart rhythm that can lead to blood clots in the heart), chronic kidney disease (means a gradual loss of kidney function), anxiety disorder, delusional disorder, and bilateral hearing loss. R45's care plan indicated a history of traumatic experience related to the death of her family during a war. R45's care plan goal indicated R45 will not experience any life threatening or traumatic events while at the facility. R45's safety care plan indicated a risk for abuse and the goal was to	F 610	F610-D Investigate/Prevent/Correct Alleged Violations of Abuse Concern: Evidence or documentation of thorough investigations of alleged abuse. Identification of other residents at risk: All current residents may be at risk for investigation of abuse Corrective Measures: •Resident interview completed with R45 regarding allegations of Abuse •OHFC report filed on R45 related to resident's report of abuse •Alleged perpetrator was suspended pending investigation •Education will be completed with nursing staff, leadership team, and social service staff responsible for the steps of completing the investigation process for abuse, neglect, mistreatment and misappropriation of property. •Education will include reporting as follows for reporting and investigation abuse, neglect, mistreatment and misappropriation of property. 1.The Terrace at Crystal instructs employees to report immediately, but no later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or no later than 24 hours if the events that cause the allegation do not involve abuse or do not result in serious bodily injury to the Administrator immediately, or designee Director of nursing, clinical supervisor or	

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F 610	Continued From page 56 keep R45 safe and free from abuse until the next review. During interview on 8/28/24 at 9:26 a.m., R45 stated "two weeks ago a big African woman grab me [demonstrated woman grabbed her by her wrists] and threw me to the floor, across the room. I got bruises and was bleeding [pointed to her left upper arm]. The nurse manager called the hospital, she lied and said I fell." During interview on 8/28/24 at 10:56 a.m., nurse manager/ registered nurse (RN)-A stated "at one point, R45 said five staff members threw her from one dining room to the next room. R45 said there were 4-5 big ladies but was unable to identify the staff members. R45 said one [staff] grabbed her by the wrists and had bruises." RN-A stated R45 refused a body check but allowed her to check her wrists. R45 had no bruises on her hands or wrists. RN-A stated, R45 told her "the bruises were not outside, they were inside her body." RN-A stated on 6/4/24 she wrote R45's statement and gave it to the previous director of nursing. RN-A stated the previous director of nursing completed an investigation, but she was not sure if it was reported to the SA. R45's progress notes from June through August 2024 lacked documentation of the alleged incident on 6/4/24. During interview and document review on 8/29/24 at 2:40 p.m. RN-A provided a Grievance/Concern or Problem Resolution form dated 6/4/24 at 12:30 p.m.. The form indicated a State Agency (SA) surveyor approached a staff member to report R45 alleged two large women approached her when she was ambulating in the dining room and	F 610	social worker. 2.Allegations of abuse, neglect, mistreatment and misappropriation of property must be reported to the state agency Office of Health Facility Complaints and to all other agencies immediately, but no later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or no later than 24 hours if the events that cause the allegation do not involve abuse or do not result in serious bodily injury. ¿ SNFs report to MAARC instead of OHFC in very limited instances where the perpetrator is not employed by, or connected to, the facility. ¿SNFs report to MAARC instead of OHFC when a resident discharges against medical advice. 3.Provide for the immediate safety of the resident upon identification of abuse, neglect, exploitation of residents, mistreatment, injuries of unknown source, and/or misappropriation of resident property. ¿Actions include, but are not limited to: ¿The resident involved is removed from the suspected perpetrator's care and reassigned to another caregiver ¿Require an alleged non-employee perpetrator to immediately leave the facility. 4.Additional means of providing protection if the abuse suspect is a resident may include, but are not limited to: o Move resident to another room or unit oProvide 1:1 monitoring or special security	

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F 610	Continued From page 57 took her back to her room. The report documented R45 alleged rough handling when they placed their hands around her wrists. The form indicated the surveyor looked at her wrists but didn't find any bruising or any signs of finger marks from any exerted pressure. The form included a section labeled Follow-up Comments which indicated the facility informed the SA surveyor, the facility had investigated the allegation. The form indicated "Interviewed resident.The details of the incident did not support the residents report. The resident did not have injuries as reported. Is a poor historian and reporter lives in Memory Care. More investigative notes taken by nurse manager. Reviewed by DON and former interim Administrator." RN-A stated there was no other documention of an investigation into R45's allegation. During interview and document review on 8/29/24 at 10:51 a.m., director of nursing (DON) stated a green folder had just been located with a handwritten allegation of abuse made by R45. Upon review the folder contained an untitled handwritten report, dated 6/4/24. The green folder didn't contain an investigation report involving interviews with other residents or staff. State Agency documentation indicated a surveyor was on-site on 6/3/24 however not on 6/4/24. Facility's Incident Reports dated 8/31/24, lacked documentation of a report to the SA or investigation being completed regarding R45's allegation of abuse. During interview on 8/29/24 at 11:02 a.m., director of nursing (DON) stated R45 reported abuse, but it was not reported to the common entry point.	F 610	oImplement discharge process, in accordance with state and federal regulation, to prevent reoccurrence in the facility. oInitiate behavior management interventions, as applicable 5.Investigations should be completed within 5 business days. 6.Investigations may include but are not limited to interviews with staff members, family, and other facility residents, witnesses' statements, skin checks, physical exam as appropriate, review of resident plan of care, physician notes, hospital notes, or notifying the police etc. 7.The facility will take all necessary corrective actions based upon the results of the investigation Monitoring Mechanisms: •All grievances will be reviewed for signs of abuse, neglect, or misappropriation 5x per week x 30 days, 3x per week x 30 days, 2x per week x 30 days. •The IDT team will perform random audits to monitor for abuse and neglect 3x per week x 90 days to monitor for signs of abuse and neglect. •Reporting of alleged violations and investigation process will be added to QAPI x 180 days then reviewed to determine if ongoing monitoring is needed. Date of compliance 4pm on 10-04-2024	

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F 610	Continued From page 58 DON stated all allegations of abuse needed to be reported. During interview on 8/29/24 at 1:19 p.m., the administrator indicated the previous DON stated she had completed an investigation and said she had reported the incident to the SA. An investigative report for the documented allegation on 6/4/24 was requested from the facility and not provided. Administrator verified the facility's Incident Report didn't include R45's allegation of abuse or investigation of it. Facility's undated policy titled Vulnerable Adult indicated "The resident has the right to be free from verbal, physical, sexual, or mental abuse, neglect, misappropriation of resident property, and exploitation as define in this policy. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's symptoms." Facility's undated policy titled Abuse Investigations indicated "all reports of resident abuse, neglect, and injuries of unknown source shall be promptly and thoroughly investigated by facility management." The policy indicated the individual conducting the investigation will, as a minimum: a. Review the completed documentation forms. b. Review the resident's medical record to determine events leading up to incident. c. Interview the person(s) reporting the incident. d. Interview any witnesses to the incident. e. Interview the resident (as medically appropriate). f. Interview the resident's Attending Physician as needed to determine the resident's current level	F 610		

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F 610	Continued From page 59 of cognitive function and medical condition. g. Interview staff members (on all shifts) who have contact with the resident during the period of the alleged incident. h. Interview the resident's roommate, family members and visitors. i. Interview other residents to whom the accused employee provides cares or services. j. Review all events leading up to the alleged incident.	F 610		
F 636 SS=D	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status.	F 636		10/4/24

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F 636	Continued From page 60 (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts. §483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.) (iii)Not less than once every 12 months. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the comprehensive Minimum Data Set (MDS) was completed in a thorough and timely manner to reflect actual resident' status and ensure appropriate	F 636	F636-D Comprehensive Assessment & Timing/MN Rule 4658.0400 Sub.1&2-2540 Concern: Open or incomplete comprehensive MDS filing.	

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F 636	Continued From page 61 care-planning for 2 of 4 residents (R7, R406) reviewed for MDS accuracy. Findings include: R7 The Centers for Medicare and Medicaid (CMS) Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, dated 10/2023, identified the RAI was used to help identify problems for a resident and address them using an individualized care plan. The manual outlined a section labeled, "Section F: Preferences for Customary Routine and Activities," which identified the intent of the items within the section was to obtain information on the resident's preferences for their daily routine adding, "Nursing homes should use this as a guide to create an individualized plan based on the resident's preferences and is not meant to be all-inclusive." The instructions outlined an interview should be done with the resident, if able to participate, and the corresponding responses coded on the MDS. On 8/26/24 at 2:33 p.m., R7 was observed in her room with her family member (FM)-G present, and the room lacked any posted activities calendar or postings. R7 was interviewed and expressed frustration over a lack of both group-based and individual activities programming at the campus. R7 stated she only attended activities "when I beg them [staff]" to include her and, if not for FM-G coming and visiting the campus often, she would "never see daylight" out of her room. R7's reiterated she was rarely, if ever, invited to group-based activities at the campus adding, "They don't take me."	F 636	Identification of other residents at risk All current facility residents are at risk Corrective Measures: "MDS completed for R406 09/18/2024 "Activity assessment will be completed with R7, and care plan updated to include activities of interest in the resident plan of care upon return inpatient hospital stay. "MDS schedule is established to ensure all required assessments are assigned and completed in a timely manner. "MDS schedule is reviewed for all residents to ensure required MDS assessments have been completed within the past 90 days and are not overdue. "Review policy and procedure for MDS assessments and completion. "Educate licensed nursing staff regarding admission, quarterly, and annual assessments. Monitoring Mechanisms: "MDS schedule and assessments due will be audited 2 times per week to ensure all assessments are completed timely and accurately x 90 days. "Comprehensive and timely assessments will be added to QAPI x 180 days then reviewed to determine if ongoing monitoring is needed. Date of complaince 4pm 10-04-2024	

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F 636	Continued From page 62 Further, R7 stated she had never, at least to both her and FM-G's recall, been asked about activities' likes or dislikes, goals or preferences since admitting to the care center several months prior adding, "They don't respond to me here." R7's admission Minimum Data Set (MDS), dated 5/23/24, identified R7 admitted to the care center in May 2024 and had moderate cognitive impairment but demonstrated no delusional thinking. Further, the MDS contained a section labeled, "Section F - Preferences for Customary Routine and Activities," which outlined questions to be answered based on R7's responses for activities and routines, however, nearly the entire section was left dashed with, "Not Assessed." In addition, R7's medical record was reviewed and lacked any evidence a comprehensive assessment for leisure or activity-based programming, including likes and dislikes or preferences for activities, had been completed despite R7 admitting to the care center several months prior. Further, R7's care plan, printed 8/27/24, identified no specific activities problem statements, goals or interventions to ensure R7's leisure and activity needs, if any, were met. On 8/28/24 at 10:01 a.m., activities assistant (AA)-A was interviewed and verified they helped with activities on R7's unit. AA-A explained the campus didn't have an activities director until "maybe two weeks ago" when the social services designee (SSD)-A was hired to fill the role. AA-A stated they were unsure who, if anyone, had assessed the residents reviewed for activities but verified the director was responsible to do such adding, "I don't know if they did on on [R7]." Further, AA-A expressed the activities department, in general, had suffered a staffing	F 636		

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F 636	Continued From page 63 cutback and, at times, seemed to not be able to function with several group-based items (i.e., Bingo, "Casino Night") having to be removed from the schedule over the past months. When interviewed on 8/28/24 at 10:07 a.m., SSD-A verified they were the new activities director for the campus being hired just within the past few weeks. SSD-A verified activities assessments would typically be completed by the director and they were trying to catch up in the role adding they were still learning "to balance everything yet." SSD-A reviewed R7's electronic medical record (EMR) and verified the lack of an activities assessment; however, expressed one should have been completed and activities were important to the resident' quality of life adding, "[Activities] give hope for themselves and [they] can actually enjoy their life still." On 8/28/24 at 11:38 a.m., the assistant director of nursing (ADON) was interviewed. ADON explained they just very recently started working at the center but verified they were the current MDS coordinator for the campus. ADON verified they had reviewed R7's completed MDS (dated 5/23/24) and 'Section F' was simply "dashed" and not completed. ADON stated the campus was working on getting their MDS' better and more timely completed. R406 The Centers for Medicare and Medicaid (CMS) Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, dated 10/2023, identified the RAI was used to help identify problems for a resident and address them using	F 636		

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F 636	Continued From page 64 an individualized care plan. The manual outlined an admission (Comprehensive) MDS should have an MDS completion date of no later than the 14th calendar day after the resident' admission date (i.e., admission date + 13 calendar days). R406's Face Sheet, printed 8/29/24, indicated R406 was admitted to the facility on 7/25/24. R406's Brief Interview for Mental Status (BIMS) assessment, dated 8/5/24 indicated R406 was had mild cognitive impairment. R406's admission Minimum Data Set (MDS), dated 7/31/24, was incomplete, with sections A, B, C, D, E, F, GG, H, I, J, L, M, N, O, P, R, S, and V listed as "In Progress". Section K was the only section listed as "Complete". During an interview on 8/29/24 at 9:08 R406 was in the dining area, eating breakfast. R406 simply shrugged his shoulders when asked if the facility was providing him help with everything he needed. During an interview on 8/29/24 at 2:45 p.m., the assistant director of nursing and MDS nurse (ADON) stated it would be expected that R406's MDS would be completed at that time. The ADON confirmed the importance of timely MDS completion to "drive resident care" and determine the level of care a resident needed. A facility' provided MDS Completion and Submission Timeframes policy, undated, identified the care center would conduct and submit resident assessments in accordance with current Federal and State timeframe requirements.	F 636		

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F 638 SS=D	Qrtly Assessment at Least Every 3 Months CFR(s): 483.20(c) §483.20(c) Quarterly Review Assessment A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to complete the required quarterly Minimum Data Set (MDS) in a timely manner for 2 of 4 residents (R45, R46) reviewed for MDS accuracy. Findings include: The Centers for Medicare and Medicaid Services (CMS) Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual, dated 10/2023, identified the RAI consists of components including the MDS, the Care Area Assessment (CAA), and the utilization guidelines, and this process (i.e., use of the entire RAI) was mandated by CMS. The manual outlined that a quarterly assessment was a non-comprehensive assessment to be completed every 92 days and was used to track a resident's status between comprehensive assessments "to ensure critical indicators of gradual change in a resident's status are monitored". R45's Annual MDS with an assessment reference date (ARD) was completed on 4/19/24. R45's MDS summary in the electronic medical record (EMR) had an ARD date of 7/19/24, indicated the MDS was in progress and still not completed or signed.	F 638	F638-D Quarterly Assessment At least Every 3 Months/MN Rule 4658.0400 Sub.4-2550 Concern: Open or incomplete quarterly MDS filing. Immediate Correction Activity Assessment completed 09-19-2024 for R45 MDS completed on 09-17-2024 for R406, & R46 Identification of other residents at risk All current facility residents are at risk Corrective Measures: "Review policy and procedure for MDS assessments and completion. "Educate licensed nursing staff regarding admission, quarterly, and annual assessments. "MDS schedule is established to ensure all assessments are completed in time. "MDS schedule is audited for all residents to ensure MDS has been completed within the past 90 days. Monitoring Mechanisms: "MDS schedule and Quarterly assessments will be audited 4x per week x 30 days, 3x per week x 30 days, 2x per week x 30 days to ensure all assessments are completed timely and accurately. "Quarterly assessments will be added to	10/4/24

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F 638	Continued From page 66 During interview on 8/29/24 at 8:52 a.m. with assistant director of nursing (ADON)/MDS coordinator verified R45's quarterly assessment dated 7/19/24, was not completed and stated it was "in progress." During interview on 8/29/24 at 11:00 a.m., director of nursing (DON) stated MDS assessments were expected to be completed in a timely manner. DON stated they were aware the facility was behind with "a number" of MDS assessments. The undated MDS Completion and Submission Timeframes policy indicated the assessment coordinator was responsible for ensuring the resident assessments were conducted and submitted according to federal and state submission timeframes. R46's admission MDS with the assessment reference date (ARD) of 5/2/24 was the last completed MDS for R46. R46's MDS summary in the electronic medical record with an ARD date of 8/2/24, indicated the MDS was "in progress" with one section "swallowing/nutritional status" completed with the other 16 sections (medications, mood, behavior, etc) marked as "in progress". The summary indicated the MDS should have been completed by 8/16/24 but the assessment was not completed. During an interview on 8/30/24 at 11:31 a.m. with the administrator and assistant director of nursing (ADON)/ MDS coordinator, the ADON stated after reviewing R46's medical, R46's MDS assessments were not up to date. The ADON	F 638	QAPI x 180 days then reviewed to determine if ongoing monitoring is needed. Date of complaince 4pm on 10-04-2024	

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F 638	Continued From page 67 stated R46's quarterly MDS should have been completed by 8/16/24 but it had not been. The undated MDS Completion and Submission Timeframes policy indicated the assessment coordinator was responsible for ensuring the resident assessments were conducted and submitted according to federal and state submission timeframes.	F 638		
F 645 SS=D	PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3) §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services; or (ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission- (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility;	F 645		10/4/24

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F 645	Continued From page 68 and (B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability. §483.20(k)(2) Exceptions. For purposes of this section- (i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital. (ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual- (A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital, (B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and (C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services. §483.20(k)(3) Definition. For purposes of this section- (i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1). (ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter.	F 645		

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F 645	Continued From page 69 This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure a level I Pre-Admission Screening (PAS) and, if needed, a Level II Pre-admission Screening and Resident Review (PASARR) was completed to screen for mental health needs for 2 of 2 residents (R46, R7) reviewed for PAS. Findings include: R46's admission Minimum Data Set (MDS), dated 5/2/24, indicated R46 had intact cognition. R46's medical diagnoses list dated 4/26/24, indicated R46 was diagnosed with depression, anxiety, and bipolar disorder (a mental health condition manifested with wide mood swings). R46's PASARR dated 4/23/24, indicated the PAS [PASARR] was "successfully submitted" and based on the information provided, "it appears" this person meets the level of care for purposes of medical assistance payment but did not include a final determination by the lead agency. R46's entire medical record was reviewed and lacked evidence a final determination had been received. During an interview on 8/28/24 at 9:11 a.m. with the director of nursing (DON) and social services designee (SSD)-A, the DON stated SSD-A oversaw ensuring PASARR's were completed and in the resident's electronic medical record (EMR). The DON confirmed that the PASARR found in the EMR dated 4/23/24 was the application and not the final determination of R46's needs. The DON stated she would expect the final determination to be kept in the medical	F 645	Citation F645-D PASARR Screening for MD & ID Concern: PASSR screening not completed or present in the resident's medical records. Immediate Correction: PASSAR completed for R7 and R46 and reviewed for recommendations Identification of other residents at risk All current residents are audited for completed PASSAR Corrective Measures: •Ensure PASSARR is completed for all current residents and care plan updated based on recommendations. Monitoring Mechanisms: •IDT team will receive education on the importance of PASSR screenings prior to admission to the facility •Admissions will be reviewed for completed PASSAR prior to admission daily x 90 days •PASSAR will be added to QAPI x 180 days then reviewed to determine if ongoing monitoring is needed.	

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F 645	Continued From page 70 record and would investigate the issue. During an interview on 8/29/24 at 11:55 a.m., SSD-A stated she was unable to locate R46's PASARR results at this time. R7's admission Minimum Data Set (MDS), dated 5/23/24, identified R7 admitted to the care center from the acute care hospital, had moderate cognitive impairment and required substantial assistance with multiple mobility-related tasks (i.e., rolling, lying to sitting). Further, the MDS outlined R7 had multiple medical conditions including heart failure, chronic kidney disease, dementia, depression and post traumatic stress disorder (PTSD). R7's Nurse Admission/ReAdmission 07192021, dated 5/20/24, identified R7 came from the hospital. The evaluation outlined, "Patient is [alert, oriented] X2 ... has a very dry mouth and is on fluid restriction, has left sided weakness ..." However, R7's entire medical record, including hospital dismissal paperwork, was reviewed and lacked evidence a Level I PAS was completed when R7 admitted to the care center on 5/20/24. On 8/29/24 at 11:04 a.m., the social services designee (SSD)-A was interviewed. SSD-A verified they had reviewed R7's medical record and were unable to locate a Level I PAS adding, "We are working on it [getting one done now]." SSD-A explained they called the Senior Linkage Line who also didn't have record of one being done so, as a result, they were going to do one now. SSD-A stated they were unsure why a Level I wasn't completed when R7 admitted to the care	F 645	Date of complaince 4pm 10-04-2024	

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F 645	Continued From page 71 center adding, "That I don't know." SSD-A stated a different social worker was in place when R7 admitted and it appeared, at least from the medical record, they had never acted or followed up on it back then. SSD-A stated it was important to ensure a Level I was done on all residents to screen for mental health issues and needs. A facility provided PASARR Policy, undated, outlined the PASARR assessment should have been completed before admittance to the facility to determine an appropriate level of care for the individual and ensure the individual's needs were adequately met.	F 645		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable.	F 655		10/4/24

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F 655	Continued From page 72 §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to ensure a baseline care plan was developed and available to facilitate person centered care for 2 of 3 residents (R53 and R406) reviewed for baseline care plans. Findings include: R53 R53's admission Minimum Data Set (MDS), dated 7/22/24, indicated R53 was admitted to the facility on 7/16/24 and had severe cognitive impairment. R53's Electronic Medical Record (EMR) lacked any evidence a baseline care plan had been	F 655	Citation F655-Baseline Care Plan Concern: Baseline/48-hour care plans incomplete, record of residents being provided a copy of care plan not recorded. Identification of other residents at risk •Residents without a baseline and/or comprehensive care plan in place. Corrective Measures: •R53 and R46 will undergo a plan of care review to create a baseline and/or	

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F 655	Continued From page 73 developed within 48 hours of admission to ensure R53's immediate care needs were addressed. During an interview on 8/29/24 at 9:50 a.m., R53's family member (FM)-A stated he did not live near the care facility but was available by phone. FM-A stated he was unaware of a care plan for R53 and had not had a care conference. FM-A stated he would like an update on how R53 was doing and what was included in her care at the care facility. R406 R406's Face Sheet, printed 8/29/24, indicated R406 was admitted to the care facility on 7/25/24. R406's admission MDS, dated 7/31/24, was incomplete, with all sections except K "Swallowing/Nutritional Status" listed as "Incomplete." R53's Electronic Medical Record (EMR) lacked any evidence a baseline care plan had been developed within 48 hours of admission to ensure R406's immediate care needs were addressed. During an interview on 8/29/24 at 9:08 a.m., R406 was sitting in the main dining area eating breakfast. R406 simply shrugged his shoulder when asked if he was getting help with everything he needed at the care facility. During an interview on 8/29/24 at 9:35 a.m., nurse manger and registered nurse (RN)-B confirmed there was not a baseline care plan for R53 and R406. RN-B stated there was not a process for baseline care plans that she was	F 655	comprehensive care of plan. •Education will be completed with nursing staff regarding baseline and comprehensive care plans. •All residents care plans will be audited and reviewed for a baseline and/or comprehensive care plan as appropriate. Resident without a baseline and/or care plan will undergo a plan of care review to create a baseline and/or comprehensive care of plan. •Residents and/or resident representative will receive a copy of the care plan to establish patient involvement in plan of care. If resident is unable to participate in the plan of care and lack representation-these patients will be referred to legal counsel and ombudsmen. Monitoring Mechanisms: •New admissions will be reviewed for the completion of a baseline within 48 hours of admission daily x 90 days •Baseline Care plans are added to QAPI x 180 days then reviewed to determine if ongoing monitoring is needed. Date of compliance 4pm 10-04-2024	

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F 655	Continued From page 74 aware of, stating she would attempt to start a resident's care plan on the day of admission, but it did not always happen, especially on the weekend. During an interview on 8/30/24 at 10:05 a.m., the director of nursing (DON) stated baseline care plans were a concern, especially on the weekends. The DON stated it would be expected that baseline care plans were completed and in the EMR for all residents. An undated facility policy titled Baseline Care Plans - Preliminary indicated, "to ensure that the resident's immediate care needs are met and maintained, a preliminary care plan will be developed within forty-eight (48) hours of the resident's admission".	F 655		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not	F 656		10/4/24

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F 656	Continued From page 75 provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure a comprehensive care plan was developed to ensure resident safety while using cannabis products for 1 of 1 residents (R28) reviewed for care planning. Findings include: R28's admission MDS dated 6/4/24, indicated	F 656	Citation F656-Development/Implement Comprehensive Care Plan Concern: Comprehensive care plan did not address safe marijuana use, storage, or side effect monitoring. Identification of other residents at risk:	

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F 656	Continued From page 76 R28 had severely impaired cognition and had no rejection of care behaviors. The MDS indicated R28 was diagnosed with hypertension, diabetes, and osteomyelitis (bone infection). The MDS indicated R28 used a walker and a wheelchair as mobility devices and required set-up help with toilet transfers, moderate assistance with walking ten feet, and was independent with wheelchair use. R28's care plan dated 6/24/24, indicated R28 had a history of substance abuse related to opioid dependency and alcohol use. The care plan indicated if facility staff witnessed or suspected "illegal" substance use or alcohol use, they were to start 15-minute safety checks and vital signs every two hours for 24 hours. The care plan indicated staff were to follow the facility policy related to resident substance abuse and report any abnormal behavior to the provider. The care plan did not acknowledge R28's cannabis use, methods to store safely cannabis, or side effects to monitor for related to cannabis use to ensure R28's safety. R28's provider note dated 7/30/24, indicated R28 had "ongoing marijuana use". During an interview on 8/26/24 at 2:08 p.m., R28 was observed sitting in his wheelchair with a hat on that had a large green cannabis leaf printed on the front. R28 stated he smoked cannabis daily with a pipe since he was admitted to the facility a few months ago. R28 stated he did not recall any staff member observing him smoke but they knew he smoked. During an interview on 8/28/24 at 11:21 a.m., the infection preventionist (IP) and LPN-B stated they	F 656	All facility residents who smoke cannabis Corrective Measures: •R28 Care plan is reviewed and updated to include safe cannabis usage as part of the personalized comprehensive care plan completed 09-23-24 •All facility residents will be reviewed for smoking to identify residents who smoke cannabis •Residents identified to smoke cannabis will undergo comprehensive care plan review and revision to include safe cannabis use, risks of cannabis use and safe smoking. •Education will be completed with all residents identified as smoking cannabis to include the related to the risks verse benefits, and effects associated with smoking cannabis. •Education will be completed with licensed nursing staff regarding smoking assessments, cannabis use, and care plan development, implementation, and comprehensive care. Monitoring Mechanisms: •Residents identified as cannabis smokers will be observed for negative side effects of cannabis use 3x times per week x 30 days, then 2x times per week x 30 days, then 1x time per week for 30 days for a total of 90 days.	

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F 656	Continued From page 77 had both been previously aware that R28 smoked cannabis. LPN-B stated it was not something R28 hid or that was new for him. During an interview on 8/28/24 at 12:10 p.m., the unit manager, RN-B stated she was unaware R28 smoked cannabis. RN-B stated the floor nurses were the ones who should have completed a smoking assessment, including observing R28 smoking cannabis to ensure he could do it safely. RN-B stated as she was unaware that R28 smoked cannabis and a plan for safe cannabis use had not been developed or documented in the medical record. The facility Care Planning- Interdisciplinary Team Policy dated 11/28/16, indicated the facility will develop and implement a comprehensive individualized care plan. The personalized care plan will identify problem areas and their risk factors and, develop interventions that are personalized to the resident. The policy further indicated the care plan was to be modified and updated as the resident's condition and care needs changed.	F 656	•Resident cannabis smoking with be added to QAPI x 180 days then reviewed to determine if ongoing monitoring is needed. Date of Complaince 4pm on 10-04-2024	
F 660 SS=D	Discharge Planning Process CFR(s): 483.21(c)(1)(i)-(ix) §483.21(c)(1) Discharge Planning Process The facility must develop and implement an effective discharge planning process that focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions. The facility's discharge planning process must be consistent with the discharge rights set forth at 483.15(b) as applicable and-	F 660		10/4/24

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F 660	Continued From page 78 (i) Ensure that the discharge needs of each resident are identified and result in the development of a discharge plan for each resident. (ii) Include regular re-evaluation of residents to identify changes that require modification of the discharge plan. The discharge plan must be updated, as needed, to reflect these changes. (iii) Involve the interdisciplinary team, as defined by §483.21(b)(2)(ii), in the ongoing process of developing the discharge plan. (iv) Consider caregiver/support person availability and the resident's or caregiver's/support person(s) capacity and capability to perform required care, as part of the identification of discharge needs. (v) Involve the resident and resident representative in the development of the discharge plan and inform the resident and resident representative of the final plan. (vi) Address the resident's goals of care and treatment preferences. (vii) Document that a resident has been asked about their interest in receiving information regarding returning to the community. (A) If the resident indicates an interest in returning to the community, the facility must document any referrals to local contact agencies or other appropriate entities made for this purpose. (B) Facilities must update a resident's comprehensive care plan and discharge plan, as appropriate, in response to information received from referrals to local contact agencies or other appropriate entities. (C) If discharge to the community is determined to not be feasible, the facility must document who made the determination and why. (viii) For residents who are transferred to another	F 660		

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F 660	Continued From page 79 SNF or who are discharged to a HHA, IRF, or LTCH, assist residents and their resident representatives in selecting a post-acute care provider by using data that includes, but is not limited to SNF, HHA, IRF, or LTCH standardized patient assessment data, data on quality measures, and data on resource use to the extent the data is available. The facility must ensure that the post-acute care standardized patient assessment data, data on quality measures, and data on resource use is relevant and applicable to the resident's goals of care and treatment preferences. (ix) Document, complete on a timely basis based on the resident's needs, and include in the clinical record, the evaluation of the resident's discharge needs and discharge plan. The results of the evaluation must be discussed with the resident or resident's representative. All relevant resident information must be incorporated into the discharge plan to facilitate its implementation and to avoid unnecessary delays in the resident's discharge or transfer. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to implement a discharge planning process to ensure discharge goals were achieved for 1 of 1 (R13) residents reviewed for discharge planning. Findings include: R13's quarterly Minimum Data Set (MDS) dated 6/17/24, identified R13 was cognitively intact and had diagnoses which included: encounter for other orthopedic aftercare, fusion of spine, xerosis cutis (very dry skin), unspecified open wound of right lesser toe(s) without damage to	F 660	Citation F660-Discharge Planning Concern: Lack of documentation of discharge planning process following resident preference from care conferences. Identification of other residents at risk MDS will be reviewed to identify residents who express a desire to discharge. Corrective Measures:	

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F 660	Continued From page 80 nail, other reduced mobility, morbid obesity due to excess calories, lipomatosis (noncancerous condition of fatty tissue overgrowth), cauda equina syndrome (nerve roots at the bottom of the spinal cord are compressed), hypokalemia (low potassium), hypomagnesemia (low magnesium), and atherosclerotic heart disease of native coronary artery without angina pectoris (arteries become narrowed and hardened due to buildup of plaque in the artery wall). R13 was dependent with activities of daily living (ADLs) such as bed mobility, toilet use, transfers, bathing, and mobility. R13 did not have a prognosis that indicated a life expectancy of less than 6 months. Further, MDS revealed no discharge planning had been assessed nor referral made to the Local Contact Agency (LCA). R13's Social Service Care Conference dated 3/21/24, documented R13 requested assistance with finding another long-term care (LTC) facility and social services planned to assist with this process. R13's Social Service Care Conference dated 6/28/24, documented R13 had again requested a UCARE worker's contact information for relocation services. R13's current care plan indicated R13's goal was to remain LTC, and social services will coordinate services for necessary discharge. R13's care plan lacked evidence of detailed discharge plan or need for relocation services. R13's progress note dated 10/11/22, indicated a message was left for a UCARE coordinator. R13's progress note dated 7/27/23, noted R13	F 660	•Social Worker will meet R13 to discuss discharge planning, review barriers, and establish goals •Education will be completed with IDT leadership team regarding discharge planning, documentation, and resident involvement with discharge process. Monitoring Mechanisms: •Weekly discharge planning meetings will be established to monitor the progress and identify barriers to discharge goals of residents who wish to discharge from the facility. •Residents identified with a goal of discharging to an alternative facility or community setting will be updated on the progress of their discharge plan bi-weekly x 90 days. •Discharge planning be added to QAPI x 180 days then reviewed to determine if ongoing monitoring is needed. Date of compliance 4pm on 10-04-2024	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 660	Continued From page 81 was informed of denial of transfer to another facility due to his refusals of care. R13's progress note dated 11/8/23, indicated the regional Ombudsman was attempting to find a facility closer to resident's sister for R13 to relocate to. R13's progress note dated 4/2/24, indicated social services had completed an online application for relocation services through Hennepin County. During interview on 8/26/24 at 5:26 p.m., R13 stated the facility claimed to be looking for a different facility for him to transfer to but they had not gotten back to him. R13 stated he did not feel that they were actively trying to find another facility for him, and he was refusing to get out of bed until he could leave this facility. During interview on 8/29/24 at 1:34 p.m., with SSD-A indicated she was not aware of this request, and she needed to follow up with R13. She stated she is new in this role and there had been a lot of turnover with the social services role recently. During interview on 8/29/24 at 1:36 p.m., director of nursing (DON) indicated she had met with R13 due to another grievance. DON stated R13 had brought up other concerns to her however she was not aware of R13's request to discharge to another facility. Review of facility policy titled Discharging the Resident (no date), revealed in preparation the resident should be consulted about the discharge. If discharging to another long-term care facility	F 660		

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F 660	Continued From page 82 the resident should be told: where the new facility is located, the size of the facility, what services it offers, what it looks like, any additional information available, who will be providing the resident's care, that his family will be informed of the discharge and where the resident will be living, and why the discharge is necessary.	F 660		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure toileting needs were comprehensively evaluated and appropriate to meet the resident' needs and prevent complication (i.e., skin damage, soiled clothing) for 1 of 2 residents (R27) reviewed who was dependent on staff for care. Findings include: R27's quarterly Minimum Data Set (MDS), dated 6/5/24, identified R27 had unclear speech, severe cognitive impairment and could typically respond to simple, direct communication only. The MDS outlined R27 demonstrated no rejection of care behavior, had frequent urinary incontinence (seven or more episodes, but at least one continent void), and a toileting program trial had never been attempted. On 8/26/24 at 1:31 p.m., R27 was observed seated in a high-back geri-chair while in her	F 677	F677-ADL CARE Provided for Dependent Residents/MN Rule 4658.0525 Subp.6-2920 Concern: Reports of incontinence not being followed up with assessments or interventions after catheter was discontinued. Identification of other residents at risk Residents identified as requiring assistance with toileting and elimination needs. Corrective Measures: " R27 will be assessed for appropriate interventions through observation/tracking of bowel and bladder frequency to maintain good skin hygiene and adequate toileting needs. "R27□s care plan is reviewed and updated to include toileting frequency and schedule. "Nursing staff will receive education on	10/4/24

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F 677	Continued From page 83 room. R27's eyes were closed and R27 responded with only mumbled, non-sensical speech with surveyor' interaction. R27 had no visible catheter drainage bag attached to the wheelchair, however, immediately underneath R27 on the floor was a large amount of yellow-tinged fluid which ran outward from the wheelchair base spreading over the floor, and R27 had a detectable urine odor present to her person. There were no visible cups or drinks on R27 or within her immediate reach at this time. Immediately following, at 1:33 p.m., nursing assistant (NA)-X was alerted to the fluid underneath R27 and running across the floor. NA-X observed and verified the fluid underneath R27 and stated they had not placed R27 back into her room after the lunch meal so they were unsure what it was. NA-X was questioned on the fluid and urine odor present to which they responded it was "maybe" urine on the floor. At 1:40 p.m., NA-Z entered the room and stated they were "coming to lay her [R27] down." NA-Z verified they had placed R27 back in her room after the lunch meal "maybe 15 minutes" prior and, at that time, there was no fluid on the floor. NA-Z stated R27 was "a heavy wetter" and they had last changed her "around 10 [a.m.] something." NA-Z stated they usually changed R27 "three times a day" on their shift and reiterated repeatedly R27 was "a big wetter." NA-Z stated all episodes of "check and change" were recorded in the point-of-care (POC) charting adding, "We chart in the computer." NA-Z stated charting was done both in real time and, at times, all at the end of the shift adding, "It depends how the day goes." At 1:50 p.m., R27 was assisted into her bed using a mechanical lift and when raised up from her wheelchair, the right side of her pants was visibly soiled with fluid. NA-Z	F 677	the importance of skin hygiene, toileting interventions, following the plan of care, and documentation. "Policies and procedures related to toileting will be reviewed and/or revised as necessary. "Residents identified as requiring assistance utilizing MDS documentation with toileting will be reviewed for appropriate interventions to maintain good skin hygiene. Monitoring Mechanisms: "Residents identified as requiring assistance with toileting will be audited 4x times per week x 30 days, then 3x times per week x 30 days, then 2x time per week for 30 days for a total of 90 days for appropriate interventions to maintain good skin hygiene. "Resident requiring toileting needs with added to QAPI x 180 days then reviewed to determine if ongoing monitoring is needed. Date of Compliance 4pm 10-04-2024	

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F 677	Continued From page 84 verified no cups or drinks were present on R27 or within the chair and expressed they were unsure what the fluid was but acknowledged it could be urine adding aloud, "I don't really know." R27 was laid on her bed and her worn brief exposed which was visibly soiled with urine with no catheter-device being present. R27 was then assisted with incontinence care in bed. R27's POC Response History, printed 8/26/24, identified a 14 day look-back period of incontinence charting. The charting had two recorded times care was provided for R27 on 8/26/24 (the day of observation). This recorded care done at 12:55 a.m. and 2:51 p.m., with no care being recorded in between (over 12 hours apart). R27's most recent Bowel and Bladder Program Screener 122719, dated 3/2023, identified multiple questions to be answered by staff during the review. These recorded responses outlined R27 never voided appropriately without incontinence, was immobile or required two person assistance, and was very confused or combative. The evaluation concluded with a section labeled, "Summary," which had a checkmark placed next to the option reading, "5. Resident has urostomy or suprapubic catheter and appropriate diagnosis is present." R27's most recent Quarterly Resident Review 11262021-V2, dated 6/5/24, identified R27 was alert but oriented to person only. The review listed a section labeled, "Bowel and Bladder," which included a checkmark placed next to an option reading, "7. Resident is totally incontinent." A section was provided which asked, "Any changes to bladder continence or plan of care?[,]" which	F 677		

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F 677	Continued From page 85 was left blank. The review lacked any further information on R27's urinary incontinence including what their current toileting plan was (i.e., if it was effective or not), what type of incontinence was present (i.e., functional, etc.), nor any further information on what, if any, interventions were considered or done to manage R27's total incontinence. R27's care plan, dated 8/27/24, identified R27 was incontinent of bladder due to impaired mobility. A goal was listed which read, "The resident will remain free from skin breakdown ...," along with interventions for R27 including peri-care with each incontinence episode, monitoring for signs of a urinary tract infection (UTI), and, "BRIEF USE: The resident uses disposable briefs. Change per schedule and PRN [as needed]." The care plan lacked any further information or clarification on what the established schedule for R27 included. R27's medical record was reviewed and lacked evidence R27 had been comprehensively re-assessed for her incontinence, including for the type of incontinence, any voiding patterns or trends, or medication use which could impact voiding, despite R27 being identified by staff as having incontinence (i.e., "heavy wetter") and R27 potentially having recorded continent voids as outlined on the most recent MDS (dated 6/5/24). The record lacked any evidence a new Bowel and Bladder Program Screener had been done since 2023 and after the catheter was removed; nor did the record have any evidence to demonstrate what 'schedule' had been assessed and determined as appropriate for R27 as outlined on the care plan.	F 677		

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F 677	Continued From page 86 On 8/28/24 at 12:14 p.m., registered nurse manager (RN)-A was interviewed and verified they had reviewed R27's medical record. RN-A stated R27 was "a total" assist with toileting and likely unable to participate in a toileting schedule or program; however, RN-A explained typically programs and toileting plans were evaluated using the Bowel and Bladder Program Screeners and Quarterly Resident Review tools. RN-A verified R27's catheter was removed awhile prior and since, the staff were just doing "check and change" for her. RN-A stated the schedule, as outlined in the care plan, would be upon rising, before and after meals, at bedtime and as needed. RN-A verified incontinence episodes and care should be recorded in the POC charting and acknowledged the lack of recorded care on 8/26/24 when the surveyor had observed R27 soiled. RN-A stated they possibly had to schedule the task differently in the record adding, "Maybe this is something we need to do with [EMR]." RN-A verified the medical record lacked evidence a comprehensive evaluation of R27's incontinence had been completed (i.e., screener, quarterly review) and expressed staff had never told them R27 was "a heavy wetter" before so maybe R27 needed "more frequent changes." RN-A stated it was important to ensure toileting needs and incontinence was evaluated to help prevent skin breakdown and "help fulfil the resident needs." A facility' Activities of Daily Living (ADLs), Supporting policy, dated 3/2018, identified residents would be provided with care, treatment and services as appropriate to maintain or improve their ability to carry out ADLs. The policy outlined, "Residents who are unable to carry out activities of daily living independently will receive	F 677		

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F 677	Continued From page 87 the services necessary to maintain good nutrition, grooming and personal and oral hygiene." This included, "Appropriate care and services will be provided for residents who are unable to carry out ADLs ... including appropriate support and assistance with ... c. elimination (toileting) ..."	F 677		
F 679 SS=D	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to comprehensively assess and, if needed or able, develop or implement activities programming to promote quality of life for 2 of 2 residents (R7, R27) reviewed for activities and leisure-based programming. Findings include: R7's admission Minimum Data Set (MDS), dated 5/23/24, identified R7 admitted to the care center in May 2024 and had moderate cognitive impairment but demonstrated no delusional thinking. Further, the MDS contained a section labeled, "Section F - Preferences for Customary	F 679	Citation F679-Activites Meet Interest/Needs Each Resident/MN Rule 4658.0900 Subp.1 Concern: Activity assessments not completed per MDS policy, resident had outdated activity calendar in their room, nonverbal resident removed from group activities for vocal outbursts. Identification of other residents at risk All residents could be impacted by activity interest and needs Corrective Measures:	10/4/24

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F 679	Continued From page 88 Routine and Activities," which outlined questions to be answered based on R7's responses for activities and routines, however, nearly the entire section was left dashed with, "Not Assessed [See F636]." On 8/26/24 at 2:33 p.m., R7 was observed in her room with her family member (FM)-G present, and the room lacked any posted activities calendar or postings. R7 was interviewed and expressed frustration over a lack of both group-based and individual activities programming at the campus. R7 stated she only attended activities "when I beg them [staff]" to include her and, if not for FM-G coming and visiting the campus often, she would "never see daylight" out of her room. R7's reiterated she was rarely, if ever, invited to group-based activities at the campus adding, "They don't take me." Further, R7 stated she had never, at least to both her and FM-G's recall, been asked about activities' likes or dislikes, goals or preferences since admitting to the care center several months prior adding, "They don't respond to me here." R7's medical record was reviewed and lacked any evidence a comprehensive assessment for leisure or activity-based programming, including likes and dislikes or preferences for activities, had been completed despite R7 admitting to the care center several months prior. Further, R7's care plan, printed 8/27/24, identified no specific activities problem statements, goals or interventions to ensure R7's leisure and activity needs, if any, were met. When interviewed on 8/28/24 at 9:11 a.m., trained medication aide (TMA)-A stated they had worked at the campus for "a year" or so and had worked	F 679	•Activity assessments will be completed for R7 upon return from hospital •R7 care plan will be updated to reflect activities of interests and appropriate interventions upon return from the hospital •Activity assessment will be completed for R27 to determine and implement appropriate interventions based on resident needs. •R27 care plan will be updated to reflect activity and appropriate interventions based on resident needs. •Activity assessments will be completed on all residents •Care plans will be updated to reflect activities of interest and goals of participation •Education will be completed with activity department on activity assessments and care planning, interventions and documentation. •Updated activity calendar will be provided to residents for current month Monitoring Mechanisms: •Resident participation in activities will be evaluated weekly x 30 days, biweekly x 30 days, and monthly x 90 days for resident participation • Activities assessments will be audited 3x	

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F 679	Continued From page 89 with R7 multiple times prior. TMA-A stated R7 was "a little confused" but typically was "on point" with her cognition and recall. TMA-A stated R7 needed "hands on" help with most cares and two people to transfer using a mechanical lift. TMA-A explained R7's family (i.e., FM-G) was often present and would, at times, take R7 outside in her wheelchair. TMA-A stated they thought activities were being offered to R7 by the activities assistant (AA) staff. R7's POC (Point of Care) Response History, dated 8/28/24, listed a 30 day review period (i.e., look back) along with corresponding activities attended. The listing outlined multiple examples recorded which read, "1:1 Activity," but lacked further detail of what, or how much time, this consumed. The listing recorded few, if any, group-based activities being completed for R7. On 8/28/24 at 10:01 a.m., AA-A was interviewed and verified they helped with activities on R7's unit. AA-A explained the campus didn't have an activities director until "maybe two weeks ago" when the social services designee (SSD)-A was hired to fill the role. AA-A stated they were unsure who, if anyone, had assessed the residents reviewed for activities (i.e., R7, R27) but verified the director was responsible to do such adding, "I don't know if they did on on [R7]." AA-A stated R7 would spend "about 20% of her time" in the commons area and, when up in her wheelchair, seemed to be "into everything" and willing to participate. AA-A stated they tracked activity attendance using a paper form which they then recorded in the POC charting, and expressed many of the 1:1 recorded were likely "coffee cart [push room-to-room]" or just touching base adding the activities department, in general, had	F 679	per week x 90 days. • Activities will be added to QAPI x 180 days then reviewed to determine if ongoing monitoring is needed. Date of Complaince 4pm on 10-04-2024	

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F 679	Continued From page 90 suffered a staffing cutback and, at times, seemed to not be able to function with several group-based items (i.e., Bingo, "Casino Night") having to be removed from the schedule over the past months. When interviewed on 8/28/24 at 10:07 a.m., SSD-A verified they were the new activities director for the campus being hired just within the past few weeks. SSD-A verified activities assessments would typically be completed by the director and they were trying to catch up in the role adding they were still learning "to balance everything yet." SSD-A reviewed R7's electronic medical record (EMR) and verified the lack of an activities assessment; however, expressed one should have been completed and activities were important to the resident' quality of life adding, "[Activities] give hope for themselves and [they] can actually enjoy their life still." R27's quarterly MDS, dated 6/5/24, identified R27 had unclear speech, was only sometimes able to understand others or be understood herself, and had severe cognitive impairment. Further, the MDS outlined R27 demonstrated no rejection of care behaviors and required assistance to complete most cares (i.e., ADLs). On 8/26/24 at 1:50 p.m., R27 was observed in her room being assisted with personal cares. R27 was mostly non-verbal but did, at times, make audible moaning noises and yell out as staff assisted her. The room had an activity posted calendar labeled, "August," on the wall which was detached on top causing it to fold over onto itself. The posting was not read-able unless physically bent back up.	F 679		

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F 679	Continued From page 91 During the recertification survey, from 8/26/24 to 8/30/24, a telephone interview with R27's family member (FM) was attempted. However, they were unable to be reached and did not return the call. R27's care plan, printed 8/26/24, identified R27 had impaired communication due to a previous traumatic brain injury (TBI) with aphasia (language disorder that affects a person's ability to communicate). The care plan listed a section which read, "The resident is dependent on staff for meeting emotional, physical, and social needs [related to] physical limitations," along with a goal which read, "The resident will maintain involvement in cognitive stimulation, social activities as desired through review date (OVERDUE)." A single intervention was listed which outlined, :The resident prefers to socialize with: 1:1 musical programs, book reading in room planned interactions." However, R27's medical record was reviewed and lacked any evidence a comprehensive assessment for leisure or activity-based programming, including likes and dislikes or preferences for activities, had been completed in the last calendar to ensure the care plan remained relevant and update with R27's preferences and needs. When interviewed on 8/29/24 at 7:59 a.m., TMA-A stated they had seen R27 had some activities before but added, "Not too much." TMA-A explained R27 would, at times, yell out and disrupt so staff seemed to include her until a "real bad outburst" would happen. TMA-A stated they were unsure what, if any, other activities (i.e.,	F 679		

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F 679	Continued From page 92 1:1) were being done with R27 adding, "I really can't tell ya." R27's POC Response History, dated 8/29/24, listed a 30 day review period along with corresponding activities attended or completed. The listing outlined a total of 11 completed, "1:1 Activity," and a single episode of, "Sensory/Small Group." The listing lacked further detail of what, or how much time, the completed 1:1 activities consumed. On 8/29/24 at 8:44 a.m., activities assistant (AA)-A was interviewed. AA-A explained R27 did not routinely attend group-based activities adding they had not noticed anything which she stayed calm at long enough to complete. AA-A verified any assessment of activities, including likes and dislikes, would be completed by the program director. AA-A recalled R27 had been to "two or three" activities in the commons area to their recall and expressed they tried to check in with her daily and "see how she's doing or whatever." AA-A added, aside from that, they had not been able to determine what, if any, activities would be helpful or meaningful with R27. When interviewed on 8/29/24 at 11:06 a.m., the social services designee (SSD)-A was interviewed and verified they were the current activities director for the care center. SSD-A explained they had been in the role for only a short period with the previous director leaving "over a month and a half ago." SSD-A reviewed R27's medical record and verified a lack of activities assessment being done adding they were "still being worked on" since coming into the role. SSD-A verified an assessment should be completed and was important adding "so we	F 679		

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F 679	Continued From page 93 know what their needs are during activities." On 8/28/24 at 10:23 a.m., the administrator was interviewed. He acknowledged the activities assessments not being completed expressing aloud, "That hasn't been done in weeks." The administrator stated the State (i.e., MDH) was aware of it as they were meeting with them routinely on special focus facility (SFF) calls, and they explained SSD-A was recently hired to fill the role within the past few weeks. The administrator verified the activities director typically was responsible to complete the required activities assessments and, if needed, care-planning for the residents. A facility' provided Activity Evaluation policy, dated 2/2023, identified an evaluation would be completed and maintained for each resident at least quarterly and with any change of condition which could affect participation. The policy added, "The activities director is responsible for completing, directing and/or delegating the completion of the activities component of the comprehensive assessment," and such evaluation would be, " ... used to develop an individual activities care plan ... that will allow the resident to participate in activities of his/her choice and interest." The policy directed such evaluation was part of the medical record and should be updated at minimum every quarter.	F 679		
F 680 SS=C	Qualifications of Activity Professional CFR(s): 483.24(c)(2)(i)(ii)(A)-(D) §483.24(c)(2) The activities program must be directed by a qualified professional who is a qualified therapeutic recreation specialist or an activities professional who-	F 680		10/4/24

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F 680	Continued From page 94 (i) Is licensed or registered, if applicable, by the State in which practicing; and (ii) Is: (A) Eligible for certification as a therapeutic recreation specialist or as an activities professional by a recognized accrediting body on or after October 1, 1990; or (B) Has 2 years of experience in a social or recreational program within the last 5 years, one of which was full-time in a therapeutic activities program; or (C) Is a qualified occupational therapist or occupational therapy assistant; or (D) Has completed a training course approved by the State. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to have a therapeutic recreation director (i.e., activities director) whom was successfully qualified and/or credentialed, as required, to ensure competent assessment and implementation of activities programming within the care center. This had potential to affect all 53 residents at the time of survey. Findings include: See F679; Based on observation, interview, and document review, the facility failed to comprehensively assess and, if needed or able, develop individualized activities to promote quality of life for 2 of 2 residents (R7, R27) reviewed for activities and leisure-based programming. When interviewed on 8/28/24 at 10:01 a.m., activities assistant (AA)-A explained themselves and another part-time person worked to help do the campus' activities programming. AA-A stated	F 680	F680-Qualifications of Activity Professional/MN Rule 4658.0900 Subp.3 Concern: Qualifications of activities professional. Immediate Correction: "Activity Professional Designee is enrolled as of 09-13-24 to complete professional certification in activities classes beginning on October 1st, 2024. Identification of other residents at risk All resident interested in participating in activities Corrective Measures: "Employees is enrolled to complete Activity Professional Training beginning October 1st, 2024. Monitoring Mechanism: "Employees progress towards completing professional activity training will be monitored 3 x per week x 90 days or until completion of activities certification is achieved.	

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F 680	Continued From page 95 the campus didn't have an activities director until "maybe two weeks ago" when the social services designee (SSD)-A was hired to fill the role. AA-A stated they were unsure who, if anyone, had assessed the residents reviewed for activities (i.e., R7, R27) but verified the director was responsible to do such. Further, AA-A stated the activities department, in general, had suffered a staffing cutback and, at times, seemed to not be able to function with several group-based items (i.e., Bingo, "Casino Night") having to be removed from the schedule over the past months. On 8/28/24 at 10:07 a.m., SSD-A was interviewed and verified they were the new activities director for the campus being hired just within the past few weeks. SSD-A stated they came from another senior care venue where they did social services and had never been hired to a full-time position for activities or leisure-based programming prior adding their experience with activities was more like "I kind of helped [with them]" and only "if I didn't have anything to do. SSD-A stated the activities-based work done was essentially, "[It was] more like volunteer [based]." SSD-A verified they had never been hired or worked in a full-time position within the activities department during the past several years and they were not licensed or credentialed for activities in the State of Minnesota; nor were they a certified occupational therapist (OT). SSD-A stated the campus' administrator had informed them of needing to complete certain courses for the position but, as of that time, they had not enrolled or started them. SSD-A stated they had worked "two or three hours a week" helping in activities prior only, and explained they found the open position for the activities director on Indeed (an online job posting site) and applied; then after	F 680	Date of Complaince 4pm on 10-04-2024	

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F 680	Continued From page 96 being hired were also given the social services position. SSD-A verified activities assessments would typically be completed by the director and they were trying to catch up in the role adding they were still learning "to balance everything yet." SSD-A reviewed the applicable medical records (i.e., R7, R27) and verified the lack of assessment; however, expressed one should have been completed and activities were important to the resident' quality of life adding, "[Activities] give hope for themselves and [they] can actually enjoy their life still." When interviewed on 8/28/24 at 10:23 a.m., the administrator acknowledged the activities assessments not being completed expressing aloud, "That hasn't been done in weeks." The administrator stated the State (i.e., MDH) was aware of it as they were meeting with them routinely on special focus facility (SFF) calls, and they explained SSD-A was recently hired to fill the role within the past few weeks. The administrator stated they recalled SSD-A having some experience in activities but verified he was aware no courses or certifications had yet been attained adding, "She will get that done." The administrator verified the activities director typically was responsible to complete the required activities assessments and, if needed, care-planning for the residents. During the recertification survey from 8/26/24 to 8/30/24, evidence or documentation supporting SSD-A being credentialed or in-compliance with the requirements of being the activities director was requested; however, none was ever received. A facility' provided Activity Director job description,	F 680		

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F 680	Continued From page 97 dated 2001, identified a primary purpose of the position with text reading, " ... is to plan, organize, develop and direct the overall operation of the activities department in accordance with current federal, state and local standards, guidelines and regulations, established facility policies and procedures and as directed by the Administrator." The description outlined evaluation and care-planning of activities both as, "Essential Function[s]." The description listed education or experience requirements which included the following: "Preferred, as a minimum, two (2) years or college. Degree preferred but not necessary," and, "Preferred be a qualified therapeutic recreation specialist ...," and, "Must have, as a minimum, two (2) year(s) experience in a social or recreation program within the last five (5) years, one (1) of which was full-time in a patient activities program in a health care setting .." or, "Must have completed or will complete a training course approved by the state."	F 680		
F 685 SS=D	Treatment/Devices to Maintain Hearing/Vision CFR(s): 483.25(a)(1)(2) §483.25(a) Vision and hearing To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility must, if necessary, assist the resident- §483.25(a)(1) In making appointments, and §483.25(a)(2) By arranging for transportation to and from the office of a practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing assistive devices. This REQUIREMENT is not met as evidenced	F 685		10/4/24

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F 685	Continued From page 98 by: Based on observation, interview and document review, the facility failed to ensure vision needs were comprehensively assessed or tracked and, if needed, referred to an appropriate service for 1 of 2 residents (R7) reviewed who complained about worsening vision. Findings include: R7's admission Minimum Data Set (MDS), dated 5/23/24, identified R7 admitted to the care center on 5/20/24 and had moderate cognitive impairment but no delusional thinking. Further, the MDS outlined R7 had adequate vision (able to see fine detail, regular print) and used corrective lenses. On 8/26/24 at 2:42 p.m., R7 was observed seated in a high-back wheelchair while in her room. Next to her was a bedside table which had various items on it including a single black-framed pair of glasses. R7 was interviewed and stated her eye sight seemed to be worsening and her glasses needed to have the prescription checked adding, "They [Rx] need to be changed." R7 stated they had last seen an eye doctor prior to admitting to the care center and nobody had asked her about vision or need for an appointment since she had admitted several months prior. R7 stated she had been telling staff her vision was poor but reiterated a lack of follow-up adding, "I tell them all the time." R7's Nurse Admission/Readmission 07192021, dated 5/20/24, identified a section labeled, "Ear, Eyes, Nose, Throat," which outlined R7 used glasses and had adequate ability to see in light. The evaluation section concluded with a section	F 685	Citation F685-Treatement/Devices to Maintain Hearing/Vision Concern: Lack of evidence of hearing and vision being assessed or treated after reports of poor vision or hearing documented. Identification of other residents at risk •All residents could be at risk for hearing and vision needs Corrective Measures: •R7 will be scheduled to see the optometrist/ophthalmologist to address the need for new glasses prescription. •Education will be completed with nursing staff, activities staff, and health information staff regarding assessment, treatment, and devices needed for hearing and vision. •All residents will be screened for hearing and vison needs utilizing the Hearing, Speech and Vision Assessment. •Resident requiring evaluations of hearing and vision needs will be scheduled at first available appointment with an ophthalmologist/optometrist or hearing specialist. Monitoring Mechanisms: •Residents identified using Hearing,	

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F 685	Continued From page 99 labeled, "Additional Comments/Observations," however, this was left blank. The completed evaluation lacked any evidence R7 was evaluated for her last vision exam or if one was currently needed or wanted. In addition, R7's Hearing, Speech and Vision Assessment, dated 8/23/24, identified the evaluation was not signed or locked with dictation present, "Section Status: Errors." The evaluation listed a section labeled, "Vision," however, the entire section and fields to record text were left blank and not completed. When interviewed on 8/28/24 at 9:11 a.m., trained medication aide (TMA)-A stated they had worked with R7 multiple times and described her as being "a little confused" but "a majority of time [she] be on point." TMA-A stated any appointments needed were scheduled by health unit coordinator (HUC)-A. Further, TMA-A stated she had never heard any complaints about vision from R7, but expressed any evaluation or asking of the need for an appointment would be the nurses' responsibility adding, "The nurse does that." When interviewed on 8/28/24 at 12:35 p.m., HUC-A verified they handled and, if needed, scheduled both in-house services and outside appointments. HUC-A stated any referrals for appointments, including vision, would typically come from the nurse managers or through a physician order. HUC-A verified the care center had in-house vision services available, if needed, but expressed nobody had ever asked to get R7 scheduled or set-up with them adding, "I haven't heard of anything." R7's medical record was reviewed and lacked evidence R7 had been assessed or asked what, if any, vision needs or outside appointments were	F 685	Speech and Vision Assessments as appropriate for evaluation by a specialist will be monitored for scheduling 2x per week x 90. •Hearing, Speech, and Vision assessments will be monitored for completion and follow up 4x per week for 30 days, 3x per week for 30 days, and 2x per week x 30 days. •Hearing, Speech, and Vision will be monitored via QAPI x 180days. Date of compliance 4pm 10-04-2024	

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F 685	Continued From page 100 wanted or desire since admitting to the care center months prior and using corrective lenses. On 8/29/24 at 9:29 a.m., registered nurse manager (RN)-A was interviewed. RN-A explained vision was evaluated using the assessments in the medical record and the nurses should be asking at that time about last appointments and if one is wanted or needed. If so, then they can reach out to themselves (RN-A) or the HUC to be it scheduled. RN-A stated the evaluation for R7 (dated 8/23/24) seemed as "it wasn't completed" so, as a result, they just did it yesterday. RN-A verified the record lacked evidence R7 had been assessed or offered a vision appointment prior to the recertification survey adding, "I don't see anywhere in the record that it was offered." RN-A stated the need for an appointment should have been asked and record upon admission adding such was important to do "so we're meeting the resident's needs." R7's corresponding Hearing, Speech and Vision Assessment, dated 8/28/24, identified the section labeled, "Vision," which had impaired vision recorded and corrective lenses being used. The evaluation section concluded with a section labeled, "Comments," which had dictation reading, "Patient complains of blurry vision, states that she has been having her corrective lenses glasses for 7 years and that they are not strong enough for her vision." A facility policy on vision evaluation and appointments was requested, however, none was received.	F 685		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii)	F 686		10/4/24

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F 686	Continued From page 101 §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 deliver pressure ulcer care consistent with professional standards of care to prevent a facility acquired pressure ulcer for one of one resident (R8) reviewed for pressure ulcers. Findings include: R8's admission Minimum Data Set (MDS) assessment, dated 7/25/24, indicated R8 had moderately impaired cognition with no hallucination, delusions or other behavioral symptoms noted and required maximal assistance with all activities of daily living (ADLs) except eating, oral, and personal hygiene. The MDS further indicated R8 did not have any pressure ulcers and identified R8 was at risk for developing pressure ulcers. R8's Braden Scale Assessment (a standardized, evidence-based assessment tool commonly used	F 686	F686-Treatmentment/SVCS to Prevent/Heal Pressure Ulcer/MN Rule 4658.0525 Sub.p3-2900 Concern: Moderate-High risk Braden scores not followed up with turn and repostion documentation, NAR guide did not indicate pressure wound, careplan did not indicate when air-mattress was initiated. Identification of other residents at risk "Residents with Moderate-High risk Braden Scores Corrective Measures: "R8 discharged from the facility on 09-08-2024 "Care plans, nursing assistant care-sheets, and Kardex of residents with Moderate to High Braden Scores will be reviewed for appropriate interventions, including turning and repositioning schedules, status of skin condition, and pressure reduction interventions.	

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F 686	Continued From page 102 in health care to assess and document a patient's risk for developing pressure injuries), dated 7/23/24, indicated R8 was at very high risk for skin breakdown. R8's progress note, dated 7/19/24, indicated, [R8] "skin looks clean and intact with no wounds or bruising." R8's Progress Note, dated 8/12/24, indicated R8 to have an open area to his bottom measuring "1 cm (centimeter) x .5 (centimeter)." R8's Skin and Wound Evaluation, dated 8/16/24, indicated R8 had a stage two (II) in-house acquired facility pressure injury (partial-thickness skin loss with exposed dermis) on his coccyx (base of the spinal column) which measured 6.7 x 3.1 centimeters (cm) with an area of 11.4 cm squared. R8's Skin and Wound Evaluation, dated 8/23/24, indicated R8's coccyx stage II pressure injury measured 7.0 x 2.9 cm with an area of 7.4 cm squared. R8's Medication and Treatment Administration Record (MAR/TAR) for August indicated the following orders: -"Wounds care, Coccyx: Cleanse with vashe[wound care solution]/normal saline, apply skin prep, and apply hydrocolloid [wound dressing] Q [every] Tuesday, Friday, and PRN [as needed] one time a day starting on 8/23/24." - "Wounds care, Coccyx: Cleanse with vashe/normal saline, apply skin prep, and apply hydrocolloid Q [every] Tuesday, Friday, Sunday, and PRN [as needed] one time a day starting on 8/20/24 and ending on 8/23/24."	F 686	"Education will be completed with nursing staff on the important of pressure ulcer prevention. Monitoring Mechanisms: "The care plans and intervention of residents with moderate-high Braden scores will be audited for appropriate interventions 3x per week for 30 days, 2x per week x 30 days, and 1x per week x 30 days. " Resident with residents with moderate-high Braden scores be added to QAPI x 180 days then reviewed to determine if ongoing monitoring is needed. Date of Complaince 10-04-2024	

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F 686	Continued From page 103 -"Barrier cream to affective areas on bottom/peri areas two times a day with a start date of 8/14/24 with an end date of 8/20/24." The MAR/TAR lacked evidence of repositioning to prevent further pressure injury or to prevent healing of in-house acquired pressure injury. The document further lacked documentation of R8's refusals. R8's care plan, printed 8/28/24, indicated R8 "has a pressure coccyx or potential for pressure ulcer development r/t [related to] immobility" which was added on 8/16/24 with the following interventions: -administer medications as ordered, -apply barrier cream after each incontinent episode -monitor /document/report PRN any changes in skin status -the resident needs assistance and to turn/reposition frequently and as needed or requested. Care plan further indicated R8 requires a mechanical lift for transfers and assist of 2 staff. R8 required a total assist of 1-2 staff with personal hygiene, oral care, dressing, and was dependent on staff for bathing. R8's care plan identified R8 has hemiplegia/hemiparesis (paralysis of one side of the body) related to a stroke with an intervention of "reposition as tolerated frequently." The care plan lacked evidence of any interventions being put in place prior to the development of a pressure injury, despite being identified at very high risk for developing a pressure injury from the Braden score. Nursing assistant care sheets, provided on 8/28/24, indicated "Toilet: Frequent check and	F 686		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 104 change, upon rising, before and after each meal, at bedtime, NOC [night] rounds and as needed ...ADLs: assist of 1-2 staff ...Transfers: Assist of 2 staffs with Hoyer [mechanical lift] and medium sling". The document lacked identification that R8 had a pressure injury, needed repositioning due to pressure injury or R8 needing assistance to reposition/offload in bed. Review of R8's medical record, lacked evidence of R8 being repositioned every 2 hours. During observation on 8/28/24 at 9:26 a.m., R8 was observed sitting in his wheelchair in the dining room. On 8/28/24 at 10:12 a.m., R8 was observed to be still sitting in his wheelchair in the same position in the dining room. R8 was observed to be calling out intermittently, "I am tired". On 8/28/24 at 10:50 a.m., R8 was observed in the dining room in the same position in his wheelchair. Trained medication aid (TMA)-A was observed to approach R8 and inquired what could they do for him. TMA-A stated they would bring him back to his room. On 8/28/24 at 11:03 a.m., TMA-A and R8 were observed in R8's room. At 11:13 a.m., R8 was observed to be lying in bed. R8 stated that he was comfortable and "ready to take a nap." During observation on 8/29/24 at 12:17 p.m., R8 was observed to be lying in bed with the head of the bed elevated. R8 stated he was just waking up for the day and indicated he had wanted to sleep in. On 8/30/24 at 9:08 a.m., R8 was observed lying in bed. R8 was observed with the head of the bed elevated and had a breakfast tray in front of him.	F 686		

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F 686	Continued From page 105 On 8/28/2024 at 12:11 p.m., nursing assistant (NA)-B verified they are helping care for R8 that day. NA-B stated they get the information that is needed to care for a resident from the nursing assistant care sheets. NA-B stated they were unsure if R8 has a pressure injury or needs repositioning as the nursing assistant care sheet did not reflect this. On 8/30/24 at 9:10 a.m., NA-A verified they are familiar with R8. NA-A stated that nursing assistants get the information they need about residents from the nursing assistant care sheets and "could ask the nurse if needed." NA-A stated if a resident needs repositioning, it would be on the care sheet. NA-A verified that care sheet indicated "offer frequent repositioning (every 1-2 hours)." NA-A stated they were unsure if R8 had any pressure injuries. On 8/28/2024 at 11:18 a.m., registered nurse (RN)-C stated that if a resident has a pressure injury, the resident should be on at least every 2 hours repositioning, applying barrier bream, completing skin checks, and having them up and out of bed as much as possible. RN-C verified that R8 has a pressure injury. RN-C stated that sometimes R8 prefers to stay in bed but should still be repositioned to prevent pressure injuries. RN-C stated that R8 "is checked and changed at the start of the shift, before and after lunch and at the end of the day which is about every 2 hours." RN-C verified that R8 has a foley catheter (a flexible tube that drains urine from the bladder into a collection bag outside the body). RN-C was unsure if R8 had a pressure relieving device in his wheelchair but then after inquiry verified R8 did.	F 686		

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F 686	Continued From page 106 On 8/29/2024 at 12:29 p.m., RN-A verified that R8 was at very high risk for developing a pressure ulcer based on Braden Score. RN-A verified the care plan had been updated on 8/14/24 identifying R8 was at risk/developed a pressure ulcer after R8 had developed a pressure ulcer which was identified on 8/12/24 in a progress note. RN-A verified the wound care team started to follow R8 on 8/16/24 and complete the Skin and Wound Evaluations. RN-A stated they received an order on 8/13/24 for R8 to be followed by the wound care team. On 8/30/24 at 10:01 a.m., RN-A verified that they updated the nursing assistant care sheets last evening (8/29/24) to indicate, "offer frequent repositioning (every 1-2 hours)." RN-A verified the document did not indicate this previously. RN-A verified they updated the Kardex at the same time. On 8/29/24 at 3:29 p.m., director of nursing (DON) indicated that if a resident is at high risk for developing a pressure ulcer, they would be on a turning and reposition every 2 hours, have a standard reduction mattress on their bed if not an air mattress "as that might be indicated." DON indicated we would help ensure they are offloading, have an appropriate cushion in their wheelchair, and other preventive measure in place. DON verified this would on their care plan. A facility policy titled Pressure Ulcer Treatment, undated, indicated "this procedure is to provide guidelines for the care of existing pressure ulcers and the prevention of additional pressure ulcers."	F 686		
F 689 SS=E	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)	F 689		10/4/24

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F 689	Continued From page 107 §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure new, person-centered fall interventions were implemented to prevent further falls and potential injury for 1 of 1 residents (R28) reviewed for repeat falls. In addition, the facility failed to accurately and comprehensively assess for smoking practices for 1 of 1 residents (28) reviewed for smoking. In addition, the facility failed to ensure an overiszed and unsecured mattress was assessed for correct fit to a resident's bed for (R44) who was reviewed saftey hazards. Findings include: FALLS R28's admission MDS dated 6/4/24, indicated R28 had severely impaired cognition and had no rejection of care behaviors. The MDS indicated R28 was diagnosed with hypertension, diabetes, and osteomyelitis. The MDS indicated R28 used a walker and a wheelchair as mobility devices and required set-up help with toilet transfers, moderate assistance with walking ten feet, and was independent with wheelchair use. R28's care plan dated 6/24/24, indicated R28 was	F 689	F689-Free of Accidents Hazards/Supervision/Devices/MN Rule. 4658.0520 Sub.p.1 Concern: Mattress was not secured to bedframe, mattress did not properly fit bed frame; resident□s care plan did not indicate new interventions after falls; smoking assessments and careplan not matching; marijuana use, side effects of marijuana, storage of marijuana not care-planned; bed rail assessment did not include need for bed rail/ grab bar. Identification of other residents at risk "All residents with a moderate to high risk for falls "All residents that currently smoke cannabis "All residents with facility issued beds Corrective Measures: "Fall interventions for R28 are reviewed and updated to include new interventions related to ETOH use to address the root cause of previous falls. "R28 was assessed for safe smoking practices and care plan updated to include current smoking the use of cannabis. "R44 mattress was changed to the	

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F 689	Continued From page 108 a "high" risk for falls related to osteomyelitis (bone infection) and cellulitis (soft tissue infection or inflammation). The fall care plan included two interventions dated 6/24/24, anticipate and meet R28's needs and ensure R28's call light was within reach and encourage R28 to use it. R28's care plan dated 6/24/24, indicated R28 had a history of substance abuse. The care plan indicated if facility staff witnessed or suspected substance use, they were to start 15-minute safety checks and vital signs every two hours for 24 hours. The substance use care plan dated 6/24/24, indicated staff were to follow the facility policy related to resident substance abuse and report any abnormal behavior to the provider. The care plan did not include new (if any) fall interventions attempted after the fall on 7/5/24 and 7/14/24. R28's progress note dated 7/5/24 at 9:19 p.m., indicated R28 was found on the floor with his wheelchair on the side with a half-empty bottle of alcohol. The note indicated R28 was assessed and had no injuries, vital signs were "stable", and R28 was transferred to bed. Facility staff completed 15-minute checks on R28, and the director of nursing (DON) and the provider were notified. R28's progress note dated 7/6/24 at 1:59 a.m., indicated R28 had two abrasions on his scalp "from the fall". R28's progress note dated 7/9/24 at 10:59 a.m., indicated the interdisciplinary team (IDT) had reviewed R28's fall and R28 was "re-educated" on the risk of substance use and that it could cause serious harm. The note indicated the policy on substance abuse was reviewed.	F 689	appropriate size to fit the bed frame. "Residents with moderate to high risk for falls who have had at least one fall in the past 9 months with be reviewed for new interventions in place post fall incident. "Smoking assessments will be conducted on all residents to include asking specifically about cannabis use. "Residents that smoke cannabis will have a care plan revision to include the use of cannabis, safe smoking practices, and the risks verse benefits of choosing to smoke cannabis. "All the resident beds in the facility will be inspected for appropriate fit and size. "Smoking, bed inspection, and fall management will be reviewed and revised as necessary. "Education completed with nursing staff regarding fall management, smoking safety, and bed/mattress safety. Monitoring Mechanisms: "Post-Fall incidents will be audited 5x a week for new interventions x 90 days. "Residents that smoke will be randomly audited 5x for safe smoking practices for 30 days, then 3x week for 30 days, time 1x for 30 days. "Resident bed and mattress will be audited for proper fit and function 3x per week for 90 days. "Smoking, Bed safety, and Falls will be added to QAPI x 180 days then reviewed to determine if ongoing monitoring is needed. Date of Complaince 4PM 10-04-2024	

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F 689	Continued From page 109 R28's progress note dated 7/14/24 at 4:00 a.m., indicated R28 was found on the floor of his room near the bathroom. The note indicated R28 was "intoxicated with alcohol" and restless in bed before the fall. The note indicated no injuries were observed and the resident was helped back to bed and encouraged to call when he needed help. The note indicated the DON and "TCP" were notified. R28's progress note dated 7/15/24 at 8:30 a.m., indicated R28 endorsed left arm pain at a "7 or 8" and said it had been bothering him since his fall. R28's progress note dated 7/15/24 at 9:37 a.m., indicated the interdisciplinary team (IDT) had reviewed R28's fall and R28 was "extremely intoxicated" throughout the shift and had attempted to self-transfer and use the bathroom. The note indicated R28 was educated on abstaining from alcohol and requesting assistance while intoxicated. R28's medical record was reviewed and did not include any new person-centered fall interventions after R28's fall on 7/14/24. During an interview on 8/26/24 at 2:01 p.m., R28 stated he had fallen a couple of times at the facility while he was drinking. R28 stated after he fell, the facility had taken his bottle of alcohol and threatened to kick him out of the facility if he didn't stop drinking. R28 stated he did not remember them implementing any new interventions to make sure he was not falling while he was drinking. During an interview on 8/28/24 at 10:27 a.m., licensed practical nurse (LPN)-B stated she was	F 689		

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F 689	Continued From page 110 aware R28 fell a couple of times while was drinking at the facility and facility staff had tried to educate R28 that drinking "will cause problems" but R28 continued to consume alcohol. LPN-C stated she was unaware of what interventions, in addition to education, facility staff had attempted. During an interview on 8/28/24 at 12:05 p.m., the unit nurse manager (RN)-B stated she was aware of R28 falling in the past. RN-B stated both of his falls were related to alcohol use, so they had implemented vital sign monitoring and encouraged him to call when he needed assistance. RN-B stated facility staff had talked to R28 about his substance use but she was unsure what other interventions would have been helpful to prevent his falls because they were related to his drinking. RN-B stated she had not attempted any additional person-centered interventions to prevent further falls other than providing R28 education on substance use. During an interview on 8/30/24 at 8:23 a.m., the DON stated she had not been at the facility at the time of the fall, so she was unsure what, if any fall interventions had been attempted for R28. The DON stated she expected staff to review the falls, determine a root cause, review old fall interventions to determine effectiveness, and implement new interventions with every new fall to reduce the risk of further falls occurring. The facility's undated Falls and Fall Risk Managing policy indicated facility staff would identify fall interventions related to the resident's specific risk and causes to try to prevent and minimize the risk of falls. The policy indicated if falling reoccurs despite initial interventions, staff would implement additional or different	F 689		

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F 689	Continued From page 111 interventions or indicate why the current approach remained relevant. SMOKING R28's Smoking Review dated 6/3/24 at 8:22 a.m., indicated R28 did not currently smoke but had a "history of smoking related incidents". The review did not indicate what these incidents were. The review indicated R28 had no signs of confusion, could make himself understood, and could verbalize the smoking policy. The review included the answer, "no", to the question, had staff reviewed the policy related to smoking times and storage materials with the resident? The review included the answer, "N/A", to the question, was a care plan initiated or updated? The review had the following questions with no answer: - Can the resident verbalize or demonstrate an understanding of the living center ' s time and place to smoke? - Does the resident remain alert during the course of smoking at all times? - Does the resident have the ability to hold a cigarette safely without a device? - Does the resident have the ability to extinguish a cigarette safely? R28's medical record was reviewed and did not include further assessment of R28's safety while smoking. R28's care plan dated 6/24/24, did not address R28's smoking status or potential smoking needs. R28's provider note dated 7/30/24, indicated R28 had "ongoing marijuana use". During an interview on 8/26/24 at 2:08 p.m., R28	F 689		

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F 689	Continued From page 112 stated he smoked cannabis daily with a pipe since he was admitted to the facility a few months ago. R28 stated he did not recall any staff member observing him smoke but they knew he smoked. During an interview on 8/28/24 at 11:21 a.m., the infection preventionist (IP) and LPN-B stated they had both been previously aware that R28 smoked cannabis. LPN-B stated it was not something R28 hid or that was new for him. During an interview on 8/28/24 at 12:10 p.m., the unit manager, RN-B stated she was unaware that R28 smoked cannabis. RN-B stated the floor nurses were the ones who should have completed a smoking assessment, including observing R28 smoking cannabis to ensure he could do it safely. The facility's undated Smoking Policy indicating the interdisciplinary team would consider dexterity, vision, range of motion, and cognitive ability to determine if smoking restrictions were needed for a resident. The policy indicated the resident's smoking status and privileges would be reviewed correlating with the MDS schedule. UNSECURED MATTRESS R44's quarterly Minimum Data Set (MDS), dated 6/11/24, identified R44 admitted to the care center in August 2023, had severe cognitive impairment, and was independent with most mobility-related activities (i.e., transfer, ambulation). On 8/26/24 at 3:12 p.m., R44 was observed lying on his bed while in his room. The bed was positioned with the head next to a wall with space	F 689		

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F 689	Continued From page 113 to exit on both sides and multiple pairs of shoes were on the floor adjacent to the bed on the right (if lying in bed) side. The bed consisted of a metallic frame, however, the mattress was oversized and hung over the edge of the frame nearly six inches on the right side. The mattress lacked any visible secure fitting to the frame and moved easily when pushed with pressure in a side-to-side motion; and bend downward over the frame when pressed from the top on the right side. R44 was asked about his loose, unsecured mattress but merely responded, "Yea," followed by, "awhile," when asked how long his mattress had been like such. Further, the bed lacked any installed grab bars or side rails and when asked if he had sustained any falls from his bed R44 responded aloud, "I don't know about that." Immediately following, at 3:16 p.m., nursing assistant (NA)-BB was interviewed and verified they had worked with R44 prior on the overnight shift. NA-BB stated R44 often self transfers and walks in his room so, as a result, the staff "have to check on him." NA-BB observed the mattress in R44's room and verified it overhung the frame adding they recalled R44 had used the same bed and mattress for awhile. NA-BB stated the mattress looked as if it "might fall off the bed" if not centered nicely on the frame, and they pushed on it which caused it to slide around. NA-BB stated the nurses had never asked them to check or monitor the bed to ensure the mattress was secure or, at minimum, centered on the frame but added, "We [aides] have responsibility to check everything [too]." Further, NA-BB asked R44 aloud if he was moving his mattress around at all which R44 responded, "Yea," along with a dismissive motion of his hand. NA-B stated they were unsure if maintenance	F 689		

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F 689	Continued From page 114 was aware of the mattress being ill-fitting or not adding, "I work overnights." R44's most recent Bed Rail/Assist Bar Evaluation 021419-V1, dated 6/11/24, identified multiple questions to be answered by staff to complete the evaluation including what, if any, device was to be used, the resident' history of falls, and rationale for the device(s). The section to record what, if any, device was being requested was left blank, and the evaluation only outlined R44 expressed no desire for a device and did not have fluctuations in his level of consciousness or cognitive deficit (despite being identified as having severe cognitive impairment on the MDS). The remainder of the evaluation was left blank and not completed; nor was there any recorded evidence on it demonstrating the mattress and frame had been reviewed or inspected to ensure appropriate size and reduce the risk of falling from bed. R44's care plan, printed 8/29/24, identified R44 had an ADL self-care deficit due to dementia but was independent with transfers. The care plan outlined R44 was at risk for falls due to gait/balance problems and listed goals including, "The resident will be free of falls through the review date," along with interventions including anticipating and meeting his needs, ensuring the call light in within reach and having therapy treat as ordered. The care plan outlined R44 had sustained a fall on 3/14/24, but it lacked any information or rationale for the use of the over-sized mattress that was unsecured to the frame. R44's medical record was reviewed and lacked evidence rationale or, if needed, interventions to	F 689		

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F 689	Continued From page 115 ensure R44 remained safe despite the ongoing use of a mattress which was too large for the frame of the bed. On 8/26/24 at 6:05 p.m., the director of maintenance (DOM) was interviewed and observed R44's bed frame and mattress. DOM stated the mattress was "clearly not the right size" and others were available which would fit the frame better adding, "This shouldn't have been an issue at all [happened]." DOM stated their day was busy with "100 other things" happening and they were working on getting the staff to enter items, such as R44's mattress, into the work-order system to ensure it's addressed. DOM verified they inspect resident' beds on a routine basis but expressed it was typically only for residents with bed rails or bars attached adding, "That's something we need to implement then [all beds]." Further, DOM verified they would have been the department to change the bed, if notified, and nobody had updated them about it adding an over-sized mattress was a fall risk. DOM added, "He's going to fall off." When interviewed on 8/27/24 at 2:43 p.m., registered nurse manager (RN)-A stated maintenance was responsible to check and "ensure the bed is OK." However, if nursing had noticed issues with it, then a work order should have been done. RN-A verified they reviewed R44's medical record and were unable to locate rationale or evidence the bed and over-sized mattress had been addressed or assessed adding, "I didn't see anything about that." RN-A stated they had just observed the bed prior and "the mattress was sliding off" so they placed some Dycem (sticky fabric) underneath of it. RN-A verified the over-sized, unsecured mattress	F 689		

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F 689	Continued From page 116 was a safety hazard for R44 adding aloud, "He could slide off." A facility' provided Bed Safety policy, undated, identified the resident's sleeping area would be evaluated by the interdisciplinary team (IDT), and the care center would provide multiple approaches to prevent death or injury from it including, "Inspection ny maintenance staff of all beds and related equipment as part of our regular bed safety program to identifiy risks and problems including potential entrapment risks."	F 689		
F 693 SS=D	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced	F 693		10/4/24

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F 693	Continued From page 117 by: Based on observation, interview, and document review, the facility failed to ensure adequate cleaning of a feeding tube port (end of tube farthest from the resident) to prevent possible complications (i.e., infection) for 1 of 1 residents (R46) reviewed for tube feedings. Findings include: R46's admission Minimum Data Set (MDS) dated 5/2/24, indicated R46 had intact cognition and required substantial assistance for bed mobility, toileting, and bathing. The MDS indicated R46 received 51 percent (%) or more of their nutrition through a feeding tube. R46's medical diagnoses list, dated 4/26/24, indicated R46 was diagnosed with intestinal malabsorption and malnutrition. R46's Order Summary Report dated 7/11/24, indicated R46 received daily enteral tube feeding from 4:00 p.m. to 8:00 a.m., at a rate of 94 cubic centimeters (CC)/hour through a gastric tube. The order summary indicated nursing staff were to "cleanse g-tube site" two times a day as wound care. R46's medical record was reviewed and did not include documentation of cleansing of the gastric tube port. During an interview and observation on 8/27/24 at 8:36 a.m., R46 stated nursing staff "never" cleaned the port of his feeding tube and it had been dirty for a while. R46's tube feeding port was observed to have a black build-up noted on the inside of the port. During an interview and observation on 8/29/24 at	F 693	F693 Tube Feeding Mgmt./Restore Eating Skills/MN Rule 4658.0525 Subp.7-2930 Concern: Equipment and orders not provided to clean G-tube port (orders for care at meatus present). Identification of other residents at risk "All residents with internal tube feeding Corrective Measures: "Physician order requested for Pancreatic Lipase to clean/disinfect inside the gastric port of R46. "Nursing orders placed for R46 to monitor for buildup/discoloration inside gastric tube/port every shift. "All residents with internal feeding tubes will be reviewed for Pancreatic Lipase orders to disinfect/clean inside of gastric port as needed. "Nursing orders placed to monitor for buildup/discoloration inside gastric tube/port every shift. "Education with licensed nursing staff regarding tube feeding management. Monitoring Mechanisms: "Resident with internal feeding tubes will be audited for buildup/discoloration inside gastric tube/port 3x per week for 30 days, then 2x per week for 30 days, then 1x per week for 30 days. "Internal Tube feeding management will be added to QAPI x 180 days then reviewed to determine if ongoing monitoring is needed. Date of complaince 4pm 10-04-2024	

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F 693	Continued From page 118 12:00 p.m., R46 stated his feeding port was still "filthy" and needed to be cleaned. R46's tube feeding port was observed to have a black build-up noted on the inside of the port. Licensed Practical Nurse (LPN)-B stated she was the nurse in charge of R46's care and had noticed the black build-up inside of R46's port. LPN-B stated she thought the nursing staff "never" cleaned inside of R46's port as they did not have anything to clean it with. During an interview on 8/29/24 at 12: 44 p.m., the nurse manager for the unit (RN)-B stated she was unaware of the black build-up on R46's tube feeding port but would have expected nursing staff to notify her so they could find something to use to clean it. RN-B stated she would worry about a possible infection if the tube feeding port was not cleaned. The facility's undated Changing a Feeding Tube procedure was received but did not include instructions on when or how a feeding tube port should be cleaned.	F 693		
F 697 SS=D	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to comprehensively reassess and, if needed, implement additional	F 697	Citation F697: Pain Management Concern: Pain management assessment	10/4/24

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F 697	Continued From page 119 interventions to provide comfort for 1 of 2 residents (R7); and failed to adequately monitor pain to ensure comfort and intervention efficacy for 1 of 2 residents (R28) reviewed for pain management. Findings include: R7's admission Minimum Data Set (MDS), dated 5/23/24, identified R7 had moderate cognitive impairment but demonstrated no delusional thinking during the review period. The MDS outlined R7 consumed scheduled and as-needed (PRN) pain medications but had no non-pharmacological interventions for it, and a corresponding pain interview identified R7 reported pain which occurred on a frequent basis with a listed rating, "7 [/10]." R7's Pain Interview (MDS) with Pain Management Review, dated 5/21/24, identified R7 frequently reported pain within the last five day period which was making it hard to sleep and causing her to limit her day-to-day activities. The evaluation listed R7 reported a pain intensity of, "7 [/10]," and recorded vocal complaints of pain as an indicator with it happening, "Indicators of pain (1 to 2 days)." A section was listed labeled, "Pain Management," with corresponding sections to record the scheduled, as needed, and non-pharmacological interventions. These were answered with, "Refused the medication," and, "Declined," and, "Ensure the patient was comfortable in bed," respectively. The evaluation concluded, "Patient was offered pain medication but she refused." The evaluation lacked what options had been offered or discussed with R7; nor evidence other interventions (i.e., non-pharmacological, referrals) had been done.	F 697	follow-up not documented for reports of pain which limited day to day activities. Charting not in evidence for pharmacological and non-pharmacological pain interventions. F697-D Screening and follow-up on Pain All current residents are audited for pain using the “Pain interview (MDS) with pain management review” assessment Identification of other residents at risk •All residents are at risk of pain Corrective Measures: •R7 will be reassessed for pain management upon return from outpatient hospitalization. •R7 will be reassessed for pain management •Pain monitoring put in place before and after the administration of PRN pain medication for R7 •Pain monitoring put in place q shift for R7 •Physician will be updated on R7 ongoing complaint of pain with medication reductions. •Non-pharma logical pain management interventions will be put in place for pain management •R28 will be reassessed for pain	

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F 697	Continued From page 120 On 8/26/24 at 2:49 p.m., R7 was observed seated in a reclined, high-back wheelchair in her room and displayed no physical signs or symptoms of pain (i.e., grimace, moaning). R7 was interviewed and expressed she had significant edema and pain in her legs which had been ongoing. R7 stated she was unsure what, if any, pain medication she consumed for her pain saying aloud, "I don't know what they give me," adding further, "I don't think they give me nothing." R7 reiterated her pain and thought she should be getting oxycodone for it but didn't feel she was as the pain was "getting worse sometimes" and left her legs "just numb." R7 stated she reported her pain to "that man" who comes and asks about it whom she thought was "a foot doctor" but wasn't sure. R7 rated her pain currently at "three" but said it "gets up to a 10." Further, R7 stated the care center staff rarely, if ever, did non-pharmacological interventions for her pain or ever asked her about her goals of care with it adding, "They ain't talked to me about 'nothin." R7's care plan, printed 8/27/24, identified R7 had chronic pain due to Lupus (illness; occurs when the immune system attacks healthy tissues/organs) and multiple goals were listed for R7 all of which were labeled, "OVERDUE," including not having interruption in normal activities due to pain and having a decrease in behaviors with inadequate pain control (i.e., irritability, agitation). The plan listed several interventions to help meet these goals including monitoring for side effects of pain medications, monitoring and reporting symptoms of pain to the nurse, and observe or report changes in her usual routine or sleep patterns.	F 697	management •Pain monitoring put in place before and after the administration of PRN pain medication for R28 •Pain monitoring put in place q shift for R28 •Physician updated on R28 ongoing complaint of pain with medication reductions. •Non-pharma logical pain management interventions put in place for pain •Education will be completed with licensed staff and trained medication administrator in Pain management •All residents will be reassessed for pain management with referrals as appropriate to the pain management team and PCP •All residents will have pain screening scheduled every shift to monitor baseline pain levels. •Residents with PRN pain medication will have pain monitoring put in place before and after the administration of PRN pain to monitor effectiveness. •All residents will have non-pharma logical pain management interventions put in place. Monitoring Mechanisms:	

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F 697	Continued From page 121 R7's Physician Order, dated 8/2/24, identified the physician wrote to discontinue R7's current oxycodone (narcotic pain medication) order and start, "Oxycodone 5 mg [milligrams] ... BID [twice daily] PRN [as needed]." Further, R7's subsequent Physician Order, dated 8/10/24, identified the physician wrote to discontinue the previous order (dated 8/2/24) and start, "Oxycodone 5 mg ... QD [daily] PRN." R7's Medication Administration Record (MAR), dated 8/2024, identified multiple orders for R7's oxycodone to reflect the ongoing, changing physician orders. The MAR outlined a total of seven doses of the PRN narcotic had been administered since the order was last revised and lowered on 8/10/24, with each having a corresponding "Pain Level" recorded. These recorded levels ranged from one (1) to nine (9) with one dose being recorded, "I [ineffective]." R7's EMR had a subsequent Pain Interview (MDS) with Pain Management Review, dated 8/23/24, loaded but identified the evaluation was unsigned with dictation reading, "Section Status: In Progress." The evaluation outlined R7 reported no pain or hurting within the last five days, however, the next question which asked, "How much of the time have you experienced pain or hurting over the last 5 days?[,]" was recorded with a response, "2. Frequently." The evaluation outlined R7 reported pain still making it hard to sleep at night and causing limitations to her day-to-day activities with a rating recorded, "3 [/10]." The evaluation section labeled, "Pain Management," was left almost entirely blank and not completed with only one sentence placed reading, "Gave fluids, ice pack." The record lacked any review of R7's recent medication	F 697	•Residents will be randomly audited 5x per week for pain management interventions and effectiveness x 30 days, then 3x per week for 30 days, and 2x per week for 30 days. •Residents identified with moderate to severe pain will be added to QAPI x 90 days then reviewed to determine if ongoing monitoring is needed Date of complaince 4pm 10-04-2024	

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F 697	Continued From page 122 changes or input from R7 if these were effective for her pain management goals. When interviewed on 8/28/24 at 9:11 a.m., trained medication aide (TMA)-A stated they had worked with R7 multiple times prior and described her as "a little confused" but was "majority of the time be on point." TMA-A explained R7 needed "hands on" help with most cares and did, at times, complain about pain adding, "She'll let you know when she's hurting." TMA-A stated they felt R7's pain often resulted from bad positioning while in bed and, at times, she would report "her butt hurt" and ask for pain medications if "really in pain." TMA-A stated she felt, overall, R7's pain medications were helping as R7 used to "cry out" with pain and doesn't as much anymore. TMA-A stated the MAR was used to track pain ratings and the nurses were supposed to be checking and assessing them adding, "The nurse do." TMA-A stated they had never really done much, if any, non-pharmacological interventions for R7 mostly "just meds." R7's entire medical record was reviewed and lacked evidence R7 had been comprehensively re-assessed to ensure the revised medication schedules were effective or what, if any, additional interventions were needed to ensure comfort despite the physician actively adjusting down R7's narcotic and R7 still having pain was witnessed by direct care staff and recorded on the MAR. On 8/29/24 at 9:29 a.m., registered nurse manager (RN)-A was interviewed and verified they had reviewed R7's medical record. RN-A explained a pain re-assessment was usually done after medications are adjusted but there was not	F 697		

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F 697	Continued From page 123 "a time frame" for when per policy or protocol. RN-A stated it was likely "good practice" to do it timely to ensure pain management program is effective and working. RN-A acknowledged the loaded pain assessment in the EMR and verified it was not completed adding, "I will have to follow up with the nurse." RN-A verified the medical record lacked a documented re-assessment of R7's pain after the medication was adjusted on 8/10/24, and they expressed it should have been re-assessed to ensure "the regimen is working and the resident is comfortable." R28's admission MDS dated 6/4/24, indicated R28 had severely impaired cognition and had no rejection of care behaviors. The MDS indicated R28 was diagnosed with high blood pressure, diabetes, and osteomyelitis (infection of the bone). The MDS indicated R28 required set-up help with toilet transfers, moderate assistance with walking ten feet, and was independent with wheelchair use. The MDS indicated R28 had not been on a scheduled pain medication regimen or received non-medication intervention for pain but had received as-needed (PRN) pain medication during the look-back period (LBP). The MDS pain assessment indicated R28 had pain "almost constantly" with an intensity of seven out of ten. R28's Pain Interview with Pain Management Review dated 6/2/24, indicated R28 had pain almost constantly over the past five days with an intensity of seven out of ten. The review indicated staff had noticed vocal complaints of pain from R28 daily. The review indicated R28 received scheduled pain medication and the form had a space for the facility staff member to describe the treatment, any side effects, and effectiveness that	F 697		

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F 697	Continued From page 124 was left blank. R28's care plan dated 6/24/24, indicated R28 was on pain medication therapy related to osteomyelitis with a goal of R28 not having any discomfort or adverse side effects of the pain medication. The care plan indicated staff were to administer the medications as ordered by the provider and monitor and document the side effects and effectiveness of the medication every shift. R28's Medication Administration Record (MAR) dated 8/3/24 through 8/27/24, indicated R28 received 1000 milligrams (mg) of acetaminophen (a pain medication) (approximately) three times a day. The MAR did not include pain assessments during this period. R28's MAR included an order for 150 mg of Lyrica (an anticonvulsant that can be used for nerve pain) (approximately) two times a day. R28's medical record dated 8/3/24 through 8/27/24 was reviewed and did not indicate R28's pain was assessed before administering acetaminophen to develop a baseline or after administration to determine medication effectiveness. R28's provider note dated 8/23/24, indicated R28 had a "chief complaint" of right foot/back pain. The note indicated R28 was to continue the acetaminophen and Lyrica for pain as needed. The note indicated staff were to "closely monitor" R28 for signs of pain and notify the provider of new-onset pain symptoms. R28's Pain Level Summary printed on 8/27/24, indicated the last recorded pain score was zero	F 697		

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F 697	Continued From page 125 on 8/2/24. During an observation and interview on 8/26/24 at 2:06 p.m., R28 was observed sitting in his wheelchair in his room with his right foot wrapped in a gauze dressing. R28 stated he was "always" in pain, especially in his right foot, and the pain was consistently at a seven out of ten. R28 said his pain was "pretty bad" and "constant" but the staff did not ask him about it before or after giving him his acetaminophen. During an interview on 8/28/24 at 10:51 a.m., licensed practical nurse (LPN)-B stated R28 had a history of pain in his right foot related to an amputation of his toe and a wound he had from that. LPN-B stated she had reviewed the medical record and did not see evidence that the nursing staff had been assessing his pain. During an interview on 8/28/24 at 12:14 p.m., the unit nurse manager (RN)-B stated nursing staff were expected to assess R28's pain every shift and reassess R28's pain after administering his acetaminophen to ensure it was effectively managing his pain. RN-B stated pain should be recorded in the MAR but after reviewing the medical record, she did not think this was being completed. The facility's undated Pain Assessment and Management policy indicated facility staff should re-assess resident pain and consequences of pain at least every shift for acute pain or significant changes in levels of chronic pain and at least weekly in stable chronic pain. The policy indicated facility staff should implement the medication regimen as ordered, and carefully document the "results of the interventions".	F 697		

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F 699 SS=D	Trauma Informed Care CFR(s): 483.25(m) §483.25(m) Trauma-informed care The facility must ensure that residents who are trauma survivors receive culturally competent, trauma-informed care in accordance with professional standards of practice and accounting for residents' experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to comprehensively assess for a history of past trauma and implement care plan interventions to identify triggers for 1 of 1 residents (R46) reviewed for trauma-informed care. Findings include: R46's admission Minimum Data Set (MDS) dated 5/2/24, indicated R46 had intact cognition. R46's medical diagnoses list dated 4/19/24, indicated R46 was diagnosed with anxiety, suicidal ideation, and bipolar disorder (a mental health condition that causes extreme mood swings). R46's diagnoses list did not include PTSD (Post-Traumatic Stress Disorder). R46's Psychiatric Evaluation provider note dated 5/23/24, indicated R46 was diagnosed with anxiety, bipolar disorder, and PTSD. The note discussed R46's history and possible causative factors of their PTSD. R46's care plan dated 4/30/24, indicated R46 had a "mood problem" related to bipolar disorder,	F 699	Citation F699: Trauma Informed Care Concern: Trauma informed care-assessment of PTSD triggers not in evidence. Identification of other residents at risk •All residents are at risk of trauma Corrective Measures: •R46 is assessed for a history of trauma using the Trauma Informed Care History assessment tool. •R46 care plan will be revised to include a history of trauma, triggers for trauma related events, and interventions. •R46 will be monitored every shift for signs of post-traumatic stress disorder. All residents will be assessed for a history of trauma, using the Trauma Informed Care History assessment tool. •Identified residents with a history of trauma will undergo a review and revision	10/4/24

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F 699	Continued From page 127 anxiety, and depression. The care plan listed interventions such as behavioral health consults as needed, monitoring mood patterns, and assisting the resident to identify strengths and positive coping mechanisms. The care plan was reviewed and did not address R646's history of PTSD, possible triggers for re-traumatization from the PTSD, or care interventions related to R46's PTSD. During an interview on 8/26/24 at 2:36 p.m., R46 stated they had discussed their trauma and PTSD history with their mental health provider outside of the facility but no one at the facility had followed up or asked about possible triggers for re-traumatization's. R46 stated their triggers for re-traumatization included confrontation related to their past occupation. During an interview on 8/28/24 at 10:22 a.m., licensed practical nurse (LPN)-C stated she thought R46 had a history of trauma related to past incarceration but was unsure when this was assessed or where this was documented. LPN-C stated she was unsure what triggers for re-traumatization R46 had and did not think this was documented in the medical record. During an interview on 8/28/24 at 12:12 p.m., the unit nurse manager (RN)-B stated she thought trauma was discussed with residents "at some point" during their stay but did not think they had a process to document these discussions or possible interventions to prevent re-traumatization for residents with PTSD. The facility's Trauma-Informed and Culturally Competent Care policy dated 11/23, indicated upon admission facility staff should assess for a	F 699	to the care plan to include a history of trauma, triggers for trauma related events, and interventions. •Identified residents with a history of trauma will be monitored every shift for signs of post-traumatic stress disorder. •Education will be completed with all nursing staff, social service, and activities staff regarding the four types of trauma, acute, chronic, complex, system induced, and five principles of Trauma-Informed Care. Monitoring mechanisms •Random audits will be performed on residents identified with a history of trauma for frequency of events, and effectiveness of interventions; 5x per week for x 30 days, then 3x per week for 30 days, and 2x per week for 30 days •Admission assessment grid will be updated to include the PCC “social service - Trauma informed care history” assessment tool •Trauma informed care will be completed annually for nursing, activities, and social service teams. •Trauma informed care will be added to QAPI x 180 days then reviewed to determine if ongoing monitoring is needed.	

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	245289	A. BUILDING _____ B. WING _____	C 08/30/2024

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F 699	Continued From page 128 resident history of trauma and become aware of any triggers for re-traumatization for the resident. The policy indicated a care plan should have been developed to address past trauma and identify and decrease exposure to potential triggers.	F 699	Date of complaince 4pm 10-04-2024	
F 732 SS=C	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to	F 732		10/4/24

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F 732	Continued From page 129 exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure the posted nurse staffing information (i.e., staff posting) displayed the total number and actual hours of the licensed and registered staff for each shift on a daily basis. This had potential to affect all 53 residents or visitors who wished to review the information. Findings include: On 8/26/24 at 12:38 p.m., a tour was completed of the main reception area of the nursing home immediately after the survey team entrance. A white-colored paper was hung on a gray bulletin board adjacent to the elevator which was labeled, "The Terrace At Crystal Direct Care Staff Tools," and dated, "08/26/24." The form had three designated shifts listed including, "Day Shift," and, "PM Shift," and, "NOC [night] Shift," along with each shift having four lines which displayed the total number of hours for registered nurses (RN), licensed practical nurses (LPN), nursing assistant (CNA) and trained medication aide (TMA). At the bottom, the form had a cumulative total of direct care staff hours which had, "200" written in blue ink; along with a heading reading, "Census," which had blue writing, "53." However, the completed form lacked any dictation or instruction on what each shifts' actual hours were	F 732	F732-Posted Nurse Staffing Information Concern: Posted nurse staffing information did not include correct format for LPN, RN, and CNA hours Immediate Correction: "Facility posted nurse staffing information was updated to include facility name, date, and total number of actual hours of worked by the following categories licensed and unlicensed nursing staff directly responsible for nursing care per shift. Identification of other residents at risk "All residents may be impacted by posted nurse staffing information Corrective Measures: "Facility posted nurse staffing information was updated to include facility name, date, and total number of actual hours of worked by the following categories licensed and unlicensed nursing staff directly responsible for nursing care per shift. "Receptionist and administrative team will be educated on the requirements of Nurse Posted Nurse Staffing Information. Monitoring Mechanisms: "Posted Nursing Staffing information will be audited 5x days per week x 30 days, 3x per week x 30 days, then 2x per week	

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F 732	Continued From page 130 (e.g., 6:00 a.m. to 2:30 p.m.) or number of staff which made up each respective total hours allotment (e.g., three LPN(s) constituted the 36 hours listed). When interviewed on 8/26/24 at 1:00 p.m., receptionist (RCP)-A stated they had worked at the campus for several years and were responsible to hang the posting every morning. RCP-A verified the displayed posting on the gray bulletin board was the only place the information was located, and they had been using the same format on the signage for "about four months" now since they switched it as the previous format didn't have the census listed and had the wrong facility' name. RCP-A stated the administrator was aware the form was changed and provided no input on it when shown months prior. On 8/27/24 at 8:25 a.m., the administrator was interviewed and reviewed the displayed format of the posting. He acknowledged it lacked actual hours or numbers of the staff on it and asked aloud to RCP-A about the form. RCP-A verified the format was changed and, again, explained it was due to a lack of census and wrong facility' name displayed on the old one. The administrator stated the previous survey team didn't mention anything about it when they had been there for a re-visit a few months prior so he was unaware it was out of compliance with the requirements. Further, the administrator stated they would revise the format and verified the actual hours and number of staff should be displayed so people reading it, including residents and families, were aware of the campus staffing levels. A facility' Posting Direct Care Daily Staffing	F 732	x 30 days. "Posted Nursing Staffing information will be added to QAPI x 180 days then reviewed to determine if ongoing monitoring is needed. Date of complaince 4pm 10-04-2024	

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F 732	Continued From page 131 Numbers policy, dated 8/2024, identified the care center would post the number of nursing personnel responsible for providing direct care on a daily basis. The posting would include the actual time worked during the shift for each category and type of nursing staff along with the total number of licensed and unlicensed staff for each shift.	F 732		
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the development of parameters for administration of high blood	F 757	F757-D Drug regimen free from unnecessary drugs/MN Rule 4658 1315 Subp.2	10/4/24

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F 757	Continued From page 132 pressure medication was assessed and implemented with blood pressure monitoring to ensure the parameters were met, if needed, to decrease the risk for complications for 1 of 5 residents (R28) reviewed for unnecessary medication use. Findings include: R28's admission MDS dated 6/4/24, indicated R28 had severely impaired cognition and had no rejection of care behaviors. The MDS indicated R28 was diagnosed with hypertension (high blood pressure), diabetes, and osteomyelitis (infection of the bone). The MDS indicated R28 used a walker and a wheelchair as mobility devices and required set-up help with toilet transfers, moderate assistance with walking ten feet, and was independent with wheelchair use. R28's care plan dated 6/24/24, indicated R28 was a "high" risk for falls related to osteomyelitis and cellulitis (soft tissue infection or inflammation). The care plan did not include antihypertensive (high blood pressure medication) medication use and required monitoring. R28's progress note dated 7/6/24 at 1:59 a.m., indicated R28's blood pressure was measured post-fall and was 151/80. R28's Order Summary Report dated 7/9/24, indicated R28 received 100 milligrams (mg) of metoprolol (an antihypertension medication) two times a day for hypertension. The order did not include parameters indicating when the medication should be held related to blood pressure or heart rate.	F 757	Concern: BP not assessed and BP parameters not in place for resident's HTN medication Identification of other residents at risk •All facility residents taking antihypertensive medications are at risk Corrective Measures: •Education will be completed with all licensed staff regarding medication monitoring •Care plan review and revision will be completed for R28 to include hypertension, and appropriate interventions. •Blood Pressure monitoring will be added before the administration of antihypertensive medication. •Parameters to hold blood pressure medication based on BP reading were requested for R28. •Residents identified as having a diagnosis of HTN and/or have a current order for antihypertensive medications will undergo Care Plan review and revision as necessary to include a diagnosis of HTN, and management interventions. •Residents identified as having a diagnosis of HTN and/or have a current order for antihypertensive medications will have monitoring orders to check blood pressure before the administration of	

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F 757	Continued From page 133 R28's progress note dated 7/14/24 at 4:00 a.m., indicated R28's blood pressure was measured post-fall and was 134/50. R28's progress note dated 8/3/24 at 10:02 p.m., indicated R28 blood pressure was taken related to alcohol intoxication and was 125/64. R28's Medication Administration Record (MAR) dated 8/1/24 through 8/27/24, indicated R28 had received metoprolol (approximately) twice a day during this period but did not include blood pressure measurements taken before metoprolol administration. R28's Blood Pressure Summary with a print date of 8/29/24, identified R28's collected blood pressures for the past several months with the last blood pressure measurement dated 7/5/24. The summary included three blood pressure measurements since admission ranging from 117-131/58-73 mmHg. During an interview on 8/29/24 at 10:21 a.m., licensed practical nurse (LPN)-C stated she had administered R28's blood pressure medication this morning. LPN-C stated she was unsure what his blood pressure was this morning or if it was safe to administer the medication as she had not measured R28's blood pressure. LPN-C stated the electronic medical record (EMR) notified her when she needed to take a resident's blood pressure and it did not for R28, so she had not taken it. LPN-C stated she was unsure why his metoprolol order did not include this notification to take his blood pressure or tell her when she should hold the medication. During an interview on 8/29/24 at 11:04 a.m., the	F 757	antihypertensive medication. •Request for parameters to hold blood pressure medication will be requested for all residents. •Policy and procedure surrounding the management of HTN will be reviewed and revised as necessary. Monitoring Mechanisms: •Residents currently receiving antihypertensive medications will be randomly audited 5x per week x 30 days, then 3x per week 30 days, then 2x per week for 30 days for a total of 90 days. •Medication monitoring will be added to QAPI x 180 days then reviewed to determine if ongoing monitoring is needed.	

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F 757	Continued From page 134 unit nurse manager (RN)-B stated she expected nursing staff to measure R28's blood pressure before giving the metoprolol to ensure R28's safety. RN-B stated she expected the provider to include parameters with the metoprolol order so nursing staff would know when it was unsafe to give the medication and when they needed to notify the provide of blood pressure readings. RN-B stated she expected nursing staff to document blood pressure measurements taken prior to administering antihypertensives in the MAR. During an interview on 8/29/24 at 2:31 p.m., nurse practitioner (NP)-A stated she expected staff to take R28's blood pressure before administering his metoprolol to ensure R28's blood pressure did not drop lower than desired causing possible safety issues. NP-A stated she would look at R28's metoprolol order as she expected parameters for when nursing staff should hold the medication and notify her and she was unsure why that was not added. The facility's undated Hypertension Clinical Protocol indicated blood pressure should be monitored over time and trends or patterns should be responded to. The protocol indicated a resident's "blood pressure control" should be monitored "periodically" but did not give a specific recommendation for how often blood pressure should be monitored for a resident on antihypertension medication.	F 757		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that	F 758		10/4/24

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F 758	Continued From page 135 affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order.	F 758		

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F 758	Continued From page 136 §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure appropriate side effect monitoring was completed in accordance with the standard of care for antipsychotic medication (group of medications used to treat psychosis) use for 1 of 5 residents (R28) reviewed for unnecessary medications. Findings include: A National Library of Medicine (NIH) Management of Common Adverse Effects of Antipsychotic Medication article, dated 9/2018, outlined, "All antipsychotics carry some risk of orthostatic hypotension ... [which can] lead to dizziness, syncope, falls ... it should be evaluated by both history and measurement ... Risk factors include systemic diseases causing autonomic (central nervous system) instability (e.g., diabetes, alcohol dependence, Parkinson's disease), dehydration, drug-drug interactions, and age." R28's admission Minimum Data Set (MDS) dated 6/4/24, indicated R28 had severely impaired cognition and had no rejection of care behaviors. The MDS indicated R28 was diagnosed with hypertension (high blood pressure), diabetes, and osteomyelitis (infection of the bone). The MDS indicated R28 used a walker and a wheelchair as mobility devices and required set-up help with toilet transfers, moderate assistance with walking	F 758	F758-Free from Unnecessary Psychotropic Meds/PRN Use Concern: Resident with daily use of psychotropic medication lacked monitoring for orthostatic hypertension as a known possible side effect of psychotropics. Identification of other residents at risk "All residents currently receiving scheduled psychotropic medications Corrective Measures: "Education for licensed nursing staff r/t psychotropic medication monitoring. "R28 is assessed for orthostatic hypotension, and results documented, and physician updated via voicemail. "Nursing order for monthly orthostatic blood pressure checks added to R28 physician orders for ongoing monitoring. "Care plan review and revision will be completed on all residents taking psychotropic medications for appropriate side effect monitoring including orthostatic hypertension. "Residents currently receiving scheduled psychotropic medications will be reviewed for current orders and documentation of orthostatic blood pressure monitoring monthly, and documentation of completion or contraindication. "Orders for orthostatic hypertension	

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F 758	Continued From page 137 ten feet, and was independent with wheelchair use. The MDS indicated R28 took antipsychotic, antidepressant, and opioid (narcotic) medications. R28's care plan dated 6/24/24, indicated R28 was a "high" risk for falls related to osteomyelitis and cellulitis (soft tissue infection or inflammation). The fall care plan included two interventions dated 6/24/24, anticipate and meet R28's needs and ensure R28's call light was within reach and encourage R28 to use it. R28's care plan dated 6/24/24, indicated R24 had a history of an alcohol use disorder. R28's Blood Pressure Summary with a print date of 8/29/24, identified R28's collected blood pressures for the past several months and included three measurements. The data included the date, time collected, blood pressure, and patient position at the time of collection (i.e., lying, sitting). R28's blood pressure ranged from 117-131/58-73 millimeters mercury (mmHg) over the past months; however, the report lacked evidence that R28's orthostatic blood pressures (i.e., lying, sitting, standing collected within minutes of each other) had been collected since admission. R28's progress note dated 7/6/24 at 1:59 a.m., indicated R28 had two abrasions on his scalp "from the fall". R28's Order Summary Report dated 7/9/24, indicated R28 received 300 milligrams (mg) of quetiapine (an antipsychotic medication) daily for major depression with psychotic features. The report included an order dated 5/29/24 for antipsychotic medication monitoring for potential side effects such as hypotension, sedation,	F 758	monitoring will be added to all residents taking scheduled psychotropic medications. Monitoring Mechanisms: "Random audits of residents currently receiving psychotropic medications will be audited 4x per week x 30 days, then 3x per week x 30 days, then 2x per week x 30day for side effects. "Psychotropic medications will be monitored via QAPI x 180 days then reviewed to determine if ongoing monitoring is needed. Date of Complaince 4PM 10-04-2024	

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F 758	Continued From page 138 drowsiness, increased falls, etc. The report included an order dated 5/29/24, that facility staff may utilize house standing orders. The report included an order with the start date of 8/29/24 to obtain orthostatic blood pressure due to antipsychotic medication use. R28's Standing Orders dated 2024, indicated facility staff should measure monthly orthostatic blood pressure monitoring for residents on antipsychotic medications. R28's medical record was reviewed and did not include orthostatic blood pressure measurements. During an interview on 8/29/24 at 2:02 p.m., the consulting pharmacist (CP) stated orthostatic hypotension was a possible side effect of antipsychotic use and she expected nursing staff to monitor this "routinely" especially for a resident with a history of falls. During an interview on 8/29/24 at 11:09 a.m., the unit nurse manager (RN)-B stated she expected nursing staff to measure orthostatic blood pressures monthly for residents on antipsychotic medication. RN-B stated after reviewing the medical record, she did not see that this had been completed. The facility's undated Antipsychotic Medication Use policy indicated nursing staff would monitor for and report any of the following side effects including orthostatic hypotension, blurred vision, sedation, etc., for residents consuming antipsychotic medications.	F 758		
F 791 SS=D	Routine/Emergency Dental Srvcs in NFs	F 791		10/4/24

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F 791	Continued From page 139 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, 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	F 791		

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F 791	Continued From page 140 §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 needs were assessed, offered and, if needed, referred to appropriate dental services in a timely manner for 2 of 3 residents (R7, R28) reviewed for dental care. Findings include: R7's admission Minimum Data Set (MDS), dated 5/23/24, identified R7 admitted to the care center from the hospital and had moderate cognitive impairment but no delusional thinking. Further, the MDS outlined "Section L - Oral/Dental Status," which identified R7 had no natural teeth but did have mouth or facial pain or difficulty chewing. R7's Clinical Census, printed 8/29/24, identified R7's current payer source as, "Minnesota Medicaid." On 8/26/24 at 2:40 p.m., R7 was observed seated in a high-back wheelchair in her room with her family member (FM)-G present. Immediately next to her, a bedside table was present which had various items sitting on it including a cup filled with water and an upper denture plate in it. R7 stated she had no bottom dentures and needed to see a dentist about getting new dentures made adding, "I'd like to see a dentist." R7 stated her dentures caused her gums to hurt but nobody from the care center had offered or helped her to set up a dental visit yet despite her being there	F 791	F791-Routine Emergency Dental Services in NFs/ MN Rule 4658.0725 Subp.2-21330 Concern: Documentation of routine or emergency dental appointments not in evidence, edentulous resident with only top plate had no documentation of being offered dental appointment. Identification of other residents at risk "All residents are potentially at risk for dental services Corrective Measures: "Request made to Health drive for in-house dental service contract for facility residents. "R28& R7 Care plan is reviewed and revised for interventions r/t Dysphagia and Oral/Dental needs. "Review policies and procedures related to Dental Services and revise as necessary. "All residents will be assessed/reassessed for dental needs/services using the Oral/Dental Observation. "Residents identified as requiring dental services will be referred and scheduled with the first available appointment or sent for emergency services as appropriate. "Education for nursing staff regarding the accuracy of Oral/Dental Observation/assessment, dysphagia	

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F 791	Continued From page 141 several months. FM-G verified no dental appointments had been offered and added, "[R7] never seen a dentist." R7's Nurse Admission/Readmission 07192021, dated 5/20/24, identified R7 admitted from the hospital on the same date and listed a section labeled, "Oral Status," which outlined R7 as edentulous (no natural teeth) and having broken or missing teeth on both her upper and lower palate. The section continued and provided spacing to record what, if any, dentures were used and this was answered with a checkmark placed, "8. None." The evaluation lacked evidence R7 was asked or offered a dental appointment despite having no teeth or dentures present. However, a subsequent progress note, dated 5/21/24, identified R7's family member brought in her upper denture and added, "[They] arrived when patient had just c/o [complained] something stuck on her throat, she added that it happens when she eats without dentures ... found she had pocketed food on the side of her mouth ..." In addition, R7's care plan, printed 8/27/24, identified no focus or problem statements or interventions for R7's dental needs despite having no natural teeth and being found to pocket food if eating without them. R7's subsequent Twin Cities Physician note, dated 6/5/24, identified R7 as having dysphagia (difficulty swallowing) and listed an order which read, "OK for dentist eval and treat r/t [related to] obtaining dentures." The note had hand-written notation on the bottom which read, "Confirmed 6/6/24 CN."	F 791	interventions, and the need for dental services Monitoring Mechanisms: "Oral/Dental Observations will be randomly audited for accuracy 4x per week for 30 days, 3x week for days, 2x per week x30 days. "Residents requiring dental services will be monitored weekly x 90 days. "Resident dental services will be monitored via QAPI x 180 days then reviewed to determine if ongoing monitoring is needed. Date of complaince 4PM 10-04-2024	

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F 791	Continued From page 142 A subsequent Oral/Dental Observation (Unscheduled), dated 8/23/24, was loaded in the electronic medical record (EMR) which indicated the evaluation as signed but unlocked. The evaluation outlined R7 used upper dentures which fit well but then recorded a, "1. Yes," response to questions asking if they were loose and broken. The evaluation continued and outlined R7 had her own teeth which also were recorded as broken, missing and loose but without obvious cavities. The evaluation outlined an oral exam was not completed with an option selected, "2) Uncooperative," and a date of last dental examination or offer of one as, "8/31/2024 [date not yet reached at time of survey]." On 8/28/24 at 9:11 a.m., trained medication aide (TMA)-A stated they had worked with R7 multiple times and described her as being "a little confused" but "a majority of time [she] be on point." TMA-A stated any appointments needed were scheduled by health unit coordinator (HUC)-A. TMA-A stated she had never heard any complaints about dental or wanting dentures from R7, but expressed any evaluation or asking of the need for an appointment would be the nurses' responsibility adding, "The nurse does that." R7's medical record was reviewed and lacked evidence a dental appointment had been offered or arranged for R7 despite the physician referral from June 2024, and R7 being evaluated as having loose or broken dentures on 8/23/24. When interviewed on 8/28/24 at 12:35 p.m., HUC-A verified they handled and, if needed, scheduled both in-house services and outside appointments. HUC-A stated they were aware of the dental referral for R7 from back in June 2024	F 791		

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F 791	Continued From page 143 but she had "been in and out of the hospital" since then so it had not been scheduled yet. HUC-A explained R7 would likely need to have an outside appointment as the facility didn't have in-house dental services and, in order to proceed, they needed a registration form completed but it wasn't done yet. HUC-A stated the care center didn't have a social worker for a period of time and that may have contributed to it not getting done. HUC-A stated they would circle back and follow-up on the dental appointment now. On 8/29/24 at 9:29 a.m., registered nurse manager (RN)-A was interviewed and verified they had reviewed R7's medical record. RN-A recalled R7's dental referral from back in June 2024, and expressed HUC-A had "said she was working on scheduling it," adding they had asked HUC-A about it again but "not recently." RN-A verified HUC-A was responsible to schedule dental appointments and acknowledged the record lacked evidence an appointment was made or rationale why it had been delayed adding, "No, I don't [see anything]." RN-A stated she just spoke with HUC-A "last week" about making sure a note gets entered into the computer with appointments moving forward but verified dental needs and appointments should be addressed "as soon as possible" to ensure no mouth pain or troubles chewing. R28's admission MDS dated 6/4/24, indicated R28 had severely impaired cognition and had no rejection of care behaviors. The MDS indicated R28 was diagnosed with high blood pressure, diabetes, and osteomyelitis (infection of the bone). The MDS indicated R28 required set-up	F 791		

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F 791	Continued From page 144 help with oral hygiene, moderate assistance with walking ten feet, and was independent with wheelchair use. The MDS indicated R28 had obvious or likely cavities or broken natural teeth. R28's care plan dated 6/24/24, indicated R28 had his own teeth and was independent with personal hygiene. R28's Oral/Dental Observation dated 6/4/24, indicated R28 had his own teeth that were broken and had no dentures. The observation included a section "date of last dental exam or if refused, date offered" which was left blank. R28's progress note dated 6/7/24 at 7:11 a.m., indicated R28 was requesting softer food at meals related to his dentition. R28's medical record was reviewed and did not indicate R28 had been offered, refused, or had received dental services. During an interview and observation on 8/26/24 at 1:51 p.m., R28 stated he did not have any teeth and opened his mouth, and no teeth were observed. R28 stated he used to have dentures, but they were stolen prior to entering the facility. R28 stated a social worker at the facility had offered to help him get set up for a dental appointment but then the social worker "got fired" and an appointment never was set up. During an interview on 8/29/24 at 11:11 a.m., the unit nurse manager (RN)-B stated the facility did not have a dentist that came to the facility to assess residents. RN-B stated the facility would need to make a dental appointment for R28 and that should have been triggered by the oral	F 791		

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F 791	Continued From page 145 observation form but that must have been missed. The facility's undated Dental Services policy indicated the facility had a contract with a dentist who came to the facility every month to provide dental services. The policy indicated a record of the dental services provided to the resident would be documented in the medical record. The policy indicated nursing services was responsible for notifying social services of any dental service needs who would then assist in making dental appointments.	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 providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;	F 880		10/4/24

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F 880	Continued From page 146 §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. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.	F 880		

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F 880	Continued From page 147 §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 enhanced barrier precautions (EBP) were implemented or followed for 2 of 2 residents (R6 and R8) reviewed for EBP. Findings include: The CDC article titled Implementation of Personal Protective Equipment (PPE) Use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms (MDROs) dated 4/2/24, indicated MDRO transmission in skilled nursing facilities was common and contributed to substantial resident morbidity. EBP is an infection control intervention to reduce transmission of MDROs by using gowns and gloves during "high contact resident care activities". The article indicated high-contact activities include changing linens, bathing, dressing, feeding tube care, etc. The article indicated EBP should be implemented (when contact precautions did not apply) for residents with wounds or indwelling medical devices (central lines, urinary catheter, feeding tube) regardless of MDRO colonization status. R6's quarterly Minimum Data Set (MDS) dated 6/19/24, indicated R6 had severely impaired cognition, was diagnosed with respiratory failure and cerebral palsy, and required total assistance with all care activities. The MDS indicated R30 received his nutrition through a feeding tube. R6's Treatment Administration Record (TAR)	F 880	F880-Infection Prevention and Control/MN Rule 4658.0800 Subp. 4 A-I-21390 Concern: EBP not in place for residents with feeding tube. Identification of other residents at risk "All residents with wounds, indwelling catheters, feeding tubes, or central lines/PICC lines or other indwelling medical devices. Corrective Measures: "Enhanced Barrier Precautions were implemented for R6 r/t indwelling feeding tube on 08/28/2024 "Education to be completed with nursing staff on transmission-based precautions "All residents with wounds, indwelling catheters, feeding tubes, or central lines/PICC lines or other indwelling medical devices will be audited for transmission-based precautions and correct signage. "Transmission based precaution were audited for correct signage "The need for transmission-based precautions will be added to the admission checklist Monitoring Mechanisms: "Correct signage for transmission-based precautions will be audited 4x per week for following transmission-based precautions x 30 days, then 3x per week for 30 days, then 2x per week for 30 days. "Staff will be randomly audited 4x per	

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F 880	Continued From page 148 dated 3/8/24, indicated R6 had an enteral feeding tube and residuals were assessed every shift. During an observation on 8/26/24 at 5:19 p.m., R6's room door was observed with no visible signage indicating what, if any, isolation precautions were necessary for resident care. During an observation on 8/28/24 at 9:38 a.m., R6's room door was observed with no visible signage indicating what, if any, isolation precautions were necessary for resident care. During an observation and interview on 8/29/24 at 7:03 a.m., R6's room door was observed with no visible signage indicating what, if any, isolation precautions were necessary for resident care. Licensed Practical Nurse (LPN)-G was observed completing hand hygiene and entering R6's room. LPN-C was not observed wearing a gown but applied gloves and was observed disconnecting R6's feeding tube from the tubing connected to the feeding pump. LPN-C was then observed assessing the feeding tube site and flushing the tube. LPN-C was observed assisting R6 with changing his shirt and applying hand splints. LPN-C stated he knew what residents needed EBP by the signage on the door and R6 did not have a sign on his door. LPN-C stated residents with wounds or urinary catheters needed EBP but not residents with a feeding tube. During an interview on 8/29/24 at 9:24 a.m. with the infection preventionist (IP) and the director of nursing (DON), the DON stated facility staff should assess resident pre-admission documentation and implement the needed EBP signage and isolation cart before the resident's arrival to the facility. The IP stated EBP should	F 880	week for following transmission-based precautions x 30 days, then 3x per week for 30 days, then 2x per week for 30 days. "Enhanced-barrier precautions/Transmission-based precautions will be added for QAPI review x 180 days then reviewed to determine if ongoing monitoring is needed. Citation: MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention and Control Correction: "All nursing staff will be educated on the importance of TB screening, testing, and documentation. "All Staff and Residents will be audited for a completion of TB screening and two-step Mantoux "All residents and staff will have a two-step Mantoux placed unless contraindicated. Monitoring: "All staff and residents identified as requiring a screening and/or two-step Mantoux will be monitored 3x per week for completion x 90 days "All new staff members and residents will be audited for a completed screening and two-step Mantoux 3x per week x 30 days or until completion. "Tuberculosis Prevention will be monitored via QAPI x 180 days. Date of compliance 4PM 10-04-2024	

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F 880	Continued From page 149 have been implemented for residents with feeding tubes including R6. The IP stated R6's isolation status had not been reassessed after they thought R6 was soon to be discharged and had preemptively removed precautions. The IP stated they communicated to staff what precautions residents were on by the signage on their door. The IP stated correctly implementing EBP was an important step in preventing the spread of infection to residents. R8's admission Minimum Data Set (MDS) assessment, dated 7/25/24, indicated R8 had moderately impaired cognition with no hallucination, delusions or other behavioral symptoms noted and required maximal assistance with all activities of daily living (ADLs) except eating, oral, and personal hygiene. The MDS further indicated R8 had an indwelling catheter. During observation on 8/28/24 at 11:03 a.m., R8 was observed sitting in his wheelchair inside his room with trained medication aid (TMA)-A standing in the doorway with gloves on. A three-drawer plastic bin was observed placed to the left of the doorway and inside the bin were personal protective gowns. On the top of the bin were surgical masks and hand sanitizer. On the door, was a single page sign hung indicating "Enhanced Barrier Precautions." noted to be outside the door. Signage indicated: "Clean their hands, including before entering and when leaving the room," and "Providers and Staff must also: wear gloves and a gown for the following High-Contact Resident Care Activities. Dressing, Bathing/Showering, Transferring, Changing Linens, Providing Hygiene, Changing briefs or	F 880		

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F 880	Continued From page 150 assisting with toileting, Device care or use: central line, urinary catheter, feeding tube, tracheostomy. Wounds Care: any skin opening requiring a dressing." Nursing assistant (NA)-B was observed to enter R8's room and shut the door. Neither NA-B or TMA-A were observed to have gowns on. NA-B was not observed to use hand sanitizer or put on gloves prior to entering R8's room gloves. NA-B was observed to exit R8's room, put the mechanical lift in the hallway and go to the clean linen room and obtain clean linen. NA-B re-entered R8's room after knocking and announcing self. At 11:13 a.m., R8 was observed lying in bed comfortably. During interview on 8/28/2024 at 12:01 p.m., NA-C stated they are unsure if R8 was on any precautions and verified they had assisted R8 with a transfer. NA-C verified they entered R8 rooms and assisted with a transfer without wearing proper PPE. NA-C verified they did not wear a gown or gloves with assisting R8. NA-C verified the signage on R8's door that R8 was on EBP precautions that indicated proper PPE should be worn if assisting resident with a transfer. During an interview on 8/28/2024 at 2:27 p.m., TMA-A verified they assisted R8 without wearing proper PPE. TMA-A stated, "should wear gown and gloves when come in contact with urinals and sores or even transferring a resident on precautions," and verified they did not have on proper PPE when caring for R8. During interview on 8/28/2024 at 11:18 a.m., registered nurse (RN)-C verified that R8 was on enhanced barrier precautions (EBP). RN-C indicated he was on EBP due to having a foley	F 880		

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F 880	Continued From page 151 catheter (a flexible tube that drains urine from the bladder into a collection bag outside the body). RN-C indicated that all staff should be wearing gowns and gloves when having any contact with R8 as EBP are in place "to help protect him." The facility's undated EBP policy indicated EBP was an infection prevention and control intervention used to reduce the spread of MDROs to residents. The policy indicated gowns and gloves were to be used during high-contact care activities including wound care to any skin opening requiring a dressing, care with indwelling devices, transferring, etc. The policy indicated EBP was needed when a resident had a wound or indwelling medical device such as a feeding tube.	F 880		
F 883 SS=D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following:	F 883		10/4/24

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F 883	Continued From page 152 (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure that recommended pneumococcal vaccinations, as outlined by the	F 883	Citation F883-Influenza and Pneumococcal Immunizations	

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F 883	Continued From page 153 Centers for Disease Control (CDC), were offered and/or provided to reduce the risk of severe disease for 2 of 5 residents (R15, R45) reviewed for immunizations. Findings include: A CDC Pneumococcal Vaccine Timing for Adults chart dated 3/15/2023, identified various tables when each (or all) of the pneumococcal vaccinations should be obtained for adults 65 years and older. The chart indicated that when a resident had received the Pneumococcal 13-valent Conjugate Vaccine (PCV13) at any age and the pneumococcal polysaccharide vaccine 23 (PPSV23) at greater than 65 years, then the resident and provider may choose to administer the Pneumococcal 20-valent Conjugate Vaccine (PCV20). The chart indicated when an adult 65 years of age or older had received the PPSV23 only at any age they should receive one dose of either PCV20 or pneumococcal 15-valent Conjugate Vaccine (PCV15) at least one year after the most recent PPSV23 dose. R15's annual Minimum Data Set (MDS) dated 6/12/24, indicated R15 was 77 years old at the time of assessment, had intact cognition, and was diagnosed with kidney disease, dementia, and diabetes. R15's Resident Vaccinations record dated 10/31/23, indicated R6 had received the PPSV23 on 6/2/14 (was greater than 65 years old) and the PCV13 on 9/10/15 and 9/20/17. R15's medical record was reviewed and did not indicate the PCV20 had been offered or administered.	F 883	Concern: Pneumococcal vaccine not charted as given or refused for residents who are eligible for the vaccine. Identification of other residents at risk •All residents could be risk for lack of inoculation for PCV/Pneumococcal vaccinations Corrective Measures: •R15 immunizations will be reviewed for PCV-immunizations and offered vaccination •R45 immunizations will be reviewed for PCV-immunizations and offered vaccination •All resident vaccination records will be reviewed for up-to-date status. •All eligible residents who have not been fully inoculated for PCV/ Pneumococcal vaccinations will be educated on the PCV/Pneumococcal vaccination series, offered vaccination if indicated, and have documentation in place related to acceptance or declination of for PCV/ Pneumococcal vaccines. Monitoring Mechanisms: •Education completed with infection control nurse and nursing leadership team regarding PCV/Pneumococcal Vaccinations, vaccination schedule,	

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F 883	Continued From page 154 R45's quarterly MDS dated 6/20/24, indicated R45 was 77 years old at the time of assessment, had intact cognition, and was diagnosed with kidney disease, dementia, and heart failure. R45's Resident Vaccinations record dated 10/31/23, indicated R45 had received the PPSV23 on 3/3/10. R45's medical record was review and did not indicate the PCV20 or the PCV15 had been offered or administered. During an interview on 8/29/24 at 8:52 a.m., R45 stated she had not been offered an additional pneumococcal vaccination, but if facility staff had, she would have said yes. During an interview on 8/29/24 at 9:40 a.m., R15's and R45's medical records were reviewed with the infection preventionist (IP) who confirmed both R15 and R45 should have been offered an additional pneumococcal vaccination. The IP stated he was new to the role and had not started reviewing residents' pneumococcal vaccination status so he was previously unaware some residents were not up to date. The facility Pneumococcal Vaccine policy dated 10/19, indicated pneumococcal vaccines would be offered to residents according to the current CDC guidance.	F 883	patient education, and documentation. Status of all residents will be monitored monthly for up-to date PCV/Pneumococcal vaccinations x 90 days, then quarterly x 180 days. •Vaccination review will be added to QAPI x 180 days then reviewed to determine if ongoing monitoring is needed. Date of Complaince 4PM 10-04-2024	
F 921 SS=F	Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i) §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for	F 921		10/4/24

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F 921	Continued From page 155 residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure structural issues and items in disrepair throughout the facility were addressed and fixed in order to help promote a functional, sanitary and safe environment. This had the potential to affect all 53 residents residing within the facility. Findings include: Kitchen During observation on 8/26/24 at 1:24 p.m., the floors throughout all areas of the main kitchen were dirty and had particles of food and small dry black particles stuck to the floor. During observation on 8/27/24 at 7:58 a.m., the main kitchen floor was dirty with food particles, small pieces of paper, and many small dry black particles stuck to the floor. During interview on 8/27/24 at 8:11 a.m., cook (C)-A stated he mopped the floor on 8/26/24 before the end of his shift. C-A verified the kitchen floor still had debris and dry black particles stuck to the floor. C-A stated, he started to work at this facility a week ago and the floor needed a deep clean. During observation and interview on 8/28/24 at 12:56 p.m., regional kitchen manager (RKM) verified the kitchen floors were dirty. RKM stated the condition of the floors was not satisfactory, and they needed to be cleaned. RKM stated a week ago, the kitchen manager was terminated	F 921	F921-Safe/Functional/Comfortable/Environment ¿ Concern: Kitchen floors noted as being dirty with debris, kitchen floors noted as dirty with debris after being washed, rubber baseboards peeling from walls, torn and damaged sheetrock, ceiling tiles and sheetrock discolored from water, spider webs around resident window, curtain rod damaged in resident room, resident reported water coming in from window resulting in water on the floor, bed control wire insulation frayed, staff reports of not being familiar with the maintenance ticket software, unsanitary dry wall patches, baseboards having fallen off the wall in residents room. Corrective Action: ¿Education was completed with maintenance by the administrator on keeping a safe, functional, and sanitary environment. An immediate audit of the full facility was conducted to look for anything that needed attention/repairs. The maintenance director corrected the following issues listed within the citation promptly and is working to address anything that might have been missed. Education was also conducted with facility staff on how to place work orders into TELS to make maintenance aware of any issues within the building as it pertains to having a functional, sanitary and safe	

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F 921	Continued From page 156 from their position and there was no documentation of the kitchen's cleaning schedule. RKM added he had written a cleaning schedule to be implemented right away. Second Floor During observation on 8/29/24 at 7:38 a.m., one of the two beams supporting a horizontal beam against the ceiling in the solarium had a crack extending its entire length, exposing the sheetrock behind the beam, and in an area of the crack, a one foot long by six-inch-wide area of the sheetrock was peeling. The vinyl base board of the beam was peeling from the wall, exposing the sheetrock. Also, a 12-inch section of the wooden baseboard, along the wall facing outside the solarium, was peeling, and rotted. During observation and interview on 8/29/24 at 11:18 a.m., the maintenance director (MD) stated he didn't have a work order for the support beam but was aware of the problem. During observation on 8/29/24 at 8 a.m., the right side of the ceiling and wall facing the nurses's station had signs of water damage. The ceiling had light brown colored areas and peeling paint. The wallpaper in some areas was bubbled up and peeling along the edges, exposing the unfinished wall. During interview on 8/29/24 at 9:34 a.m., nursing assistant (NA)-CC stated the wall and ceiling had water damage and it should be repaired. NA-CC state the wall and ceiling had been like this for a several months. During observation and interview on 8/29/24 at	F 921	environment. Citation issues corrected: 1A. Kitchen floors were cleaned with floor buffer to get floors more sanitary and cleaner. 1B. Wall damage from water was examined and repaired ¿ 1C. Observed baseboards around the community were found and repaired. 1D. Frayed cords found in resident rooms during inspection were immediately 1E. Overhead light was found drooping off wall and was immediately repaired 1F. Nursing staff were instructed on how to properly communicate work orders to maintenance and received instruction on how to submit work orders. 1G. Cobwebs and hanging craps were cleaned and repaired Identification of other residents: This deficient practice could affect all residents, staff and visitors. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? The maintenance director has created an environmental audit log that he will do rounds throughout the facility weekly to check for any noticeable repairs. TELS app will be checked weekly to monitor any work orders that may be outstanding.¿ Date of Compliance 4PM 10-04-2024	

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F 921	Continued From page 157 11:18 a.m., the MD stated he didn t have a work order for disrepair on the ceiling but was aware of the problem. During observation on 8/29/24 at 7:18 a.m. the window frame had cobwebs from the top of the window frame down to a large clear plastic bin sitting on the vent unit. The curtain on the left side of the window was hanging down with only half of the curtain on the curtain rod. During observation and interview on 8/29/24 at 11:18 a.m., the MD stated he didn't have a work an order and was aware not aware of this problem. During observation and interview on 8/30/24 at 9:42 a.m., the floor of a R49's room was observed to be wet. There were several comforters on the floor underneath and around the ventilation unit below the window sill. R49 stated, whenever it rains, "Every time it rains, I get water in my room. The water comes through the vent and floods my room." R49 stated he had reported this issue "over and over", but maintenance had not done anything about it and the wet floors were a reported safety concern. During observation and interview on 8/29/24 at 11:18 a.m., the MD stated he didn't have a work order but has been aware of the water leaking into the room from the outside. Second Floor- Memory Care unit During observation on 8/29/24 at 8:00 a.m., a two by two-and-a-half-foot section of the baseboard on the wall behind the TV was peeling from the wall exposing the sheetrock.	F 921		

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F 921	Continued From page 158 During interview on 8/29/24 at 10:08 a.m., nurse manager/registered nurse (RN)-A verified the baseboard was peeling from the wall. RN-A stated maintenance needed to repair it. RN-A was not sure if there was a work order for the maintenance department. During observation and interview on 8/29/24 at 11:18 a.m., the MD stated he didn't have a work order but was aware of the problem. During observation on 8/28/24 at 10:32 a.m., R45's bed control cord had black tape around several areas of the cord. The cord was frayed and had a three to four inches of exposed copper wires touching the bed linen. During interview on 8/28/24 at 10:37 a.m., trained medication aid (TMA)-A verified the condition of the bed control's cord. TMA-A stated the staff is expected to report concerns to the nurse on duty or the nurse manager. TMA-A stated the bed control cord had been taped like that for "months". TMA-A stated she had no knowledge of how to request or fill out a work order for the maintenance department. TMA-A stated she didn't know if the maintenance department had a work order. During interview on 8/28/24 at 10:40 a.m., the MD verified the condition of the bed control cord and said "Oh my God. The staff didn't place a work order." MD stated the condition of the cord was unsafe because the copper wires were exposed and were touching bed linen. During observation on 8/26/24 at 3:12 p.m., a room had dry unsanded dry wall repair exposed	F 921		

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F 921	Continued From page 159 in two walls. In addition, the wall behind the head of the bed had various sizes of orange and red splattered marks. Some of them were flat while others had a grainy surface. The observed marks covered the wall behind and around the head of the bed, about one and a half feet to each side and up to three feet above the head of the bed. During interview TMA-A stated the unrepaired areas on the walls "had been like that for a while", as well as the colored spots on the wall. TMA-A added the walls had been like that for two to three months, the repairs should be finished and the wall should be cleaned and re-painted. TMA-A stated she didn't know if the maintenance department had a work order. During observation and interview on 8/29/24 at 11:18 a.m., the MD stated he didn't have a work order but was aware of the problem. During observation on 8/26/24 at 1:31 p.m., a resident's room had an about six feet of a gray colored baseboard on the wall which was pulled away and was laying on the floor exposing the sheetrock behind it. Cardboard colored debris was observed on the floor between the wall and the peeled baseboard. During interview on 8/29/24 at 8:34 a.m., TMA-A stated the baseboard had been like that for a while, at least a few months. TMA-A said she was not sure if this was reported to the nurse manager or the maintenance department. During observation and interview on 8/29/24 at 11:18 a.m., the MD stated he didn't have a work order but was aware of the problem.	F 921		

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F 921	Continued From page 160 Third Floor During observation and interview on 8/26/24 at 2:53 p.m., a R40 stated the overhead light in their room had been broken for two to three months. R40 stated two maintenance staff members on different occasions, checked the overhead light. Resident both maintenance "guys" told her, the overhead light was old and the parts required to fix it were hard to find. R40 stated the light was on 24/7 and it was hard to sleep. Resident stated the light always being on was causing her to lose sleep. During observation and interview on 8/29/24 at 11:18 a.m., the MD stated he didn't have a work order but was aware of the problem. During observation on 8/29/24 at 11:15 a.m., a two by two foot area of the wall next to the door had signs of water damage. This area had a tan to brownish color. The paint was bubbled and some to the paint close to the ceiling was peeling. Small particles of paint were observed on the floor and on the back and seat of R53's reclining wheelchair. During observation and interview on 8/29/24 at 11:18 a.m., the MD stated he didn ' t have a work order but was aware of the problem. A facility document titled, Work Orders for the Terrace at The Terrace at Crystal LLC dated 8/26/24, identified 19 "Open & in Progress work orders". None of the concerns identified on the second or the third floor were included in this document. On 8/29/24 at 11:18 a.m. a full tour of the building	F 921		

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F 921	Continued From page 161 was completed with surveyor and MD in which MD verified all the above documented areas of concern identified on the second and third floor. MD stated he was hired at the end of June 2024 and did a walk-through at the time of the whole building. MD stated, he didn't have work orders for any of the problems above identified on the second or third floor, but he was aware of all the issues identified during the facility's tour. MD stated the building had not been properly mantained. MD stated, he has been working on the most urgent issues, including the air conditioning. During interview on 8/30/24 at 10:30 a.m., the administrator stated, when he started to work at this facility, he walked through the building and determined the walls needed to be repaired, carpets and floors needed deep cleaning, and the call light system needed to be repaired. Administrator stated new blinds and curtains were needed. Administrator stated "it's important to have a functional building and do it right. The residents and family members will be happier to be here." The undated facility policy titled Nursing Home Maintenance and Upkeep Policy, indicated "The purpose of this policy is to ensure that The Terrace at Crystal maintains a safe, clean, and comfortable environment for all residents by establishing guidelines for routine maintenance, repairs, safety, and sanitation."	F 921		
F 943 SS=C	Abuse, Neglect, and Exploitation Training CFR(s): 483.95(c)(1)-(3) §483.95(c) Abuse, neglect, and exploitation. In addition to the freedom from abuse, neglect,	F 943		10/4/24

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 943	Continued From page 162 and exploitation requirements in § 483.12, facilities must also provide training to their staff that at a minimum educates staff on- §483.95(c)(1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property as set forth at § 483.12. §483.95(c)(2) Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property §483.95(c)(3) Dementia management and resident abuse prevention. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure abuse, neglect, and exploitation prevention and dementia management training was completed for 5 of 8 employees (LPN-D, LPN-E, administrator, director of nursing, NA-G) reviewed. Furthermore, the facility failed to develop and provide facility specific abuse prevention training and Alzheimer's/dementia training to 20 of 20 agency staff who had worked in the facility in the past 30 days. This had the potential to affect all 53 residing in the facility. Findings include: During interview on 8/28/24 at 12:11 p.m., NA-B stated they have not received any dementia training through the agency they are currently working for or from the facility. NA-B stated they have received dementia training in the past, from another agency, but unsure if it is in the past year and has not provided documentation to the facility or agency of this training.	F 943	F943-Abuse, Neglect, and Exploitation Training/MN State Statue 144.6503-2302 Concern: Training records of Abuse, Neglect, and Exploitation training not available for facility employees. Records of ANE training for agency staff not available. Could not provide evidence of current ANE training for requested staff. Immediate Correction: "Agency staff will not be scheduled at the facility until/unless proof of education on Abuse, Neglect, and Exploitation, Dementia, and Alzheimer training is received and reviewed to meet the areas of required training. Identification of other residents at risk "All residents are at risk related to lack of staff education on Abuse, Neglect, and Exploitation, Dementia, and Alzheimer Disease training. Corrective Measures: "Facility employees will be audited for the completion of Abuse, Neglect, and	

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	245289	A. BUILDING _____ B. WING _____	C 08/30/2024

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F 943	Continued From page 163 During interview on 8/28/24 at 2:23 p.m., trained medication aid (TMA)-A verified they are employed with the facility. TMA-A verified they have received some trainings through "Educare" but "not sure about any dementia training." On 8/29/24 at 12:19 p.m., LPN-A stated she has worked at the facility for over a year. LPN-A stated they have not received any dementia training and added, "it just got assigned on Educare to be completed." During interview on 8/28/24 at 11:18 a.m., registered nurse (RN)-C verified they are an employee of the facility for more than 1 year. RN-C was "not sure about any dementia training," when asked about dementia management training. LPN-D employee training record was reviewed and lacked evidence of dementia training and it showed completed abuse prevention training on 8/27/24 (one day after survey entrance). LPN-E employee training record was reviewed and lacked evidence of dementia training or abuse training completion. Employee training records for administrator, director of nursing and NA-G were requested and not received. A list was provided by the facility of 20 agency staff that have worked in the facility in the past 30 days (since the start of survey), which consisted of 17 nursing assistants, 2 trained medication assistants and 1 licensed practical nurse. A request for trainings was requested from the	F 943	Exploitation, Dementia, and Alzheimer training. "Group and/or individual educational/training sessions will be held for Abuse, Neglect, and Exploitation, Dementia, and Alzheimer training. "Employees who have not completed education on Abuse, Neglect, and Exploitation, Dementia, and Alzheimer training will be removed from the schedule effective October 3rd. Monitoring Mechanisms: "Mandatory education/training for Abuse, Neglect, and Exploitation, Dementia, and Alzheimer training will be audited weekly x 30 days, then monthly x 30 days, then quarterly x 90 days. "Mandatory education/training needs will be monitored via QAPI x 180 days. Date of Complaince 4PM 10-04-2024	

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F 943	Continued From page 164 facility but was not provided. These staff were recorded as LPN-F, TMA-B, TMA-C, NA-H, NA-I, NA-J, NA-K, NA-L, NA-M, NA-N, NA-O, NA-P, NA-Q, NA-R, NA-S, NA-T, NA-U, NA-V, NA-W, NA-C. On 8/29/24 at 11:07 a.m., assistant director of nursing (ADON) provided a copy of the employee records that the facility had for the following staff requested; NA-F, NA-G, . ADON verified this was all the trainings that have been completed that the facility had a record of for employees listed above. ADON stated, "we switched to a new system." ADON verified again, "this is all the records of the trainings that we have," adding, "if they aren't there, we don't have them." During interview on 8/29/24 at 10:27 a.m., director of human resources verified she was responsible for assigning Educare (electronic learning management system) to all staff. DHR indicated when she started recently, she was made aware of issues Educare and "recently got it up and running." DHR verified staff have been assigned Educare courses as of 8/21/24. DHR verified they are not in compliance with the trainings and are working on getting into compliance. DHR stated she was going to look into the employee paper charts to see if she could find any more trainings and provide them if she could. DHR did not provide any additional employee or agency staff trainings. On 8/29/24 at 12:33 p.m., administrator verified there was no dementia or emergency preparedness trainings for the list of staff requested or for agency staff. A copy of facility's dementia training was	F 943		

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F 943	Continued From page 165 requested and not provided. A facility policy on staff training on abuse, neglect, and exploitation prevention and dementia management training was requested and not received.	F 943		

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{E 000}	Initial Comments The Terrace at Crystal is a Special Focus Facility. On 10/7/24, an onsite revisit was conducted to determine compliance with CMS Appendix Z Emergency Preparedness Requirements cited during a standard recertification survey exited on 8/30/24. The facility is not in compliance with Appendix Z Emergency Preparedness Requirements. The following citation was recited: E007	{E 000}		
{E 007} SS=C	EP Program Patient Population CFR(s): 483.73(a)(3) §403.748(a)(3), §416.54(a)(3), §418.113(a)(3), §441.184(a)(3), §460.84(a)(3), §482.15(a)(3), §483.73(a)(3), §483.475(a)(3), §484.102(a)(3), §485.68(a)(3), §485.542(a)(3), §485.625(a)(3), §485.727(a)(3), §485.920(a)(3), §491.12(a)(3), §494.62(a)(3). [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following:] (3) Address [patient/client] population, including, but not limited to, persons at-risk; the type of services the [facility] has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans.** *[For LTC facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do all of the following:	{E 007}		10/29/24

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

Electronically Signed | 10/25/2024

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

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{E 007}	Continued From page 1 (3) Address resident population, including, but not limited to, persons at-risk; the type of services the LTC facility has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans. *NOTE: ["Persons at risk" does not apply to: ASC, hospice, PACE, HHA, CORF, CMCH, RHC/FQHC, or ESRD facilities.] This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to address the resident population including, but not limited to, residents most at-risk (vulnerable population) and the type of services the facility has the ability to provide in an emergency. This had the potential to affect all 51 residents residing in the facility. Findings include: Review of the facility Emergency Preparedness Plan (EPP) lacked components regarding the facility's patient populations that would be at risk during an emergency event and the types of services the facility has the ability to provide to those resident populations in an emergency. During interview on 10/7/24 at 2:45 p.m., director of maintenance (DOM) verified he oversaw emergency preparedness for the facility. DOM confirmed EPP does not identify what resident populations are most at risk during an emergency and did not specify how continuity of services would be maintained to such residents during an emergency. DOM verified the Emergency Transportation Agreement, found in the EPP, did not identify residents most at-risk and the type of	{E 007}	What corrective action will be accomplished for those residents found to have been affected by the deficient practice? 1.Facility revised emergency preparedness plan to address resident population, including, but not limited to, persons at risk; the type of services the LTC facility has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken? 2.This deficient practice could affect all residents, staff and visitors. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?	

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{E 007}	Continued From page 2 services the facility has the ability to provide in an emergency. DOM indicated he would think all resident would be transferred out in the case of an emergency. During interview on 10/7/24 at 3:08 p.m., administrator verified the EPP does not specify what residents are most at-risk and the type of services the facility has the ability to provide in an emergency. Administrator stated, "we don't do vents here." A policy titled Emergency Transport Resident Identification Policy, undated, was provided. The policy lacked identification of addressing resident population, including, but not limited to, persons at-risk and the types of services the facility has the ability to provide in an emergency.	{E 007}	3.The policy/EP plan will be reviewed annually to ensure that it is up to date with the most accurate information. A reminder will be placed into TELS to ensure completion. Staff will be educated by the maintenance director on what the at risk populations are and how the facility will manage continuity of care for them in an emergency situation. How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? 4.The at risk patient population policy/procedure will be annually reviewed to ensure all information is up to date. Post-test will be given to employees to evaluate knowledge on the subject. Policy and procedures will be reviewed annually and discussed in QAPI to ensure everything is current. 5. The systemic change be completed by 10/29/2024.	
{F 000}	INITIAL COMMENTS The Terrace at Crystal is a Special Focus Facility. On 10/7/24, an onsite revisit was conducted to follow up on deficiencies related to a recertification survey exited on 8/30/24. The facility was not to be in compliance with the requirements of 42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities. The following citation was recited: F689 In addition, deficiencies were cited at F584 and	{F 000}		

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{F 000}	Continued From page 3 F835 The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	{F 000}		
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;	F 584		10/29/24

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F 584	Continued From page 4 §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 indoor, ambient air temperature was maintained to provide resident' comfort or, if needed, take reasonable and appropriate actions to evaluate and ensure resident' safety and comfort when the facility indoor air temperature was unable to be consistently maintained at or above 71 degrees Fahrenheit (F) due to lack of payment on multiple heating system (i.e., HVAC) invoices. This affected 7 of 10 residents (R1, R5, R6, R7, R2, R3, R4) reviewed for comfortable environment who voiced complaints of the cold temperature which, at times, caused them periods of emotional or physical distress. Findings include: On 10/7/24 at 9:36 a.m., the second-floor locked unit (i.e., memory care) was toured which was	F 584	F584 1.What corrective action will be accomplished for those residents found to have been affected by the deficient practice? All residents were immediately assessed for comfort and adequate living temperature. The heating/cooling company was called out to switch over to heating system. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken? This deficient practice could affect all residents, staff and visitors.	

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F 584	Continued From page 5 housed behind a set of locked, coded doors. On the unit, nearly all resident' room doors were open and many residents on the unit were in bed covered under blankets, and the ambient air on the entire unit was cold feeling to open skin. At the same time, trained medication aide (TMA)-A was standing at a mobile medication cart with their plush winter jacket on. TMA-A was interviewed and stated the unit was too cold, adding aloud, "That's why many of them [residents] don't wanna get up." TMA-A stated the indoor air had been cold "since it got cold outside" but clarified a timeframe adding it had been like such for "the last four days" or so. TMA-A stated the maintenance team was aware of the air being cold and added, to their knowledge, the management team was aware of the cold air adding, "You can't help but notice it." TMA-A stated multiple residents had complained about the cold air but added it would be hard to visit with them about it as "this [unit] is memory care," however, TMA-A directed the surveyor to R1 who could likely be interviewed about it. Immediately following on 10/7/24 at 9:41 a.m., R1 was observed lying in bed while in her room. R1's knees were bent up causing her to appear with a fetal-like position while covered under multiple, different colored blankets which were pulled up to her chin. R1 stated the air was cold in her room adding aloud, "It is!" R1 stated the air had been cold for "awhile now" adding she was unsure a timeframe but expressed, "Sometimes [it's] even colder at night." R1 reiterated it was too cold and she wished it was warmer on the unit. On 10/7/24 at 9:46 a.m., the director of maintenance (DOM) was interviewed and verified knowledge of the building cold air temperature	F 584	3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? The maintenance director and or designee will ensure that daily checks on indoor temps for all floors are completed and nursing will take night temps per shift for added accuracy on the current indoor temperature. Administrator and maintenance director created a policy and procedure on how to respond to out of range temperatures in the building. Education with staff on the policy and procedure was conducted by maintenance director. 4. How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? The Maintenance Director/designee will log temperatures in building throughout the day. The daily temp will be taken/logged on to the facility audit tool by maintenance and or a designee for the first 2 shifts and by nursing staff for the night shift. All results will be presented to the Quality Assurance Committee until the committee determines that there is no necessity to continue based on the findings of continued compliance. 5. The systemic change be completed by 10/28/2024.	

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F 584	Continued From page 6 adding it was "a building wide" issue. DOM explained they had just that day (10/7/24) got the cooling system for the HVAC deactivated but stated it had been working and actively cooling for the past week or so. DOM stated the facility had an outside company who helped manage their HVAC system, and they were needed to switch the system from cooling to heating so DOM had reached out them on 10/7/24, and they were now "getting preparations ready" to make the switch over to heating. DOM verified the building had no current active building-wide heating system due to the system not being changed over from cooling to heating. DOM reiterated they had just prior deactivated the cooling system so any air blowing from the ventilation would just be ambient air and not actively chilled like it had been prior. DOM stated they had been checking some ambient air temperatures within the building over the past few weeks, however, had not been tracking or documenting them. Following this discussion, a tour of the entire building was completed with DOM and, using a facility' supplied hand-held thermometer, DOM obtained a series of temperature checks with the surveyor present. These were as follows: 1) The basement level (included various offices and conference rooms) was measured at 65.5 F; 2) The first-floor level (included various offices, a central commons area, and the main resident dining room) was measured at 65.0 F; 3) The second-floor level (off the elevators and included a nursing station, resident rooms) was measured at 65 F; and the locked memory care unit (which contained resident rooms) measured at 64 F;	F 584		

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F 584	Continued From page 7 4) The third-floor level (which included a nursing station and resident rooms) was measured at 63 F. DOM acknowledged the temperatures being below 71 F and reiterated they were waiting on the outside company to switch over the HVAC system to heating adding they anticipated such would happen "within the week" but were not exactly sure. DOM expressed there wasn't anything else they could do to provide heating within the building until the company was onsite adding, "That's just where we're at." DOM stated they were unsure exactly what, if any, actions the nursing department was doing to monitor resident comfort or safety such as offering extra blankets but added, "At least they should be [doing that]." DOM stated the director of nursing (DON) was aware of the building temperature issue as they had texted them (DOM) the day prior (on 10/6/24) saying people were "getting cold," so DOM reported back they were "starting to get stuff going" with the HVAC system. DOM explained part of the reason the HVAC system had not been changed over sooner was due to monitoring the weather forecast and potentially higher temperatures were anticipated during the upcoming week. However, despite the cold ambient inside air temperature within the building, DOM verified there was no formal tracking or documentation to show routine, ongoing temperature checks had been taken or evaluated to ensure resident comfort while the facility was waiting for the HVAC system to be switched over to heating. A National Oceanic and Atmospheric Administration (NOAA) Online Weather Data	F 584		

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THE TERRACE AT CRYSTAL LLC	3245 VERA CRUZ AVENUE NORTH CRYSTAL, MN 55422

(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 report, dated 10/01/24 to 10/07/24, outlined the outside weather for each daily period including the high temperature, the low temperature and a 24-hour average of the temperatures which were reached/recorded. This identified: On 10/03/24, the low temperature recorded was 50 F and the 24-hour average was recorded as 57.5 F; On 10/04/24, the low temperature recorded was 44 F and the 24-hour average was recorded as 56.5 F; On 10/05/24, the low temperature recorded was 50 F and the 24-hour average was recorded as 64.5 F; On 10/06/24, the low temperature recorded was 47 F and the 24-hour average was recorded as 56.0 F. R5's admission Minimum Data Set (MDS) dated 6/4/24, indicated R5 had severely impaired cognition and had no rejection of care behaviors. On 10/7/24 at 10:09 a.m., R5 was observed seated in his wheelchair only wearing a short-sleeved shirt and a pair of jeans. No visible sweater or coats overtop. R5 was interviewed and voiced frustration with the cold temperature and stated it was "really cold" in the building for the last week. R5 stated he had told maintenance staff about the temperature and he was told the heat would not be turned on until next month. R5 stated facility staff had been wearing jackets inside for the last week and R5 thought this was related to the cold temperature inside the building. R5 stated he didn't have a coat of his own so he had been feeling very cold adding staff	F 584		

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F 584	Continued From page 9 had not offered him extra blankets or clothing during the past week. R6's quarterly MDS dated 8/2/24, indicated R6 had intact cognition. On 10/7/24 at 10:13 a.m., R6 was observed lying in bed with a sweatshirt on and the hood pulled up over his head. R6 was interviewed and stated it had been "freezing" in the facility for the past three to four days. R6 stated it was especially "chilly" at night which was annoying and caused trouble sleeping adding facility staff had not offered him anything extra to keep him warm. R7's quarterly MDS dated 8/16/24, indicated R7 had intact cognition and was diagnosed with anemia (deficiency of blood cells that carry oxygen). During interview on 10/7/23 at 10:24 a.m., R7 stated it had been very cold in the facility for the past week, and facility staff had not offered any additional interventions to keep warm. R2's annual MDS dated 9/19/24, indicated R2 had moderate cognitive impairment and was diagnosed with coronary artery disease. On 10/7/24 at 10:29 a.m. R2 was observed wearing a thick sweater, winter jacket, jogging pants, hat and snow boots. R2 stated aloud, "It's very cold [in here]." R3's quarterly MDS dated 6/26/24, indicated R3 was cognitively impaired. On 10/7/24 at 10:24 a.m. R3 was wearing a sweater, and a winter jacket. R3 stated it was very chilly and she was cold. R3 stood up and said she was going to her room, "I think it will be warmer there." R4's quarterly MDS dated 8/23/24, indicated resident had impaired cognition and diabetes	F 584		

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F 584	Continued From page 10 mellitus. On 10/7/24 at 10:33 a.m., R4 was observed lying in bed covered with multiple blankets, including up around her face. R4 stated, "I won't get out of bed or take my pills because I am too cold." R4 stated she was fully dressed adding it had "been cold for days" in the care center. R4 then re-covered her face again and said, "just take me out of here, take me somewhere else where is warm." On 10/7/24 at 10:12 a.m., the assistant director of nursing (ADON) was interviewed. ADON acknowledged the building temperature and expressed it had been like such "for the last couple of days." ADON stated maintenance staff were "keeping track" of the building temperature and nursing was not, at least to their knowledge, tracking or monitoring it adding, "Nursing is not doing that, no." ADON stated they were unsure what, if any, interventions were being done to help ensure resident' comfort was maintained adding, "I don't have an answer right off the top of my head." However, ADON expressed they had communicated with the DON about the cool temperatures and they had "talked about turning the AC off." ADON stated they had directed the floor staff to try to keep the window blinds closed at night to help conserve heat inside the building but felt, overall, the temperature inside "wasn't bad" as the weather outside was "still in the 50's [temperature]." ADON stated they did not recall anyone from nursing leadership, including the DON, to start checking resident' temperatures or do any additional interventions despite the cool building temperature but added they didn't absolutely know if anyone had or not adding aloud, "[at least] not that I have a sign up sheet for." ADON stated they anticipated staff would likely have offered blankets, if needed, but	F 584		

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F 584	Continued From page 11 verified their only direction to the floor staff had been "just the blinds." ADON stated the current week (10/7/24 to 10/11/24) was the "last week it's supposed to be this warm," and they recalled some hesitation to activate the heating system due to not wanting to "roast people," either. ADON stated they believed the administrator to be aware of the issue and "once the averages [temperatures] are lower" the heating system in the building would be activated. Further, ADON stated they had heard some resident comments about "feeling it's cooler in here [inside]" and maintenance was aware and going to address it adding, "There's been communication on this." During interview on 10/7/24 at 10:19 a.m., licensed practical nurse (LPN)-A stated they worked on 10/4/24 and residents had complained of the low temperature in the building and they were worried about residents getting sick related to this. LPN-A stated they had notified maintenance and the administrator of the temperature and asked if the heat could be turned on but they were told they wouldn't be able to do that. LPN-C stated facility management had not instructed them to increase monitoring of the residents given the cold temperature or to make sure residents were dressed appropriately. LPN-C stated nursing staff should be dressing residents appropriately for the weather but did not recall management giving specific instructions regarding this. During subsequent interview on 10/7/24 at 10:19 a.m., TMA-A stated the residents were cold, they are shivering in their beds, and they don't want to get up. TMA-A stated staff were complaining about it being cold, too. TMA-A stated the nurses had not been provided any instructions and she	F 584		

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F 584	Continued From page 12 had not heard anything about checking vital signs or anything else that we should be doing differently. TMA-A added staff were trying to help put blankets on people and keep them warm but reiterated nobody had told them actions to take, adding giving blankets just was "using commons sense" due to the cold temperature. When interviewed on 10/7/24 at 10:54 a.m., registered nurse (RN)-B stated they had worked last Wednesday (10/2/24) and the building was cold then so, as a result, they talked to management about the facility's temperature and were told maintenance was working on it. RN-B stated residents have been complaining about how cold it is so, today (10/7/24), they finally completed a 'concern form' about it adding the second-floor locked memory care unit was even colder. RN-B stated management have not provided any instructions about monitoring residents vital signs or any other interventions to assure residents were warm and able to remain comfortable; however, RN-B stated they themselves had been trying to offer extra blankets, sweaters, and jackets because the residents had been complaining about the cold for days. During the post-certification re-visit (PCR), on 10/07/24, the medical records for R1, R2, R3, R4, R5, R6 and R7, were reviewed and each lacked evidence the facility of what, if any, special interventions were evaluated, considered or implemented to ensure adequate body heat was maintained; nor evidence of what, if any, increased monitoring of the residents (i.e., body temperature checks) had been completed to ensure safety and comfort despite the low building temperature. Further, there was no	F 584		

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F 584	Continued From page 13 evidence provided to demonstrate what, if any, actions or direction floor staff had been provided to ensure residents were kept comfortable in the low(er) temperatures (i.e., evaluate/provide blankets if needed, hot drinks, vitals monitoring). On 10/7/24 at 10:37 a.m., a subsequent interview with DOM was held. DOM verified there was no documentation to provide to demonstrate any ongoing monitoring of the building temperature was or had been completed, including on the overnight hours, despite the onset of fall-like weather patterns setting in outdoors. DOM reiterated they had been checking some temperatures though adding most of them had been "72 or 73 ish [degrees]" over the past weeks with some periods of "68 to 70 [degrees]," adding though, "If I had to guess." DOM verified there had been no checks completed during the night hours and stated the HVAC system couldn't be activated until the outside company arrived onsite to do such. However, there had been an issue with the payment to them and they would not return onsite "because of the payment stuff [SEE F835 FOR ADDITIONAL INFORMATION]." During an interview on 10/7/24 at 11:31 a.m., the DON stated they first became aware of staff and residents feeling cold on 10/6/24 and, as a result, had instructed the nursing assistant who had reported the concern to provide extra blankets to the residents who had reported feeling cold. The DON stated DOM had informed her the temperature in the building was 72 degrees, so no additional interventions had been put in place at that time. The DON stated if she had been aware the building temperature was "out of range" she would have ensured staff were assessing residents for appropriate clothing,	F 584		

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F 584	Continued From page 14 given out additional blankets, and/or given out hand/feet warmers. The DON stated she had not told nursing staff to monitor for signs and symptoms of low body temperature and was not aware of them doing so. Further, DON stated DOM had reported to her they wouldn't be turning the heat on this week as it was supposed to get warmer outside later on in the week. On 10/7/24 at 1:17 p.m., the administrator was interviewed, and they explained the DON had updated them about the cold building temperatures earlier the same day (10/7/24) adding they were unaware there was any concern about it prior. The administrator stated they had been onsite over the last weekend and felt "the temperature was fine," but expressed they had discussed the building temperature with DOM after "some staff" reported being cold. The administrator expressed the outside weather seemed to be heating back up and they decided to not activate the HVAC system to not overheat people, either. The administrator verified the staff concerns about the building temperature were initially reported over the weekend, however, he added, "But everybody's body temp is different." The administrator verified no systemic actions were taken to ensure resident comfort with the cold building temperature and attributed such due to a lack of being told about resident' concerns with it adding, "I wasn't alerted." The administrator stated had he known, then they would have done "different interventions" to ensure comfort like ensuring everyone had socks on, blankets available and doing vital sign checks. The administrator recalled visited with DOM about the HVAC system and having the outside contractor (OC)-A come back to activate the system adding they were trying to determine	F 584		

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F 584	Continued From page 15 when a "good time to do it" would be. The administrator verified knowledge of the overdue invoices to the company and expressed, "The company [care center] has been slower in giving out the payments." However, the administrator stated they, just that day (10/7/24), spoke with the care center owner and a payment would be made. The administrator stated the "back office" was responsible for the payments to vendors and reiterated no interventions for resident' comfort were done as nothing was reported to him which would have "triggered" a response. On 10/7/24 at 3:56 p.m., a subsequent interview was held with the administrator and DON. The DON verified they had texted DOM about "people [were] complaining it's cold" in the building on 10/6/24 (Sunday), but stated it had been staff complaining and not residents to their recall. DON stated DOM reported the temperature ranges but they had possible been based "off his last check" and not in-the-moment when it was reported as DOM expressed the building was 72 F. DON stated they didn't feel it was a building-wide issue over the weekend and verified no systemic evaluation or actions to ensure resident comfort was completed as knowing the temperature was out of range (i.e., outside 71 F to 81 F) is "what would trigger that." DON and the administrator both verified nobody had alerted them it was out of range until the morning of 10/7/24 when the health survey arrived. As a result, the nurse managers then went around to each resident and checked vitals and ensure blankets for everyone. The administrator reiterated cold sensation could be different from person-to-person and expressed no systemic action was taken as nobody , , according to administrator, was aware the temperature was out-of-range. However, the	F 584		

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F 584	Continued From page 16 DON stated had staff reported the resident concerns with it, such as described by the floor staff, then action would have been taken. DON added, "If we knew our residents were being impacted by the temperature, we'd take action." A facility' policy on building temperature maintenance and/or monitoring including with what, if any, actions are completed if outside ideal range was requested. However, none was received.	F 584		
{F 689} SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure new, person-centered fall interventions were implemented to prevent further falls and potential injury for 1 of 3 residents (R5) reviewed for repeat falls. Findings include: R5's admission MDS dated 6/4/24, indicated R5 had severely impaired cognition and had no rejection of care behaviors. The MDS indicated R5 was diagnosed with hypertension, diabetes, and osteomyelitis. The MDS indicated R5 used a walker and a wheelchair as mobility devices and	{F 689}	Citation F689-Free of Accidents Hazards/Supervision/Devices/MN Rule. 4658.0520 Sub.p.1 Concern: Resident care plan did not indicate new interventions post falls Identification of other residents at risk All residents with a moderate to high risk for falls Corrective Measures: Fall interventions for R5 Care plan reviewed and updated to include new interventions for falls that occurred on 07/04/2024 & 07/14/2024-Resident has	10/29/24

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{F 689}	Continued From page 17 required set-up help with toilet transfers, moderate assistance with walking ten feet, and was independent with wheelchair use. R5's care plan dated 6/24/24, indicated R5 was at a "high" risk for falls related to osteomyelitis (bone infection) and cellulitis (soft tissue infection or inflammation). The fall care plan included two interventions dated 6/24/24, anticipate and meet R5's needs and ensure R5's call light was within reach and encourage R5 to use it. R5's care plan dated 6/24/24, indicated R5 had a history of substance abuse. The care plan indicated if facility staff witnessed or suspected substance use, they would start vital signs every two hours for 24 hours. The substance use care plan dated 6/24/24, indicated staff were to follow the facility policy related to resident substance abuse and report any abnormal behavior to the provider. The care plan did not include new (if any) fall interventions attempted after the fall on 7/5/24 and 7/14/24. R5's progress note dated 7/5/24 at 9:19 p.m., indicated R5 was found on the floor with his wheelchair on the side with a half-empty bottle of alcohol. The note indicated R5 was assessed and had no injuries, vital signs were "stable", and R5 was transferred to bed. Facility staff completed 15-minute checks on R5, and the director of nursing (DON) and the provider were notified. R5's progress note dated 7/6/24 at 1:59 a.m., indicated R5 had two abrasions on his scalp "from the fall". R5's progress note dated 7/9/24 at 10:59 a.m., indicated the interdisciplinary team (IDT) had reviewed R5's fall and R5 was "re-educated" on	{F 689}	had no further falls to address as of 10-25-2024. Residents with moderate to high risk for falls who have had at least one fall in the past 6 months with be reviewed for new interventions in place post fall incident. Education will be completed with licensed nursing and interdisciplinary leadership team staff r/t Fall Prevention which will include Pre/Post Fall Assessments, identification of risk factors, root cause analysis, care plan review, current fall interventions, and the implementation of new interventions post fall utilizing case studies, discussion and posttest. Monitoring Mechanisms: The interdisciplinary team will review, implement, or revise for post-fall interventions 5x per week x 90 days Post-Fall incidents will be audited 5x a week for new interventions x 90 days. Fall management will be added to QAPI x 90 days for monitoring and quality improvement, then determine if ongoing monitoring is appropriate. Date of compliance 10-29-24	

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{F 689}	Continued From page 18	{F 689}		

the risk of substance use and that it could cause serious harm. The note indicated the policy on substance abuse was reviewed.

R5's progress note dated 7/14/24 at 4:00 a.m., indicated R5 was found on the floor of his room near the bathroom. The note indicated R5 was "intoxicated with alcohol" and restless in bed before the fall. The note indicated no injuries were observed and the resident was helped back to bed and encouraged to call when he needed help. The note indicated the DON and "TCP" were notified.

R5's progress note dated 7/15/24 at 8:30 a.m., indicated R5 endorsed left arm pain at a "7 or 8" and said it had been bothering him since his fall.

R5's progress note dated 7/15/24 at 9:37 a.m., indicated the interdisciplinary team (IDT) had reviewed R5's fall and R5 was "extremely intoxicated" throughout the shift and had attempted to self-transfer and use the bathroom. The note indicated R5 was educated on abstaining from alcohol and requesting assistance while intoxicated. R5's medical record was reviewed and did not include any new person-centered fall interventions after R5's fall on 7/14/24.

R5's progress noted dated 9/23/24 at 7:31 p.m., indicated R5 was referred to a skilled nursing facility that had an in-house licensed alcohol and drug counselor (LADC) as part of the resident's discharge plan and "falls interventions". The progress note did not indicate what new interventions were placed to ensure R5 was safe will he was still residing at the facility.

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{F 689}	Continued From page 19 During at interview on 10/7/24 at 9:56 a.m., R5 stated he had fallen a couple of times at the facility while he was drinking. R5 stated he did not recall the facility discussing interventions to help him reduce his drinking while residing at the facility or ensuring he was safe while he was drinking. During an interview on 10/7/24 at 2:45 p.m., registered nurse (RN)-A, the unit nurse manager (RN)-B stated R5's past falls had been related to alcohol use so the facility had referred him to a different facility that had LADC services. RN-A stated they had re-educated R5 in the past on calling for assistance but acknowledged this was not a new fall intervention. RN-A stated she was unsure what new interventions had been put in place to ensure R5 was safe. RN-A stated she had not but someone might have talked to R5 about alcoholics anonymous (AA) but the director of nursing (DON) might know more about this. During an interview on 10/7/24 at 2:57 p.m., the social services director (SSD) stated she had not discussed AA with R5 as no one had asked her to. During an interview on 10/7/24 at 2:54 p.m., the DON stated she had not been a part of ensuring new fall interventions had been placed for R5 since the last survey and this was RN-A's responsibility so she was unaware if AA had been discussed with R5 or if any new fall interventions had been put into place.	{F 689}		
F 835 SS=F	Administration CFR(s): 483.70 §483.70 Administration.	F 835		10/28/24

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F 835	Continued From page 20 A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility' administration failed to provide oversight to ensure financial obligations to an outside contractor were effectively administered and adequately maintained to ensure ongoing, uninterrupted service of the facility-wide heating, ventilation, and air conditioning (i.e., HVAC) system. This resulted in an unpaid balance of several thousand dollars causing the contractor to stop service and corresponding resident' discomfort (i.e., cold) when the heating system couldn't be activated causing indoor temperatures to fall below 71 degrees (F). This had the potential to affect all 51 residents who resided in the facility and staff and volunteers who worked in the facility at the time of the survey. Findings include: On 10/7/24 at 9:36 a.m., the second-floor locked unit (i.e., memory care) was toured which was housed behind a set of locked, coded doors. On the unit, nearly all resident' room doors were open and many residents on the unit were in bed covered under blankets, and the ambient air on the entire unit was cold feeling to open skin. At the same time, trained medication aide (TMA)-A was standing at a mobile medication cart with their plush winter jacket on. TMA-A was interviewed and stated the unit was too cold, adding aloud, "That's why many of them [residents] don't wanna get up." TMA-A stated the	F 835	F835 What corrective action will be accomplished for those residents found to have been affected by the deficient practice? 1.The administrator made the call to the facility heating/air company to ensure a payment plan was put into place to address the delay in payment. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken? 2.This deficient practice could affect all residents, staff and visitors. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? 3.BOC will be preparing monthly AP reports for the facility to distribute to the administrator, owner, and back office as a way to inform the back office of any outstanding invoices that need payment. How the corrective action will be	

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F 835	Continued From page 21 indoor air had been cold "since it got cold outside" but clarified a timeframe adding it had been like such for "the last four days" or so. TMA-A stated the maintenance team was aware of the air being cold and added, to their knowledge, the management team was aware of the cold air adding, "You can't help but notice it." TMA-A stated multiple residents had complained about the cold air but added it would be hard to visit with them about it as "this [unit] is memory care," however, TMA-A directed the surveyor to R1 who could likely be interviewed about it. Immediately following on 10/7/24 at 9:41 a.m., R1 was observed lying in bed while in her room. R1's knees were bent up causing her to appear with a fetal-like position while covered under multiple, different colored blankets which were pulled up to her chin. R1 stated the air was cold in her room adding aloud, "It is!" R1 stated the air had been cold for "awhile now" adding she was unsure a timeframe but expressed, "Sometimes [it's] even colder at night." R1 reiterated it was too cold and she wished it was warmer on the unit. On 10/7/24 at 9:46 a.m., the director of maintenance (DOM) was interviewed and verified knowledge of the building cold air temperature adding it was "a building wide" issue. DOM explained they had just that day (10/7/24) got the cooling system for the HVAC deactivated but stated it had been working and actively cooling for the past week or so. DOM stated the facility had an outside company who helped manage their HVAC system, and they were needed to switch the system from cooling to heating so DOM had reached out them on 10/7/24, and they were now "getting preparations ready" to make the switch over to heating. DOM verified the building had no current active building-wide heating system due	F 835	monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? 4.BOC and administrator will be meeting monthly to review AP outstanding. Findings will be emailed to the back office and owner for discussion. BOC will be documenting that the meetings between the administrator and BOC occurred. 5.The systemic change be completed by 10/28/2024.	

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F 835	Continued From page 22 to the system not being changed over from cooling to heating. DOM stated they had been checking some ambient air temperatures within the building over the past few weeks, however, had not been tracking or documenting them. Following this discussion, a tour of the entire building was completed with DOM and, using a facility' supplied hand-held thermometer, DOM obtained a series of temperature checks with the surveyor present. These were as follows: 1) The basement level (included various offices and conference rooms) was measured at 65.5 F; 2) The first-floor level (included various offices, a central commons area, and the main resident dining room) was measured at 65.0 F; 3) The second-floor level (off the elevators and included a nursing station, resident rooms) was measured at 65 F; and the locked memory care unit (which contained resident rooms) measured at 64 F; 4) The third-floor level (which included a nursing station and resident rooms) was measured at 63 F. DOM acknowledged the temperatures being below 71 F and reiterated they were waiting on the outside company to switch over the HVAC system to heating adding they anticipated such would happen "within the week" but were not exactly sure. DOM expressed there wasn't anything else they could do to provide heating within the building until the company was onsite adding, "That's just where we're at." DOM stated the director of nursing (DON) was aware of the building temperature issue as they had texted	F 835		

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F 835	Continued From page 23 them (DOM) the day prior (on 10/6/24) saying people were "getting cold," so DOM reported back they were "starting to get stuff going" with the HVAC system. DOM explained part of the reason the HVAC system had not been changed over sooner was due to monitoring the weather forecast and potentially higher temperatures were anticipated during the upcoming week. R5's admission Minimum Data Set (MDS) dated 6/4/24, indicated R5 had severely impaired cognition and had no rejection of care behaviors. On 10/7/24 at 10:09 a.m., R5 was observed seated in his wheelchair only wearing a short-sleeved shirt and a pair of jeans. No visible sweater or coats overtop. R5 was interviewed and voiced frustration with the cold temperature and stated it was "really cold" in the building for the last week. R5 stated he had told maintenance staff about the temperature and he was told the heat would not be turned on until next month. R5 stated facility staff had been wearing jackets inside for the last week and R5 thought this was related to the cold temperature inside the building. R5 stated he didn't have a coat of his own so he had been feeling very cold adding staff had not offered him extra blankets or clothing during the past week. R6's quarterly MDS dated 8/2/24, indicated R6 had intact cognition. On 10/7/24 at 10:13 a.m., R6 was observed lying in bed with a sweatshirt on and the hood pulled up over his head. R6 was interviewed and stated it had been "freezing" in the facility for the past three to four days. R6 stated it was especially "chilly" at night which was annoying and caused trouble sleeping adding facility staff had not offered him anything extra to keep him warm.	F 835		

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F 835	Continued From page 24 R7's quarterly MDS dated 8/16/24, indicated R7 had intact cognition and was diagnosed with anemia (deficiency of blood cells that carry oxygen). During interview on 10/7/23 at 10:24 a.m., R7 stated it had been very cold in the facility for the past week, and facility staff had not offered any additional interventions to keep warm. R2's annual MDS dated 9/19/24, indicated R2 had moderate cognitive impairment and was diagnosed with coronary artery disease. On 10/7/24 at 10:29 a.m. R2 was observed wearing a thick sweater, winter jacket, jogging pants, hat and snow boots. R2 stated aloud, "It's very cold [in here]." R3's quarterly MDS dated 6/26/24, indicated R3 was cognitively impaired. On 10/7/24 at 10:24 a.m. R3 was wearing a sweater, and a winter jacket. R3 stated it was very chilly and she was cold. R3 stood up and said she was going to her room, "I think it will be warmer there." R4's quarterly MDS dated 8/23/24, indicated resident had impaired cognition and diabetes mellitus. On 10/7/24 at 10:33 a.m., R4 was observed lying in bed covered with multiple blankets, including up around her face. R4 stated, "I won't get out of bed or take my pills because I am too cold." R4 stated she was fully dressed adding it had "been cold for days" in the care center. R4 then re-covered her face again and said, "just take me out of here, take me somewhere else where is warm." When interviewed on 10/7/24 at 10:54 a.m., registered nurse (RN)-B stated they had worked last Wednesday (10/2/24) and the building was	F 835		

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F 835	Continued From page 25 cold then so, as a result, they talked to management about the facility's temperature and were told maintenance was working on it. RN-B stated residents have been complaining about how cold it is so, today (10/7/24), they finally completed a 'concern form' about it adding the second-floor locked memory care unit was even colder. RN-B stated they themselves had been trying to offer extra blankets, sweaters, and jackets because the residents had been complaining about the cold for multiple days. SEE F584 FOR ADDITIONAL INFORMATION. On 10/7/24 at 10:37 a.m., a subsequent interview with DOM was held. DOM verified there was no documentation to provide to demonstrate any ongoing monitoring of the building temperature was or had been completed, including on the overnight hours, despite the onset of fall-like weather patterns setting in outdoors. DOM reiterated they had been checking some temperatures though adding most of them had been "72 or 73 ish [degrees]" over the past weeks with some periods of "68 to 70 [degrees]," adding though, "If I had to guess." DOM verified there had been no checks completed during the night hours. DOM explained the outside company had a payment plan agreement with the care center adding the accounts payable (ACP)-A person offsite typically made and managed the payments. However, DOM stated within the past week or so a payment had possibly been missed or not completed due to ACP-A being on Holiday adding, as a result, the heating system couldn't be activated by the outside company "because of the payment stuff." DOM verified the heating system would not be activated until the past due invoices were either paid or a payment was made. At 10:50 a.m., the care center business	F 835		

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F 835	Continued From page 26 office manager (BOM) joined the interviewed. BOM explained they received invoices and placed them into the "AP System" for approval by the administrator and payment via the "back office." BOM provided the current invoices for the outside company which showed a due balance which listed, "$19,328.64." The invoices had been collecting since 7/16/24, with no payment being made at all until 9/13/24 when a $5,000.00 payment was recorded. BOM stated they had just that day (10/7/24) messaged ACP-A about it, inquiring about the payment, however, expressed they had sent multiple e-mails in the past asking for the same information and never received a response. BOM provided these e-mails for review during the interview. An e-mail dated 8/30/24, was sent from DOM to BOM asking if the outside company had been paid for any of the invoices they had sent. A response, also dated 8/30/24, identified BOM showed no payments having been made to the company. A subsequent e-mail, dated 9/4/24, was sent from BOM to ACP-A, the administrator, and facility' owner. The e-mail outlined, " ... Please advise when [outside company] will receive payment. We currently owe them $9,445.49." [DOM] stated we need to keep in good standing with this company for further work." There was no response received. A subsequent e-mail, dated 9/16/24, was sent from BOM to ACP-A, the administrator, and facility' owner. The e-mail outlined DOM called the outside company to complete work on the chillers, however, the company stated they only received a $5,000.00 payment on 9/13/24 and, " ... a large balance is still owed to them," adding further, "[DOM] stated they did not want to come	F 835		

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F 835	Continued From page 27 out to service the chiller until they knew when the remaining payment would be made." However, again, there was no response to the e-mail. Further, an additional e-mail, dated 10/7/24, was sent from BOM to the same individuals (after the survey team arrived). The e-mail outlined, "Please advise when [outside company] will receive payment. They need to receive payment before they will come shut the chillers off and transition to heat. Weather is starting to get cooler here in Minnesota. [DOM] stated they will not come out and do any more work until payment is received." This was responded to by the care center owner asking how much was owed and how much was needed to," ... get things under way?" DOM verified the outside company would not return until the invoices were paid or, at minimum, a payment was made towards them. DOM stated the company owner had been coming and helping them off and on since July 2024, but added it was not due to payment rather just "the kindness of his heart." BOM verified the response from the care center owner (dated 10/7/24) was the first response to any of the sent e-mails from anyone whom they were sent to adding, "Today was the first response." DOM stated ACP-A was "very hard to get ahold of" and, at times, getting information or communication with them was difficult adding, "It's been ridiculous." On 10/7/24 at 11:27 a.m., a telephone call was placed to the HVAC company outside contractor (OC)-A and a callback was requested. On 10/7/24 at 1:17 p.m., the administrator was interviewed, and they explained the DON had	F 835		

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F 835	Continued From page 28 updated them about the cold building temperatures earlier the same day (10/7/24) adding they were unaware there was any concern about it prior. The administrator stated they had been onsite over the last weekend and felt "the temperature was fine," but expressed they had discussed the building temperature with DOM after "some staff" reported being cold. The administrator expressed the outside weather seemed to be heating back up and they decided to not activate the HVAC system to not overheat people, either. The administrator verified the staff concerns about the building temperature were initially reported over the weekend, however, he added, "But everybody's body temp is different." The administrator recalled a visit with the DOM about the HVAC system and having the outside contractor (OC)-A come back to activate the system. The administrator acknowledged being aware of repeated missed payments to OC-A adding aloud, "The company [care center] has been slower in giving out the payments." However, the administrator stated they, just that day (10/7/24), spoke with the care center owner and a payment would be made but added, "I don't think it's going to be the whole payment." The administrator stated OC-A "seemed OK with that right now." The administrator explained the "back office" was responsible for the payments adding he himself had been trying for awhile to get OC-A paid even reaching out to the owner the week prior inquiring about the past-due invoices expressing hope they would connect with payment to OC-A "pretty soon." The administrator stated they had no involvement with any pre-arranged payment plans to OC-A. When interviewed on 10/7/24 at 4:36 p.m., ACP-A verified they helped oversee the accounts	F 835		

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F 835	Continued From page 29 payable to outside vendors for the care center, and vendor invoices or bills are filed with the building and routed to them for payment, typically. ACP-A verified the past-due invoices for OC-A and stated they had not been made aware of them until September 2024 adding there was "a whole slew" of bills and invoices which had not been processed yet. ACP-A stated when they were made aware of them back in September, they reached out to OC-A and a payment plan was arranged with multiple payments being made since then but with still current, past due invoices totaling several thousand dollars. ACP-A stated they had just that day (on 10/7/24) made another $11,000 payment so the OC-A invoices would now be paid up until the "early August" billing period (still two months prior). Further, ACP-A stated the care center had "several bills" which had not been processed timely, including to OC-A, and they were unsure of the rationale for it (i.e., vendor error, care center issue). A return call from OC-A was received on 10/8/24 at 7:43 a.m., and they were interviewed. OC-A verified they owned the company who had been working with the care center with their HVAC system. OC-A explained they had been involved with the care center since July 2024 and "the biggest concern" for resident's was their heating system. OC-A stated the care center was behind on payments and they had just now (on 10/7/24) finally "got the green light" from the office to service the system as a payment was made adding the partial payment was enough "just to allow us to be onsite." OC-A verified if no payment had been made on 10/7/24 (when the health survey was onsite), then no work or activation on the HVAC system would have been completed adding, "We couldn't be onsite." OC-A	F 835		

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F 835	Continued From page 30 verified the HVAC system was unable to be activated or switched over without OC-A being onsite, adding the system, in general, was an "old application" and "[we] need to do everything manually."	F 835		

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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: The Terrace at Crystal is a Special Focus Facility (SFF). On 8/26/24 - 8/30/24, 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	2 000		

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2 000	Continued From page 1 correction you have reviewed these orders and identify the date when they will be completed. The following complaints were reviewed with no licensing orders issued H52896512C (MN00105426) H52895949C (MN00101491) H52895950C (MN00098833) H52895951C (MN00097757) H52895791C (MN00097229) H52895953C (MN00096923) H52895953C (MN00096922) H52895953C (MN00096919) H52895865C (MN00096533) H52895867C (MN00095875) H52895869C (MN00092173) H52895870C (MN00092145) H52895871C (MN00091654) H52895873C (MN00091493) H52895873C (MN00091358) H52895874C (MN00091299) H52895875C (MN00090821) H52895875C (MN00090765) H52895876C (MN00090694) H52895877C (MN00090270) H52895794C (MN00087667) H52895795C (MN00087193) H52895796C (MN00086993) H52895797C (MN00086851) H52896003C (MN00086697) H52896004C (MN00086388) H52896005C (MN00086362) H52895956C (MN00085438) H52895872C (MN00091629) H52896000C (MN00089858) H52895741C (MN00104838) The following complaints with licensing orders issued:	2 000		

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	00255	A. BUILDING: _____ B. WING _____	C 08/30/2024

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2 000	Continued From page 2 H52895961C (MN00101860) with a licensing order issued at 1665 H52895866C (MN00095959) with a licensing order issued at 1665 H52895868C (MN00095542) with a licensing order issued at 0920 H52895878C (MN00090052) with a licensing order issued at 0920 H52895879C (MN00089861) with licensing orders issued at 0920 and 1665 H52896001C (MN00089652) with a licensing order issued at 0920 H52895792C (MN00089548) with a licensing order issued at 0920 H52895793C (MN00087927) with a licensing order issued at 0920 H52896005C (MN00086361) with a licensing order issued at 0920 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	2 000		

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2 000	Continued From page 3 the Minnesota Department of Health Informational Bulletin https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 302	MN State Statute 144.6503 Alzheimer's disease or related disorder train ALZHEIMER'S DISEASE OR RELATED DISORDER TRAINING: MN St. Statute 144.6503 (a) If a nursing facility serves persons with Alzheimer's disease or related disorders, whether in a segregated or general unit, the facility's direct care staff and their supervisors must be trained in dementia care.	2 302		10/4/24

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2 302	Continued From page 4 (b) Areas of required training include: (1) an explanation of Alzheimer's disease and related disorders; (2) assistance with activities of daily living; (3) problem solving with challenging behaviors; and (4) communication skills. (c) The facility shall provide to consumers in written or electronic form a description of the training program, the categories of employees trained, the frequency of training, and the basic topics covered. (d) The facility shall document compliance with this section. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure 6 of 8 staff (TMA-A, LPN-D, LPN-E, administrator, director of nursing, NA-G) received annual training that included all required components of Alzheimer's/dementia care. Furthermore, the facility failed to ensure 20 of 20 agency staff who had worked in the facility in the past 30 days received annual training that included all components of Alzheimer's/dementia care. This had the potential to affect all 53 residents currently residing in the facility. Findings include: Minnesota state statute 144.6503 for Alzheimer's disease or related disorder training, directed areas of required training for direct care staff and their supervisors included: -an explanation of Alzheimer's disease and related disorders -assistance with activities of daily living	2 302	Corrected	

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2 302	Continued From page 5 -problem solving with challenging behaviors -communication skills During interview on 8/28/24 at 12:11 p.m., nursing assistant (NA)-B stated they have not received any Alzheimer's/dementia care training through the agency they are currently working for or from the facility. NA-B stated they have received dementia training in the past, from another agency, but unsure if it is in the past year and has not provided documentation to the facility or agency of this training. During interview on 8/28/24 at 2:23 p.m., trained medication aid (TMA)-A verified they are employed with the facility. TMA-A verified they have received some trainings through "Educare" but "not sure about any dementia training." On 8/29/24 at 12:19 p.m., licensed practical nurse (LPN)-A stated she has worked at the facility for over a year. LPN-A stated they have not received any Alzheimer's/dementia care training and added, "it just got assigned on Educare to be completed." During interview on 8/28/24 at 11:18 a.m., registered nurse (RN)-C verified they are an employee of the facility for more than 1 year. RN-C was "not sure about any dementia training," when asked about dementia/Alzheimer's training. TMA-A employee training record was reviewed and lacked evidence of Alzheimer's/dementia care training in the past year. LPN-D employee training record was reviewed and lacked evidence of Alzheimer's/dementia care training.	2 302		

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2 302	Continued From page 6 LPN-E employee training record was reviewed and lacked evidence of Alzheimer's/dementia care training completion. Employee training records for administrator, director of nursing and NA-G were requested and not received. A list was provided by the facility of 20 agency staff that have worked in the facility in the past 30 days (since the start of survey), which consisted of 17 nursing assistants, 2 trained medication assistants and 1 licensed practical nurse. A request for trainings was requested from the facility but was not provided. These staff were recorded as LPN-F, TMA-B, TMA-C, NA-H, NA-I, NA-J, NA-K, NA-L, NA-M, NA-N, NA-O, NA-P, NA-Q, NA-R, NA-S, NA-T, NA-U, NA-V, NA-W, NA-C. On 8/29/24 at 11:07 a.m., assistant director of nursing (ADON) provided a copy of the employee records that the facility had for the following staff requested: NA-F, TMA-A, LPN-D, LPN-E, RN-C. ADON verified this was all the trainings that have been completed that the facility had a record of for employees listed above. ADON stated, "we switched to a new system." ADON verified again, "this is all the records of the trainings that we have," adding, "if they aren't there, we don't have them." During interview on 8/29/24 at 10:27 a.m., director of human resources (DHR) verified she was responsible for assigning Educare (electronic learning management system) to all staff. DHR indicated when she started recently, she was made aware of issues Educare and "recently got it up and running." DHR verified staff have been assigned Educare courses as of 8/21/24. DHR	2 302		

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2 302	Continued From page 7 verified they are not in compliance with the trainings and are working on getting into compliance. DHR stated she was going to look into the employee paper charts to see if she could find any more trainings and provide them if she could. DHR did not provide any additional employee or agency staff trainings. On 8/29/24 at 12:33 p.m., administrator verified there was no Alzheimer's/dementia care trainings for the list of staff requested or for agency staff. A copy of facility's dementia training was requested and not provided. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could develop, review, and/or revise policies and procedures related to staff training pertaining to Alzheimer's and dementia. The DON or designee could educate all appropriate staff on the policies and procedures. The DON or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 302		
2 355	MN Rule 4658.0145 Subp. 1 Agreement as to Rates and Charges Subpart 1. Written agreement. At the time of admission, there must be a written agreement between the nursing home and the resident, the resident's agent, or the resident's guardian, which includes:	2 355		10/4/24

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2 355	Continued From page 8 A. the base rate and what services and items are provided by the nursing home and are included in that base rate; B. extra charges for care or services; C. obligations concerning payment of the rates and charges; and D. the refund policy of the home. All residents' bills must be itemized for services rendered. This MN Requirement is not met as evidenced by: Based on interview and record review, the facility failed to inform residents of rules and regulations governing their rights and responsiblities as residents in a Long-Term Care facility affecting 2 of 2 residents (R49 and R406) reviewed for resident rights. Findings include: R49 R49's admission Minimum Data Set (MDS), dated 3/10/24, indicated R49 was admitted to the care facility on 3/4/24 and was cognitively intact. R49'S Electronic Medical Record (EMR) lacked any evidence of admission paperwork being completed with R49, including rights and responsibilities of being a resident of a long-term care facility. This information was confirmed by social services on 8/27/24. During an interview on 8/29/24 at 9:40 a.m., R49 stated he was unable to determine if he had signed an admission agreement or if his rights and responsibilities as a resident of the care facility were discussed with him prior to or at	2 355	Corrected	

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2 355	Continued From page 9 admission. R406 R406's Face Sheet, printed 8/29/24, indicated R406 was admitted to the care facility on 7/25/24. R406's Brief Interview for Mental Status (BIMS) assessment, dated 8/5/24 indicated R406 had mild cognitive impairment. R406's admission MDS, dated 7/31/24, was incomplete, with all sections except K "Swallowing/Nutritional Status" listed as "Incomplete." R406'S Electronic Medical Record (EMR) lacked any evidence of admission paperwork being completed with R406, including rights and responsibilities of being a resident of a long-term care facility. This information was confirmed by social services on 8/27/24. During an interview on 8/29/24 at 9:08 a.m., R406 was in the main dining area eating breakfast. R406 stated he was not asked to sign any admission paperwork for the facility that would have included his rights and responsibilities as a resident of the care facility. R406 stated his daughter, listed as a contact in his EMR, lived out of state and did not visit or speak with him often. R406 shrugged his shoulders when asked if he was getting all the care he needed at the care facility. During an interview on 8/29/24 at 9:35 a.m., nurse manager and registered nurse (RN)-B stated the care facility used to have an admission nurse who would review all the admission paperwork with residents admitted to the facility,	2 355		

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2 355	Continued From page 10 but the role had been open for about a month. Social services then took over the admission paperwork, but she is unaware of who does it now with social services being new in the role. During an interview on 8/30/24 at 10:05 a.m., the director of nursing (DON) confirmed R49 and R406 were missing admission paperwork and that going forward the social worker would be responsible for completing the admission paperwork, including reviewing the residents' rights and responsibilities while residing in the care facility. A facility policy on admission agreements was requested but not received. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON), or designee, could review applicable policies and procedures on admission agreement completion to ensure accuracy; revise any polices as needed; then educate staff to ensure accuracy and timely completion. They could then audit to ensure ongoing compliance and timely admission agreement completion. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	2 355		
2 540	MN Rule 4658.0400 Subp. 1 & 2 Comprehensive Resident Assessment Subpart 1. Assessment. A nursing home must conduct a comprehensive assessment of each resident's needs, which describes the resident's capability to perform daily life functions and	2 540		10/4/24

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2 540	Continued From page 11 significant impairments in functional capacity. A nursing assessment conducted according to Minnesota Statutes, section 148.171, subdivision 15, may be used as part of the comprehensive resident assessment. The results of the comprehensive resident assessment must be used to develop, review, and revise the resident's comprehensive plan of care as defined in part 4658.0405. Subp. 2. Information gathered. The comprehensive resident assessment must include at least the following information: A. medically defined conditions and prior medical history; B. medical status measurement; C. physical and mental functional status; D. sensory and physical impairments; E. nutritional status and requirements; F. special treatments or procedures; G. mental and psychosocial status; H. discharge potential; I. dental condition; J. activities potential; K. rehabilitation potential; L. cognitive status; M. drug therapy; and N. resident preferences. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure the comprehensive Minimum Data Set (MDS) was completed in a thorough and timely manner to reflect actual resident' status and ensure appropriate care-planning for 2 of 4 residents (R7, R406) reviewed for MDS accuracy. Findings include:	2 540	Corrected	

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2 540	Continued From page 12 R7 The Centers for Medicare and Medicaid (CMS) Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, dated 10/2023, identified the RAI was used to help identify problems for a resident and address them using an individualized care plan. The manual outlined a section labeled, "Section F: Preferences for Customary Routine and Activities," which identified the intent of the items within the section was to obtain information on the resident's preferences for their daily routine adding, "Nursing homes should use this as a guide to create an individualized plan based on the resident's preferences and is not meant to be all-inclusive." The instructions outlined an interview should be done with the resident, if able to participate, and the corresponding responses coded on the MDS. On 8/26/24 at 2:33 p.m., R7 was observed in her room with her family member (FM)-G present, and the room lacked any posted activities calendar or postings. R7 was interviewed and expressed frustration over a lack of both group-based and individual activities programming at the campus. R7 stated she only attended activities "when I beg them [staff]" to include her and, if not for FM-G coming and visiting the campus often, she would "never see daylight" out of her room. R7's reiterated she was rarely, if ever, invited to group-based activities at the campus adding, "They don't take me." Further, R7 stated she had never, at least to both her and FM-G's recall, been asked about activities' likes or dislikes, goals or preferences since admitting to the care center several months prior adding, "They don't respond to me here."	2 540		

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2 540	Continued From page 13 R7's admission Minimum Data Set (MDS), dated 5/23/24, identified R7 admitted to the care center in May 2024 and had moderate cognitive impairment but demonstrated no delusional thinking. Further, the MDS contained a section labeled, "Section F - Preferences for Customary Routine and Activities," which outlined questions to be answered based on R7's responses for activities and routines, however, nearly the entire section was left dashed with, "Not Assessed." In addition, R7's medical record was reviewed and lacked any evidence a comprehensive assessment for leisure or activity-based programming, including likes and dislikes or preferences for activities, had been completed despite R7 admitting to the care center several months prior. Further, R7's care plan, printed 8/27/24, identified no specific activities problem statements, goals or interventions to ensure R7's leisure and activity needs, if any, were met. On 8/28/24 at 10:01 a.m., activities assistant (AA)-A was interviewed and verified they helped with activities on R7's unit. AA-A explained the campus didn't have an activities director until "maybe two weeks ago" when the social services designee (SSD)-A was hired to fill the role. AA-A stated they were unsure who, if anyone, had assessed the residents reviewed for activities but verified the director was responsible to do such adding, "I don't know if they did on on [R7]." Further, AA-A expressed the activities department, in general, had suffered a staffing cutback and, at times, seemed to not be able to function with several group-based items (i.e., Bingo, "Casino Night") having to be removed from the schedule over the past months. When interviewed on 8/28/24 at 10:07 a.m., SSD-A verified they were the new activities	2 540		

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2 540	Continued From page 14 director for the campus being hired just within the past few weeks. SSD-A verified activities assessments would typically be completed by the director and they were trying to catch up in the role adding they were still learning "to balance everything yet." SSD-A reviewed R7's electronic medical record (EMR) and verified the lack of an activities assessment; however, expressed one should have been completed and activities were important to the resident' quality of life adding, "[Activities] give hope for themselves and [they] can actually enjoy their life still." On 8/28/24 at 11:38 a.m., the assistant director of nursing (ADON) was interviewed. ADON explained they just very recently started working at the center but verified they were the current MDS coordinator for the campus. ADON verified they had reviewed R7's completed MDS (dated 5/23/24) and 'Section F' was simply "dashed" and not completed. ADON stated the campus was working on getting their MDS' better and more timely completed. R406 The Centers for Medicare and Medicaid (CMS) Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, dated 10/2023, identified the RAI was used to help identify problems for a resident and address them using an individualized care plan. The manual outlined an admission (Comprehensive) MDS should have an MDS completion date of no later than the 14th calendar day after the resident' admission date (i.e., admission date + 13 calendar days). R406's Face Sheet, printed 8/29/24, indicated R406 was admitted to the facility on 7/25/24.	2 540		

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2 540	Continued From page 15 R406's Brief Interview for Mental Status (BIMS) assessment, dated 8/5/24 indicated R406 was had mild cognitive impairment. R406's admission Minimum Data Set (MDS), dated 7/31/24, was incomplete, with sections A, B, C, D, E, F, GG, H, I, J, L, M, N, O, P, R, S, and V listed as "In Progress". Section K was the only section listed as "Complete". During an interview on 8/29/24 at 9:08 R406 was in the dining area, eating breakfast. R406 simply shrugged his shoulders when asked if the facility was providing him help with everything he needed. During an interview on 8/29/24 at 2:45 p.m., the assistant director of nursing and MDS nurse (ADON) stated it would be expected that R406's MDS would be completed at that time. The ADON confirmed the importance of timely MDS completion to "drive resident care" and determine the level of care a resident needed. A facility' provided MDS Completion and Submission Timeframes policy, undated, identified the care center would conduct and submit resident assessments in accordance with current Federal and State timeframe requirements. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON), or designee, could review applicable policies and procedures on MDS completion to ensure accuracy; revise any polices as needed; then educate staff to ensure accuracy and timely completion. They could then audit to ensure ongoing compliance and timely	2 540		

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2 540	Continued From page 16 assessment completion. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	2 540		
2 550	MN Rule 4658.0400 Subp. 4 Comprehensive Resident Assessment; Review Subp. 4. Review of assessments. A nursing home must examine each resident at least quarterly and must revise the resident's comprehensive assessment to ensure the continued accuracy of the assessment. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to complete the required quarterly Minimum Data Set (MDS) in a timely manner for 2 of 4 residents (R45, R46) reviewed for MDS accuracy. Findings include: The Centers for Medicare and Medicaid Services (CMS) Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual, dated 10/2023, identified the RAI consists of components including the MDS, the Care Area Assessment (CAA), and the utilization guidelines, and this process (i.e., use of the entire RAI) was mandated by CMS. The manual outlined that a quarterly assessment was a non-comprehensive assessment to be completed every 92 days and was used to track a resident's status between comprehensive assessments "to ensure critical indicators of gradual change in a resident's status are monitored".	2 550	Corrected	10/4/24

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2 550	Continued From page 17 R45's Annual MDS with an assessment reference date (ARD) was completed on 4/19/24. R45's MDS summary in the electronic medical record (EMR) had an ARD date of 7/19/24, indicated the MDS was in progress and still not completed or signed. During interview on 8/29/24 at 8:52 a.m. with assistant director of nursing (ADON)/MDS coordinator verified R45's quarterly assessment dated 7/19/24, was not completed and stated it was "in progress." During interview on 8/29/24 at 11:00 a.m., director of nursing (DON) stated MDS assessments were expected to be completed in a timely manner. DON stated they were aware the facility was behind with "a number" of MDS assessments. The undated MDS Completion and Submission Timeframes policy indicated the assessment coordinator was responsible for ensuring the resident assessments were conducted and submitted according to federal and state submission timeframes. R46's admission MDS with the assessment reference date (ARD) of 5/2/24 was the last completed MDS for R46. R46's MDS summary in the electronic medical record with an ARD date of 8/2/24, indicated the MDS was "in progress" with one section "swallowing/nutritional status" completed with the other 16 sections (medications, mood, behavior, etc) marked as "in progress". The summary indicated the MDS should have been completed by 8/16/24 but the assessment was not	2 550		

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2 550	Continued From page 18 completed. During an interview on 8/30/24 at 11:31 a.m. with the administrator and assistant director of nursing (ADON)/ MDS coordinator, the ADON stated after reviewing R46's medical, R46's MDS assessments were not up to date. The ADON stated R46's quarterly MDS should have been completed by 8/16/24 but it had not been. The undated MDS Completion and Submission Timeframes policy indicated the assessment coordinator was responsible for ensuring the resident assessments were conducted and submitted according to federal and state submission timeframes. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON), or designee, could review applicable policies and procedures on MDS completion to ensure accuracy; revise any polices as needed; then educate staff to ensure accuracy and timely completion. They could then audit to ensure ongoing compliance and timely assessment completion. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	2 550		
2 555	MN Rule 4658.0405 Subp. 1 Comprehensive Plan of Care; Development Subpart 1. Development. A nursing home must develop a comprehensive plan of care for each resident within seven days after the completion of the comprehensive resident	2 555		10/4/24

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2 555	Continued From page 19 assessment as defined in part 4658.0400. The comprehensive plan of care must be developed by an interdisciplinary team that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, with the participation of the resident, the resident's legal guardian or chosen representative. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure the resident and/or resident representative participated in care conferences for the care planning process and development of care plan interventions for 2 of 4 residents (R53 and R406) reviewed for participation of care planning. Findings include: R53 R53's admission Minimum Data Set (MDS), dated 7/22/24, indicated R53 was admitted to the facility on 7/16/24 and had severe cognitive impairment. R53's Electronic Medical Record (EMR) lacked evidence a care conference had taken place for R53 or that care needs were discussed with R53 and/or her representative. R53's EMR further lacked evidence of a baseline care plan to ensure staff were aware of her care needs within the first 48 hours of admission. During an interview on 8/29/24 at 9:50 a.m., R53's family member (FM)-A confirmed he had not been contacted about a care conference for	2 555	Corrected	

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2 555	Continued From page 20 his mom. FM-A stated he did not live near the care facility, but was able to be contacted via phone. FM-A further stated he wished he had more updates from the facility on how R53 was doing and what cares she was receiving from the facility. R406 R406's Face Sheet, printed 8/29/24, indicated R406 was admitted to the care facility on 7/25/24. R406's admission MDS, dated 7/31/24, was incomplete, with all sections except K "Swallowing/Nutritional Status" listed as "Incomplete." R406's EMR lacked evidence a care conference had taken place for R406 or that care needs were discussed with R406 and/or his representative. R406's EMR further lacked evidence of a baseline care plan to ensure staff were aware of his care needs within the first 48 hours of admission. During an interview on 8/29/24 at 9:08 a.m., R406 was in the main dining area eating breakfast. R406 stated he did not remember having a care conference since admission to the care facility and shrugged his shoulders when asked if he was receiving all the care he needed. R406 stated his daughter, listed as a contact in his EMR, lived out of town and that she did not visit. During an interview on 8/29/24 at 9:35 a.m., registered nurse and nurse manager (RN)-B stated social services had previously been responsible for setting up care conferences, but that the role had been open until recently, so she was unaware of who was currently responsible for	2 555		

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2 555	Continued From page 21 setting up care conferences. RN-B confirmed she had not been involved in a care conference for R53 or R406 and that neither resident had had a care conference since admission to the care facility. RN-B stated administration has discussed the need for care conferences, stating it was important for residents and their families/representatives to be able to voice concerns, be informed on the resident's care and what has been going on for the resident since admission to the care facility. RN-B further stated it would be expected that an admission care conference had been already held for both R53 and R406. During an interview on 8/30/24 at 10:05 a.m., the director of nursing (DON) confirmed it would be expected that an admission care conference had been held for R53 and R406 to establish resident goals and plans of care. A facility policy titled Care Planning - Interdisciplinary Team, revised 11/28/16, indicated the resident and/or the resident representative was encouraged to participate in the development of the residents' care plan, indicating every effort would be made to schedule a care conference when it was convenient for the resident and/or their representative. The policy further indicated if a resident was unable to make decision about their care or treatments, they would continue to be consulted on personal preferences. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON), or designee, could review applicable policies and procedures on care conference completion to ensure timeliness; revise any polices as needed; then educate staff to ensure accuracy and timely completion. They could then audit to ensure ongoing compliance	2 555		

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2 555	Continued From page 22 and timely care conference completion. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	2 555		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure new, person-centered fall interventions were implemented to prevent further falls and potential injury for 1 of 1 residents (R28) reviewed for repeat falls. In addition, the facility failed to accurately and comprehensively assess for smoking practices for 1 of 1 residents (28) reviewed for smoking. In addition, the facility failed to ensure an overiszed and unsecured mattress was assessed for correct fit to a resident's bed for (R44) who was reviewed saftey hazards. Findings include:	2 830	Corrected	10/4/24

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2 830	Continued From page 23 FALLS R28's admission MDS dated 6/4/24, indicated R28 had severely impaired cognition and had no rejection of care behaviors. The MDS indicated R28 was diagnosed with hypertension, diabetes, and osteomyelitis. The MDS indicated R28 used a walker and a wheelchair as mobility devices and required set-up help with toilet transfers, moderate assistance with walking ten feet, and was independent with wheelchair use. R28's care plan dated 6/24/24, indicated R28 was a "high" risk for falls related to osteomyelitis (bone infection) and cellulitis (soft tissue infection or inflammation). The fall care plan included two interventions dated 6/24/24, anticipate and meet R28's needs and ensure R28's call light was within reach and encourage R28 to use it. R28's care plan dated 6/24/24, indicated R28 had a history of substance abuse. The care plan indicated if facility staff witnessed or suspected substance use, they were to start 15-minute safety checks and vital signs every two hours for 24 hours. The substance use care plan dated 6/24/24, indicated staff were to follow the facility policy related to resident substance abuse and report any abnormal behavior to the provider. The care plan did not include new (if any) fall interventions attempted after the fall on 7/5/24 and 7/14/24. R28's progress note dated 7/5/24 at 9:19 p.m., indicated R28 was found on the floor with his wheelchair on the side with a half-empty bottle of alcohol. The note indicated R28 was assessed and had no injuries, vital signs were "stable", and R28 was transferred to bed. Facility staff completed 15-minute checks on R28, and the	2 830		

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2 830	Continued From page 24 director of nursing (DON) and the provider were notified. R28's progress note dated 7/6/24 at 1:59 a.m., indicated R28 had two abrasions on his scalp "from the fall". R28's progress note dated 7/9/24 at 10:59 a.m., indicated the interdisciplinary team (IDT) had reviewed R28's fall and R28 was "re-educated" on the risk of substance use and that it could cause serious harm. The note indicated the policy on substance abuse was reviewed. R28's progress note dated 7/14/24 at 4:00 a.m., indicated R28 was found on the floor of his room near the bathroom. The note indicated R28 was "intoxicated with alcohol" and restless in bed before the fall. The note indicated no injuries were observed and the resident was helped back to bed and encouraged to call when he needed help. The note indicated the DON and "TCP" were notified. R28's progress note dated 7/15/24 at 8:30 a.m., indicated R28 endorsed left arm pain at a "7 or 8" and said it had been bothering him since his fall. R28's progress note dated 7/15/24 at 9:37 a.m., indicated the interdisciplinary team (IDT) had reviewed R28's fall and R28 was "extremely intoxicated" throughout the shift and had attempted to self-transfer and use the bathroom. The note indicated R28 was educated on abstaining from alcohol and requesting assistance while intoxicated. R28's medical record was reviewed and did not include any new person-centered fall interventions after R28's fall on 7/14/24.	2 830		

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2 830	Continued From page 25 During an interview on 8/26/24 at 2:01 p.m., R28 stated he had fallen a couple of times at the facility while he was drinking. R28 stated after he fell, the facility had taken his bottle of alcohol and threatened to kick him out of the facility if he didn't stop drinking. R28 stated he did not remember them implementing any new interventions to make sure he was not falling while he was drinking. During an interview on 8/28/24 at 10:27 a.m., licensed practical nurse (LPN)-B stated she was aware R28 fell a couple of times while was drinking at the facility and facility staff had tried to educate R28 that drinking "will cause problems" but R28 continued to consume alcohol. LPN-C stated she was unaware of what interventions, in addition to education, facility staff had attempted. During an interview on 8/28/24 at 12:05 p.m., the unit nurse manager (RN)-B stated she was aware of R28 falling in the past. RN-B stated both of his falls were related to alcohol use, so they had implemented vital sign monitoring and encouraged him to call when he needed assistance. RN-B stated facility staff had talked to R28 about his substance use but she was unsure what other interventions would have been helpful to prevent his falls because they were related to his drinking. RN-B stated she had not attempted any additional person-centered interventions to prevent further falls other than providing R28 education on substance use. During an interview on 8/30/24 at 8:23 a.m., the DON stated she had not been at the facility at the time of the fall, so she was unsure what, if any fall interventions had been attempted for R28. The DON stated she expected staff to review the falls, determine a root cause, review old fall	2 830		

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2 830	Continued From page 26 interventions to determine effectiveness, and implement new interventions with every new fall to reduce the risk of further falls occurring. The facility's undated Falls and Fall Risk Managing policy indicated facility staff would identify fall interventions related to the resident's specific risk and causes to try to prevent and minimize the risk of falls. The policy indicated if falling reoccurs despite initial interventions, staff would implement additional or different interventions or indicate why the current approach remained relevant. SMOKING R28's Smoking Review dated 6/3/24 at 8:22 a.m., indicated R28 did not currently smoke but had a "history of smoking related incidents". The review did not indicate what these incidents were. The review indicated R28 had no signs of confusion, could make himself understood, and could verbalize the smoking policy. The review included the answer, "no", to the question, had staff reviewed the policy related to smoking times and storage materials with the resident? The review included the answer, "N/A", to the question, was a care plan initiated or updated? The review had the following questions with no answer: - Can the resident verbalize or demonstrate an understanding of the living center ' s time and place to smoke? - Does the resident remain alert during the course of smoking at all times? - Does the resident have the ability to hold a cigarette safely without a device? - Does the resident have the ability to extinguish a cigarette safely? R28's medical record was reviewed and did not	2 830		

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2 830	Continued From page 27 include further assessment of R28's safety while smoking. R28's care plan dated 6/24/24, did not address R28's smoking status or potential smoking needs. R28's provider note dated 7/30/24, indicated R28 had "ongoing marijuana use". During an interview on 8/26/24 at 2:08 p.m., R28 stated he smoked cannabis daily with a pipe since he was admitted to the facility a few months ago. R28 stated he did not recall any staff member observing him smoke but they knew he smoked. During an interview on 8/28/24 at 11:21 a.m., the infection preventionist (IP) and LPN-B stated they had both been previously aware that R28 smoked cannabis. LPN-B stated it was not something R28 hid or that was new for him. During an interview on 8/28/24 at 12:10 p.m., the unit manager, RN-B stated she was unaware that R28 smoked cannabis. RN-B stated the floor nurses were the ones who should have completed a smoking assessment, including observing R28 smoking cannabis to ensure he could do it safely. The facility's undated Smoking Policy indicating the interdisciplinary team would consider dexterity, vision, range of motion, and cognitive ability to determine if smoking restrictions were needed for a resident. The policy indicated the resident's smoking status and privileges would be reviewed correlating with the MDS schedule. UNSECURED MATTRESS	2 830		

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2 830	Continued From page 28 R44's quarterly Minimum Data Set (MDS), dated 6/11/24, identified R44 admitted to the care center in August 2023, had severe cognitive impairment, and was independent with most mobility-related activities (i.e., transfer, ambulation). On 8/26/24 at 3:12 p.m., R44 was observed lying on his bed while in his room. The bed was positioned with the head next to a wall with space to exit on both sides and multiple pairs of shoes were on the floor adjacent to the bed on the right (if lying in bed) side. The bed consisted of a metallic frame, however, the mattress was oversized and hung over the edge of the frame nearly six inches on the right side. The mattress lacked any visible secure fitting to the frame and moved easily when pushed with pressure in a side-to-side motion; and bend downward over the frame when pressed from the top on the right side. R44 was asked about his loose, unsecured mattress but merely responded, "Yea," followed by, "awhile," when asked how long his mattress had been like such. Further, the bed lacked any installed grab bars or side rails and when asked if he had sustained any falls from his bed R44 responded aloud, "I don't know about that." Immediately following, at 3:16 p.m., nursing assistant (NA)-BB was interviewed and verified they had worked with R44 prior on the overnight shift. NA-BB stated R44 often self transfers and walks in his room so, as a result, the staff "have to check on him." NA-BB observed the mattress in R44's room and verified it overhung the frame adding they recalled R44 had used the same bed and mattress for awhile. NA-BB stated the mattress looked as if it "might fall off the bed" if not centered nicely on the frame, and they pushed on it which caused it to slide around.	2 830		

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2 830	Continued From page 29 NA-BB stated the nurses had never asked them to check or monitor the bed to ensure the mattress was secure or, at minimum, centered on the frame but added, "We [aides] have responsibility to check everything [too]." Further, NA-BB asked R44 aloud if he was moving his mattress around at all which R44 responded, "Yea," along with a dismissive motion of his hand. NA-B stated they were unsure if maintenance was aware of the mattress being ill-fitting or not adding, "I work overnights." R44's most recent Bed Rail/Assist Bar Evaluation 021419-V1, dated 6/11/24, identified multiple questions to be answered by staff to complete the evaluation including what, if any, device was to be used, the resident' history of falls, and rationale for the device(s). The section to record what, if any, device was being requested was left blank, and the evaluation only outlined R44 expressed no desire for a device and did not have fluctuations in his level of consciousness or cognitive deficit (despite being identified as having severe cognitive impairment on the MDS). The remainder of the evaluation was left blank and not completed; nor was there any recorded evidence on it demonstrating the mattress and frame had been reviewed or inspected to ensure appropriate size and reduce the risk of falling from bed. R44's care plan, printed 8/29/24, identified R44 had an ADL self-care deficit due to dementia but was independent with transfers. The care plan outlined R44 was at risk for falls due to gait/balance problems and listed goals including, "The resident will be free of falls through the review date," along with interventions including anticipating and meeting his needs, ensuring the call light in within reach and having therapy treat	2 830		

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2 830	Continued From page 30 as ordered. The care plan outlined R44 had sustained a fall on 3/14/24, but it lacked any information or rationale for the use of the over-sized mattress that was unsecured to the frame. R44's medical record was reviewed and lacked evidence rationale or, if needed, interventions to ensure R44 remained safe despite the ongoing use of a mattress which was too large for the frame of the bed. On 8/26/24 at 6:05 p.m., the director of maintenance (DOM) was interviewed and observed R44's bed frame and mattress. DOM stated the mattress was "clearly not the right size" and others were available which would fit the frame better adding, "This shouldn't have been an issue at all [happened]." DOM stated their day was busy with "100 other things" happening and they were working on getting the staff to enter items, such as R44's mattress, into the work-order system to ensure it's addressed. DOM verified they inspect resident' beds on a routine basis but expressed it was typically only for residents with bed rails or bars attached adding, "That's something we need to implement then [all beds]." Further, DOM verified they would have been the department to change the bed, if notified, and nobody had updated them about it adding an over-sized mattress was a fall risk. DOM added, "He's going to fall off." When interviewed on 8/27/24 at 2:43 p.m., registered nurse manager (RN)-A stated maintenance was responsible to check and "ensure the bed is OK." However, if nursing had noticed issues with it, then a work order should have been done. RN-A verified they reviewed R44's medical record and were unable to locate	2 830		

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2 830	Continued From page 31 rationale or evidence the bed and over-sized mattress had been addressed or assessed adding, "I didn't see anything about that." RN-A stated they had just observed the bed prior and "the mattress was sliding off" so they placed some Dycem (sticky fabric) underneath of it. RN-A verified the over-sized, unsecured mattress was a safety hazard for R44 adding aloud, "He could slide off." A facility' provided Bed Safety policy, undated, identified the resident's sleeping area would be evaluated by the interdisciplinary team (IDT), and the care center would provide multiple approaches to prevent death or injury from it including, "Inspection ny maintenance staff of all beds and related equipment as part of our regular bed safety program to identifiy risks and problems including potential entrapment risks." SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures related to comprehensive assessments regarding falls. The director of nursing or designee could develop a system to educate staff and develop a monitoring system to ensure collaboration in the development individual care plans. Additionally, the administrator or designee could develop/revise policies or procedures to ensure residents who smoke are assessed appropriately for safety. The facility should re-educate all staff identified to policies and procedures, and audit residents who smoke to determine safety and supervision occurred. The results of those audits should be taken to the Quality Assurance Performance Improvement (QAPI) committee to determine the need for further monitoring or compliance.	2 830		

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2 830	Continued From page 32 Time period for correction: 21 Days	2 830		
2 900	MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to deliver pressure ulcer care consistent with professional standards of care to prevent a facility acquired pressure ulcer for one of one resident (R8) reviewed for pressure ulcers. Findings include: R8's admission Minimum Data Set (MDS) assessment, dated 7/25/24, indicated R8 had moderately impaired cognition with no hallucination, delusions or other behavioral	2 900	Corrected	10/4/24

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2 900	Continued From page 33 symptoms noted and required maximal assistance with all activities of daily living (ADLs) except eating, oral, and personal hygiene. The MDS further indicated R8 did not have any pressure ulcers and identified R8 was at risk for developing pressure ulcers. R8's Braden Scale Assessment (a standardized, evidence-based assessment tool commonly used in health care to assess and document a patient's risk for developing pressure injuries), dated 7/23/24, indicated R8 was at very high risk for skin breakdown. R8's progress note, dated 7/19/24, indicated, [R8] "skin looks clean and intact with no wounds or bruising." R8's Progress Note, dated 8/12/24, indicated R8 to have an open area to his bottom measuring "1 cm (centimeter) x .5 (centimeter)." R8's Skin and Wound Evaluation, dated 8/16/24, indicated R8 had a stage two (II) in-house acquired facility pressure injury (partial-thickness skin loss with exposed dermis) on his coccyx (base of the spinal column) which measured 6.7 x 3.1 centimeters (cm) with an area of 11.4 cm squared. R8's Skin and Wound Evaluation, dated 8/23/24, indicated R8's coccyx stage II pressure injury measured 7.0 x 2.9 cm with an area of 7.4 cm squared. R8's Medication and Treatment Administration Record (MAR/TAR) for August indicated the following orders: -"Wounds care, Coccyx: Cleanse with vashe[wound care solution]/normal saline, apply	2 900		

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2 900	Continued From page 34 skin prep, and apply hydrocolloid [wound dressing] Q [every] Tuesday, Friday, and PRN [as needed] one time a day starting on 8/23/24." - "Wounds care, Coccyx: Cleanse with vashe/normal saline, apply skin prep, and apply hydrocolloid Q [every] Tuesday, Friday, Sunday, and PRN [as needed] one time a day starting on 8/20/24 and ending on 8/23/24." -"Barrier cream to affective areas on bottom/peri areas two times a day with a start date of 8/14/24 with an end date of 8/20/24." The MAR/TAR lacked evidence of repositioning to prevent further pressure injury or to prevent healing of in-house acquired pressure injury. The document further lacked documentation of R8's refusals. R8's care plan, printed 8/28/24, indicated R8 "has a pressure coccyx or potential for pressure ulcer development r/t [related to] immobility" which was added on 8/16/24 with the following interventions: -administer medications as ordered, -apply barrier cream after each incontinent episode -monitor /document/report PRN any changes in skin status -the resident needs assistance and to turn/reposition frequently and as needed or requested. Care plan further indicated R8 requires a mechanical lift for transfers and assist of 2 staff. R8 required a total assist of 1-2 staff with personal hygiene, oral care, dressing, and was dependent on staff for bathing. R8's care plan identified R8 has hemiplegia/hemiparesis (paralysis of one side of the body) related to a stroke with an intervention of "reposition as tolerated frequently." The care plan lacked evidence of any	2 900		

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2 900	Continued From page 35 interventions being put in place prior to the development of a pressure injury, despite being identified at very high risk for developing a pressure injury from the Braden score. Nursing assistant care sheets, provided on 8/28/24, indicated "Toilet: Frequent check and change, upon rising, before and after each meal, at bedtime, NOC [night] rounds and as needed ...ADLs: assist of 1-2 staff ...Transfers: Assist of 2 staffs with Hoyer [mechanical lift] and medium sling". The document lacked identification that R8 had a pressure injury, needed repositioning due to pressure injury or R8 needing assistance to reposition/offload in bed. Review of R8's medical record, lacked evidence of R8 being repositioned every 2 hours. During observation on 8/28/24 at 9:26 a.m., R8 was observed sitting in his wheelchair in the dining room. On 8/28/24 at 10:12 a.m., R8 was observed to be still sitting in his wheelchair in the same position in the dining room. R8 was observed to be calling out intermittently, "I am tired". On 8/28/24 at 10:50 a.m., R8 was observed in the dining room in the same position in his wheelchair. Trained medication aid (TMA)-A was observed to approach R8 and inquired what could they do for him. TMA-A stated they would bring him back to his room. On 8/28/24 at 11:03 a.m., TMA-A and R8 were observed in R8's room. At 11:13 a.m., R8 was observed to be lying in bed. R8 stated that he was comfortable and "ready to take a nap." During observation on 8/29/24 at 12:17 p.m., R8 was observed to be lying in bed with the head of the bed elevated. R8 stated he was just waking up for the day and indicated he had wanted to	2 900		

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2 900	Continued From page 36 sleep in. On 8/30/24 at 9:08 a.m., R8 was observed lying in bed. R8 was observed with the head of the bed elevated and had a breakfast tray in front of him. On 8/28/2024 at 12:11 p.m., nursing assistant (NA)-B verified they are helping care for R8 that day. NA-B stated they get the information that is needed to care for a resident from the nursing assistant care sheets. NA-B stated they were unsure if R8 has a pressure injury or needs repositioning as the nursing assistant care sheet did not reflect this. On 8/30/24 at 9:10 a.m., NA-A verified they are familiar with R8. NA-A stated that nursing assistants get the information they need about residents from the nursing assistant care sheets and "could ask the nurse if needed." NA-A stated if a resident needs repositioning, it would be on the care sheet. NA-A verified that care sheet indicated "offer frequent repositioning (every 1-2 hours)." NA-A stated they were unsure if R8 had any pressure injuries. On 8/28/2024 at 11:18 a.m., registered nurse (RN)-C stated that if a resident has a pressure injury, the resident should be on at least every 2 hours repositioning, applying barrier bream, completing skin checks, and having them up and out of bed as much as possible. RN-C verified that R8 has a pressure injury. RN-C stated that sometimes R8 prefers to stay in bed but should still be repositioned to prevent pressure injuries. RN-C stated that R8 "is checked and changed at the start of the shift, before and after lunch and at the end of the day which is about every 2 hours." RN-C verified that R8 has a foley catheter (a flexible tube that drains urine from the bladder	2 900		

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2 900	Continued From page 37 into a collection bag outside the body). RN-C was unsure if R8 had a pressure relieving device in his wheelchair but then after inquiry verified R8 did. On 8/29/2024 at 12:29 p.m., RN-A verified that R8 was at very high risk for developing a pressure ulcer based on Braden Score. RN-A verified the care plan had been updated on 8/14/24 identifying R8 was at risk/developed a pressure ulcer after R8 had developed a pressure ulcer which was identified on 8/12/24 in a progress note. RN-A verified the wound care team started to follow R8 on 8/16/24 and complete the Skin and Wound Evaluations. RN-A stated they received an order on 8/13/24 for R8 to be followed by the wound care team. On 8/30/24 at 10:01 a.m., RN-A verified that they updated the nursing assistant care sheets last evening (8/29/24) to indicate, "offer frequent repositioning (every 1-2 hours)." RN-A verified the document did not indicate this previously. RN-A verified they updated the Kardex at the same time. On 8/29/24 at 3:29 p.m., director of nursing (DON) indicated that if a resident is at high risk for developing a pressure ulcer, they would be on a turning and reposition every 2 hours, have a standard reduction mattress on their bed if not an air mattress "as that might be indicated." DON indicated we would help ensure they are offloading, have an appropriate cushion in their wheelchair, and other preventive measure in place. DON verified this would on their care plan. A facility policy titled Pressure Ulcer Treatment, undated, indicated "this procedure is to provide guidelines for the care of existing pressure ulcers	2 900		

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2 900	Continued From page 38 and the prevention of additional pressure ulcers." SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, should review all residents at risk for pressure ulcers to assure they are receiving the necessary treatment/services to prevent pressure ulcers from developing and to promote healing of pressure ulcers. The director of nursing or designee should conduct measurable audits for a specific amount of time of the delivery of care to residents affected and those who have the potential to be affected to ensure appropriate care and services are implemented and reduce the risk for pressure ulcer development. The DON or designee should bring all audit information to the Quality Assurance Performance Improvement (QAPI) committee to determine compliance or the need for further monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 900		
2 920	MN Rule 4658.0525 Subp. 6 B Rehab - ADLs Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that: B. a resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This MN Requirement is not met as evidenced by: Based on observation, interview, and document	2 920	Corrected	10/4/24

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2 920	Continued From page 39 review, the facility failed to ensure toileting needs were comprehensively evaluated and appropriate to meet the resident' needs and prevent complication (i.e., skin damage, soiled clothing) for 1 of 2 residents (R27) reviewed who was dependent on staff for care. Findings include: R27's quarterly Minimum Data Set (MDS), dated 6/5/24, identified R27 had unclear speech, severe cognitive impairment and could typically respond to simple, direct communication only. The MDS outlined R27 demonstrated no rejection of care behavior, had frequent urinary incontinence (seven or more episodes, but at least one continent void), and a toileting program trial had never been attempted. On 8/26/24 at 1:31 p.m., R27 was observed seated in a high-back geri-chair while in her room. R27's eyes were closed and R27 responded with only mumbled, non-sensical speech with surveyor' interaction. R27 had no visible catheter drainage bag attached to the wheelchair, however, immediately underneath R27 on the floor was a large amount of yellow-tinged fluid which ran outward from the wheelchair base spreading over the floor, and R27 had a detectable urine odor present to her person. There were no visible cups or drinks on R27 or within her immediate reach at this time. Immediately following, at 1:33 p.m., nursing assistant (NA)-X was alerted to the fluid underneath R27 and running across the floor. NA-X observed and verified the fluid underneath R27 and stated they had not placed R27 back into her room after the lunch meal so they were unsure what it was. NA-X was questioned on the fluid and urine odor present to which they	2 920		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 920	Continued From page 40 responded it was "maybe" urine on the floor. At 1:40 p.m., NA-Z entered the room and stated they were "coming to lay her [R27] down." NA-Z verified they had placed R27 back in her room after the lunch meal "maybe 15 minutes" prior and, at that time, there was no fluid on the floor. NA-Z stated R27 was "a heavy wetter" and they had last changed her "around 10 [a.m.] something." NA-Z stated they usually changed R27 "three times a day" on their shift and reiterated repeatedly R27 was "a big wetter." NA-Z stated all episodes of "check and change" were recorded in the point-of-care (POC) charting adding, "We chart in the computer." NA-Z stated charting was done both in real time and, at times, all at the end of the shift adding, "It depends how the day goes." At 1:50 p.m., R27 was assisted into her bed using a mechanical lift and when raised up from her wheelchair, the right side of her pants was visibly soiled with fluid. NA-Z verified no cups or drinks were present on R27 or within the chair and expressed they were unsure what the fluid was but acknowledged it could be urine adding aloud, "I don't really know." R27 was laid on her bed and her worn brief exposed which was visibly soiled with urine with no catheter-device being present. R27 was then assisted with incontinence care in bed. R27's POC Response History, printed 8/26/24, identified a 14 day look-back period of incontinence charting. The charting had two recorded times care was provided for R27 on 8/26/24 (the day of observation). This recorded care done at 12:55 a.m. and 2:51 p.m., with no care being recorded in between (over 12 hours apart). R27's most recent Bowel and Bladder Program Screener 122719, dated 3/2023, identified	2 920		

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2 920	Continued From page 41 multiple questions to be answered by staff during the review. These recorded responses outlined R27 never voided appropriately without incontinence, was immobile or required two person assistance, and was very confused or combative. The evaluation concluded with a section labeled, "Summary," which had a checkmark placed next to the option reading, "5. Resident has urostomy or suprapubic catheter and appropriate diagnosis is present." R27's most recent Quarterly Resident Review 11262021-V2, dated 6/5/24, identified R27 was alert but oriented to person only. The review listed a section labeled, "Bowel and Bladder," which included a checkmark placed next to an option reading, "7. Resident is totally incontinent." A section was provided which asked, "Any changes to bladder continence or plan of care?[,]" which was left blank. The review lacked any further information on R27's urinary incontinence including what their current toileting plan was (i.e., if it was effective or not), what type of incontinence was present (i.e., functional, etc.), nor any further information on what, if any, interventions were considered or done to manage R27's total incontinence. R27's care plan, dated 8/27/24, identified R27 was incontinent of bladder due to impaired mobility. A goal was listed which read, "The resident will remain free from skin breakdown ...," along with interventions for R27 including peri-care with each incontinence episode, monitoring for signs of a urinary tract infection (UTI), and, "BRIEF USE: The resident uses disposable briefs. Change per schedule and PRN [as needed]." The care plan lacked any further information or clarification on what the established schedule for R27 included.	2 920		

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2 920	Continued From page 42 R27's medical record was reviewed and lacked evidence R27 had been comprehensively re-assessed for her incontinence, including for the type of incontinence, any voiding patterns or trends, or medication use which could impact voiding, despite R27 being identified by staff as having incontinence (i.e., "heavy wetter") and R27 potentially having recorded continent voids as outlined on the most recent MDS (dated 6/5/24). The record lacked any evidence a new Bowel and Bladder Program Screener had been done since 2023 and after the catheter was removed; nor did the record have any evidence to demonstrate what 'schedule' had been assessed and determined as appropriate for R27 as outlined on the care plan. On 8/28/24 at 12:14 p.m., registered nurse manager (RN)-A was interviewed and verified they had reviewed R27's medical record. RN-A stated R27 was "a total" assist with toileting and likely unable to participate in a toileting schedule or program; however, RN-A explained typically programs and toileting plans were evaluated using the Bowel and Bladder Program Screeners and Quarterly Resident Review tools. RN-A verified R27's catheter was removed awhile prior and since, the staff were just doing "check and change" for her. RN-A stated the schedule, as outlined in the care plan, would be upon rising, before and after meals, at bedtime and as needed. RN-A verified incontinence episodes and care should be recorded in the POC charting and acknowledged the lack of recorded care on 8/26/24 when the surveyor had observed R27 soiled. RN-A stated they possibly had to schedule the task differently in the record adding, "Maybe this is something we need to do with [EMR]." RN-A verified the medical record lacked evidence	2 920		

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2 920	Continued From page 43 a comprehensive evaluation of R27's incontinence had been completed (i.e., screener, quarterly review) and expressed staff had never told them R27 was "a heavy wetter" before so maybe R27 needed "more frequent changes." RN-A stated it was important to ensure toileting needs and incontinence was evaluated to help prevent skin breakdown and "help fulfil the resident needs." A facility' Activities of Daily Living (ADLs), Supporting policy, dated 3/2018, identified residents would be provided with care, treatment and services as appropriate to maintain or improve their ability to carry out ADLs. The policy outlined, "Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene." This included, "Appropriate care and services will be provided for residents who are unable to carry out ADLs ... including appropriate support and assistance with ... c. elimination (toileting) ..." SUGGESTED METHOD OF CORRECTION: The director of nursing (DON), or designee, could review applicable policies and procedures on the evaluation of toileting needs for dependent residents; then educate staff on expectations and audit to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	2 920		
2 930	MN Rule 4658.0525 Subp. 7 B. Rehab - Nasogastric, Gastrostomy tubes Subp. 7. Nasogastric tubes, gastrostomy tubes,	2 930		10/4/24

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2 930	Continued From page 44 and feeding syringes. Based on the comprehensive resident assessment, a nursing home must ensure that: B. a resident who is fed by a nasogastric or gastrostomy tube or feeding syringe receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal feeding function. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure adequate cleaning of a feeding tube port (end of tube farthest from the resident) to prevent possible complications (i.e., infection) for 1 of 1 residents (R46) reviewed for tube feedings. Findings include: R46's admission Minimum Data Set (MDS) dated 5/2/24, indicated R46 had intact cognition and required substantial assistance for bed mobility, toileting, and bathing. The MDS indicated R46 received 51 percent (%) or more of their nutrition through a feeding tube. R46's medical diagnoses list, dated 4/26/24, indicated R46 was diagnosed with intestinal malabsorption and malnutrition. R46's Order Summary Report dated 7/11/24, indicated R46 received daily enteral tube feeding from 4:00 p.m. to 8:00 a.m., at a rate of 94 cubic	2 930	Corrected	

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2 930	Continued From page 45 centimeters (CC)/hour through a gastric tube. The order summary indicated nursing staff were to "cleanse g-tube site" two times a day as wound care. R46's medical record was reviewed and did not include documentation of cleansing of the gastric tube port. During an interview and observation on 8/27/24 at 8:36 a.m., R46 stated nursing staff "never" cleaned the port of his feeding tube and it had been dirty for a while. R46's tube feeding port was observed to have a black build-up noted on the inside of the port. During an interview and observation on 8/29/24 at 12:00 p.m., R46 stated his feeding port was still "filthy" and needed to be cleaned. R46's tube feeding port was observed to have a black build-up noted on the inside of the port. Licensed Practical Nurse (LPN)-B stated she was the nurse in charge of R46's care and had noticed the black build-up inside of R46's port. LPN-B stated she thought the nursing staff "never" cleaned inside of R46's port as they did not have anything to clean it with. During an interview on 8/29/24 at 12: 44 p.m., the nurse manager for the unit (RN)-B stated she was unaware of the black build-up on R46's tube feeding port but would have expected nursing staff to notify her so they could find something to use to clean it. RN-B stated she would worry about a possible infection if the tube feeding port was not cleaned. The facility's undated Changing a Feeding Tube procedure was received but did not include instructions on when or how a feeding tube port should be cleaned.	2 930		

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2 930	Continued From page 46 SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON) or designee could review and revise policies for the proper care and use of feeding tubes according to professional standards of practice. Nursing staff could be educated as necessary to the importance of regular care and cleaning of feeding tubes according to professional standards to avoid complications and/or infections. The DON or designee, should audit nursing staff assigned to residents effected and take that information to QAPI to ensure compliance and determine the need for further education/monitoring/compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 930		
21330	MN Rule 4658.0725 Subp. 2 A&B Providing Routine & Emergency Oral Health Ser Subp. 2. Annual dental visit. A. Within 90 days after admission, a resident must be referred for an initial dental examination unless the resident has received a dental examination within the six months before admission. B. After the initial dental examination, a nursing home must ask the resident if the resident wants to see a dentist and then provide any necessary help to make the appointment, on at least an annual basis. This opportunity for an annual dental checkup must be provided within one year from the date of the initial dental examination or within one year from the date of the examination done within the six months before admission.	21330		10/4/24

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21330	Continued From page 47 This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure dental needs were assessed, offered and, if needed, referred to appropriate dental services in a timely manner for 2 of 3 residents (R7, R28) reviewed for dental care. Findings include: R7's admission Minimum Data Set (MDS), dated 5/23/24, identified R7 admitted to the care center from the hospital and had moderate cognitive impairment but no delusional thinking. Further, the MDS outlined "Section L - Oral/Dental Status," which identified R7 had no natural teeth but did have mouth or facial pain or difficulty chewing. R7's Clinical Census, printed 8/29/24, identified R7's current payer source as, "Minnesota Medicaid." On 8/26/24 at 2:40 p.m., R7 was observed seated in a high-back wheelchair in her room with her family member (FM)-G present. Immediately next to her, a bedside table was present which had various items sitting on it including a cup filled with water and an upper denture plate in it. R7 stated she had no bottom dentures and needed to see a dentist about getting new dentures made adding, "I'd like to see a dentist." R7 stated her dentures caused her gums to hurt but nobody from the care center had offered or helped her to set up a dental visit yet despite her being there several months. FM-G verified no dental appointments had been offered and added, "[R7] never seen a dentist." R7's Nurse Admission/Readmission 07192021,	21330	Corrected	

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21330	Continued From page 48 dated 5/20/24, identified R7 admitted from the hospital on the same date and listed a section labeled, "Oral Status," which outlined R7 as edentulous (no natural teeth) and having broken or missing teeth on both her upper and lower palate. The section continued and provided spacing to record what, if any, dentures were used and this was answered with a checkmark placed, "8. None." The evaluation lacked evidence R7 was asked or offered a dental appointment despite having no teeth or dentures present. However, a subsequent progress note, dated 5/21/24, identified R7's family member brought in her upper denture and added, "[They] arrived when patient had just c/o [complained] something stuck on her throat, she added that it happens when she eats without dentures ... found she had pocketed food on the side of her mouth ..." In addition, R7's care plan, printed 8/27/24, identified no focus or problem statements or interventions for R7's dental needs despite having no natural teeth and being found to pocket food if eating without them. R7's subsequent Twin Cities Physician note, dated 6/5/24, identified R7 as having dysphagia (difficulty swallowing) and listed an order which read, "OK for dentist eval and treat r/t [related to] obtaining dentures." The note had hand-written notation on the bottom which read, "Confirmed 6/6/24 CN." A subsequent Oral/Dental Observation (Unscheduled), dated 8/23/24, was loaded in the electronic medical record (EMR) which indicated the evaluation as signed but unlocked. The evaluation outlined R7 used upper dentures which fit well but then recorded a, "1. Yes,"	21330		

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21330	Continued From page 49 response to questions asking if they were loose and broken. The evaluation continued and outlined R7 had her own teeth which also were recorded as broken, missing and loose but without obvious cavities. The evaluation outlined an oral exam was not completed with an option selected, "2) Uncooperative," and a date of last dental examination or offer of one as, "8/31/2024 [date not yet reached at time of survey]." On 8/28/24 at 9:11 a.m., trained medication aide (TMA)-A stated they had worked with R7 multiple times and described her as being "a little confused" but "a majority of time [she] be on point." TMA-A stated any appointments needed were scheduled by health unit coordinator (HUC)-A. TMA-A stated she had never heard any complaints about dental or wanting dentures from R7, but expressed any evaluation or asking of the need for an appointment would be the nurses' responsibility adding, "The nurse does that." R7's medical record was reviewed and lacked evidence a dental appointment had been offered or arranged for R7 despite the physician referral from June 2024, and R7 being evaluated as having loose or broken dentures on 8/23/24. When interviewed on 8/28/24 at 12:35 p.m., HUC-A verified they handled and, if needed, scheduled both in-house services and outside appointments. HUC-A stated they were aware of the dental referral for R7 from back in June 2024 but she had "been in and out of the hospital" since then so it had not been scheduled yet. HUC-A explained R7 would likely need to have an outside appointment as the facility didn't have in-house dental services and, in order to proceed, they needed a registration form completed but it wasn't done yet. HUC-A stated the care center	21330		

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21330	Continued From page 50 didn't have a social worker for a period of time and that may have contributed to it not getting done. HUC-A stated they would circle back and follow-up on the dental appointment now. On 8/29/24 at 9:29 a.m., registered nurse manager (RN)-A was interviewed and verified they had reviewed R7's medical record. RN-A recalled R7's dental referral from back in June 2024, and expressed HUC-A had "said she was working on scheduling it," adding they had asked HUC-A about it again but "not recently." RN-A verified HUC-A was responsible to schedule dental appointments and acknowledged the record lacked evidence an appointment was made or rationale why it had been delayed adding, "No, I don't [see anything]." RN-A stated she just spoke with HUC-A "last week" about making sure a note gets entered into the computer with appointments moving forward but verified dental needs and appointments should be addressed "as soon as possible" to ensure no mouth pain or troubles chewing. R28's admission MDS dated 6/4/24, indicated R28 had severely impaired cognition and had no rejection of care behaviors. The MDS indicated R28 was diagnosed with high blood pressure, diabetes, and osteomyelitis (infection of the bone). The MDS indicated R28 required set-up help with oral hygiene, moderate assistance with walking ten feet, and was independent with wheelchair use. The MDS indicated R28 had obvious or likely cavities or broken natural teeth. R28's care plan dated 6/24/24, indicated R28 had his own teeth and was independent with personal hygiene. R28's Oral/Dental Observation dated 6/4/24,	21330		

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21330	Continued From page 51 indicated R28 had his own teeth that were broken and had no dentures. The observation included a section "date of last dental exam or if refused, date offered" which was left blank. R28's progress note dated 6/7/24 at 7:11 a.m., indicated R28 was requesting softer food at meals related to his dentition. R28's medical record was reviewed and did not indicate R28 had been offered, refused, or had received dental services. During an interview and observation on 8/26/24 at 1:51 p.m., R28 stated he did not have any teeth and opened his mouth, and no teeth were observed. R28 stated he used to have dentures, but they were stolen prior to entering the facility. R28 stated a social worker at the facility had offered to help him get set up for a dental appointment but then the social worker "got fired" and an appointment never was set up. During an interview on 8/29/24 at 11:11 a.m., the unit nurse manager (RN)-B stated the facility did not have a dentist that came to the facility to assess residents. RN-B stated the facility would need to make a dental appointment for R28 and that should have been triggered by the oral observation form but that must have been missed. The facility's undated Dental Services policy indicated the facility had a contract with a dentist who came to the facility every month to provide dental services. The policy indicated a record of the dental services provided to the resident would be documented in the medical record. The policy indicated nursing services was responsible for notifying social services of any dental service	21330		

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21330	Continued From page 52 needs who would then assist in making dental appointments. SUGGESTED METHOD OF CORRECTION: The director or nursing and/or designee could develop and or revise policies for provision of dental services and educate responsible staff to ensure dental needs are assessed, dental appointments are scheduled, and residents are assisted in arranging tranportation when residents request. The DON and/or designee could conduct audits of residents with dental needs to ensure residents recieve dental services consistently. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21330		
21390	MN Rule 4658.0800 Subp. 4 A-I Infection Control Subp. 4. Policies and procedures. The infection control program must include policies and procedures which provide for the following: A. surveillance based on systematic data collection to identify nosocomial infections in residents; B. a system for detection, investigation, and control of outbreaks of infectious diseases; C. isolation and precautions systems to reduce risk of transmission of infectious agents; D. in-service education in infection prevention and control; E. a resident health program including an immunization program, a tuberculosis program as defined in part 4658.0810, and policies and procedures of resident care practices to assist in the prevention and treatment of infections; F. the development and implementation of employee health policies and infection control	21390		10/4/24

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21390	Continued From page 53 practices, including a tuberculosis program as defined in part 4658.0815; G. a system for reviewing antibiotic use; H. a system for review and evaluation of products which affect infection control, such as disinfectants, antiseptics, gloves, and incontinence products; and I. methods for maintaining awareness of current standards of practice in infection control. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure enhanced barrier precautions (EBP) were implemented or followed for 2 of 2 residents (R6 and R8) reviewed for EBP. Findings include: The CDC article titled Implementation of Personal Protective Equipment (PPE) Use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms (MDROs) dated 4/2/24, indicated MDRO transmission in skilled nursing facilities was common and contributed to substantial resident morbidity. EBP is an infection control intervention to reduce transmission of MDROs by using gowns and gloves during "high contact resident care activities". The article indicated high-contact activities include changing linens, bathing, dressing, feeding tube care, etc. The article indicated EBP should be implemented (when contact precautions did not apply) for residents with wounds or indwelling medical devices (central lines, urinary catheter, feeding tube) regardless of MDRO colonization status. R6's quarterly Minimum Data Set (MDS) dated	21390	Corrected	

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21390	Continued From page 54 6/19/24, indicated R6 had severely impaired cognition, was diagnosed with respiratory failure and cerebral palsy, and required total assistance with all care activities. The MDS indicated R30 received his nutrition through a feeding tube. R6's Treatment Administration Record (TAR) dated 3/8/24, indicated R6 had an enteral feeding tube and residuals were assessed every shift. During an observation on 8/26/24 at 5:19 p.m., R6's room door was observed with no visible signage indicating what, if any, isolation precautions were necessary for resident care. During an observation on 8/28/24 at 9:38 a.m., R6's room door was observed with no visible signage indicating what, if any, isolation precautions were necessary for resident care. During an observation and interview on 8/29/24 at 7:03 a.m., R6's room door was observed with no visible signage indicating what, if any, isolation precautions were necessary for resident care. Licensed Practical Nurse (LPN)-G was observed completing hand hygiene and entering R6's room. LPN-C was not observed wearing a gown but applied gloves and was observed disconnecting R6's feeding tube from the tubing connected to the feeding pump. LPN-C was then observed assessing the feeding tube site and flushing the tube. LPN-C was observed assisting R6 with changing his shirt and applying hand splints. LPN-C stated he knew what residents needed EBP by the signage on the door and R6 did not have a sign on his door. LPN-C stated residents with wounds or urinary catheters needed EBP but not residents with a feeding tube. During an interview on 8/29/24 at 9:24 a.m. with	21390		

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21390	Continued From page 55 the infection preventionist (IP) and the director of nursing (DON), the DON stated facility staff should assess resident pre-admission documentation and implement the needed EBP signage and isolation cart before the resident's arrival to the facility. The IP stated EBP should have been implemented for residents with feeding tubes including R6. The IP stated R6's isolation status had not been reassessed after they thought R6 was soon to be discharged and had preemptively removed precautions. The IP stated they communicated to staff what precautions residents were on by the signage on their door. The IP stated correctly implementing EBP was an important step in preventing the spread of infection to residents. R8's admission Minimum Data Set (MDS) assessment, dated 7/25/24, indicated R8 had moderately impaired cognition with no hallucination, delusions or other behavioral symptoms noted and required maximal assistance with all activities of daily living (ADLs) except eating, oral, and personal hygiene. The MDS further indicated R8 had an indwelling catheter. During observation on 8/28/24 at 11:03 a.m., R8 was observed sitting in his wheelchair inside his room with trained medication aid (TMA)-A standing in the doorway with gloves on. A three-drawer plastic bin was observed placed to the left of the doorway and inside the bin were personal protective gowns. On the top of the bin were surgical masks and hand sanitizer. On the door, was a single page sign hung indicating "Enhanced Barrier Precautions." noted to be outside the door. Signage indicated: "Clean their hands, including before entering and when leaving the room," and "Providers and Staff must	21390		

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21390	Continued From page 56 also: wear gloves and a gown for the following High-Contact Resident Care Activities. Dressing, Bathing/Showering, Transferring, Changing Linens, Providing Hygiene, Changing briefs or assisting with toileting, Device care or use: central line, urinary catheter, feeding tube, tracheostomy. Wounds Care: any skin opening requiring a dressing." Nursing assistant (NA)-B was observed to enter R8's room and shut the door. Neither NA-B or TMA-A were observed to have gowns on. NA-B was not observed to use hand sanitizer or put on gloves prior to entering R8's room gloves. NA-B was observed to exit R8's room, put the mechanical lift in the hallway and go to the clean linen room and obtain clean linen. NA-B re-entered R8's room after knocking and announcing self. At 11:13 a.m., R8 was observed lying in bed comfortably. During interview on 8/28/2024 at 12:01 p.m., NA-C stated they are unsure if R8 was on any precautions and verified they had assisted R8 with a transfer. NA-C verified they entered R8 rooms and assisted with a transfer without wearing proper PPE. NA-C verified they did not wear a gown or gloves with assisting R8. NA-C verified the signage on R8's door that R8 was on EBP precautions that indicated proper PPE should be worn if assisting resident with a transfer. During an interview on 8/28/2024 at 2:27 p.m., TMA-A verified they assisted R8 without wearing proper PPE. TMA-A stated, "should wear gown and gloves when come in contact with urinals and sores or even transferring a resident on precautions," and verified they did not have on proper PPE when caring for R8. During interview on 8/28/2024 at 11:18 a.m.,	21390		

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21390	Continued From page 57 registered nurse (RN)-C verified that R8 was on enhanced barrier precautions (EBP). RN-C indicated he was on EBP due to having a foley catheter (a flexible tube that drains urine from the bladder into a collection bag outside the body). RN-C indicated that all staff should be wearing gowns and gloves when having any contact with R8 as EBP are in place "to help protect him." The facility's undated EBP policy indicated EBP was an infection prevention and control intervention used to reduce the spread of MDROs to residents. The policy indicated gowns and gloves were to be used during high-contact care activities including wound care to any skin opening requiring a dressing, care with indwelling devices, transferring, etc. The policy indicated EBP was needed when a resident had a wound or indwelling medical device such as a feeding tube. SUGGESTED METHOD OF CORRECTION: The administrator or designee could review policies and procedures to ensure proper infection control policies included up to date EBP techniques are followed per CDC and CMS guidelines. Facility staff could be re-educated on identifying and implementing appropriate transmission based precautions, and auditing of the infection control processes developed to ensure compliance and help control/prevent exposure and spread of infectious diseases. TIME PERIOD FOR CORRECTION: seven (7) days.	21390		
21426	MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control	21426		10/4/24

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21426	Continued From page 58 (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure that required tuberculosis (TB) testing was completed for 5 of 6 staff members and 2 of 6 residents (R7, R406) with the potential to affect all 53 residents residing in the facility. In addition, the facility failed to ensure TB symptom screenings were completed for 5 of 6 residents (R7, R8, R28, R46, R406) reviewed for TB screening. Findings include: The CDC Guidelines for Preventing the Transmission of Mycobacterium Tuberculosis in	21426	Corrected	

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21426	Continued From page 59 Health Care Setting, 2005, directed that all residents must receive a baseline TB screening. The baseline TB screening should consist of an assessment for TB risk factors and history; assessment for current symptoms of active TB; and testing for infection with mycobacterium tuberculosis. In addition to screenings, the residents and employees were to receive a two-step tuberculin skin test (TST) or a laboratory screening for TB. If an employee or resident tested positive for any of the aforementioned tests, a chest x-ray, and/or medical examination by a medical practitioner was to be completed to rule out active disease. RESIDENTS R7's admission Minimum Data Set (MDS) dated 5/23/24, indicated R7 was admitted to the facility on 5/20/24 and was diagnosed with heart failure, kidney failure, and dementia. R7's immunization record dated 8/29/24, indicated the first step of the TST was administered on 5/21/24 and was negative. The record indicated step two of the TST was given on 6/6/24 and the results were "pending". The record indicated step one of the TST was given on 8/29/24 and the results were pending. The record did not indicate R7 had a completed two-step TST. R8's admission MDS dated 7/25/24, indicated R8 was admitted to the facility on 7/19/24 and was diagnosed with dementia and malnutrition. R28's admission MDS dated 6/4/24, indicated R28 was admitted to the facility on 5/29/24 and was diagnosed with high blood pressure and diabetes.	21426		

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21426	Continued From page 60 R46's admission MDS dated 5/2/24, indicated R46 was admitted to the facility on 4/26/24 and was diagnosed with high blood pressure, malnutrition, and a seizure disorder. R406's Entry Tracking Record indicated R406 was admitted to the facility on 7/25/24. R406's immunization record dated 8/29/24, indicated the first step of the TST was administered on 7/26/24 and was negative. The record indicated step two of the TST was administered on 8/9/24 and the results were "pending". The record indicated step one of the TST was given on 8/29/24 and the results were pending. The record did not indicate R406 had a completed two-step TST. R7, R8, R28, R46, and R406's medical records were reviewed and no TB symptom screenings (a tool used to determine if active TB infection could be present) were identified. STAFF Nursing assistant (NA)-G TB screening tool signed on 8/9/23, indicated a TST was administered on 8/9/23 and read on 8/11/23 at zero millimeters. The form had a spot labeled "test #2" that was left blank. The form indicated a "2nd step" would be administered within one to three weeks. The form had a spot labeled "date of hire" that was blank. Licensed practical nurse (LPN)-E's TB screening tool signed on 1/25/24, indicated a TST was administered on 1/25/24 and read on 1/27/24 at zero millimeters. The form had a spot labeled "test #2" that was left blank. The form indicated a	21426		

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21426	Continued From page 61 "2nd step" would be administered within one to three weeks. The form indicated that LPN-E was hired on 1/31/24. LPN-D's TB screening tool signed on 4/18/24, indicated a TST was administered on 4/18/24 and read on 4/20/24 at zero millimeters. The form had a spot labeled "test #2" that was left blank. The form indicated a "2nd step" would be administered within one to three weeks. The form had a spot labeled "date of hire" that was blank. The administrator's TB screening tool signed on 5/30/24, indicated a TST was administered on 5/30/24 and read on 6/1/24 at zero millimeters. The form had a spot labeled "test #2" that was blank. The form indicated a "2nd step" would be administered within one to three weeks. The form indicated the administrator was hired on 6/3/24. The director of nursing's (DON) TB screening tool signed on 8/5/24, indicated a TST was administered on 8/5/24 and read on 8/7/24 at zero millimeters. The form had a spot labeled "test #2" that was blank. The form indicated a "2nd step" would be administered within one to three weeks. The form indicated the DON was hired on 8/5/24. During an interview on 8/30/24 at 9:48 a.m., the infection preventionist (IP) stated the floor nurses oversaw completing the TB symptom screening and ensuring the TST was completed. The IP stated facility staff had reviewed R7, R8, R28, R46, and R406's medical records and had not found evidence TB symptom screening was completed. The IP stated he had reviewed R7's and R406's medical records and a two-step TST was not completed. The IP stated he oversaw ensuring staff TB testing was completed but he	21426		

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21426	Continued From page 62 did not realize the TST required two steps, so he had not been having staff complete the second step. The facility Screening Residents for Tuberculosis policy dated 8/19, indicated screening of residents admitted to the facility for TB would be completed in compliance with state regulations. The facility's undated Employee Screening for Tuberculosis policy indicated the facility would ensure a newly hired employee was screened for TB before the employee started work. The policy indicated if a TST was the method used for testing a staff member for TB, it required a "two-step TST". SUGGESTED METHOD FOR CORRECTION: The director of nursing (DON) could review and revise policies and procedures for TB surveillance. The DON could educate all appropriate staff on the policies and procedures. The DON could monitor resident and employee TB screening to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21426		
21435	MN Rule 4658.0900 Subp. 1 Activity and Recreation Program; General Subpart 1. General requirements. A nursing home must provide an organized activity and recreation program. The program must be based on each individual resident's interests, strengths, and needs, and must be designed to meet the physical, mental, and psychological	21435		10/4/24

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21435	Continued From page 63 well-being of each resident, as determined by the comprehensive resident assessment and comprehensive plan of care required in parts 4658.0400 and 4658.0405. Residents must be provided opportunities to participate in the planning and development of the activity and recreation program. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to comprehensively assess and, if needed or able, develop or implement activities programming to promote quality of life for 2 of 2 residents (R7, R27) reviewed for activities and leisure-based programming. Findings include: R7's admission Minimum Data Set (MDS), dated 5/23/24, identified R7 admitted to the care center in May 2024 and had moderate cognitive impairment but demonstrated no delusional thinking. Further, the MDS contained a section labeled, "Section F - Preferences for Customary Routine and Activities," which outlined questions to be answered based on R7's responses for activities and routines, however, nearly the entire section was left dashed with, "Not Assessed [See F636]." On 8/26/24 at 2:33 p.m., R7 was observed in her room with her family member (FM)-G present, and the room lacked any posted activities calendar or postings. R7 was interviewed and expressed frustration over a lack of both group-based and individual activities programming at the campus. R7 stated she only	21435	Corrected	

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21435	Continued From page 64 attended activities "when I beg them [staff]" to include her and, if not for FM-G coming and visiting the campus often, she would "never see daylight" out of her room. R7's reiterated she was rarely, if ever, invited to group-based activities at the campus adding, "They don't take me." Further, R7 stated she had never, at least to both her and FM-G's recall, been asked about activities' likes or dislikes, goals or preferences since admitting to the care center several months prior adding, "They don't respond to me here." R7's medical record was reviewed and lacked any evidence a comprehensive assessment for leisure or activity-based programming, including likes and dislikes or preferences for activities, had been completed despite R7 admitting to the care center several months prior. Further, R7's care plan, printed 8/27/24, identified no specific activities problem statements, goals or interventions to ensure R7's leisure and activity needs, if any, were met. When interviewed on 8/28/24 at 9:11 a.m., trained medication aide (TMA)-A stated they had worked at the campus for "a year" or so and had worked with R7 multiple times prior. TMA-A stated R7 was "a little confused" but typically was "on point" with her cognition and recall. TMA-A stated R7 needed "hands on" help with most cares and two people to transfer using a mechanical lift. TMA-A explained R7's family (i.e., FM-G) was often present and would, at times, take R7 outside in her wheelchair. TMA-A stated they thought activities were being offered to R7 by the activities assistant (AA) staff. R7's POC (Point of Care) Response History, dated 8/28/24, listed a 30 day review period (i.e., look back) along with corresponding activities	21435		

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21435	Continued From page 65 attended. The listing outlined multiple examples recorded which read, "1:1 Activity," but lacked further detail of what, or how much time, this consumed. The listing recorded few, if any, group-based activities being completed for R7. On 8/28/24 at 10:01 a.m., AA-A was interviewed and verified they helped with activities on R7's unit. AA-A explained the campus didn't have an activities director until "maybe two weeks ago" when the social services designee (SSD)-A was hired to fill the role. AA-A stated they were unsure who, if anyone, had assessed the residents reviewed for activities (i.e., R7, R27) but verified the director was responsible to do such adding, "I don't know if they did on on [R7]." AA-A stated R7 would spend "about 20% of her time" in the commons area and, when up in her wheelchair, seemed to be "into everything" and willing to participate. AA-A stated they tracked activity attendance using a paper form which they then recorded in the POC charting, and expressed many of the 1:1 recorded were likely "coffee cart [push room-to-room]" or just touching base adding the activities department, in general, had suffered a staffing cutback and, at times, seemed to not be able to function with several group-based items (i.e., Bingo, "Casino Night") having to be removed from the schedule over the past months. When interviewed on 8/28/24 at 10:07 a.m., SSD-A verified they were the new activities director for the campus being hired just within the past few weeks. SSD-A verified activities assessments would typically be completed by the director and they were trying to catch up in the role adding they were still learning "to balance everything yet." SSD-A reviewed R7's electronic medical record (EMR) and verified the lack of an	21435		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21435	Continued From page 66 activities assessment; however, expressed one should have been completed and activities were important to the resident' quality of life adding, "[Activities] give hope for themselves and [they] can actually enjoy their life still." R27's quarterly MDS, dated 6/5/24, identified R27 had unclear speech, was only sometimes able to understand others or be understood herself, and had severe cognitive impairment. Further, the MDS outlined R27 demonstrated no rejection of care behaviors and required assistance to complete most cares (i.e., ADLs). On 8/26/24 at 1:50 p.m., R27 was observed in her room being assisted with personal cares. R27 was mostly non-verbal but did, at times, make audible moaning noises and yell out as staff assisted her. The room had an activity posted calendar labeled, "August," on the wall which was detached on top causing it to fold over onto itself. The posting was not read-able unless physically bent back up. During the recertification survey, from 8/26/24 to 8/30/24, a telephone interview with R27's family member (FM) was attempted. However, they were unable to be reached and did not return the call. R27's care plan, printed 8/26/24, identified R27 had impaired communication due to a previous traumatic brain injury (TBI) with aphasia (language disorder that affects a person's ability to communicate). The care plan listed a section which read, "The resident is dependent on staff for meeting emotional, physical, and social needs [related to] physical limitations," along with a goal which read, "The resident will maintain	21435		

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21435	Continued From page 67 involvement in cognitive stimulation, social activities as desired through review date (OVERDUE)." A single intervention was listed which outlined, :The resident prefers to socialize with: 1:1 musical programs, book reading in room planned interactions." However, R27's medical record was reviewed and lacked any evidence a comprehensive assessment for leisure or activity-based programming, including likes and dislikes or preferences for activities, had been completed in the last calendar to ensure the care plan remained relevant and update with R27's preferences and needs. When interviewed on 8/29/24 at 7:59 a.m., TMA-A stated they had seen R27 had some activities before but added, "Not too much." TMA-A explained R27 would, at times, yell out and disrupt so staff seemed to include her until a "real bad outburst" would happen. TMA-A stated they were unsure what, if any, other activities (i.e., 1:1) were being done with R27 adding, "I really can't tell ya." R27's POC Response History, dated 8/29/24, listed a 30 day review period along with corresponding activities attended or completed. The listing outlined a total of 11 completed, "1:1 Activity," and a single episode of, "Sensory/Small Group." The listing lacked further detail of what, or how much time, the completed 1:1 activities consumed. On 8/29/24 at 8:44 a.m., activities assistant (AA)-A was interviewed. AA-A explained R27 did not routinely attend group-based activities adding they had not noticed anything which she stayed calm at long enough to complete. AA-A verified	21435		

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21435	Continued From page 68 any assessment of activities, including likes and dislikes, would be completed by the program director. AA-A recalled R27 had been to "two or three" activities in the commons area to their recall and expressed they tried to check in with her daily and "see how she's doing or whatever." AA-A added, aside from that, they had not been able to determine what, if any, activities would be helpful or meaningful with R27. When interviewed on 8/29/24 at 11:06 a.m., the social services designee (SSD)-A was interviewed and verified they were the current activities director for the care center. SSD-A explained they had been in the role for only a short period with the previous director leaving "over a month and a half ago." SSD-A reviewed R27's medical record and verified a lack of activities assessment being done adding they were "still being worked on" since coming into the role. SSD-A verified an assessment should be completed and was important adding "so we know what their needs are during activities." On 8/28/24 at 10:23 a.m., the administrator was interviewed. He acknowledged the activities assessments not being completed expressing aloud, "That hasn't been done in weeks." The administrator stated the State (i.e., MDH) was aware of it as they were meeting with them routinely on special focus facility (SFF) calls, and they explained SSD-A was recently hired to fill the role within the past few weeks. The administrator verified the activities director typically was responsible to complete the required activities assessments and, if needed, care-planning for the residents. A facility' provided Activity Evaluation policy, dated 2/2023, identified an evaluation would be	21435		

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21435	Continued From page 69 completed and maintained for each resident at least quarterly and with any change of condition which could affect participation. The policy added, "The activities director is responsible for completing, directing and/or delegating the completion of the activities component of the comprehensive assessment," and such evaluation would be, " ... used to develop an individual activities care plan ... that will allow the resident to participate in activities of his/her choice and interest." The policy directed such evaluation was part of the medical record and should be updated at minimum every quarter. SUGGESTED METHOD OF CORRECTION: The administrator, or designee, could ensure the activities director, or designee, completes all needed assessments and care planning; then audit scheduled activities and new admissions to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	21435		
21445	MN Rule 4658.0900 Subp. 3 Activity and Recreation Program; Director Subp. 3. Activity and recreation program director. The activity and recreation program director must be a person who is trained or experienced to direct the activity and recreation staff and program at that nursing home. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to have a therapeutic recreation director (i.e., activities director) whom was	21445	Corrected	10/4/24

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21445	Continued From page 70 successfully qualified and/or credentialed, as required, to ensure competent assessment and implementation of activities programming within the care center. This had potential to affect all 53 residents at the time of survey. Findings include: See F679; Based on observation, interview, and document review, the facility failed to comprehensively assess and, if needed or able, develop individualized activities to promote quality of life for 2 of 2 residents (R7, R27) reviewed for activities and leisure-based programming. When interviewed on 8/28/24 at 10:01 a.m., activities assistant (AA)-A explained themselves and another part-time person worked to help do the campus' activities programming. AA-A stated the campus didn't have an activities director until "maybe two weeks ago" when the social services designee (SSD)-A was hired to fill the role. AA-A stated they were unsure who, if anyone, had assessed the residents reviewed for activities (i.e., R7, R27) but verified the director was responsible to do such. Further, AA-A stated the activities department, in general, had suffered a staffing cutback and, at times, seemed to not be able to function with several group-based items (i.e., Bingo, "Casino Night") having to be removed from the schedule over the past months. On 8/28/24 at 10:07 a.m., SSD-A was interviewed and verified they were the new activities director for the campus being hired just within the past few weeks. SSD-A stated they came from another senior care venue where they did social services and had never been hired to a full-time position for activities or leisure-based programming prior adding their experience with	21445		

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21445	Continued From page 71 activities was more like "I kind of helped [with them]" and only "if I didn't have anything to do. SSD-A stated the activities-based work done was essentially, "[It was] more like volunteer [based]." SSD-A verified they had never been hired or worked in a full-time position within the activities department during the past several years and they were not licensed or credentialed for activities in the State of Minnesota; nor were they a certified occupational therapist (OT). SSD-A stated the campus' administrator had informed them of needing to complete certain courses for the position but, as of that time, they had not enrolled or started them. SSD-A stated they had worked "two or three hours a week" helping in activities prior only, and explained they found the open position for the activities director on Indeed (an online job posting site) and applied; then after being hired were also given the social services position. SSD-A verified activities assessments would typically be completed by the director and they were trying to catch up in the role adding they were still learning "to balance everything yet." SSD-A reviewed the applicable medical records (i.e., R7, R27) and verified the lack of assessment; however, expressed one should have been completed and activities were important to the resident' quality of life adding, "[Activities] give hope for themselves and [they] can actually enjoy their life still." When interviewed on 8/28/24 at 10:23 a.m., the administrator acknowledged the activities assessments not being completed expressing aloud, "That hasn't been done in weeks." The administrator stated the State (i.e., MDH) was aware of it as they were meeting with them routinely on special focus facility (SFF) calls, and they explained SSD-A was recently hired to fill the role within the past few weeks. The administrator	21445		

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21445	Continued From page 72 stated they recalled SSD-A having some experience in activities but verified he was aware no courses or certifications had yet been attained adding, "She will get that done." The administrator verified the activities director typically was responsible to complete the required activities assessments and, if needed, care-planning for the residents. During the recertification survey from 8/26/24 to 8/30/24, evidence or documentation supporting SSD-A being credentialed or in-compliance with the requirements of being the activities director was requested; however, none was ever received. A facility' provided Activity Director job description, dated 2001, identified a primary purpose of the position with text reading, " ... is to plan, organize, develop and direct the overall operation of the activities department in accordance with current federal, state and local standards, guidelines and regulations, established facility policies and procedures and as directed by the Administrator." The description outlined evaluation and care-planning of activities both as, "Essential Function[s]." The description listed education or experience requirements which included the following: "Preferred, as a minimum, two (2) years or college. Degree preferred but not necessary," and, "Preferred be a qualified therapeutic recreation specialist ...," and, "Must have, as a minimum, two (2) year(s) experience in a social or recreation program within the last five (5) years, one (1) of which was full-time in a patient activities program in a health care setting .." or, "Must have completed or will complete a training course approved by the state."	21445		

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21445	Continued From page 73 SUGGESTED METHOD OF CORRECTION: The administrator, or designee, could ensure training courses are completed in accordance with the appliable regulations or hire/promote another person who meets the criteria to lead the department. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	21445		
21540	MN Rule 4658.1315 Subp. 2 Unnecessary Drug Usage; Monitoring Subp. 2. Monitoring. A nursing home must monitor each resident's drug regimen for unnecessary drug usage, based on the nursing home's policies and procedures, and the pharmacist must report any irregularity to the resident's attending physician. If the attending physician does not concur with the nursing home's recommendation, or does not provide adequate justification, and the pharmacist believes the resident's quality of life is being adversely affected, the pharmacist must refer the matter to the medical director for review if the medical director is not the attending physician. If the medical director determines that the attending physician does not have adequate justification for the order and if the attending physician does not change the order, the matter must be referred for review to the Quality Assurance and Assessment (QAA) committee required by part 4658.0070. If the attending physician is the medical director, the consulting pharmacist shall refer the matter directly to the QAA. This MN Requirement is not met as evidenced by:	21540		10/4/24

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21540	Continued From page 74 Based on interview and document review, the facility failed to ensure the development of parameters for administration of high blood pressure medication was assessed and implemented with blood pressure monitoring to ensure the parameters were met, if needed, to decrease the risk for complications for 1 of 5 residents (R28) reviewed for unnecessary medication use. Findings include: R28's admission MDS dated 6/4/24, indicated R28 had severely impaired cognition and had no rejection of care behaviors. The MDS indicated R28 was diagnosed with hypertension (high blood pressure), diabetes, and osteomyelitis (infection of the bone). The MDS indicated R28 used a walker and a wheelchair as mobility devices and required set-up help with toilet transfers, moderate assistance with walking ten feet, and was independent with wheelchair use. R28's care plan dated 6/24/24, indicated R28 was a "high" risk for falls related to osteomyelitis and cellulitis (soft tissue infection or inflammation). The care plan did not include antihypertensive (high blood pressure medication) medication use and required monitoring. R28's progress note dated 7/6/24 at 1:59 a.m., indicated R28's blood pressure was measured post-fall and was 151/80. R28's Order Summary Report dated 7/9/24, indicated R28 received 100 milligrams (mg) of metoprolol (an antihypertension medication) two times a day for hypertension. The order did not include parameters indicating when the medication should be held related to blood	21540	Corrected	

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21540	Continued From page 75 pressure or heart rate. R28's progress note dated 7/14/24 at 4:00 a.m., indicated R28's blood pressure was measured post-fall and was 134/50. R28's progress note dated 8/3/24 at 10:02 p.m., indicated R28 blood pressure was taken related to alcohol intoxication and was 125/64. R28's Medication Administration Record (MAR) dated 8/1/24 through 8/27/24, indicated R28 had received metoprolol (approximately) twice a day during this period but did not include blood pressure measurements taken before metoprolol administration. R28's Blood Pressure Summary with a print date of 8/29/24, identified R28's collected blood pressures for the past several months with the last blood pressure measurement dated 7/5/24. The summary included three blood pressure measurements since admission ranging from 117-131/58-73 mmHg. During an interview on 8/29/24 at 10:21 a.m., licensed practical nurse (LPN)-C stated she had administered R28's blood pressure medication this morning. LPN-C stated she was unsure what his blood pressure was this morning or if it was safe to administer the medication as she had not measured R28's blood pressure. LPN-C stated the electronic medical record (EMR) notified her when she needed to take a resident's blood pressure and it did not for R28, so she had not taken it. LPN-C stated she was unsure why his metoprolol order did not include this notification to take his blood pressure or tell her when she should hold the medication.	21540		

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21540	Continued From page 76 During an interview on 8/29/24 at 11:04 a.m., the unit nurse manager (RN)-B stated she expected nursing staff to measure R28's blood pressure before giving the metoprolol to ensure R28's safety. RN-B stated she expected the provider to include parameters with the metoprolol order so nursing staff would know when it was unsafe to give the medication and when they needed to notify the provide of blood pressure readings. RN-B stated she expected nursing staff to document blood pressure measurements taken prior to administering antihypertensives in the MAR. During an interview on 8/29/24 at 2:31 p.m., nurse practitioner (NP)-A stated she expected staff to take R28's blood pressure before administering his metoprolol to ensure R28's blood pressure did not drop lower than desired causing possible safety issues. NP-A stated she would look at R28's metoprolol order as she expected parameters for when nursing staff should hold the medication and notify her and she was unsure why that was not added. The facility's undated Hypertension Clinical Protocol indicated blood pressure should be monitored over time and trends or patterns should be responded to. The protocol indicated a resident's "blood pressure control" should be monitored "periodically" but did not give a specific recommendation for how often blood pressure should be monitored for a resident on antihypertension medication. SUGGESTED METHOD OF CORRECTION: The director of nursing or desginee could review records of residents prescribed medications for appropriate monitoring. Education of appropriate	21540		

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21540	Continued From page 77 staff could be provided. Audits could be conducted and the results brought to the quality committee for review. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21540		
21665	MN Rule 4658.1400 Physical Environment A nursing home must provide a safe, clean, functional, comfortable, and homelike physical environment, allowing the resident to use personal belongings to the extent possible. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure structural issues and items in disrepair throughout the facility were addressed and fixed in order to help promote a functional, sanitary and safe environment. This had the potential to affect all 53 residents residing within the facility. Findings include: Kitchen During observation on 8/26/24 at 1:24 p.m., the floors throughout all areas of the main kitchen were dirty and had particles of food and small dry black particles stuck to the floor. During observation on 8/27/24 at 7:58 a.m., the main kitchen floor was dirty with food particles, small pieces of paper, and many small dry black particles stuck to the floor.	21665	Corrected	10/4/24

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21665	Continued From page 78 During interview on 8/27/24 at 8:11 a.m., cook (C)-A stated he mopped the floor on 8/26/24 before the end of his shift. C-A verified the kitchen floor still had debris and dry black particles stuck to the floor. C-A stated, he started to work at this facility a week ago and the floor needed a deep clean. During observation and interview on 8/28/24 at 12:56 p.m., regional kitchen manager (RKM) verified the kitchen floors were dirty. RKM stated the condition of the floors was not satisfactory, and they needed to be cleaned. RKM stated a week ago, the kitchen manager was terminated from their position and there was no documentation of the kitchen's cleaning schedule. RKM added he had written a cleaning schedule to be implemented right away. Second Floor During observation on 8/29/24 at 7:38 a.m., one of the two beams supporting a horizontal beam against the ceiling in the solarium had a crack extending its entire length, exposing the sheetrock behind the beam, and in an area of the crack, a one foot long by six-inch-wide area of the sheetrock was peeling. The vinyl base board of the beam was peeling from the wall, exposing the sheetrock. Also, a 12-inch section of the wooden baseboard, along the wall facing outside the solarium, was peeling, and rotted. During observation and interview on 8/29/24 at 11:18 a.m., the maintenance director (MD) stated he didn't have a work order for the support beam but was aware of the problem. During observation on 8/29/24 at 8 a.m., the right side of the ceiling and wall facing the nurses's	21665		

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21665	Continued From page 79 station had signs of water damage. The ceiling had light brown colored areas and peeling paint. The wallpaper in some areas was bubbled up and peeling along the edges, exposing the unfinished wall. During interview on 8/29/24 at 9:34 a.m., nursing assistant (NA)-CC stated the wall and ceiling had water damage and it should be repaired. NA-CC state the wall and ceiling had been like this for a several months. During observation and interview on 8/29/24 at 11:18 a.m., the MD stated he didn t have a work order for disrepair on the ceiling but was aware of the problem. During observation on 8/29/24 at 7:18 a.m. the window frame had cobwebs from the top of the window frame down to a large clear plastic bin sitting on the vent unit. The curtain on the left side of the window was hanging down with only half of the curtain on the curtain rod. During observation and interview on 8/29/24 at 11:18 a.m., the MD stated he didn't have a work an order and was aware not aware of this problem. During observation and interview on 8/30/24 at 9:42 a.m., the floor of a R49's room was observed to be wet. There were several comforters on the floor underneath and around the ventilation unit below the window sill. R49 stated, whenever it rains, "Every time it rains, I get water in my room. The water comes through the vent and floods my room." R49 stated he had reported this issue "over and over", but maintenance had not done anything about it and the wet floors were a reported safety concern.	21665		

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	00255	A. BUILDING: _____ B. WING _____	C 08/30/2024

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21665	Continued From page 80 During observation and interview on 8/29/24 at 11:18 a.m., the MD stated he didn't have a work order but has been aware of the water leaking into the room from the outside. Second Floor- Memory Care unit During observation on 8/29/24 at 8:00 a.m., a two by two-and-a-half-foot section of the baseboard on the wall behind the TV was peeling from the wall exposing the sheetrock. During interview on 8/29/24 at 10:08 a.m., nurse manager/registered nurse (RN)-A verified the baseboard was peeling from the wall. RN-A stated maintenance needed to repair it. RN-A was not sure if there was a work order for the maintenance department. During observation and interview on 8/29/24 at 11:18 a.m., the MD stated he didn't have a work order but was aware of the problem. During observation on 8/28/24 at 10:32 a.m., R45's bed control cord had black tape around several areas of the cord. The cord was frayed and had a three to four inches of exposed copper wires touching the bed linen. During interview on 8/28/24 at 10:37 a.m., trained medication aid (TMA)-A verified the condition of the bed control's cord. TMA-A stated the staff is expected to report concerns to the nurse on duty or the nurse manager. TMA-A stated the bed control cord had been taped like that for "months". TMA-A stated she had no knowledge of how to request or fill out a work order for the maintenance department. TMA-A stated she didn't know if the maintenance department had a	21665		

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21665	Continued From page 81 work order. During interview on 8/28/24 at 10:40 a.m., the MD verified the condition of the bed control cord and said "Oh my God. The staff didn't place a work order." MD stated the condition of the cord was unsafe because the copper wires were exposed and were touching bed linen. During observation on 8/26/24 at 3:12 p.m., a room had dry unsanded dry wall repair exposed in two walls. In addition, the wall behind the head of the bed had various sizes of orange and red splattered marks. Some of them were flat while others had a grainy surface. The observed marks covered the wall behind and around the head of the bed, about one and a half feet to each side and up to three feet above the head of the bed. During interview TMA-A stated the unrepaired areas on the walls "had been like that for a while", as well as the colored spots on the wall. TMA-A added the walls had been like that for two to three months, the repairs should be finished and the wall should be cleaned and re-painted. TMA-A stated she didn't know if the maintenance department had a work order. During observation and interview on 8/29/24 at 11:18 a.m., the MD stated he didn't have a work order but was aware of the problem. During observation on 8/26/24 at 1:31 p.m., a resident's room had an about six feet of a gray colored baseboard on the wall which was pulled away and was laying on the floor exposing the sheetrock behind it. Cardboard colored debris was observed on the floor between the wall and the peeled baseboard.	21665		

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21665	Continued From page 82 During interview on 8/29/24 at 8:34 a.m., TMA-A stated the baseboard had been like that for a while, at least a few months. TMA-A said she was not sure if this was reported to the nurse manager or the maintenance department. During observation and interview on 8/29/24 at 11:18 a.m., the MD stated he didn't have a work order but was aware of the problem. Third Floor During observation and interview on 8/26/24 at 2:53 p.m., a R40 stated the overhead light in their room had been broken for two to three months. R40 stated two maintenance staff members on different occasions, checked the overhead light. Resident both maintenance "guys" told her, the overhead light was old and the parts required to fix it were hard to find. R40 stated the light was on 24/7 and it was hard to sleep. Resident stated the light always being on was causing her to lose sleep. During observation and interview on 8/29/24 at 11:18 a.m., the MD stated he didn't have a work order but was aware of the problem. During observation on 8/29/24 at 11:15 a.m., a two by two foot area of the wall next to the door had signs of water damage. This area had a tan to brownish color. The paint was bubbled and some to the paint close to the ceiling was peeling. Small particles of paint were observed on the floor and on the back and seat of R53's reclining wheelchair. During observation and interview on 8/29/24 at 11:18 a.m., the MD stated he didn ' t have a work order but was aware of the problem.	21665		

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21665	Continued From page 83 A facility document titled, Work Orders for the Terrace at The Terrace at Crystal LLC dated 8/26/24, identified 19 "Open & in Progress work orders". None of the concerns identified on the second or the third floor were included in this document. On 8/29/24 at 11:18 a.m. a full tour of the building was completed with surveyor and MD in which MD verified all the above documented areas of concern identified on the second and third floor. MD stated he was hired at the end of June 2024 and did a walk-through at the time of the whole building. MD stated, he didn't have work orders for any of the problems above identified on the second or third floor, but he was aware of all the issues identified during the facility's tour. MD stated the building had not been properly mantained. MD stated, he has been working on the most urgent issues, including the air conditioning. During interview on 8/30/24 at 10:30 a.m., the administrator stated, when he started to work at this facility, he walked through the building and determined the walls needed to be repaired, carpets and floors needed deep cleaning, and the call light system needed to be repaired. Administrator stated new blinds and curtains were needed. Administrator stated "it's important to have a functional building and do it right. The residents and family members will be happier to be here." The undated facility policy titled Nursing Home Maintenance and Upkeep Policy, indicated "The purpose of this policy is to ensure that The Terrace at Crystal maintains a safe, clean, and comfortable environment for all residents by	21665		

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21665	Continued From page 84 establishing guidelines for routine maintenance, repairs, safety, and sanitation." SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could educate staff regarding the importance of a safe, clean, functional and homelike environment. The DON or designee, could coordinate with maintenance and housekeeping staff to conduct periodic audits of areas residents frequent to ensure a safe, clean, functional and homelike environment is maintained to the extent possible. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	21665		
21685	MN Rule 4658.1415 Subp. 2 Plant Housekeeping, Operation, & Maintenance Subp. 2. Physical plant. The physical plant, including walls, floors, ceilings, all furnishings, systems, and equipment must be kept in a continuous state of good repair and operation with regard to the health, comfort, safety, and well-being of the residents according to a written routine maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure structural issues and items in disrepair throughout the facility were addressed and fixed in order to help promote a functional, sanitary and safe environment. This had the potential to affect all 53 residents residing within the facility.	21685	Corrected	10/4/24

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21685	Continued From page 85 Findings include: Kitchen During observation on 8/26/24 at 1:24 p.m., the floors throughout all areas of the main kitchen were dirty and had particles of food and small dry black particles stuck to the floor. During observation on 8/27/24 at 7:58 a.m., the main kitchen floor was dirty with food particles, small pieces of paper, and many small dry black particles stuck to the floor. During interview on 8/27/24 at 8:11 a.m., cook (C)-A stated he mopped the floor on 8/26/24 before the end of his shift. C-A verified the kitchen floor still had debris and dry black particles stuck to the floor. C-A stated, he started to work at this facility a week ago and the floor needed a deep clean. During observation and interview on 8/28/24 at 12:56 p.m., regional kitchen manager (RKM) verified the kitchen floors were dirty. RKM stated the condition of the floors was not satisfactory, and they needed to be cleaned. RKM stated a week ago, the kitchen manager was terminated from their position and there was no documentation of the kitchen's cleaning schedule. RKM added he had written a cleaning schedule to be implemented right away. Second Floor During observation on 8/29/24 at 7:38 a.m., one of the two beams supporting a horizontal beam against the ceiling in the solarium had a crack extending its entire length, exposing the	21685		

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21685	Continued From page 86 sheetrock behind the beam, and in an area of the crack, a one foot long by six-inch-wide area of the sheetrock was peeling. The vinyl base board of the beam was peeling from the wall, exposing the sheetrock. Also, a 12-inch section of the wooden baseboard, along the wall facing outside the solarium, was peeling, and rotted. During observation and interview on 8/29/24 at 11:18 a.m., the maintenance director (MD) stated he didn't have a work order for the support beam but was aware of the problem. During observation on 8/29/24 at 8 a.m., the right side of the ceiling and wall facing the nurses's station had signs of water damage. The ceiling had light brown colored areas and peeling paint. The wallpaper in some areas was bubbled up and peeling along the edges, exposing the unfinished wall. During interview on 8/29/24 at 9:34 a.m., nursing assistant (NA)-CC stated the wall and ceiling had water damage and it should be repaired. NA-CC state the wall and ceiling had been like this for a several months. During observation and interview on 8/29/24 at 11:18 a.m., the MD stated he didn t have a work order for disrepair on the ceiling but was aware of the problem. During observation on 8/29/24 at 7:18 a.m. the window frame had cobwebs from the top of the window frame down to a large clear plastic bin sitting on the vent unit. The curtain on the left side of the window was hanging down with only half of the curtain on the curtain rod. During observation and interview on 8/29/24 at	21685		

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21685	Continued From page 87 11:18 a.m., the MD stated he didn't have a work an order and was aware not aware of this problem. During observation and interview on 8/30/24 at 9:42 a.m., the floor of a R49's room was observed to be wet. There were several comforters on the floor underneath and around the ventilation unit below the window sill. R49 stated, whenever it rains, "Every time it rains, I get water in my room. The water comes through the vent and floods my room." R49 stated he had reported this issue "over and over", but maintenance had not done anything about it and the wet floors were a reported safety concern. During observation and interview on 8/29/24 at 11:18 a.m., the MD stated he didn't have a work order but has been aware of the water leaking into the room from the outside. Second Floor- Memory Care unit During observation on 8/29/24 at 8:00 a.m., a two by two-and-a-half-foot section of the baseboard on the wall behind the TV was peeling from the wall exposing the sheetrock. During interview on 8/29/24 at 10:08 a.m., nurse manager/registered nurse (RN)-A verified the baseboard was peeling from the wall. RN-A stated maintenance needed to repair it. RN-A was not sure if there was a work order for the maintenance department. During observation and interview on 8/29/24 at 11:18 a.m., the MD stated he didn't have a work order but was aware of the problem. During observation on 8/28/24 at 10:32 a.m.,	21685		

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21685	Continued From page 88 R45's bed control cord had black tape around several areas of the cord. The cord was frayed and had a three to four inches of exposed copper wires touching the bed linen. During interview on 8/28/24 at 10:37 a.m., trained medication aid (TMA)-A verified the condition of the bed control's cord. TMA-A stated the staff is expected to report concerns to the nurse on duty or the nurse manager. TMA-A stated the bed control cord had been taped like that for "months". TMA-A stated she had no knowledge of how to request or fill out a work order for the maintenance department. TMA-A stated she didn't know if the maintenance department had a work order. During interview on 8/28/24 at 10:40 a.m., the MD verified the condition of the bed control cord and said "Oh my God. The staff didn't place a work order." MD stated the condition of the cord was unsafe because the copper wires were exposed and were touching bed linen. During observation on 8/26/24 at 3:12 p.m., a room had dry unsanded dry wall repair exposed in two walls. In addition, the wall behind the head of the bed had various sizes of orange and red splattered marks. Some of them were flat while others had a grainy surface. The observed marks covered the wall behind and around the head of the bed, about one and a half feet to each side and up to three feet above the head of the bed. During interview TMA-A stated the unrepaired areas on the walls "had been like that for a while", as well as the colored spots on the wall. TMA-A added the walls had been like that for two to three months, the repairs should be finished and the wall should be cleaned and re-painted. TMA-A	21685		

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21685	Continued From page 89 stated she didn't know if the maintenance department had a work order. During observation and interview on 8/29/24 at 11:18 a.m., the MD stated he didn't have a work order but was aware of the problem. During observation on 8/26/24 at 1:31 p.m., a resident's room had an about six feet of a gray colored baseboard on the wall which was pulled away and was laying on the floor exposing the sheetrock behind it. Cardboard colored debris was observed on the floor between the wall and the peeled baseboard. During interview on 8/29/24 at 8:34 a.m., TMA-A stated the baseboard had been like that for a while, at least a few months. TMA-A said she was not sure if this was reported to the nurse manager or the maintenance department. During observation and interview on 8/29/24 at 11:18 a.m., the MD stated he didn't have a work order but was aware of the problem. Third Floor During observation and interview on 8/26/24 at 2:53 p.m., a R40 stated the overhead light in their room had been broken for two to three months. R40 stated two maintenance staff members on different occasions, checked the overhead light. Resident both maintenance "guys" told her, the overhead light was old and the parts required to fix it were hard to find. R40 stated the light was on 24/7 and it was hard to sleep. Resident stated the light always being on was causing her to lose sleep. During observation and interview on 8/29/24 at	21685		

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21685	Continued From page 90 11:18 a.m., the MD stated he didn't have a work order but was aware of the problem. During observation on 8/29/24 at 11:15 a.m., a two by two foot area of the wall next to the door had signs of water damage. This area had a tan to brownish color. The paint was bubbled and some to the paint close to the ceiling was peeling. Small particles of paint were observed on the floor and on the back and seat of R53's reclining wheelchair. During observation and interview on 8/29/24 at 11:18 a.m., the MD stated he didn ' t have a work order but was aware of the problem. A facility document titled, Work Orders for the Terrace at The Terrace at Crystal LLC dated 8/26/24, identified 19 "Open & in Progress work orders". None of the concerns identified on the second or the third floor were included in this document. On 8/29/24 at 11:18 a.m. a full tour of the building was completed with surveyor and MD in which MD verified all the above documented areas of concern identified on the second and third floor. MD stated he was hired at the end of June 2024 and did a walk-through at the time of the whole building. MD stated, he didn't have work orders for any of the problems above identified on the second or third floor, but he was aware of all the issues identified during the facility's tour. MD stated the building had not been properly mantained. MD stated, he has been working on the most urgent issues, including the air conditioning. During interview on 8/30/24 at 10:30 a.m., the administrator stated, when he started to work at	21685		

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21685	Continued From page 91 this facility, he walked through the building and determined the walls needed to be repaired, carpets and floors needed deep cleaning, and the call light system needed to be repaired. Administrator stated new blinds and curtains were needed. Administrator stated "it's important to have a functional building and do it right. The residents and family members will be happier to be here." The undated facility policy titled Nursing Home Maintenance and Upkeep Policy, indicated "The purpose of this policy is to ensure that The Terrace at Crystal maintains a safe, clean, and comfortable environment for all residents by establishing guidelines for routine maintenance, repairs, safety, and sanitation." SUGGESTED METHOD OF CORRECTION: The administrator or designee could conduct necessary deep clean to the kitchen floors. The The administrator or designee could set up a routine deep cleaning task. The administrator or designee could conduct routine audits of kitchen sanitation. In addtion, the administrator, maintanice director or designee could develop, review, and/or revise policies and procedures to ensure the building is kept in continuous state of good repair and operation. The administrator or designee could educate all appropriate staff on the policies and procedures. The administrator or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21685		

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21880	Continued From page 92	21880		
21880	MN St. Statute 144.651 Subd. 20 Patients & Residents of HC Fac.Bill of Rights Subd. 20. Grievances. Patients and residents shall be encouraged and assisted, throughout their stay in a facility or their course of treatment, to understand and exercise their rights as patients, residents, and citizens. Patients and residents may voice grievances and recommend changes in policies and services to facility staff and others of their choice, free from restraint, interference, coercion, discrimination, or reprisal, including threat of discharge. Notice of the grievance procedure of the facility or program, as well as addresses and telephone numbers for the Office of Health Facility Complaints and the area nursing home ombudsman pursuant to the Older Americans Act, section 307(a)(12) shall be posted in a conspicuous place. Every acute care inpatient facility, every residential program as defined in section 253C.01, every nonacute care facility, and every facility employing more than two people that provides outpatient mental health services shall have a written internal grievance procedure that, at a minimum, sets forth the process to be followed; specifies time limits, including time limits for facility response; provides for the patient or resident to have the assistance of an advocate; requires a written response to written grievances; and provides for a timely decision by an impartial decision maker if the grievance is not otherwise resolved. Compliance by hospitals, residential programs as defined in section 253C.01 which are hospital-based primary treatment programs, and outpatient surgery centers with section 144.691 and compliance by health maintenance organizations with section	21880		10/4/24

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	00255	A. BUILDING: _____ B. WING _____	C 08/30/2024

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21880	Continued From page 93 62D.11 is deemed to be compliance with the requirement for a written internal grievance procedure. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure a voiced and logged grievance concerning missing item(s) was addressed and resolved to satisfaction for 1 of 1 resident (R12) reviewed for grievances who reported missing items. Findings include: R12's quarterly Minimum Data Set (MDS) assessment, dated 7/18/24, identified R12 had intact cognition and demonstrated no delusions or other behavioral symptoms. During interview on 8/27/24 at 11:33 a.m., R12 stated he had several clothing items gone missing. R12 stated he reported missing items to staff and completed a Personal Belongings Inventory log with staff, which he provided a signed copy. The log was signed by staff and R12 on 7/12/24 which included items R12 currently had and items R12 reported missing. The list included a total of 14 detailed clothing items that were reported missing. R12 stated he was told, "probably won't be able to refund your clothes .... don't know exactly what you had...would check lost and found but not sure if did it ... never had follow-up or grievance with them." R12's Personal Belonging Inventory document, signed and dated 7/12/24 by R12 and staff,	21880	Corrected	

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21880	Continued From page 94 included items reported missing. The document included a detailed list of 14 clothing items R12 reported to staff as missing. During an interview on 8/28/2024 at 11:18 a.m., registered nurse (RN)-C stated when a resident reports clothing items are missing, the facility tries to help the resident find the item and lets the housekeeper and their manager know about the missing item. RN-C stated they will then write it on a piece of paper to pass it along to the next staff or manager. RN-C stated she has not seen any form to fill out for reported missing items. RN-C stated all clothing items should be labeled, laundry takes care of that and was unsure of the process besides notifying laundry if she notices a piece of laundry needs to be labeled. During an interview on 8/29/24 at 12:00 p.m., laundry aid (LA)-A stated laundry labels all clothing. LA-A stated when a new resident moves in, nursing typically lets us know and will put all their clothing in a bag and bring it down to be labeled. LA-A stated usually only new residents have clothing that is not labeled. LA-A stated when they get clothing that is not labeled, they will keep it for a little while, "maybe 3 weeks" and then will put it in the lost and found. LA-A added, "sometimes we might bring upstairs and ask." During an interview on 8/29/2024 at 12:29 p.m., RN-A indicated that the social worker would be the person to follow up on missing clothing items. RN-A stated they would work on replacing items. RN-A indicated that nursing would fills out an Inventory Form and brings it to social services to follow up. During an interview on 8/29/24 at 3:25 p.m., social services designee (SSD)-A stated the	21880		

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21880	Continued From page 95 process for a missing item is to fill out a grievance form, attempt to find the item and replace the item if needed. SSD-A reviewed R12's Personal Belongings Inventory document, verified that it was completed by R12 and a previous staff member and stated it had not been followed up on at this time. SSD-A indicated she was going to follow up regarding R12's reported missing items. During interview on 8/29/24 at 3:29 p.m., director of nursing (DON) indicated they are working on a new grievance process with new forms. A facility policy on grievances was requested and not provided. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee should review and revise policies and procedures related to greivances to ensure grievances are acted upon and the resident given a resolution to the identified grievance. The director of nursing, social worker, or designee should develop a system to educate staff and develop a monitoring system such as measurable audits to ensure grievacnes are acted upon and the resolution notification is made to the resident and/or family. The results of those audits should be taken to the QAPI committee to determine compliance or the need for further monitoring. The administrator should be responsible to ensure this occurs. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21880		

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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 10/7/24, an onsite revisit was conducted to follow up on deficiencies issued related to a licensing survey exited onn 8/30/24, by the Minnesota Department of Health (MDH). Your facility was not in compliance with the MN State Licensure. The original licensing order issued will remain in effect, and a penalty assessment was	{2 000}		

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{2 000}	Continued From page 1 issued. The following licensing order was recited: St 0830 In addition, licensing orders were cited at St 0130 and St 1705 Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin <https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html> The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. PLEASE DISREGARD THE HEADING OF THE	{2 000}		

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{2 000}	Continued From page 2 FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	{2 000}		
2 130	MN Rule 4658.0050 Subp. 1 Licensee;General duties Subpart 1. General duties. The licensee of a nursing home is responsible for its management, control, and operation. A nursing home must be managed, controlled, and operated in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility' administration failed to provide oversight to ensure financial obligations to an outside contractor were effectively administered and adequately maintained to ensure ongoing, uninterrupted service of the facility-wide heating, ventilation, and air conditioning (i.e., HVAC) system. This resulted in an unpaid balance of several thousand dollars causing the contractor to stop service and corresponding resident' discomfort (i.e., cold) when the heating system couldn't be activated causing indoor temperatures to fall below 71 degrees (F). This had the potential to affect all 51 residents who resided in the facility and staff and volunteers who worked in	2 130	Corrected	10/29/24

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2 130	Continued From page 3 the facility at the time of the survey. Findings include: On 10/7/24 at 9:36 a.m., the second-floor locked unit (i.e., memory care) was toured which was housed behind a set of locked, coded doors. On the unit, nearly all resident' room doors were open and many residents on the unit were in bed covered under blankets, and the ambient air on the entire unit was cold feeling to open skin. At the same time, trained medication aide (TMA)-A was standing at a mobile medication cart with their plush winter jacket on. TMA-A was interviewed and stated the unit was too cold, adding aloud, "That's why many of them [residents] don't wanna get up." TMA-A stated the indoor air had been cold "since it got cold outside" but clarified a timeframe adding it had been like such for "the last four days" or so. TMA-A stated the maintenance team was aware of the air being cold and added, to their knowledge, the management team was aware of the cold air adding, "You can't help but notice it." TMA-A stated multiple residents had complained about the cold air but added it would be hard to visit with them about it as "this [unit] is memory care," however, TMA-A directed the surveyor to R1 who could likely be interviewed about it. Immediately following on 10/7/24 at 9:41 a.m., R1 was observed lying in bed while in her room. R1's knees were bent up causing her to appear with a fetal-like position while covered under multiple, different colored blankets which were pulled up to her chin. R1 stated the air was cold in her room adding aloud, "It is!" R1 stated the air had been cold for "awhile now" adding she was unsure a timeframe but expressed, "Sometimes [it's] even colder at night." R1 reiterated it was too cold and she wished it was warmer on the unit.	2 130		

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2 130	Continued From page 4 On 10/7/24 at 9:46 a.m., the director of maintenance (DOM) was interviewed and verified knowledge of the building cold air temperature adding it was "a building wide" issue. DOM explained they had just that day (10/7/24) got the cooling system for the HVAC deactivated but stated it had been working and actively cooling for the past week or so. DOM stated the facility had an outside company who helped manage their HVAC system, and they were needed to switch the system from cooling to heating so DOM had reached out them on 10/7/24, and they were now "getting preparations ready" to make the switch over to heating. DOM verified the building had no current active building-wide heating system due to the system not being changed over from cooling to heating. DOM stated they had been checking some ambient air temperatures within the building over the past few weeks, however, had not been tracking or documenting them. Following this discussion, a tour of the entire building was completed with DOM and, using a facility' supplied hand-held thermometer, DOM obtained a series of temperature checks with the surveyor present. These were as follows: 1) The basement level (included various offices and conference rooms) was measured at 65.5 F; 2) The first-floor level (included various offices, a central commons area, and the main resident dining room) was measured at 65.0 F; 3) The second-floor level (off the elevators and included a nursing station, resident rooms) was measured at 65 F; and the locked memory care unit (which contained resident rooms) measured at 64 F;	2 130		

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2 130	Continued From page 5 4) The third-floor level (which included a nursing station and resident rooms) was measured at 63 F. DOM acknowledged the temperatures being below 71 F and reiterated they were waiting on the outside company to switch over the HVAC system to heating adding they anticipated such would happen "within the week" but were not exactly sure. DOM expressed there wasn't anything else they could do to provide heating within the building until the company was onsite adding, "That's just where we're at." DOM stated the director of nursing (DON) was aware of the building temperature issue as they had texted them (DOM) the day prior (on 10/6/24) saying people were "getting cold," so DOM reported back they were "starting to get stuff going" with the HVAC system. DOM explained part of the reason the HVAC system had not been changed over sooner was due to monitoring the weather forecast and potentially higher temperatures were anticipated during the upcoming week. R5's admission Minimum Data Set (MDS) dated 6/4/24, indicated R5 had severely impaired cognition and had no rejection of care behaviors. On 10/7/24 at 10:09 a.m., R5 was observed seated in his wheelchair only wearing a short-sleeved shirt and a pair of jeans. No visible sweater or coats overtop. R5 was interviewed and voiced frustration with the cold temperature and stated it was "really cold" in the building for the last week. R5 stated he had told maintenance staff about the temperature and he was told the heat would not be turned on until next month. R5 stated facility staff had been wearing jackets inside for the last week and R5 thought this was related to the cold temperature inside the building. R5 stated he didn't have a coat of his	2 130		

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2 130	Continued From page 6 own so he had been feeling very cold adding staff had not offered him extra blankets or clothing during the past week. R6's quarterly MDS dated 8/2/24, indicated R6 had intact cognition. On 10/7/24 at 10:13 a.m., R6 was observed lying in bed with a sweatshirt on and the hood pulled up over his head. R6 was interviewed and stated it had been "freezing" in the facility for the past three to four days. R6 stated it was especially "chilly" at night which was annoying and caused trouble sleeping adding facility staff had not offered him anything extra to keep him warm. R7's quarterly MDS dated 8/16/24, indicated R7 had intact cognition and was diagnosed with anemia (deficiency of blood cells that carry oxygen). During interview on 10/7/23 at 10:24 a.m., R7 stated it had been very cold in the facility for the past week, and facility staff had not offered any additional interventions to keep warm. R2's annual MDS dated 9/19/24, indicated R2 had moderate cognitive impairment and was diagnosed with coronary artery disease. On 10/7/24 at 10:29 a.m. R2 was observed wearing a thick sweater, winter jacket, jogging pants, hat and snow boots. R2 stated aloud, "It's very cold [in here]." R3's quarterly MDS dated 6/26/24, indicated R3 was cognitively impaired. On 10/7/24 at 10:24 a.m. R3 was wearing a sweater, and a winter jacket. R3 stated it was very chilly and she was cold. R3 stood up and said she was going to her room, "I think it will be warmer there." R4's quarterly MDS dated 8/23/24, indicated resident had impaired cognition and diabetes	2 130		

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2 130	Continued From page 7 mellitus. On 10/7/24 at 10:33 a.m., R4 was observed lying in bed covered with multiple blankets, including up around her face. R4 stated, "I won't get out of bed or take my pills because I am too cold." R4 stated she was fully dressed adding it had "been cold for days" in the care center. R4 then re-covered her face again and said, "just take me out of here, take me somewhere else where is warm." When interviewed on 10/7/24 at 10:54 a.m., registered nurse (RN)-B stated they had worked last Wednesday (10/2/24) and the building was cold then so, as a result, they talked to management about the facility's temperature and were told maintenance was working on it. RN-B stated residents have been complaining about how cold it is so, today (10/7/24), they finally completed a 'concern form' about it adding the second-floor locked memory care unit was even colder. RN-B stated they themselves had been trying to offer extra blankets, sweaters, and jackets because the residents had been complaining about the cold for multiple days. On 10/7/24 at 10:37 a.m., a subsequent interview with DOM was held. DOM verified there was no documentation to provide to demonstrate any ongoing monitoring of the building temperature was or had been completed, including on the overnight hours, despite the onset of fall-like weather patterns setting in outdoors. DOM reiterated they had been checking some temperatures though adding most of them had been "72 or 73 ish [degrees]" over the past weeks with some periods of "68 to 70 [degrees]," adding though, "If I had to guess." DOM verified there had been no checks completed during the night hours. DOM explained the outside company had a payment plan agreement with the care center	2 130		

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2 130	Continued From page 8 adding the accounts payable (ACP)-A person offsite typically made and managed the payments. However, DOM stated within the past week or so a payment had possibly been missed or not completed due to ACP-A being on Holiday adding, as a result, the heating system couldn't be activated by the outside company "because of the payment stuff." DOM verified the heating system would not be activated until the past due invoices were either paid or a payment was made. At 10:50 a.m., the care center business office manager (BOM) joined the interviewed. BOM explained they received invoices and placed them into the "AP System" for approval by the administrator and payment via the "back office." BOM provided the current invoices for the outside company which showed a due balance which listed, "$19,328.64." The invoices had been collecting since 7/16/24, with no payment being made at all until 9/13/24 when a $5,000.00 payment was recorded. BOM stated they had just that day (10/7/24) messaged ACP-A about it, inquiring about the payment, however, expressed they had sent multiple e-mails in the past asking for the same information and never received a response. BOM provided these e-mails for review during the interview. An e-mail dated 8/30/24, was sent from DOM to BOM asking if the outside company had been paid for any of the invoices they had sent. A response, also dated 8/30/24, identified BOM showed no payments having been made to the company. A subsequent e-mail, dated 9/4/24, was sent from BOM to ACP-A, the administrator, and facility' owner. The e-mail outlined, " ... Please advise when [outside company] will receive payment. We currently owe them $9,445.49." [DOM] stated we need to keep in good standing with this company for further	2 130		

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2 130	Continued From page 9 work." There was no response received. A subsequent e-mail, dated 9/16/24, was sent from BOM to ACP-A, the administrator, and facility' owner. The e-mail outlined DOM called the outside company to complete work on the chillers, however, the company stated they only received a $5,000.00 payment on 9/13/24 and, " ... a large balance is still owed to them," adding further, "[DOM] stated they did not want to come out to service the chiller until they knew when the remaining payment would be made." However, again, there was no response to the e-mail. Further, an additional e-mail, dated 10/7/24, was sent from BOM to the same individuals (after the survey team arrived). The e-mail outlined, "Please advise when [outside company] will receive payment. They need to receive payment before they will come shut the chillers off and transition to heat. Weather is starting to get cooler here in Minnesota. [DOM] stated they will not come out and do any more work until payment is received." This was responded to by the care center owner asking how much was owed and how much was needed to," ... get things under way?" DOM verified the outside company would not return until the invoices were paid or, at minimum, a payment was made towards them. DOM stated the company owner had been coming and helping them off and on since July 2024, but added it was not due to payment rather just "the kindness of his heart." BOM verified the response from the care center owner (dated 10/7/24) was the first response to any of the sent e-mails from anyone whom they were sent to adding, "Today was the first response." DOM stated ACP-A was "very hard to get ahold of" and, at times, getting	2 130		

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2 130	Continued From page 10 information or communication with them was difficult adding, "It's been ridiculous." On 10/7/24 at 11:27 a.m., a telephone call was placed to the HVAC company outside contractor (OC)-A and a callback was requested. On 10/7/24 at 1:17 p.m., the administrator was interviewed, and they explained the DON had updated them about the cold building temperatures earlier the same day (10/7/24) adding they were unaware there was any concern about it prior. The administrator stated they had been onsite over the last weekend and felt "the temperature was fine," but expressed they had discussed the building temperature with DOM after "some staff" reported being cold. The administrator expressed the outside weather seemed to be heating back up and they decided to not activate the HVAC system to not overheat people, either. The administrator verified the staff concerns about the building temperature were initially reported over the weekend, however, he added, "But everybody's body temp is different." The administrator recalled a visit with the DOM about the HVAC system and having the outside contractor (OC)-A come back to activate the system. The administrator acknowledged being aware of repeated missed payments to OC-A adding aloud, "The company [care center] has been slower in giving out the payments." However, the administrator stated they, just that day (10/7/24), spoke with the care center owner and a payment would be made but added, "I don't think it's going to be the whole payment." The administrator stated OC-A "seemed OK with that right now." The administrator explained the "back office" was responsible for the payments adding he himself had been trying for awhile to get OC-A paid even reaching out to the owner the week	2 130		

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2 130	Continued From page 11 prior inquiring about the past-due invoices expressing hope they would connect with payment to OC-A "pretty soon." The administrator stated they had no involvement with any pre-arranged payment plans to OC-A. When interviewed on 10/7/24 at 4:36 p.m., ACP-A verified they helped oversee the accounts payable to outside vendors for the care center, and vendor invoices or bills are filed with the building and routed to them for payment, typically. ACP-A verified the past-due invoices for OC-A and stated they had not been made aware of them until September 2024 adding there was "a whole slew" of bills and invoices which had not been processed yet. ACP-A stated when they were made aware of them back in September, they reached out to OC-A and a payment plan was arranged with multiple payments being made since then but with still current, past due invoices totaling several thousand dollars. ACP-A stated they had just that day (on 10/7/24) made another $11,000 payment so the OC-A invoices would now be paid up until the "early August" billing period (still two months prior). Further, ACP-A stated the care center had "several bills" which had not been processed timely, including to OC-A, and they were unsure of the rationale for it (i.e., vendor error, care center issue). A return call from OC-A was received on 10/8/24 at 7:43 a.m., and they were interviewed. OC-A verified they owned the company who had been working with the care center with their HVAC system. OC-A explained they had been involved with the care center since July 2024 and "the biggest concern" for resident's was their heating system. OC-A stated the care center was behind on payments and they had just now (on 10/7/24) finally "got the green light" from the office to	2 130		

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2 130	Continued From page 12 service the system as a payment was made adding the partial payment was enough "just to allow us to be onsite." OC-A verified if no payment had been made on 10/7/24 (when the health survey was onsite), then no work or activation on the HVAC system would have been completed adding, "We couldn't be onsite." OC-A verified the HVAC system was unable to be activated or switched over without OC-A being onsite, adding the system, in general, was an "old application" and "[we] need to do everything manually." SUGGESTED METHOD FOR CORRECTION: The administrator,director of nursing or designee could develop and implement policies and procedures to ensure adequate resources were available to maintain the highest practicable physical, mental and psychosocial well-being of each resident. The quality assessment and assurance committee could perform random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty (21) days.	2 130		
{2 830}	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the	{2 830}		10/29/24

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{2 830}	Continued From page 13 resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure new, person-centered fall interventions were implemented to prevent further falls and potential injury for 1 of 3 residents (R5) reviewed for repeat falls. Findings include: R5's admission MDS dated 6/4/24, indicated R5 had severely impaired cognition and had no rejection of care behaviors. The MDS indicated R5 was diagnosed with hypertension, diabetes, and osteomyelitis. The MDS indicated R5 used a walker and a wheelchair as mobility devices and required set-up help with toilet transfers, moderate assistance with walking ten feet, and was independent with wheelchair use. R5's care plan dated 6/24/24, indicated R5 was at a "high" risk for falls related to osteomyelitis (bone infection) and cellulitis (soft tissue infection or inflammation). The fall care plan included two interventions dated 6/24/24, anticipate and meet R5's needs and ensure R5's call light was within reach and encourage R5 to use it. R5's care plan dated 6/24/24, indicated R5 had a history of substance abuse. The care plan indicated if facility staff witnessed or suspected substance use, they would start vital signs every two hours for 24 hours. The substance use care plan dated 6/24/24, indicated staff were to follow the facility policy related to resident substance abuse and	{2 830}	Corrected	

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{2 830}	Continued From page 14 report any abnormal behavior to the provider. The care plan did not include new (if any) fall interventions attempted after the fall on 7/5/24 and 7/14/24. R5's progress note dated 7/5/24 at 9:19 p.m., indicated R5 was found on the floor with his wheelchair on the side with a half-empty bottle of alcohol. The note indicated R5 was assessed and had no injuries, vital signs were "stable", and R5 was transferred to bed. Facility staff completed 15-minute checks on R5, and the director of nursing (DON) and the provider were notified. R5's progress note dated 7/6/24 at 1:59 a.m., indicated R5 had two abrasions on his scalp "from the fall". R5's progress note dated 7/9/24 at 10:59 a.m., indicated the interdisciplinary team (IDT) had reviewed R5's fall and R5 was "re-educated" on the risk of substance use and that it could cause serious harm. The note indicated the policy on substance abuse was reviewed. R5's progress note dated 7/14/24 at 4:00 a.m., indicated R5 was found on the floor of his room near the bathroom. The note indicated R5 was "intoxicated with alcohol" and restless in bed before the fall. The note indicated no injuries were observed and the resident was helped back to bed and encouraged to call when he needed help. The note indicated the DON and "TCP" were notified. R5's progress note dated 7/15/24 at 8:30 a.m., indicated R5 endorsed left arm pain at a "7 or 8" and said it had been bothering him since his fall. R5's progress note dated 7/15/24 at 9:37 a.m.,	{2 830}		

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{2 830}	Continued From page 15 indicated the interdisciplinary team (IDT) had reviewed R5's fall and R5 was "extremely intoxicated" throughout the shift and had attempted to self-transfer and use the bathroom. The note indicated R5 was educated on abstaining from alcohol and requesting assistance while intoxicated. R5's medical record was reviewed and did not include any new person-centered fall interventions after R5's fall on 7/14/24. R5's progress noted dated 9/23/24 at 7:31 p.m., indicated R5 was referred to a skilled nursing facility that had an in-house licensed alcohol and drug counselor (LADC) as part of the resident's discharge plan and "falls interventions". The progress note did not indicate what new interventions were placed to ensure R5 was safe will he was still residing at the facility. During at interview on 10/7/24 at 9:56 a.m., R5 stated he had fallen a couple of times at the facility while he was drinking. R5 stated he did not recall the facility discussing interventions to help him reduce his drinking while residing at the facility or ensuring he was safe while he was drinking. During an interview on 10/7/24 at 2:45 p.m., registered nurse (RN)-A, the unit nurse manager (RN)-B stated R5's past falls had been related to alcohol use so the facility had referred him to a different facility that had LADC services. RN-A stated they had re-educated R5 in the past on calling for assistance but acknowledged this was not a new fall intervention. RN-A stated she was unsure what new interventions had been put in place to ensure R5 was safe. RN-A stated she had not but someone might have talked to R5 about alcoholics anonymous (AA) but the director	{2 830}		

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{2 830}	Continued From page 16 of nursing (DON) might know more about this. During an interview on 10/7/24 at 2:57 p.m., the social services director (SSD) stated she had not discussed AA with R5 as no one had asked her to. During an interview on 10/7/24 at 2:54 p.m., the DON stated she had not been a part of ensuring new fall interventions had been placed for R5 since the last survey and this was RN-A's responsibility so she was unaware if AA had been discussed with R5 or if any new fall interventions had been put into place. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures related to comprehensive assessments regarding falls. The director of nursing or designee could develop a system to educate staff and develop a monitoring system to ensure collaboration in the development individual care plans. The facility should re-educate all staff identified to policies and procedures, and audit residents associated with falls. The results of those audits should be taken to the Quality Assurance Performance Improvement (QAPI) committee to determine the need for further monitoring or compliance. Time period for correction: 21 Days	{2 830}		
21705	MN Rule 4658.1415 Subp. 6 Plant Housekeeping, Operation, & Maintenance Subp. 6. Heating, air conditioning, and ventilation. A nursing home must operate and maintain the mechanical systems to provide	21705		10/29/24

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21705	Continued From page 17 comfortable and safe temperatures, air changes, and humidity levels. Temperatures in all resident areas must be maintained according to items A to C: A. For construction of a new physical plant, a nursing home must maintain a temperature range of 71 degrees Fahrenheit to 81 degrees Fahrenheit at all times. B. For existing facilities, a nursing home must maintain a minimum temperature of 71 degrees Fahrenheit during the heating season. C. Variations of the temperatures required by items A and B are allowed if the variations are based on documented resident preferences. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure indoor, ambient air temperature was maintained to provide resident' comfort or, if needed, take reasonable and appropriate actions to evaluate and ensure resident' safety and comfort when the facility indoor air temperature was unable to be consistently maintained at or above 71 degrees Fahrenheit (F) due to lack of payment on multiple heating system (i.e., HVAC) invoices. This affected 7 of 10 residents (R1, R5, R6, R7, R2, R3, R4) reviewed for comfortable environment who voiced complaints of the cold temperature which, at times, caused them periods of emotional or physical distress. Findings include: On 10/7/24 at 9:36 a.m., the second-floor locked unit (i.e., memory care) was toured which was housed behind a set of locked, coded doors. On the unit, nearly all resident' room doors were open and many residents on the unit were in bed	21705	Corrected	

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21705	Continued From page 18 covered under blankets, and the ambient air on the entire unit was cold feeling to open skin. At the same time, trained medication aide (TMA)-A was standing at a mobile medication cart with their plush winter jacket on. TMA-A was interviewed and stated the unit was too cold, adding aloud, "That's why many of them [residents] don't wanna get up." TMA-A stated the indoor air had been cold "since it got cold outside" but clarified a timeframe adding it had been like such for "the last four days" or so. TMA-A stated the maintenance team was aware of the air being cold and added, to their knowledge, the management team was aware of the cold air adding, "You can't help but notice it." TMA-A stated multiple residents had complained about the cold air but added it would be hard to visit with them about it as "this [unit] is memory care," however, TMA-A directed the surveyor to R1 who could likely be interviewed about it. Immediately following on 10/7/24 at 9:41 a.m., R1 was observed lying in bed while in her room. R1's knees were bent up causing her to appear with a fetal-like position while covered under multiple, different colored blankets which were pulled up to her chin. R1 stated the air was cold in her room adding aloud, "It is!" R1 stated the air had been cold for "awhile now" adding she was unsure a timeframe but expressed, "Sometimes [it's] even colder at night." R1 reiterated it was too cold and she wished it was warmer on the unit. On 10/7/24 at 9:46 a.m., the director of maintenance (DOM) was interviewed and verified knowledge of the building cold air temperature adding it was "a building wide" issue. DOM explained they had just that day (10/7/24) got the cooling system for the HVAC deactivated but stated it had been working and actively cooling for	21705		

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21705	Continued From page 19 the past week or so. DOM stated the facility had an outside company who helped manage their HVAC system, and they were needed to switch the system from cooling to heating so DOM had reached out them on 10/7/24, and they were now "getting preparations ready" to make the switch over to heating. DOM verified the building had no current active building-wide heating system due to the system not being changed over from cooling to heating. DOM reiterated they had just prior deactivated the cooling system so any air blowing from the ventilation would just be ambient air and not actively chilled like it had been prior. DOM stated they had been checking some ambient air temperatures within the building over the past few weeks, however, had not been tracking or documenting them. Following this discussion, a tour of the entire building was completed with DOM and, using a facility' supplied hand-held thermometer, DOM obtained a series of temperature checks with the surveyor present. These were as follows: 1) The basement level (included various offices and conference rooms) was measured at 65.5 F; 2) The first-floor level (included various offices, a central commons area, and the main resident dining room) was measured at 65.0 F; 3) The second-floor level (off the elevators and included a nursing station, resident rooms) was measured at 65 F; and the locked memory care unit (which contained resident rooms) measured at 64 F; 4) The third-floor level (which included a nursing station and resident rooms) was measured at 63 F.	21705		

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21705	Continued From page 20 DOM acknowledged the temperatures being below 71 F and reiterated they were waiting on the outside company to switch over the HVAC system to heating adding they anticipated such would happen "within the week" but were not exactly sure. DOM expressed there wasn't anything else they could do to provide heating within the building until the company was onsite adding, "That's just where we're at." DOM stated they were unsure exactly what, if any, actions the nursing department was doing to monitor resident comfort or safety such as offering extra blankets but added, "At least they should be [doing that]." DOM stated the director of nursing (DON) was aware of the building temperature issue as they had texted them (DOM) the day prior (on 10/6/24) saying people were "getting cold," so DOM reported back they were "starting to get stuff going" with the HVAC system. DOM explained part of the reason the HVAC system had not been changed over sooner was due to monitoring the weather forecast and potentially higher temperatures were anticipated during the upcoming week. However, despite the cold ambient inside air temperature within the building, DOM verified there was no formal tracking or documentation to show routine, ongoing temperature checks had been taken or evaluated to ensure resident comfort while the facility was waiting for the HVAC system to be switched over to heating. A National Oceanic and Atmospheric Administration (NOAA) Online Weather Data report, dated 10/01/24 to 10/07/24, outlined the outside weather for each daily period including the high temperature, the low temperature and a 24-hour average of the temperatures which were reached/recorded. This identified:	21705		

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21705	Continued From page 21 On 10/03/24, the low temperature recorded was 50 F and the 24-hour average was recorded as 57.5 F; On 10/04/24, the low temperature recorded was 44 F and the 24-hour average was recorded as 56.5 F; On 10/05/24, the low temperature recorded was 50 F and the 24-hour average was recorded as 64.5 F; On 10/06/24, the low temperature recorded was 47 F and the 24-hour average was recorded as 56.0 F. R5's admission Minimum Data Set (MDS) dated 6/4/24, indicated R5 had severely impaired cognition and had no rejection of care behaviors. On 10/7/24 at 10:09 a.m., R5 was observed seated in his wheelchair only wearing a short-sleeved shirt and a pair of jeans. No visible sweater or coats overtop. R5 was interviewed and voiced frustration with the cold temperature and stated it was "really cold" in the building for the last week. R5 stated he had told maintenance staff about the temperature and he was told the heat would not be turned on until next month. R5 stated facility staff had been wearing jackets inside for the last week and R5 thought this was related to the cold temperature inside the building. R5 stated he didn't have a coat of his own so he had been feeling very cold adding staff had not offered him extra blankets or clothing during the past week. R6's quarterly MDS dated 8/2/24, indicated R6 had intact cognition. On 10/7/24 at 10:13 a.m., R6 was observed lying in bed with a sweatshirt on and the hood pulled up over his head. R6 was	21705		

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	00255	A. BUILDING: _____ B. WING _____	R-C 10/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE TERRACE AT CRYSTAL LLC	3245 VERA CRUZ AVENUE NORTH CRYSTAL, MN 55422

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21705	Continued From page 22 interviewed and stated it had been "freezing" in the facility for the past three to four days. R6 stated it was especially "chilly" at night which was annoying and caused trouble sleeping adding facility staff had not offered him anything extra to keep him warm. R7's quarterly MDS dated 8/16/24, indicated R7 had intact cognition and was diagnosed with anemia (deficiency of blood cells that carry oxygen). During interview on 10/7/23 at 10:24 a.m., R7 stated it had been very cold in the facility for the past week, and facility staff had not offered any additional interventions to keep warm. R2's annual MDS dated 9/19/24, indicated R2 had moderate cognitive impairment and was diagnosed with coronary artery disease. On 10/7/24 at 10:29 a.m. R2 was observed wearing a thick sweater, winter jacket, jogging pants, hat and snow boots. R2 stated aloud, "It's very cold [in here]." R3's quarterly MDS dated 6/26/24, indicated R3 was cognitively impaired. On 10/7/24 at 10:24 a.m. R3 was wearing a sweater, and a winter jacket. R3 stated it was very chilly and she was cold. R3 stood up and said she was going to her room, "I think it will be warmer there." R4's quarterly MDS dated 8/23/24, indicated resident had impaired cognition and diabetes mellitus. On 10/7/24 at 10:33 a.m., R4 was observed lying in bed covered with multiple blankets, including up around her face. R4 stated, "I won't get out of bed or take my pills because I am too cold." R4 stated she was fully dressed adding it had "been cold for days" in the care center. R4 then re-covered her face again and said, "just take me out of here, take me	21705		

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21705	Continued From page 23 somewhere else where is warm." On 10/7/24 at 10:12 a.m., the assistant director of nursing (ADON) was interviewed. ADON acknowledged the building temperature and expressed it had been like such "for the last couple of days." ADON stated maintenance staff were "keeping track" of the building temperature and nursing was not, at least to their knowledge, tracking or monitoring it adding, "Nursing is not doing that, no." ADON stated they were unsure what, if any, interventions were being done to help ensure resident' comfort was maintained adding, "I don't have an answer right off the top of my head." However, ADON expressed they had communicated with the DON about the cool temperatures and they had "talked about turning the AC off." ADON stated they had directed the floor staff to try to keep the window blinds closed at night to help conserve heat inside the building but felt, overall, the temperature inside "wasn't bad" as the weather outside was "still in the 50's [temperature]." ADON stated they did not recall anyone from nursing leadership, including the DON, to start checking resident' temperatures or do any additional interventions despite the cool building temperature but added they didn't absolutely know if anyone had or not adding aloud, "[at least] not that I have a sign up sheet for." ADON stated they anticipated staff would likely have offered blankets, if needed, but verified their only direction to the floor staff had been "just the blinds." ADON stated the current week (10/7/24 to 10/11/24) was the "last week it's supposed to be this warm," and they recalled some hesitation to activate the heating system due to not wanting to "roast people," either. ADON stated they believed the administrator to be aware of the issue and "once the averages [temperatures] are lower" the heating system in	21705		

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21705	Continued From page 24 the building would be activated. Further, ADON stated they had heard some resident comments about "feeling it's cooler in here [inside]" and maintenance was aware and going to address it adding, "There's been communication on this." During interview on 10/7/24 at 10:19 a.m., licensed practical nurse (LPN)-A stated they worked on 10/4/24 and residents had complained of the low temperature in the building and they were worried about residents getting sick related to this. LPN-A stated they had notified maintenance and the administrator of the temperature and asked if the heat could be turned on but they were told they wouldn't be able to do that. LPN-C stated facility management had not instructed them to increase monitoring of the residents given the cold temperature or to make sure residents were dressed appropriately. LPN-C stated nursing staff should be dressing residents appropriately for the weather but did not recall management giving specific instructions regarding this. During subsequent interview on 10/7/24 at 10:19 a.m., TMA-A stated the residents were cold, they are shivering in their beds, and they don't want to get up. TMA-A stated staff were complaining about it being cold, too. TMA-A stated the nurses had not been provided any instructions and she had not heard anything about checking vital signs or anything else that we should be doing differently. TMA-A added staff were trying to help put blankets on people and keep them warm but reiterated nobody had told them actions to take, adding giving blankets just was "using commons sense" due to the cold temperature. When interviewed on 10/7/24 at 10:54 a.m., registered nurse (RN)-B stated they had worked	21705		

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21705	Continued From page 25 last Wednesday (10/2/24) and the building was cold then so, as a result, they talked to management about the facility's temperature and were told maintenance was working on it. RN-B stated residents have been complaining about how cold it is so, today (10/7/24), they finally completed a 'concern form' about it adding the second-floor locked memory care unit was even colder. RN-B stated management have not provided any instructions about monitoring residents vital signs or any other interventions to assure residents were warm and able to remain comfortable; however, RN-B stated they themselves had been trying to offer extra blankets, sweaters, and jackets because the residents had been complaining about the cold for days. During the post-certification re-visit (PCR), on 10/07/24, the medical records for R1, R2, R3, R4, R5, R6 and R7, were reviewed and each lacked evidence the facility of what, if any, special interventions were evaluated, considered or implemented to ensure adequate body heat was maintained; nor evidence of what, if any, increased monitoring of the residents (i.e., body temperature checks) had been completed to ensure safety and comfort despite the low building temperature. Further, there was no evidence provided to demonstrate what, if any, actions or direction floor staff had been provided to ensure residents were kept comfortable in the low(er) temperatures (i.e., evaluate/provide blankets if needed, hot drinks, vitals monitoring). On 10/7/24 at 10:37 a.m., a subsequent interview with DOM was held. DOM verified there was no documentation to provide to demonstrate any ongoing monitoring of the building temperature was or had been completed, including on the	21705		

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21705	Continued From page 26 overnight hours, despite the onset of fall-like weather patterns setting in outdoors. DOM reiterated they had been checking some temperatures though adding most of them had been "72 or 73 ish [degrees]" over the past weeks with some periods of "68 to 70 [degrees]," adding though, "If I had to guess." DOM verified there had been no checks completed during the night hours and stated the HVAC system couldn't be activated until the outside company arrived onsite to do such. However, there had been an issue with the payment to them and they would not return onsite "because of the payment stuff." During an interview on 10/7/24 at 11:31 a.m., the DON stated they first became aware of staff and residents feeling cold on 10/6/24 and, as a result, had instructed the nursing assistant who had reported the concern to provide extra blankets to the residents who had reported feeling cold. The DON stated DOM had informed her the temperature in the building was 72 degrees, so no additional interventions had been put in place at that time. The DON stated if she had been aware the building temperature was "out of range" she would have ensured staff were assessing residents for appropriate clothing, given out additional blankets, and/or given out hand/feet warmers. The DON stated she had not told nursing staff to monitor for signs and symptoms of low body temperature and was not aware of them doing so. Further, DON stated DOM had reported to her they wouldn't be turning the heat on this week as it was supposed to get warmer outside later on in the week. On 10/7/24 at 1:17 p.m., the administrator was interviewed, and they explained the DON had updated them about the cold building temperatures earlier the same day (10/7/24)	21705		

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21705	Continued From page 27 adding they were unaware there was any concern about it prior. The administrator stated they had been onsite over the last weekend and felt "the temperature was fine," but expressed they had discussed the building temperature with DOM after "some staff" reported being cold. The administrator expressed the outside weather seemed to be heating back up and they decided to not activate the HVAC system to not overheat people, either. The administrator verified the staff concerns about the building temperature were initially reported over the weekend, however, he added, "But everybody's body temp is different." The administrator verified no systemic actions were taken to ensure resident comfort with the cold building temperature and attributed such due to a lack of being told about resident' concerns with it adding, "I wasn't alerted." The administrator stated had he known, then they would have done "different interventions" to ensure comfort like ensuring everyone had socks on, blankets available and doing vital sign checks. The administrator recalled visited with DOM about the HVAC system and having the outside contractor (OC)-A come back to activate the system adding they were trying to determine when a "good time to do it" would be. The administrator verified knowledge of the overdue invoices to the company and expressed, "The company [care center] has been slower in giving out the payments." However, the administrator stated they, just that day (10/7/24), spoke with the care center owner and a payment would be made. The administrator stated the "back office" was responsible for the payments to vendors and reiterated no interventions for resident' comfort were done as nothing was reported to him which would have "triggered" a response. On 10/7/24 at 3:56 p.m., a subsequent interview	21705		

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21705	Continued From page 28 was held with the administrator and DON. The DON verified they had texted DOM about "people [were] complaining it's cold" in the building on 10/6/24 (Sunday), but stated it had been staff complaining and not residents to their recall. DON stated DOM reported the temperature ranges but they had possible been based "off his last check" and not in-the-moment when it was reported as DOM expressed the building was 72 F. DON stated they didn't feel it was a building-wide issue over the weekend and verified no systemic evaluation or actions to ensure resident comfort was completed as knowing the temperature was out of range (i.e., outside 71 F to 81 F) is "what would trigger that." DON and the administrator both verified nobody had alerted them it was out of range until the morning of 10/7/24 when the health survey arrived. As a result, the nurse managers then went around to each resident and checked vitals and ensure blankets for everyone. The administrator reiterated cold sensation could be different from person-to-person and expressed no systemic action was taken as nobody , , according to administrator, was aware the temperature was out-of-range. However, the DON stated had staff reported the resident concerns with it, such as described by the floor staff, then action would have been taken. DON added, "If we knew our residents were being impacted by the temperature, we'd take action." A facility' policy on building temperature maintenance and/or monitoring including with what, if any, actions are completed if outside ideal range was requested. However, none was received. Suggested Method of Correction: The director of facility maintenance (DOM) or desigee could work	21705		

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21705	Continued From page 29 with the administrator to update policies and procedures for how and when to regulate the heat for the residents, and then could educate staff. In addition the director of nursing could work with the administrator regarding how to respond to resident care needs when there is a no heat situation. The DOM or designee could also perform audits of resident rooms to determine if the temperature is adequate. Time Period for Correction: Twenty-one (21) days.	21705		

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	245289	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/27/2024**

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 08/27/2024. At the time of this survey, The Terrace At Crystal was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.	K 000		

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

Electronically Signed | 09/24/2024

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

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K 000	Continued From page 1 Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. The Terrace at Crystal is a 3-story building with a full basement that was constructed in 1971 and was determined to be of Type II (111) construction. This facility is fully protected throughout by an automatic fire sprinkler system and has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification.	K 000		

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K 000	Continued From page 2 The facility has a capacity of 85 beds and had a census of 53 at the time of the survey. The requirements at 42 CFR, Subpart 483.70(a), are NOT MET as evidenced by:	K 000		
K 211 SS=D	Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain clear path of egress per NFPA 101 (2012 edition), Life Safety Code, sections 19.2.1, 19.2.3.4, and 7.1.10.1. These deficient findings could have an isolated impact on the residents within the facility. Findings include: 1. On 08/27/2024 at 11:07 AM, it was revealed by observation that there was a cart and a recliner being stored in the egress corridor in the basement outside of the Maintenance Directors office. 2. On 08/27/2024 at 11:16 AM, it was revealed by observation that there was a mini refrigerator and a	K 211	POC K211 1.What corrective action will be accomplished for those residents found to have been affected by the deficient practice? All corridors serving as exit accesses were checked to ensure that they are available and functional for instant use. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken? This deficient practice could affect all residents,	10/5/24

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K 211	Continued From page 3 pallet jack in the egress corridor near room B20. An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K 211	staff and visitors. 3.What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? The maintenance director and or designee will ensure that monthly checks using the facility-designated audit tool on the use of corridor exit doors are completed and that they are functional and available for instant use. 4. How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? The Maintenance Director/designee will add the monthly corridor exit door checks audit to their life safety inspection log. All results will be presented monthly to the Quality Assurance Committee until the committee determines that there is no necessity to continue based on findings of continued compliance. 5. The systemic change be completed by 10/4/2024.	
K 225 SS=E	Stairways and Smokeproof Enclosures CFR(s): NFPA 101 Stairways and Smokeproof Enclosures Stairways and Smokeproof enclosures used as exits are in accordance with 7.2. 18.2.2.3, 18.2.2.4, 19.2.2.3, 19.2.2.4, 7.2	K 225		10/4/24

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 225	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain emergency egress doors per NFPA 101 (2012 edition), Life Safety Code, sections 19.2.2.2.1 and 7.2.1.4.5.1. This deficient finding could have a patterned impact on the residents within the facility. Findings include: On 08/27/2024 at 12:05 PM, it was revealed by observation that the door exiting out of the south stairwell on the first floor was difficult to open. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 225	K225 – stairway and smokeproof enclosure 1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? The stairwell fire exit doors was examined and repaired in order to be in compliance. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken? This deficient practice could affect all residents, staff, and visitors. 3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? The maintenance director will examine fire exit doors monthly following using a fire door audit log to ensure that it is in compliance. 4. How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? The maintenance director and or designee will oversee preventative maintenance on doors throughout the facility documenting monthly using fire door exit audit log. All results will be presented monthly to the	

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	245289	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/27/2024**

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K 225	Continued From page 5	K 225	Quality Assurance Committee until the committee determines that there is no necessity to continue based on findings of continued compliance. 5. The systemic change be completed by 10/4/2024	
K 291 SS=E	Emergency Lighting CFR(s): NFPA 101 Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to test emergency lighting per NFPA 101 (2012 edition), Life Safety Code, sections 19.2.9.1 and 7.9.3.1.1. This deficient finding could have a patterned impact on the residents within the facility. Findings include: On 08/27/2024 between 08:45 AM and 12:30 PM, it was revealed by a review of available documentation that the emergency lighting testing documentation that the facility provided at the time of the survey was not filled out, and the Maintenance Director stated they had their testing in the computer system but it does not list what lights are being tested. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 291	K291 1.What corrective action will be accomplished for those residents found to have been affected by the deficient practice? The monthly 30 second functional test for the battery-operated lights was completed on 9/17/2024. 2.How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken? This deficient practice could affect all residents, staff, and visitors. 3.What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? The maintenance director and or designee will ensure that the monthly audits for the 30-second test and the	10/4/24

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K 291	Continued From page 6	K 291	annual 90-minute test are added to the Life Safety Book for the facility. 4.How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? The Maintenance Director/designee will also add the monthly 30-second test and the annual 90-minute test to the TELS in addition to the life-safety book. All results will be presented monthly to the Quality Assurance Committee until the committee determines that there is no necessity to continue based on findings of continued compliance. 5.The systemic change be completed by 10/4/2024.	
K 321 SS=D	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS.	K 321		10/4/24

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K 321	Continued From page 7 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain hazardous rooms per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.2.1.2, 19.3.2.1.3, 8.4.3.5, 8.3.3.1, and 7.2.1.8.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 08/27/2024 at 12:17 PM, it was revealed by observation that the door to the soiled utility room 1J on the first floor would not fully close and latch when testing the self-closing device. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 321	K321 – hazardous areas – enclosures 1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? All doors in facility were examined and necessary repairs were done to ensure that doors close and latch properly. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken? This deficient practice could affect all residents, staff, and visitors. 3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? Maintenance will perform preventative maintenance audits on door	

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K 321	Continued From page 8	K 321	latches throughout the facility using a facility-designated audit tool to meet standards monthly. 4. How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? The maintenance director and assistant will document door-latching log inspections monthly. All results will be presented monthly to the Quality Assurance Committee until the committee determines that there is no necessity to continue based on findings of continued compliance. 5. The systemic change be completed by 10/4/2024.	
K 324 SS=D	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96	K 324		10/4/24

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K 324	Continued From page 9 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain kitchen doors per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.2.5.4, 19.3.6.3.1, 19.3.6.3.2, and 19.3.6.3.5. These deficient findings could have an isolated impact on the residents within the facility. Findings include: 1. On 08/27/2024 at 12:11 PM, it was revealed by observation that the drop-down fire door in between the kitchen and the dining room on the first floor was zip-tied open. 2. On 08/27/2024 at 12:17 PM, it was revealed by observation that the kitchen door near resident room 105 had cardboard stuffed in the latch plate causing the door to not latch. An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K 324	K324 – cooking facilities 1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Drop down window was repaired to ensure fire safety compliance and the door exiting the kitchen to the main hallways that had paper jammed in it was corrected to keep in compliance with proper door latching. Started staff education on the dangers of not allowing the door to shut and latch properly. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken? This deficient practice could affect all residents, staff, and visitors. 3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? Facility-wide door/drop-down window checks will be done using door latch/window log audits monthly to keep in	

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K 324	Continued From page 10	K 324	compliance and ensure that facility-wide doors/drop-down windows can function properly. Inservice staff on the dangers of not allowing the doors to shut and latch properly. 4. How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? The maintenance director will be monitoring the drop-down window functionality of the facility as well as the door latch using facility designated audit log. All results will be presented monthly to the Quality Assurance Committee until the committee determines that there is no necessity to continue based on findings of continued compliance. 5. The systemic change be completed by 10/4/2024.	
K 345 SS=E	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and	K 345	K345 Fire alarm system – testing and	10/5/24

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K 345	Continued From page 11 staff interview, the facility failed to maintain the fire alarm system per NFPA 101 (2012 edition), Life Safety Code, section 9.6.1.3, and NFPA 72 (2010 edition), National Fire Alarm and Signaling Code section 14.2.1.2.2. This deficient finding could have a patterned impact on the residents within the facility. Findings include: On 08/27/2024 between 08:45 AM and 12:30 PM, it was revealed by a review of available documentation that two deficiencies were not corrected on the annual fire alarm testing report. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 345	maintenance 1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? The deficiency was corrected by a qualified outside fire alarm company. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken? This deficient practice could affect all residents, staff, and visitors. 3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? Fire alarm testing/device audit will be done monthly by the maintenance director or designee. 4. How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? The maintenance director or designee is responsible for monitoring and documenting in their facility-designated audit tool. All results will be presented monthly to the Quality Assurance Committee until the committee determines that there is no necessity to continue based on findings of continued compliance. 5. The systemic change be completed by 10/4/2024.	

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K 346 SS=F	Fire Alarm System - Out of Service CFR(s): NFPA 101 Fire Alarm - Out of Service Where required fire alarm system is out of services for more than 4 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.6 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to implement a fire alarm out-of-service policy per NFPA 101 (2012 edition), Life Safety Code, section 9.6.1.6. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 08/27/2024 between 08:45 AM and 12:30 PM, it was revealed by a review of available documentation that the fire alarm out-of-service policy that was provided at the time of the survey did not have contact information filled out it appeared that the form was a generic form that was not filled out. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 346	K346 – fire alarm system – Out of service 1. .What corrective action will be accomplished for those residents found to have been affected by the deficient practice? The policy was immediately updated, and any missing information was filled in. 2.How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken? This deficient practice could affect all residents, staff, and visitors. 3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? The policies will be checked yearly or when there is a change to ensure that all information is correct and up to date. Policies will be reviewed by IDT during QAPI yearly.	10/4/24

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K 346	Continued From page 13	K 346	4. How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? The maintenance director and or designee will be responsible for ensuring policies for life-safety/environmental are updated annually and presented to IDT during QAPI yearly and or as needed. All results will be presented monthly to the Quality Assurance Committee until the committee determines that there is no necessity to continue based on findings of continued compliance. 5. The systemic change be completed by 10/4/2024.	
K 353 SS=D	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler	K 353		10/4/24

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K 353	Continued From page 14 system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain their sprinkler system per NFPA 101 (2012 edition), Life Safety Code, section 9.7.1.1 and 9.7.5, NFPA 25 (2011 edition), Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, sections 4.1.5, 4.1.5.2 (3), 4.1.6.1, and 4.1.6.2, and NFPA 13 (2010 edition), Standard for the Installation of Sprinkler Systems, section 8.6.4.1.1.1. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 08/27/2024 at 11:13 AM, it was revealed by observation that multiple ceiling tiles were missing in room B23 in the basement. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 353	K353- sprinkler system – maintenance and testing 1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? All ceiling tiles throughout the facility were checked thoroughly and any broken or missing tiles were replaced to ensure compliance. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken? This deficient practice could affect all residents, staff and visitors. 3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? A monthly log for ceiling tile upkeep will be done to keep in compliance with state regulations. Any issues regarding the integrity of ceiling tiles will be corrected immediately. 4. How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? Maintenance staff are responsible for upkeep of ceiling tile preventative maintenance by walking throughout the	

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K 353	Continued From page 15	K 353	facility monthly to check for ceiling tile issues. All results will be presented monthly to the Quality Assurance Committee until the committee determines that there is no necessity to continue based on findings of continued compliance. 5. The systemic change be completed by 10/4/2024.	
K 354 SS=F	Sprinkler System - Out of Service CFR(s): NFPA 101 Sprinkler System - Out of Service Where the sprinkler system is impaired, the extent and duration of the impairment has been determined, areas or buildings involved are inspected and risks are determined, recommendations are submitted to management or designated representative, and the fire department and other authorities having jurisdiction have been notified. Where the sprinkler system is out of service for more than 10 hours in a 24-hour period, the building or portion of the building affected are evacuated or an approved fire watch is provided until the sprinkler system has been returned to service. 18.3.5.1, 19.3.5.1, 9.7.5, 15.5.2 (NFPA 25) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to implement a fire sprinkler out-of-service policy per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.5.1 and 9.7.5, and NFPA 25 (2011 edition), Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, section	K 354	K354 – Sprinkler system – out of service 1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Proper contact information and documentation for what to do if the	10/4/24

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K 354	Continued From page 16 15.5.2. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 08/27/2024 between 08:45 AM and 12:30 PM, it was revealed by a review of available documentation that the fire sprinkler out-of-service policy that was provided at the time of the survey did not have contact information filled out it appeared that the form was a generic form that was not filled out. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 354	sprinkler system is out of service was completed and staff education was started. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken? This deficient practice could affect all residents, staff, and visitors. 3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? The policies will be checked yearly or when there is a change to ensure that all information is correct and up to date. Policies will be reviewed by IDT during QAPI yearly. 4 How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? The maintenance director and or designee will be responsible for ensuring policies for life-safety/environmental are updated annually and presented to IDT during QAPI yearly and or as needed. All results will be presented monthly to the Quality Assurance Committee until the committee determines that there is no necessity to continue based on findings of continued compliance. The systemic change be completed by 10/4/2024.	
K 355	Portable Fire Extinguishers	K 355		10/4/24

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	245289	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/27/2024**

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K 355 SS=D	Continued From page 17 CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain access to fire extinguishers per NFPA 101 (2012 edition), Life Safety Code sections 19.3.5.12 and 9.7.4.1, and NFPA 10 (2010 edition), Standard for Portable Fire Extinguishers, section 6.1.3.3.1. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 08/27/2024 at 10:38 AM, it was revealed by observation that there was a patient lift blocking the fire extinguisher near resident room 309. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 355	K355 – portable fire extinguishers 1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? All halls and emergency equipment compartments were checked to clear any obstructions. A full building in-service was done to educate all staff on the proper storage of equipment and the dangers of blocking halls with equipment and clutter. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken? This deficient practice could affect all residents, staff, and visitors. 3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? A hallway audit tool will be used to periodically check weekly on all floors that all hallways are unobstructed in the event of an emergency. A full building in-service was done to educate all staff on the proper storage of equipment and the	

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K 355	Continued From page 18	K 355	dangers of blocking halls with equipment and clutter. 4. How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? Maintenance or designee is responsible for completing the weekly audits using the facility-designated log to monitor compliance and educate staff on the proper procedures as needed. All results will be presented monthly to the Quality Assurance Committee until the committee determines that there is no necessity to continue based on findings of continued compliance. 5. The systemic change be completed by 10/4/2024.	
K 363 SS=E	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material.	K 363		10/4/24

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K 363	Continued From page 19 Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain corridor doors per NFPA 101 (2012 edition), Life Safety Code, section 19.3.6.3.5 and 19.3.6.3.10. These deficient findings could have an isolated impact on the residents within the facility. Findings include: 1. On 08/27/2024 at 11:53 AM, it was revealed by observation that there was cloth wrapped around the latch for the door to resident room 321 causing the door to not latch. The cloth was removed at the time of the survey.	K 363	K363 – corridor – doors 1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? All doors not latching appropriately around the facility were identified and were fixed by maintenance. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken? This deficient practice could affect all residents,	

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K 363	Continued From page 20 2. On 08/27/2024 at 12:01 PM, it was revealed by observation that the door to resident room 208 would not latch. 3. On 08/27/2024 at 12:18 PM, it was revealed by observation that the door to resident room 114 would not latch. An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K 363	staff, and visitors. 3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? A door latch log will be conducted monthly by maintenance director and or designee. 4. How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? Maintenance director and or designee will conduct monthly checks on door latches using their audit logs. All results will be presented monthly to the Quality Assurance Committee until the committee determines that there is no necessity to continue based on findings of continued compliance. 5. The systemic change be completed by 10/4/2024.	
K 372 SS=D	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier.	K 372		10/4/24

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K 372	Continued From page 21 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain smoke barrier per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.7.1, 19.3.7.3, 8.5.2.2, and 8.5.6.2. This deficient finding could have a patterned impact on the residents within the facility. Findings include: On 08/27/2024 at 11:00 AM, it was revealed by observation that a section of the wall was missing and there were large holes not sealed in the smoke barrier on the first floor above the public restroom and med room. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 372	K372 – subdivision of building spaces-smoke barrier construction 1. .What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Fire caulking for the ceiling on 1st floor with walls or gaps was repaired with fire caulking to ensure the fire barrier is within compliance. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken? This deficient practice could affect all residents, staff, and visitors. 3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? Quarterly (every 3 months) the fire barrier will be inspected thoroughly using an audit tool throughout the facility to ensure proper fire barrier regulation. 4. How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? Maintenance director is responsible for these actions by inspecting the barrier quarterly using an audit tool. All results will	

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K 372	Continued From page 22	K 372	be presented monthly to the Quality Assurance Committee until the committee determines that there is no necessity to continue based on findings of continued compliance. 5. The systemic change be completed by 10/4/2024.	
K 374 SS=D	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain smoke barrier doors per NFPA 101 (2012 edition), Life Safety Code, sections 19.2.1, 19.3.7.8, 7.1.10.2.1, 7.2.1.4.5.1, and 8.5.4.3. These deficient findings could have a patterned impact on the residents within the facility. Findings include: 1. On 08/27/2024 at 10:42 AM, it was revealed by	K 374	K374 - subdivision of building spaces-smoke barrier doors 1. .What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Smoke barrier doors located on 2nd floor had illuminated exit signs installed to display that it is an exit and not a dead end. Other fire barrier doors that were difficult to open were repaired to	10/4/24

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K 374	Continued From page 23 observation that the smoke barrier doors on the second floor were painted to disguise the doors and make them look like a dead-end corridor. 2. On 08/27/2024 at 11:00 AM, it was revealed by observation that the public restroom door on the first floor is a part of the smoke barrier, and the door would not fully close and latch when testing the self-closing device. 3. On 08/27/2024 at 11:47 AM, it was revealed by observation that the smoke barrier door located on the third floor near resident room 318 was difficult to open. An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K 374	function properly. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken? This deficient practice could affect all residents, staff, and visitors. 3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? The maintenance director and or designee will inspect exit lights monthly using an audit log. Maintenance and or designee will be responsible for ensuring completion. 4. How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? The maintenance director and or designee will monitor exit lights using the audit logs completed monthly. All results will be presented monthly to the Quality Assurance Committee until the committee determines that there is no necessity to continue based on findings of continued compliance. 5. The systemic change be completed by 10/4/2024.	
K 521 SS=D	HVAC CFR(s): NFPA 101	K 521		10/4/24

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K 521	Continued From page 24 HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to maintain fire dampers per NFPA 101 (2012 edition), Life Safety Code, section 8.5.5.4.2, and NFPA 105 (2010 edition), Standard for Smoke Door Assemblies and Other Opening Protectives, section 6.4.1.3, 6.5.8, and 6.5.9. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 08/27/2024 at 11:15 AM, it was revealed by observation that wires were going through the damper located in the basement electrical room. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 521	K521- hvac 1. .What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Outside electrician was called to perform the correct procedure for running the cables through the wall and not through the fire damper. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken? This deficient practice could affect all residents, staff, and visitors. 3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? When getting outside vendors for work on the building the maintenance director will check thoroughly to ensure that the work being performed on the property is in compliance and does not affect life safety.	

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K 521	Continued From page 25	K 521	4. How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? The maintenance director is responsible for keeping track of repairs and the scope of work being performed. These actions will be monitored after the completion of the work being done and inspected quarterly. All results will be presented monthly to the Quality Assurance Committee until the committee determines that there is no necessity to continue based on findings of continued compliance. 5. The systemic change be completed by 10/4/2024.	
K 711 SS=F	Evacuation and Relocation Plan CFR(s): NFPA 101 Evacuation and Relocation Plan There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. Employees are periodically instructed and kept informed with their duties under the plan, and a copy of the plan is readily available with telephone operator or with security. The plan addresses the basic response required of staff per 18/19.7.2.1.2 and provides for all of the fire safety plan components per 18/19.2.2. 18.7.1.1 through 18.7.1.3, 18.7.2.1.2, 18.7.2.2, 18.7.2.3, 19.7.1.1 through 19.7.1.3, 19.7.2.1.2, 19.7.2.2, 19.7.2.3 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to implement a fire	K 711	K711- evacuation and relocation plan	10/4/24

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K 711	Continued From page 26 safety plan per NFPA 101 (2012 edition), Life Safety Code, sections 19.7.2.1.2 and 19.7.2.2. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 08/27/2024 between 08:45 AM and 12:30 PM, it was revealed by a review of available documentation that the fire safety plan that was provided at the time of the survey did not include evacuation of the smoke compartment. The smoke compartment evacuation section stated that they would evacuate rooms near the fire, not the entire smoke compartment. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 711	1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? The fire evacuation of smoke compartment is now in place and is filled in with correct information , 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken? This deficient practice could affect all residents, staff, and visitors. 3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? The evacuation/relocation plan will be checked yearly or when there is a change to ensure that all information is correct and up to date. Policies will be reviewed by IDT during QAPI yearly. 4. How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? The maintenance director is responsible for these actions and documentation will be reviewed yearly to ensure information is up to date. All results will be presented monthly to the Quality Assurance Committee until the committee determines that there is no necessity to continue based on findings of continued compliance. 5. The systemic change be completed by	

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K 711	Continued From page 27	K 711	10/4/2024.	
K 761 SS=F	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to inspect fire doors per NFPA 101 (2012 edition), Life Safety Code section 8.3.3.1, and NFPA 80 (2010 edition), Standard for Fire Doors and Other Opening Protectives, section 5.2.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 08/27/2024 between 08:45 AM and 12:30 PM, it was revealed by a review of available documentation that at the time of the survey the facility could not provide documentation showing that all of the fire doors in the facility had been inspected and tested. The Maintenance Director	K 761	K761- Maintenance, inspection and testing – doors 1. .What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Documentation of door latch inspections is filled out in detail on paper logs to ensure proper information for what was done and dated. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken? This deficient practice could affect all residents, staff, and visitors.	10/4/24

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K 761	Continued From page 28 stated that they have inspections in their computer system but it does not list each door. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 761	3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? Facility-wide door latch audit logs will be filled out monthly by maintenance and or designee. 4. How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? Maintenance and or designee is responsible for monitoring all door functionality throughout the facility using door latch log audits. All results will be presented monthly to the Quality Assurance Committee until the committee determines that there is no necessity to continue based on findings of continued compliance. 5. The systemic change be completed by 10/4/2024.	
K 901 SS=F	Fundamentals - Building System Categories CFR(s): NFPA 101 Fundamentals - Building System Categories Building systems are designed to meet Category 1 through 4 requirements as detailed in NFPA 99. Categories are determined by a formal and documented risk assessment procedure performed by qualified personnel. Chapter 4 (NFPA 99)	K 901		10/4/24

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	245289	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/27/2024**

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K 901	Continued From page 29 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to provide a Risk Assessment per NFPA 99 (2012 edition), Health Care Facilities Code, section 4.2. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 08/27/2024 between 08:45 AM and 12:30 PM, it was revealed by a review of available documentation that at the time of the survey the facility could not provide an NFPA 99 risk assessment that was completed on the facility. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 901	K901 – Fundamentals- building system categories 1. .What corrective action will be accomplished for those residents found to have been affected by the deficient practice? A hazard risk assessment was immediately completed and was filled out and placed in EP binder. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken? This deficient practice could affect all residents, staff, and visitors. 3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? Risk assessment reminder will be placed in TELS to alert maintenance of reviewing the hazard risk assessment yearly. 4. How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? This task is to be performed by the maintenance director and reviewed yearly to keep documentation up to date. The maintenance director will check his monthly TELS report to be aware of the inspection/tasks to be completed for the month. 5. The systemic change be completed by 10/4/2024.	
K 914	Electrical Systems - Maintenance and Testing	K 914		10/4/24

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K 914 SS=F	Continued From page 30 CFR(s): NFPA 101 Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to conduct the electrical testing and maintenance per NFPA 99 Standards for Health Care Facilities 2012 edition, section 6.3.3.2 , 6.3.4.1.3, and 6.3.4.2.1.2. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 08/27/2024 between 08:45 AM and 12:30 PM, it was revealed by a review of available documentation that at the time of the survey the	K 914	K914- electrical systems – maintenance and testing 1. .What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Documentation of electrical receptacles in resident rooms are now documented and all resident room receptacles were tested, documented, and placed in EP binder. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what	

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K 914	Continued From page 31 facility could not provide documentation showing that the resident room electrical receptacle testing had been completed within the last year. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 914	corrective action will be taken? This deficient practice could affect all residents, staff, and visitors. 3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? Receptacles will be tested and logged quarterly (every 3 months) in detail to ensure compliance. 4. How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? Tests are done by maintenance yearly using electrical receptacle logs. Results from the audits/findings will be presented monthly to the Quality Assurance Committee until the committee determines that there is no necessity to continue based on findings of continued compliance. 5. The systemic change be completed by 10/4/2024.	
K 920 SS=E	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A	K 920		10/4/24

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K 920	Continued From page 32 or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the usage of electrical adaptive devices NFPA 99 (2012 edition), Health Care Facilities Code, sections 10.5.2.3.1 and 10.2.4.2.1, NFPA 101 (2012 edition), Life Safety Code, section 9.1.2, NFPA 70, (2011 edition), National Electrical Code, sections 400.8, and UL 1363. These deficient findings could have a patterned impact on the residents within the facility. Findings include: 1. On 08/27/2024 at 10:36 AM, it was revealed by observation that an extension cord with a phone charger plugged into it was being used in resident room 314. 2. On 08/27/2024 at 10:36 AM, it was revealed by observation that a microwave and a refrigerator was plugged into a power strip in the laundry office in the basement. 3. On 08/27/2024 at 10:36 AM, it was revealed by	K 920	K920 electrical equipment – power cords and extension cords. 1. .What corrective action will be accomplished for those residents found to have been affected by the deficient practice? All cords were disconnected from the extension cords identified and plugged into the wall directly. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken? This deficient practice could affect all residents, staff, and visitors. 3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? Maintenance and or designee will inspect portable units using a weekly audit log. Any noncompliance will follow with an immediate correction when doing facility-wide room checks. 4. How the corrective action will be monitored to ensure the deficient practice	

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K 920	Continued From page 33 observation that medical equipment was plugged into a non-hospital grade power strip in resident room 308. 4. On 08/27/2024 between 08:45 AM and 12:30 PM, it was revealed by observation that an air conditioner was plugged into an extension cord in resident rooms 318, 203, 205, and 211. An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K 920	will not recur, i.e., what quality assurance program will be put into place? The maintenance director and or designee will be responsibility for inspecting rooms weekly while doing facility-wide walk-throughs. All results will be presented monthly to the Quality Assurance Committee until the committee determines that there is no necessity to continue based on findings of continued compliance. 5. The systemic change be completed by 10/4/2024.	

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{K 000}	INITIAL COMMENTS Based on an on-site revisit, the facility remains out of compliance with the Federal requirements identified as deficient at the time of their recertification survey.	{K 000}		
{K 363} SS=E	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or	{K 363}		10/25/24

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

Electronically Signed | 10/22/2024

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

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{K 363}	Continued From page 1 frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: Based on an on-site revisit, the facility remains out of compliance with the Federal requirements identified as deficient at the time of their recertification survey.	{K 363}	K363 1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? All corridor doors in the facility were thoroughly checked to ensure that there are no blockages in corridor doors in facility. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken? This deficient practice could affect all residents, staff and visitors. 3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? The maintenance director and or designee will ensure that weekly checks using the facility-designated audit tool on the use of corridor doors are completed and that they are functional and available for instant use. 4. How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance	

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{K 363}	Continued From page 2	{K 363}	program will be put into place? The Maintenance Director/designee will add the monthly corridor door checks audit to their life safety inspection log. All results will be presented to the Quality Assurance Committee until the committee determines that there is no necessity to continue based on findings of continued compliance. 5. The systemic change be completed by 10/25/2024.	
{K 374} SS=D	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 This REQUIREMENT is not met as evidenced by: Based on an on-site revisit, the facility remains out of compliance with the Federal requirements identified as deficient at the time of their recertification survey.	{K 374}	K374 1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice?	10/25/24

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{K 374}	Continued From page 3	{K 374}	Assessed all fire doors in facility for compliance. The two double doors that make up smoke barrier in memory care section of building were immediately painted to reflect a door rather than a dead end as well as installing fire exit signs. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken? This deficient practice could affect all residents, staff and visitors. 3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? The maintenance director and or designee will ensure that weekly checks using the facility-designated audit tool on the use of fire doors are completed and that they are functional and available for instant use. 4. How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? The Maintenance Director/designee will add the monthly fire door checks audit to their life safety inspection log. All results will be presented to the Quality Assurance Committee until the committee	

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{K 374}	Continued From page 4	{K 374}	determines that there is no necessity to continue based on findings of continued compliance. 5. The systemic change be completed by 10/25/2024.	