Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
January 17, 2024

Administrator
Charter House Inc
211 Northwest Second Street
Rochester, MN 55901

RE: CCN: 245282
Cycle Start Date: November 16, 2023

Dear Administrator:

On January 4, 2024, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

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

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

January 17, 2024

Administrator
Charter House Inc
211 Northwest Second Street
Rochester, MN 55901

Re: Reinspection Results
Event ID: UYKJ12

Dear Administrator:

On January 4, 2024 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on November 16, 2023. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

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

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
December 12, 2023

Administrator
Charter House Inc
211 Northwest Second Street
Rochester, MN 55901

RE: CCN: 245282
Cycle Start Date: November 16, 2023

Dear Administrator:

On November 16, 2023, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Jennifer Kolsrud Brown, RN, Unit Supervisor
Rochester District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904-5506
Email: jennifer.kolsrud@state.mn.us
Office: (507) 206-2727 Mobile: (507) 461-9125

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of

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

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

If substantial compliance with the regulations is not verified by February 16, 2024 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by May 16, 2024 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

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

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

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

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

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

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

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

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

Feel free to contact me if you have questions.

Sincerely,

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

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
December 12, 2023

Administrator
Charter House Inc
211 Northwest Second Street
Rochester, MN 55901

Re: State Nursing Home Licensing Orders
Event ID: UYKJ11

Dear Administrator:

The above facility was surveyed on November 13, 2023 through November 16, 2023 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

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

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

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

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

Jennifer Kolsrud Brown, RN, Unit Supervisor
Rochester District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904-5506
Email: jennifer.kolsrud@state.mn.us
Office: (507) 206-2727 Mobile: (507) 461-9125

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
	245282	A. BUILDING _____ B. WING _____	11/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHARTER HOUSE INC	211 NORTHWEST SECOND STREET ROCHESTER, MN 55901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments On 11/13/23 to 11/16/23, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73 was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On 11/13/23 to 11/16/23, a standard recertification survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities. Your 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. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F 000		
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer	F 554		1/2/24

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

Electronically Signed | 12/21/2023

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

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F 554	Continued From page 1 medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a self-administration of medication (SAM) assessment was completed for 1 of 1 resident (R1), reviewed for medication administration . Findings Include: R1's significant change minimum data set (MDS) assessment dated 9/29/23, indicated R1 was cognitively impaired and totally dependent on staff for bed mobility, dressing and toilet use. R1 diagnosis included aphasia (language disorder caused by damage in a specific area of the brain that controls language expression and comprehension; it leaves a person unable to communicate effectively with others), and respiratory failure. R1's face sheet included diagnosis of cerebral vascular accident (CVA, or a brain attack, is an interruption in the flow of blood to cells in the brain), non-Alzheimer's dementia (a variety of disorders characterized by pathological changes involving various cortical and subcortical circuits), hemiplegia (paralysis of one side of the body), seizure disorder, asthma, chronic obstructive pulmonary disease (a condition involving constriction of the airways and difficulty or discomfort in breathing). R1's care plan updated 10/6/23, indicated pulmonary/oxygen use with pneumonia history and interventions included nursing to provide	F 554	As noted in attachment: Plan of Correction (WHAT): Immediate verbal feedback was provided to nursing staff at the time of the survey observation that residents must have a documented assessment allowing for self administration of medication in the care plan before self-administration of medication occurs and that this resident should not be left alone during nebulizer treatment. Verbal reminders were also shared with nursing staff about ensuring the appropriateness for residents to self-administer medications. All current residents□ care plans and orders were reviewed on 11/15/2023 to ensure the correct documentation was in place for self-administration of medications, if applicable. The Self-Administration of Medication Policy was reviewed and revised on 12/18/2023 to provide clarification about the necessary criteria for self-administration of medication, specifically including nebulizer treatments, and that it would be documented on the care plan. All nurses will be educated on the updated policy by 1/2/2024, reinforcing that if an order for self-administration is not in place and the resident has not been	

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CHARTER HOUSE INC	211 NORTHWEST SECOND STREET ROCHESTER, MN 55901

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F 554	Continued From page 2 medications and oxygen supplements per orders and to encourage cough and deep breathing exercises especially after each pair of nebulizer's. R1's physician orders dated 9/5/23, included ipratropium 0.5 milligram(mg)-albuterol 3 mg (2.5 mg base)/3 milliliters (ml) nebulization solution (3ml) ampule for nebulization; ipratropium-albuterol (duoneb) 0.5-2.5 mg/3 mL nebulizer solution. Inhale 3 ml by nebulization four times a day. During observation on 11/14/23 at 12:41 p.m., registered nurse (RN)-A emptied a vial/ampule of duoneb into nebulizer container and placed face mask onto R1's face. After set up, with duoneb being administered via inhalation, RN-A stated R1 had a self-administration of nebulizer and could be left alone while nebulizer treatments were ongoing. RN-A left R1's room. During observation on 11/14/23 at 1:01 p.m., R1 was in room alone while nebulizer treatment was being administered via face mask. R1's medical record lacked a self-administration of medication (SAM) assessment. During interview on 11/14/23 at 3:00 p.m., RN-A stated her understanding was R1 had a SAM assessment and could be left alone since there was also a camera monitor in R1's room. Care coordinator, RN-C, mentioned during interview with RN-A, R1 did not have a SAM assessment and should not be left alone during nebulizer treatment. During interview on 11/14/23 at 3:05 p.m., nurse manager, RN-B verified R1 did not have a SAM	F 554	assessed for self-administration, staff must be present in the room for the entire medication administration, including nebulizer treatments. Procedure for Implementing Plan of Correction (HOW/WHERE): The Nursing leadership team reviewed and revised the Self-Administration of Medication Policy on 12/15/2023 and it was approved by the interdisciplinary team on 12/18/23. The policy and key education points will be sent to all staff for review with a quiz to staff via email that must be completed by 1/2/2024. The Nurse Manager and the Care Coordinator will review new and current residents for self-administration of medication and add appropriate documentation, if necessary. Monitoring Procedure (HOW/WHERE): All new admissions will be audited once weekly for the first month to ensure that each resident has been assessed for their capacity for self-administration of medication and that the resident□s care plan accurately reflects the acceptable method of medication administration per that assessment. After the first month, the same audit will occur monthly for 3 months, then quarterly for 3 quarters. Audit results will be reviewed monthly with the Quality Assurance Committee for 3 months, then quarterly for 3 quarters. Any further	

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CHARTER HOUSE INC	211 NORTHWEST SECOND STREET ROCHESTER, MN 55901

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F 554	Continued From page 3 assessment and should not be left alone during nebulizer treatment administration. During interview on 11/16/23 at 12:06 p.m., with director of nursing and quality assurance nurse (RN)-D stated residents should have a SAM assessment completed to ensure resident could be left alone based on the assessment findings. The facility policy for self administration of medication was requested and was not received.	F 554	action needed during or after the audit period based on audit results will be determined by the Quality Assurance Committee. Person Responsible for Implementing the Plan of Correction (WHO): The Nurse Manager and the Care Coordinator are responsible for implementing the Plan of Correction. Date of Correction (WHEN): All corrective actions described above will be completed by 1/2/2024.	
F 604 SS=D	Right to be Free from Physical Restraints CFR(s): 483.10(e)(1), 483.12(a)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. 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 medical symptoms. §483.12(a) The facility must-	F 604		1/2/24

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F 604	Continued From page 4 §483.12(a)(2) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. This REQUIREMENT is not met as evidenced by: Based upon observation, interview and document review, the facility failed to ensure residents were free from physical restraints for 1 of 1 resident (R1) reviewed. Findings include: R1's quarterly Minimum Data Set (MDS) assessment dated 8/27/23, indicated R1 was dependent on almost all activities of daily living (ADLs) and did not use restraints. R1's Medical Diagnosis Form (undated) indicated the following diagnosis: diabetes, Aphasia from stroke, hemiparesis, hemiplegia, muscle weakness, morbid obesity, abnormal posture, debility, unspecified dementia. During an observation on 11/13/23 at 6:46 p.m., R1 was in the dining room, right arm was secured to right arm rest of wheelchair with two Velcro straps. Under same right arm was a wedge shaped cushion that elevated R1's elbow. No visible skin abrasions, tears, or issues observed on right arm. R1's clinical physician orders were reviewed and	F 604	Plan of Correction (WHAT): Resident R1 required assistance with positioning and was at risk for falls due to weakness, hemiparesis, hemiplegia on her right side, and the Velcro straps and wedge cushion served as a clinical intervention for the resident’s safety and comfort. The use of the arm rest with Velcro straps and a wedge cushion was reviewed with the resident's provider on 11/15/2023 and it was determined that the devices did not restrict voluntary movement and were appropriate for the resident’s support and positioning due to the resident’s condition. R1 was further assessed by Nursing on 11/15/2023 and the resident’s care plan was updated to include the reason for use and a plan for monitoring the use of those assistive devices. Charter House will also audit the assistive devices listed and/or in-use for all other	

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F 604	Continued From page 5 lacked orders for a restraint. R1's most recent care plan dated 9/8/23 indicated assistance with positioning and risk of falls due related to weakness, hemiparesis, hemiplegia, but had no indication of restraint or durable medical equipment use. During interview on 11/14/23 at 2:37 p.m., R1 stated they don't remember who ordered the Velcro straps for her arm and wheelchair, or how long they had been used. During interview on 11/14/23 at 3:03 p.m., Registered Nurse (RN)-E, stated only been employed at facility for around three months, no training given regarding R1's Velcro straps, only that they're present for safety and protection. RN-E further stated no mention by facility that the straps were used as a restraint. During interview on 11/14/23 at 3:32 p.m., Registered Nurse (RN)-B, stated not sure how long ago the Velcro straps were ordered or implemented. During interview on 11/15/23 at 7:20 a.m., RN-B acknowledged R1's current care plan does not mention reason for use, an assessment, or have a record of a physical device evaluation, or how to evaluate use of straps for R1, and mentioned the straps are not a restraint. RN-B indicated they are being used as a safety device due to R1's lack of use of her right side. RN-B also stated no record of staff training for Velcro straps. RN-B further stated the facility found a durable medical equipment (DME) order, dated 5/31/19, which was only for a swing away lateral pad. No other documentation was provided by facility. RN-B	F 604	current residents and determine if any of those devices restrict movement. If any are found, Nursing staff will assess those devices to ensure they are necessary and, if so, ensure that the appropriate interventions and documentation is in place in the resident's care plan. This audit will be completed by 12/22/2023. The Use of Restraints policy was created by the interdisciplinary team on 12/15/2023 and approved by the interdisciplinary team on 12/18/2023 stating that Charter House is a restraint-free facility and outlined the difference between a restraint and a physical assistive device, along with direction to consult with leadership if a device is in question. Nursing staff will be educated on this policy via email that includes a related quiz that must be completed by 1/2/2024. Nursing staff will be educated on the new Use of Restraints policy and re-educated to ensure understanding that Charter House is a restraint-free facility. Charter House will provide additional education on the requirements for appropriate use of assistive devices, which includes an assessment of each	

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CHARTER HOUSE INC	211 NORTHWEST SECOND STREET ROCHESTER, MN 55901

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F 604	Continued From page 6 stated facility expectations are every resident is receiving the appropriate care and devices as needed and each staff member is aware, educated, and trained on use of DME and competencies are evaluated. RN-B also stated a resident using any DME would receive ongoing evaluation of DME usage to ensure safe and appropriate use. RN-B further stated an expectation is care plans are properly followed, and evaluated. During an interview on 11/15/23 at 8:02 a.m., Nursing Assistant (NA)-B, stated received training around two and half years ago regarding how to use the Velcro straps for R1, but believed it was an informal, on-the-job type of instruction and training. NA-B further stated does not remember receiving training or instruction on charting and assessment of the straps and has not been charting these areas. Facility restraint policy requested. Director of Nursing (DON) stated they don't have one because they don't use restraints, documentation provided was a copy of the Bill of Rights.	F 604	device and updating the resident's care plan. All assistive devices require a documented need from therapy/nursing/medical provider. Staff will attest to their understanding of the education prior to 01/02/2024. Procedure for Implementing Plan of Correction (HOW/WHERE): The resident's provider and nursing staff assessed the resident's assistive devices and updated the care plan accordingly. An audit of all other current residents' assistive devices will be assessed for appropriate documentation in the care plan as well. All re-education for Nursing staff on the new Use of Restraints policy, on being a restraint-free facility, and on appropriate use of assistive devices will be provided via email, along with a related quiz that must be completed by 1/2/2024. Monitoring Procedure (HOW/WHERE): All new admissions will be audited monthly for appropriate assessment and documentation related to residents' assistive devices for 3 months. Assistive devices will continue to be evaluated at the time of each resident's quarterly assessment thereafter. Audit results will be reviewed monthly with the Quality Assurance Committee for 3 months,	

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	245282	A. BUILDING _____ B. WING _____	11/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHARTER HOUSE INC	211 NORTHWEST SECOND STREET ROCHESTER, MN 55901

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F 604	Continued From page 7	F 604	then quarterly for 3 quarters. Any further action needed during or after the audit period based on the audit results will be determined by the Quality Assurance Committee. Person Responsible for Implementing the Plan of Correction (WHO): The Nurse Manager and the Care Coordinator are responsible for implementing the Plan of Correction. Date of Correction (WHEN): All corrective actions described above will be completed by 1/2/2024.	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals	F 880		1/2/24

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F 880	Continued From page 8 providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens.	F 880		

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F 880	Continued From page 9 Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure gloves were changed during dressing change for 1 of 1 resident (R109) reviewed for skin tear. Findings Include: R109's face sheet included diagnosis of unspecified dementia, and history of falling. R109's physician orders dated 11/14/23, indicated check wound for drainage. Cleanse with normal saline, pat dry leave steristrips in place for seven days or until falls off. During observation on 11/14/23 at 1:53 p.m., registered nurse (RN)-C entered R109's room. RN-C donned gloves and removed old transparent dressing from skin tear to R109's right thigh. RN-C did not change gloves. RN-C then took saline and placed onto 4x4 gauze and cleaned the skin tear to R109's right thigh. RN-C did not change gloves and then placed steristrips onto R109's skin tear. RN-C assisted R109 to pull up pants and then removed gloves and sanitized hands. During interview on 11/14/23 at 2:03 p.m., RN-C verified had not changed gloves after removing R109's old dressing, cleaning the skin tear with	F 880	Plan of Correction (WHAT): Immediate feedback was provided to nurse involved in the noted citation, along with reminders to all staff about proper wound care and hand hygiene during resident care. The Nursing leadership team reviewed the Wound Care Policy on 12/14/2023 and determined it to be compliant with standards of care. All nursing and nursing aide staff will be reeducated on wound care and hand hygiene. Procedure for Implementing Plan of Correction (HOW/WHERE): The facility Wound Care Policy was reviewed on 12/14/2023 and determined to be compliant with standards of care. All nurses are being re-educated on proper wound care techniques, along with hand hygiene and all aides are being re-educated on hand hygiene via virtual education with a quiz that must be completed by 1/2/2024. Monitoring Procedure (HOW/WHERE):	

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F 880	Continued From page 10 saline and gauze and then applying steristrips to R109's right thigh skin tear. RN-C stated she normally would have changed gloves but had not done so during R109's observed dressing change to right thigh skin tear. During interview on 11/16/23 at 12:06 p.m., with director of nursing and quality assurance nurse, RN-D stated it was the expectation hands should be sanitized before cares, gloves donned and when soiled dressings were removed, glove were to be changed and hand sanitized. The facility Hand Hygiene policy updated 10/4/21, indicated hand hygiene must be performed in patient care settings: after contact with blood or body fluids and after glove removal; when moving from contaminated body sit or activity to another body site during patient care (e.g., after changing a wound dressing and then brushing the patient's teeth).	F 880	Wound care audits will be completed on all current residents receiving wound care and within 1 week for each new admission receiving wound care through 1/1/2024. Wound care audits will be completed weekly for 1 month, then monthly for 3 months. Audit results will be reviewed by the Quality Assurance Committee. Any further action needed during or after the audit period based on the audit results will be determined by the Quality Assurance Committee. Hand hygiene audits will be completed 3 times per week on each shift for 2 weeks, then 5 times per month for 3 months. Audit results will be reviewed by the Quality Committee. Any further action needed during or after the audit period based on the audit results will be determined by the Quality Assurance Committee. Person Responsible for Implementing the Plan of Correction: The Nurse Manager is responsible for implementing the Plan of Correction. Date of Correction: All corrective actions described above will be completed by 1/2/2024.	

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	245421	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**11/21/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 11/21/2023. At the time of this survey, New Brighton Care Center 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	K 000		

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

Electronically Signed | 12/18/2023

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

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K 000	Continued From page 1 IS NOT REQUIRED. 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. New Brighton Care Center is a 2-story building with no basement. The building at 2 different times. The original building was constructed in 1964 and was determined to be of Type II (111) construction. In 1997 an addition was constructed to the north and was determined to be of Type II (111) construction. Because the original building and the 1 addition are of the same type of	K 000		

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K 000	Continued From page 2 construction, the building was surveyed as 1 building. The building has a complete automatic fire sprinkler system. The facility has a fire alarm system that consists of smoke detection in the corridors and areas open to the corridors that is monitored for fire department notification. The facility has a capacity of 57 beds and had a census of 37 at the time of the survey.	K 000		
K 211 SS=E	The requirements at 42 CFR, Subpart 483.70(a), are NOT MET as evidenced by: 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.This deficient finding could have a patterned impact on the residents within the facility. Findings include: 1. On 11/21/2023 at 10:37 AM, it was revealed by observation that there was a chair in the corridor	K 211	Please accept the following as the facility's credible allegation of compliance. This Plan of Correction does not constitute any admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. K211 – Means of Egress • Stationary chairs have been removed from hallways. • Means of Egress will be added to a weekly maintenance rounding checklist.	1/29/24

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K 211	Continued From page 3 near resident room 105. 2. On 11/21/2023 at 11:05 AM, it was revealed by observation that there were two chairs in the corridor near resident room 202 and 212. An interview with the Administrator verified these deficient findings at the time of discovery.	K 211	• A copy of the checklist will need to be emailed to the Administrator weekly • Maintenance Manager/Technician is responsible. • Date Corrected: January 29th, 2024.	
K 225 SS=D	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 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain stairwells per NFPA 101 (2012 edition), Life Safety Code, sections 19.2.2.3, and 7.2.2.5.3. This deficient finding could have a patterned impact on the residents within the facility. Findings include: On 11/21/2023 at 11:10 AM, it was revealed by observation that there was a floor fan stored at the bottom of the stairwell by the main entrance. An interview with the Administrator verified this deficient finding at the time of discovery.	K 225	K225 – Stairways and Smokeproof Enclosures • Any items stored in the stairwells will be removed. • Stairway storage will be checked weekly by the maintenance manager/technician. • Date Corrected: January 29th, 2024.	1/29/24
K 291 SS=D	Emergency Lighting	K 291		1/29/24

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K 291	Continued From page 4 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, observation, 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. These deficient findings could have an isolated impact on the residents within the facility. Findings include: 1. On 11/21/2023 between 08:45 AM and 11:45 AM, it was revealed by a review of available documentation that at the time of the survey the facility could not provide documentation showing that they have been testing emergency lighting. 2. On 11/21/2023 between 08:45 AM and 11:45 AM, it was revealed by observation that the emergency lighting located in the occupational therapy room 112 was not operational when tested. An interview with the Administrator verified these deficient findings at the time of discovery.	K 291	K291 – Emergency Lighting • Check illumination of exit lighting and exit signs has been added to the monthly TELS software system. • The system alerts the Administrator on a weekly basis of incomplete tasks. Administrator will follow up with maintenance manager or technician if notified of incompleteness. • Maintenance Manager/Technician • Date Corrected: January 29th, 2024.	
K 321 SS=E	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing	K 321		1/29/24

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K 321	Continued From page 5 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. 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, 19.3.2.1.2, 19.3.2.1.3, 8.4.3.5, 8.3.3.1, and 7.2.1.8.1. These deficient findings could have a patterned impact on the residents within the facility. Findings include: 1. On 11/21/2023 at 10:31 AM, it was revealed by	K 321	K321 – Hazardous Areas – Enclosures • The two small holes in the door for the East utility room will be filled appropriately. • Staff will be educated about propping doors open at the all-staff meetings 1/16 & 1/18/2024. • Doors will be labeled, “Keep Closed.” • The Lower-Level Apartment will be assessed for storage need and the closure will be updated if needed. • Date Corrected: January 29th, 2024.	

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K 321	Continued From page 6 observation that there were two small holes in the door for the east utility room. 2. On 11/21/2023 at 10:56 AM, it was revealed by observation that there was paper stuffed in the door strike for the soiled utility room 229 causing the door to not latch. 3. On 11/21/2023 at 11:30 AM, it was revealed by observation that room 2 on the lower level was repurposed as a storage room and the door was not self-closing. An interview with the Administrator verified these deficient findings at the time of discovery.	K 321		
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 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor.	K 324		1/29/24

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K 324	Continued From page 7 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 install the required safety features for cooking equipment per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.2.5.3 (9) and 19.3.2.5.4. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 11/21/2023 at 11:26 AM, it was revealed by observation that the lockout switch installed on the residential stove located in Occupational Therapy room 112 was not on a timer, not exceeding a 120-minute capacity, that automatically deactivates the cooktop or range, independent of staff action. An interview with the Administrator verified this deficient findings at the time of discovery.	K 324	K324 – Cooking Facilities • Have timer installed on lockout switch. • Maintenance Manager/Technician • Date Corrected: January 29th, 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	K 363		1/29/24

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	245421	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**11/21/2023**

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K 363	Continued From page 8 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 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 19.3.6.3.10. This deficient finding could have a patterned impact on the residents within the facility. Findings include:	K 363	K363 – Corridor – Doors • Staff will be educated on Door propping at the All Staff 1/16 & 1/18/2024. • Door propping with wedge or tissue in door strike have been added to the weekly maintenance rounding checklist. • The Maintenance Manager or Technician are responsible.	

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K 363	Continued From page 9 1. On 11/21/2023 at 10:29 AM, it was revealed by observation that the south nursing station charting room door was propped open with a rubber wedge. 2. On 11/21/2023 at 10:49 AM, it was revealed by observation the kitchen door was propped open with a rubber wedge. An interview with the Administrator verified these deficient findings at the time of discovery.	K 363	• Date Corrected: January 29th, 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. 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 an isolated impact on the residents within the facility. Findings include:	K 372	K372 – Building Spaces – Smoke Barriers • The penetrations will be filled by January 29th, 2024, by the maintenance manager/technician.	1/29/24

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K 372	Continued From page 10 On 11/21/2023 at 10:26 AM, it was revealed by observation that there was a penetration in the smoke barrier above the smoke barrier doors near resident room 105 caused by wires. An interview with the Administrator verified this deficient finding at the time of discovery.	K 372		
K 521 SS=F	HVAC CFR(s): NFPA 101 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 inspect 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 6.5.2 and 6.5.12. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 11/21/2023 between 08:45 AM and 11:45 AM, it was revealed by a review of available documentation that at the time of the survey the facility could not provide a report showing that they had their fire dampers inspected.	K 521	K521 – HVAC • Fire Damper and Smoke Damper Inspection and Testing has been added to the TELS software system for January 2024. • The inspection will be scheduled or completed by January 29th, 2024, by the maintenance manager or technician.	1/29/24

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K 521	Continued From page 11 An interview with the Administrator verified these deficient findings at the time of discovery.	K 521		
K 712 SS=F	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to conduct fire drills per NFPA 101 (2012 edition), Life Safety Code sections 4.6.1.1 and 19.7.1.6. This deficient finding could have a widespread impact on the residents within the facility. Findings include: 1. On 11/21/2023 between 08:45 AM and 11:45 AM, it was revealed by a review of available documentation that at the time of the survey the facility could not provide documentation showing that a fire drill had been completed during the third shift during the first quarter of 2023. 2. On 11/21/2023 between 08:45 AM and 11:45 AM, it was revealed by a review of available documentation that the facility was not varying the	K 712	K712 - Fire Drills • The fire drill book is being redeveloped to be organized and proactive. • The maintenance manager and technician will be educated on the fire drill book and the need to stagger drill times more drastically than prior. • The fire drills are part of the TELS software system currently. • Date Corrected: January 29th, 2024.	1/29/24

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K 712	Continued From page 12 times that they were conducting the fire drills. The second shift drills were conducted on 03/03/2023 at 03:45 PM, 06/26/2023 at 04:00 PM, and 09/29/2023 04:00 PM. The two third shift drill that were completed were completed on 04/15/2023 at 04:50 AM and 07/21/2023 at 05:04 AM. An interview with the Administrator verified these deficient findings at the time of discovery.	K 712		
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.	K 761	K761 – Maintenance, Inspection & Testing Doors • Inspection – Latch and Gap has been scheduled annually in TELS software system for January 2024. • The inspection will be scheduled or completed by January 29th, 2024, by the maintenance manager or technician. • Completion date: January 29th, 2024	1/29/24

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K 761	Continued From page 13 Findings include: On 11/21/2023 between 08:45 AM and 11:45 AM, it was revealed by a review of available documentation that at the time of the survey the facility could not provide documentation showing that there had been an inspection completed on the fire doors in the facility. An interview with the Administrator verified this deficient finding at the time of discovery.	K 761		
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) 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 11/21/2023 between 08:45 AM and 11:45 AM, it was revealed by a review of available	K 901	K901 – Building System Categories • The Administrator was not asked for this documentation. The NBCC Administrator and the President of North Cities Health Care, owner and operator of New Brighton Care Center completed a Risk Assessment 1/31/2023. • Completed.	1/29/24

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K 901	Continued From page 14 documentation that at the time of the survey the facility could not provide an NFPA 99 Risk Assessment. An interview with the Administrator verified this deficient finding at the time of discovery.	K 901		
K 914 SS=E	Electrical Systems - Maintenance and Testing 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, sections 6.3.3.2 , 6.3.4.1.3, and 6.3.4.2.1.2. These deficient findings could have a widespread	K 914	K914 – Electrical Systems – maintenance and testing • The electrical receptacle testing document is being reconfigured and developed with complete details of date and room numbers.	1/29/24

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K 914	Continued From page 15 impact on the residents within the facility. Findings include: On 11/21/2023 between 08:45 AM and 11:45 AM, it was revealed by a review of available documentation that the electrical receptacle testing documentation that was provided at the survey showed that resident rooms 202 and 222 had not been tested, and the page for the 200 wings of the building did not have a date so the surveyor was unable to determine when the inspections happened. An interview with the Administrator verified these deficient findings at the time of discovery.	K 914	• The maintenance manager and technician will be trained in necessary complete documentation. • Date Completed: January 29th, 2024.	
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel.	K 918		1/29/24

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K 918	Continued From page 16 Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to test their Emergency Power Supply System (EPSS) per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.4.4.1.1.3, and NFPA 110 (2010 edition), Standard for Emergency and Standby Power Systems, sections 8.4.1, 8.4.2, 8.4.2.1, 8.4.2.3, 8.4.9, 8.4.9.1, 8.4.9.2, and 8.4.9.5.1. These deficient findings could have a widespread impact on the residents within the facility. Findings include: 1. On 11/21/2023 between 08:45 AM and 11:45 AM, it was revealed by a review of available documentation that at the time of the survey the facility could not provide documentation showing that weekly inspections were completed on the emergency generator during the week of November 6th 2023, and November 13th 2023, or before March of 2023.	K 918	K918 – Electrical Systems – Essential Electric System Maintenance and Testing • Weekly Generator Inspection has been added to the Weekly Maintenance Rounding Checklist • The monthly generator run – transfer load – inspection is in the TELS software system. • The 4-hour generator test is scheduled on January 24th, 2024. • The report will be filed in the maintenance book for completion. • Date Completed: January 24th, 2024.	

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K 918	Continued From page 17 2. On 11/21/2023 between 08:45 AM and 11:45 AM, it was revealed by a review of available documentation that the inspection report for the monthly emergency generator inspection that was completed for January 2023 was not filled out. 3. On 11/21/2023 between 08:45 AM and 11:45 AM, it was revealed by a review of available documentation that at the time of the survey the facility could not provide documentation showing that the generator has had a four (4) hour load bank test completed within the last 36 months. An interview with the Administrator verified these deficient findings at the time of discovery.	K 918		
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 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	K 920		1/29/24

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K 920	Continued From page 18 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, section 400.8. These deficient findings could have a patterned impact on the residents within the facility. Findings include: 1. On 11/21/2023 at 10:41 AM, it was revealed observation that there was a blue extension cord in resident room 111 that the team from the Minnesota Department of Health (MDH) witnessed being used. 2. On 11/21/2023 at 10:47 AM, it was revealed observation there was a tan extension cord in the CPR board room being used to power computer equipment. An interview with the Administrator verified these deficient findings at the time of discovery.	K 920	K920 – Electrical Equipment • Blue extension cord in room 111 will be evaluated for use. • The tan extension cord in the CPR board will be replaced with an outlet. • The outlet will be planned to be installed or will be complete by January 29th, 2024.	
K 923 SS=D	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and	K 923		1/29/24

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K 923	Continued From page 19 ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited-combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to store oxygen cylinders per NFPA 99 (2012 edition), Health Care Facilities Code,	K 923	K923 – Gas Equipment – Cylinder and Container Storage • The empty and full cylinders will be	

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	245421	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**11/21/2023**

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K 923	Continued From page 20 sections 11.6.2.3, 11.6.5.2 and 11.6.5.3. These deficient findings could have an isolated impact on the residents within the facility. Findings include: 1. On 11/21/2023 at 11:23 AM, it was revealed observation that the empty and full oxygen cylinders in the oxygen room were not segregated, and empty cylinders were not marked to avoid confusion and delay if a full cylinder is needed in a rapid manner. 2. On 11/21/2023 at 11:23 AM, it was revealed observation there was one freestanding oxygen cylinder that was not properly chained or supported in a proper cylinder stand or cart. An interview with the Administrator verified these deficient findings at the time of discovery.	K 923	separated in the oxygen room. • Empty cylinders will be marked with a tag stating empty. • Staff will be educated on the importance of oxygen room, the cylinders being chained or supported in the proper cylinder stand at the whole staff meeting in January 2024. • Date Completed: January 29th, 2024.	
K 926 SS=F	Gas Equipment - Qualifications and Training CFR(s): NFPA 101 Gas Equipment - Qualifications and Training of Personnel Personnel concerned with the application, maintenance and handling of medical gases and cylinders are trained on the risk. Facilities provide continuing education, including safety guidelines and usage requirements. Equipment is serviced only by personnel trained in the maintenance and operation of equipment. 11.5.2.1 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to implement medical gas training for staff per NFPA 99 (2012	K 926	K926 – Gas Equipment – Qualifications and Training • All current staff of NBCC have been	1/29/24

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K 926	Continued From page 21 edition), Health Care Facilities Code, section 11.5.2.1.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 11/21/2023 between 08:45 AM and 11:45 AM, it was revealed by available documentation that at the time of the survey the facility could not provide documentation showing that personnel in the facility concerned with the application and maintenance of medical gases and others who handle medical gases are receiving continuing education for the safety guidelines and usage requirements for medical gases and their cylinders. An interview with the Administrator verified this deficient finding at the time of discovery.	K 926	assigned oxygen training in Relias with due date of January 29th, 2024. • Oxygen safety training has been assigned to all nurses and nursing assistants annual training. • Date Completed: January 29th, 2024.	

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	00193	A. BUILDING: _____ B. WING _____	11/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHARTER HOUSE INC	211 NORTHWEST SECOND STREET ROCHESTER, MN 55901

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 11/13/23 to 11/16/23, a licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you have reviewed these orders and	2 000		

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2 000	Continued From page 1 identify the date when they will be completed. 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. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. PLEASE DISREGARD THE HEADING OF THE	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		
2 505	MN Rule 4658.0300 Subp. 1 A-E Use of Restraints Subpart 1. Definitions. For purposes of this part, the following terms have the meanings given. A. "Physical restraints" means any manual method or physical or mechanical device, material, or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body. Physical restraints include, but are not limited to, leg restraints, arm restraints, hand mitts, soft ties or vests, and wheelchair safety bars. Physical restraints also include practices which meet the definition of a restraint, such as tucking in a sheet so tightly that a resident confined to bed cannot move; bed rails; chairs that prevent rising; or placing a resident in a wheelchair so close to a wall that the wall prevents the resident from rising. Bed rails are considered a restraint if they restrict freedom of movement. If the bed rail is used solely to assist the resident in turning or to help the resident get out of bed, then the bed rail is not used as a restraint. Wrist bands or devices on clothing that trigger electronic alarms to warn staff that a resident is leaving a room or area do not, in and of themselves, restrict freedom of movement and should not be considered restraints.	2 505		12/21/23

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2 505	Continued From page 3 B. "Chemical restraints" means any psychopharmacologic drug that is used for discipline or convenience and is not required to treat medical symptoms. C. "Discipline" means any action taken by the nursing home for the purpose of punishing or penalizing a resident. D. "Convenience" means any action taken solely to control resident behavior or maintain a resident with a lesser amount of effort that is not in the resident's best interest. E. "Emergency measures" means the immediate action necessary to alleviate an unexpected situation or sudden occurrence of a serious and urgent nature. This MN Requirement is not met as evidenced by: Based upon observation, interview and document review, the facility failed to ensure residents were free from physical restraints for 1 of 1 resident (R1) reviewed. Findings include: R1's quarterly Minimum Data Set (MDS) assessment dated 8/27/23, indicated R1 was dependent on almost all activities of daily living (ADLs) and did not use restraints. R1's Medical Diagnosis Form (undated) indicated the following diagnosis: diabetes, Aphasia from stroke, hemiparesis, hemiplegia, muscle weakness, morbid obesity, abnormal posture, debility, unspecified dementia. During an observation on 11/13/23 at 6:46 p.m., R1 was in the dining room, right arm was secured to right arm rest of wheelchair with two Velcro	2 505	As noted in attachment: Plan of Correction (WHAT): Resident R1 required assistance with positioning and was at risk for falls due to weakness, hemiparesis, hemiplegia on her right side, and the Velcro straps and wedge cushion served as a clinical intervention for the resident’s safety and comfort. The use of the arm rest with Velcro straps and a wedge cushion was reviewed with the resident's provider on 11/15/2023 and it was determined that the devices did not restrict voluntary movement and were appropriate for the resident’s support and positioning due to the resident’s condition. R1 was further assessed by Nursing on 11/15/2023 and	

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2 505	Continued From page 4 straps. Under same right arm was a wedge shaped cushion that elevated R1's elbow. No visible skin abrasions, tears, or issues observed on right arm. R1's clinical physician orders were reviewed and lacked orders for a restraint. R1's most recent care plan dated 9/8/23 indicated assistance with positioning and risk of falls due related to weakness, hemiparesis, hemiplegia, but had no indication of restraint or durable medical equipment use. During interview on 11/14/23 at 2:37 p.m., R1 stated they don't remember who ordered the Velcro straps for her arm and wheelchair, or how long they had been used. During interview on 11/14/23 at 3:03 p.m., Registered Nurse (RN)-E, stated only been employed at facility for around three months, no training given regarding R1's Velcro straps, only that they're present for safety and protection. RN-E further stated no mention by facility that the straps were used as a restraint. During interview on 11/14/23 at 3:32 p.m., Registered Nurse (RN)-B, stated not sure how long ago the Velcro straps were ordered or implemented. During interview on 11/15/23 at 7:20 a.m., RN-B acknowledged R1's current care plan does not mention reason for use, an assessment, or have a record of a physical device evaluation, or how to evaluate use of straps for R1, and mentioned the straps are not a restraint. RN-B indicated they are being used as a safety device due to R1's lack of use of her right side. RN-B also stated no	2 505	the resident’s care plan was updated to include the reason for use and a plan for monitoring the use of those assistive devices. Charter House will also audit the assistive devices listed and/or in-use for all other current residents and determine if any of those devices restrict movement. If any are found, Nursing staff will assess those devices to ensure they are necessary and, if so, ensure that the appropriate interventions and documentation is in place in the resident’s care plan. This audit will be completed by 12/22/2023. The Use of Restraints policy was created by the interdisciplinary team on 12/15/2023 and approved by the interdisciplinary team on 12/18/2023 stating that Charter House is a restraint-free facility and outlined the difference between a restraint and a physical assistive device, along with direction to consult with leadership if a device is in question. Nursing staff will be educated on this policy via email that includes a related quiz that must be completed by 1/2/2024. Nursing staff will be educated on the new Use of Restraints policy and re-educated to ensure understanding that Charter House	

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2 505	Continued From page 5 record of staff training for Velcro straps. RN-B further stated the facility found a durable medical equipment (DME) order, dated 5/31/19, which was only for a swing away lateral pad. No other documentation was provided by facility. RN-B stated facility expectations are every resident is receiving the appropriate care and devices as needed and each staff member is aware, educated, and trained on use of DME and competencies are evaluated. RN-B also stated a resident using any DME would receive ongoing evaluation of DME usage to ensure safe and appropriate use. RN-B further stated an expectation is care plans are properly followed, and evaluated. During an interview on 11/15/23 at 8:02 a.m., Nursing Assistant (NA)-B, stated received training around two and half years ago regarding how to use the Velcro straps for R1, but believed it was an informal, on-the-job type of instruction and training. NA-B further stated does not remember receiving training or instruction on charting and assessment of the straps and has not been charting these areas. Facility restraint policy requested. Director of Nursing (DON) stated they don't have one because they don't use restraints, documentation provided was a copy of the Bill of Rights. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could ensure potential restraint use is identified. Staff education could be completed to identify use of restraints. The information could be shared with the quality committee. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 505	is a restraint-free facility. Charter House will provide additional education on the requirements for appropriate use of assistive devices, which includes an assessment of each device and updating the resident's care plan. All assistive devices require a documented need from therapy/nursing/medical provider. Staff will attest to their understanding of the education prior to 01/02/2024. Procedure for Implementing Plan of Correction (HOW/WHERE): The resident's provider and nursing staff assessed the resident's assistive devices and updated the care plan accordingly. An audit of all other current residents' assistive devices will be assessed for appropriate documentation in the care plan as well. All re-education for Nursing staff on the new Use of Restraints policy, on being a restraint-free facility, and on appropriate use of assistive devices will be provided via email, along with a related quiz that must be completed by 1/2/2024. Monitoring Procedure (HOW/WHERE): All new admissions will be audited monthly for appropriate assessment and documentation related to residents' assistive devices for 3 months. Assistive devices will continue to be	

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2 505	Continued From page 6	2 505	evaluated at the time of each resident's quarterly assessment thereafter. Audit results will be reviewed monthly with the Quality Assurance Committee for 3 months, then quarterly for 3 quarters. Any further action needed during or after the audit period based on the audit results will be determined by the Quality Assurance Committee. Person Responsible for Implementing the Plan of Correction (WHO): The Nurse Manager and the Care Coordinator are responsible for implementing the Plan of Correction. Date of Correction (WHEN): All corrective actions described above will be completed by 1/2/2024.	
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	21390		12/21/23

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21390	Continued From page 7 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 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 gloves were changed during dressing change for 1 of 1 resident (R109) reviewed for skin tear. Findings Include: R109's face sheet included diagnosis of unspecified dementia, and history of falling. R109's physician orders dated 11/14/23, indicated check wound for drainage. Cleanse with normal saline, pat dry leave steristrips in place for seven days or until falls off. During observation on 11/14/23 at 1:53 p.m., registered nurse (RN)-C entered R109's room. RN-C donned gloves and removed old transparent dressing from skin tear to R109's right thigh. RN-C did not change gloves. RN-C then took saline and placed onto 4x4 gauze and cleaned the skin tear to R109's right thigh. RN-C	21390	As noted in attachment: Plan of Correction (WHAT): Immediate feedback was provided to nurse involved in the noted citation, along with reminders to all staff about proper wound care and hand hygiene during resident care. The Nursing leadership team reviewed the Wound Care Policy on 12/14/2023 and determined it to be compliant with standards of care. All nursing and nursing aide staff will be reeducated on wound care and hand hygiene. Procedure for Implementing Plan of Correction (HOW/WHERE): The facility Wound Care Policy was reviewed on 12/14/2023 and determined to be	

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21390	Continued From page 8 did not change gloves and then placed steristrips onto R109's skin tear. RN-C assisted R109 to pull up pants and then removed gloves and sanitized hands. During interview on 11/14/23 at 2:03 p.m., RN-C verified had not changed gloves after removing R109's old dressing, cleaning the skin tear with saline and gauze and then applying steristrips to R109's right thigh skin tear. RN-C stated she normally would have changed gloves but had not done so during R109's observed dressing change to right thigh skin tear. During interview on 11/16/23 at 12:06 p.m., with director of nursing and quality assurance nurse, RN-D stated it was the expectation hands should be sanitized before cares, gloves donned and when soiled dressings were removed, glove were to be changed and hand sanitized. The facility Hand Hygiene policy updated 10/4/21, indicated hand hygiene must be performed in patient care settings: after contact with blood or body fluids and after glove removal; when moving from contaminated body sit or activity to another body site during patient care (e.g., after changing a wound dressing and then brushing the patient's teeth). SUGGESTED METHOD OF CORRECTION: The ICP or designee could review facility policies/procedures regarding appropriate infection control technique during dressing changes. The ICP or designee could provide staff education regarding the policies and educate staff on appropriate IC technique while performing dressing changes. The ICP or designee should complete timely audits to ensure policies are being followed to ensure on-going competence.	21390	compliant with standards of care. All nurses are being re-educated on proper wound care techniques, along with hand hygiene and all aides are being re-educated on hand hygiene via virtual education with a quiz that must be completed by 1/2/2024. Monitoring Procedure (HOW/WHERE): Wound care audits will be completed on all current residents receiving wound care and within 1 week for each new admission receiving wound care through 1/1/2024. Wound care audits will be completed weekly for 1 month, then monthly for 3 months. Audit results will be reviewed by the Quality Assurance Committee. Any further action needed during or after the audit period based on the audit results will be determined by the Quality Assurance Committee. Hand hygiene audits will be completed 3 times per week on each shift for 2 weeks, then 5 times per month for 3 months. Audit results will be reviewed by the Quality Committee. Any further action needed during or after the audit period based on the audit results will be determined by the Quality Assurance Committee. Person Responsible for Implementing the Plan of Correction:	

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21390	Continued From page 9 The ICP, or designee should take education verifications and the audits to the Quality Assurance Performance Improvement (QAPI) committee to determine compliance or the need for continued monitoring. TIME PERIOD FOR CORRECTION: 21 (twenty-one) DAYS	21390	The Nurse Manager is responsible for implementing the Plan of Correction. Date of Correction: All corrective actions described above will be completed by 1/2/2024.	
21565	MN Rule 4658.1325 Subp. 4 Administration of Medications Self Admin Subp. 4. Self-administration. A resident may self-administer medications if the comprehensive resident assessment and comprehensive plan of care as required in parts 4658.0400 and 4658.0405 indicate this practice is safe and there is a written order from the attending physician. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a self-administration of medication (SAM) assessment was completed for 1 of 1 resident (R1), reviewed for medication administration . Findings Include: R1's significant change minimum data set (MDS) assessment dated 9/29/23, indicated R1 was cognitively impaired and totally dependent on staff for bed mobility, dressing and toilet use. R1 diagnosis included aphasia (language disorder caused by damage in a specific area of the brain that controls language expression and comprehension; it leaves a person unable to communicate effectively with others), and respiratory failure.	21565	See attachment	12/21/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00193	A. BUILDING: _____ B. WING _____	11/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHARTER HOUSE INC	211 NORTHWEST SECOND STREET ROCHESTER, MN 55901

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21565	Continued From page 10 R1's face sheet included diagnosis of cerebral vascular accident (CVA, or a brain attack, is an interruption in the flow of blood to cells in the brain), non-Alzheimer's dementia (a variety of disorders characterized by pathological changes involving various cortical and subcortical circuits), hemiplegia (paralysis of one side of the body), seizure disorder, asthma, chronic obstructive pulmonary disease (a condition involving constriction of the airways and difficulty or discomfort in breathing). R1's care plan updated 10/6/23, indicated pulmonary/oxygen use with pneumonia history and interventions included nursing to provide medications and oxygen supplements per orders and to encourage cough and deep breathing exercises especially after each pair of nebulizer's. R1's physician orders dated 9/5/23, included ipratropium 0.5 milligram(mg)-albuterol 3 mg (2.5 mg base)/3 milliliters (ml) nebulization solution (3ml) ampule for nebulization; ipratropium-albuterol (duoneb) 0.5-2.5 mg/3 mL nebulizer solution. Inhale 3 ml by nebulization four times a day. During observation on 11/14/23 at 12:41 p.m., registered nurse (RN)-A emptied a vial/ampule of duoneb into nebulizer container and placed face mask onto R1's face. After set up, with duoneb being administered via inhalation, RN-A stated R1 had a self-administration of nebulizer and could be left alone while nebulizer treatments were ongoing. RN-A left R1's room. During observation on 11/14/23 at 1:01 p.m., R1 was in room alone while nebulizer treatment was being administered via face mask.	21565		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00193	A. BUILDING: _____ B. WING _____	11/16/2023

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21565	Continued From page 11 R1's medical record lacked a self-administration of medication (SAM) assessment. During interview on 11/14/23 at 3:00 p.m., RN-A stated her understanding was R1 had a SAM assessment and could be left alone since there was also a camera monitor in R1's room. Care coordinator, RN-C, mentioned during interview with RN-A, R1 did not have a SAM assessment and should not be left alone during nebulizer treatment. During interview on 11/14/23 at 3:05 p.m., nurse manager, RN-B verified R1 did not have a SAM assessment and should not be left alone during nebulizer treatment administration. During interview on 11/16/23 at 12:06 p.m., with director of nursing and quality assurance nurse (RN)-D stated residents should have a SAM assessment completed to ensure resident could be left alone based on the assessment findings. The facility policy for self administration of medication was requested and was not received. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review applicable policies and procedures to ensure residents' are assessed timely with self administration of nebulzier medications; then provide staff education. The quality assurance committe could monitor for compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21565		