Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
July 5, 2023

Administrator
The Emeralds At St Paul LLC
420 Marshall Avenue
Saint Paul, MN 55102

RE: CCN: 245295
Cycle Start Date: April 27, 2023

Dear Administrator:

On June 28, 2023, the Minnesota Departments 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

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
May 10, 2023

Administrator
The Emeralds At St Paul LLC
420 Marshall Avenue
Saint Paul, MN 55102

RE: CCN: 245295
Cycle Start Date: April 27, 2023

Dear Administrator:

On April 27, 2023, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

DEPARTMENT CONTACT

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

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

If substantial compliance with the regulations is not verified by July 27, 2023 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by October 27, 2023 (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:

William Abderhalden, Fire Safety Supervisor
Deputy State Fire Marshal
Health Care/Corrections Supervisor – Interim
Minnesota Department of Public Safety
445 Minnesota Street, Suite 145
St. Paul, MN 55101-5145
Cell: (507) 361-6204
Email: william.abderhalden@state.mn.us
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245295	A. BUILDING _____ B. WING _____	C 04/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE EMERALDS AT ST PAUL LLC	420 MARSHALL AVENUE SAINT PAUL, MN 55102

(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 4/24/23 - 4/27/23, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) was conducted during a standard recertification survey. The facility was in compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On 4/24/23 through 4/27/23, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was not in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. In addition to the recertification survey, the following complaints were reviewed with no deficiencies cited: H52951546C (MN00088451) H52951545C (MN00085007) H52951544C (MN00084758) H5295261C (MN00082564) H5295262C (MN00082405) H52951543C (MN00091875) H52951566C (MN00091431) The facility's plan of correction (POC) will serve as your allegation of compliance upon the	F 000		

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

Electronically Signed — 05/19/2023

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 000	Continued From page 1 Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to assess the resident and determine safety for self-administration of medications (SAM) for 1 of 1 (R25) resident who was observed to have prescribed nicotine replacement gum at the bedside. Findings include: R25's quarterly Minimum Data Set (MDS) dated 3/8/23, indicated R25 was moderately cognitively impaired and required set up help for locomotion and eating, and extensive, one-person physical assistance with most other activities of daily living (ADL)s. R25's diagnoses included chronic obstructive pulmonary disease (COPD), respiratory failure, schizophrenia, bipolar disorder, insomnia, and diabetes.	F 554	Immediate Corrective Action: Nicorette Gum removed from R25s room R25's Nicorette Gum was discontinued on 4/27/23 Self-Administration Assessment completed for R25 Self-Administration Care Plan Completed for R25 Corrective Action as it applies to others: The Self-Administration of Medications Policy was reviewed and remains current Nurses and TMAs were educated on the self-administration process Residents that self-administer medications audited to ensure an assessment and care plan have been completed.	6/7/23

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F 554	Continued From page 2 R25's care plan dated 3/15/23, identified R25 was currently independent with smoking at this facility and instructed staff to complete a smoking evaluation quarterly and as needed. R25's care plan further identified R25 had history of suicidal ideation. The CP lacked evidencen R25 was assessed for SAM. R25's physician orders indicated the following: -Nicotine Polacrilex Mouth/Throat Gum 2 milligram (mg), give 2mg by mouth every 2 hours for nicotine addiction. Start date 4/18/23. -Nicotine Transdermal Patch 24 Hour 14 MG/24HR (milligram per 24 hours). Apply 1 patch transdermally one time a day for smoking and remove per schedule. Start date 4/19/23. R25's physician orders lacked evidence of a SAM order. R25's April 2023, medication administration record (MAR) indicated R25 received nicotine gum 47 times between 4/18/23 and 4/27/23. During the same time frame R25 did not receive nicotine gum 26 times due to refusal, sleeping, medication held, or other. R25's MAR further indicated R25 received a nicotine patch daily from 4/20/23 through 4/27/23. R25's electronic health record lacked evidence of a SAM assessment. During observation and interview on 4/25/23 at 8:40 a.m., R25 stated she had not smoked in a while. Nicotine gum was on the bedside table. During observation and interview on 4/27/23 at 9:30 a.m., five pieces of unused packets of nicotine gum was observed on R25's bedside table. Registered nurse (RN)-A stated R25	F 554	Date of Compliance: 6/7/2023 Re-occurrence will be prevented by: Audit new residents that self-administer medications to ensure that an assessment and care plan is completed weekly x 4 weeks, then monthly x 2 months. The results of these audits will be reviewed at the facility QAPI meeting for input on the need to increase, decrease, or discontinue the audits Corrections will be monitored by: DON/Designee	

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F 554	Continued From page 3 smoked and used the nicotine gum. R25 stated she quit smoking a month ago and had been using a nicotine patch as well. RN-A confirmed R25 should not have the nicotine gum at the bed side and removed the gum from R25's room. During interview on 4/27/23 at 10:51 a.m., RN-G stated R25 was not assessed to self-administer medications and should not have the nicotine gum at the bedside. During interview on 4/27/23 at 10:58 a.m., trained medication aide (TMA)-A stated she thought R25 still smoked and used both a nicotine patch and the nicotine gum. TMA-A stated R25 did not self-administer medications and should not have the nicotine gum at the bedside. During follow up interview on 4/27/23 at 12:01 pm., RN-A stated R25 was not assessed for safe self-administration of medications and should not have had the gum at her bedside. During interview on 4/27/23 at 12:52 p.m., director of nursing (DON) stated nicotine gum was considered a medication and should be kept in the medication cart and administered by a nurse or TMA. DON further stated medications could be self-administered only if the resident was assessed as safe to do so. Facility policy Self-Administration of Medications dated 2/2021, indicated residents have the right to self-administer medications if determined clinically appropriate and safe for the resident to do so.	F 554		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15)	F 580		6/7/23

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F 580	Continued From page 4 §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).	F 580		

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F 580	Continued From page 5 §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to notify the physician timely of a change of condition (COC) for 1 of 1 (R92) resident reviewed for hospitalization. Findings include: R92's admission Minimum Data Set (MDS) dated 2/23/23, identified moderately cognitively impaired per staff interview. R92 had no rejection of care. R92 required extensive assist with activities of daily living (ADLs) except required only supervision for walking in room. R92's diagnoses included debility related to cardiorespiratory conditions and respiratory failure. R92 required tracheostomy care and a ventilator. R92's admission Care Area Assessment (CAA) dated 2/23/23, identified R92 triggered for cognition. Resident interview was unable to be completed due to hospitalization. Per the staff interview R92's memory was okay and resident recognized staff members, knew the location of her room and that she resided in a nursing home. R92's care plan dated 3/20/23, identified R92 was	F 580	Immediate Corrective Action R92 discharged from facility 3/17/2023. Corrective Action as it applies to others Change in resident's condition or status policy was reviewed and remains current Nursing staff educated on significant changes and when to notify the Medical Provider Residents that reside in the facility have the potential to be affected. All progress notes reviewed for changes in condition and notifications to Medical Provider Date of Compliance: 6/7/2023 Re-Occurrence will be prevented by: Audit progress notes for changes in conditions to ensure that any changes in condition were communicated to the provider timely. Audits to be completed 5 days per week x 4 weeks, then 2 twice per week x 2 weeks. The results of these audits will be reviewed at the facility QAPI meeting for input on the need to increase, decrease, or discontinue the audits	

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F 580	Continued From page 6 alert and oriented times three (x 3 to person, place and time) and could communicate verbally. The care plan lacked any behaviors such as confusion or attempts to pull out trach (breathing tube). Additionally, R92 depended on a ventilator. Staff were directed to observe for change in condition and abilities, evaluate, and report pertinent information to the MD (medical doctor) or NP (nurse practitioner) for follow up. R92's nursing progress notes identified: - 2/23/23 at 3:14 p.m., R92 was "confused throughout the shift", tried to pull our her trach, had bitten, bleeding lips. R92 pushed staff's hands off her. Vital signs (blood pressure, temperature, pulse and oxygen) were within normal limits. R92 was closely monitored and incoming staff would be updated. - 2/23/23 at 6:29 p.m., R92 had a change of condition which started at 10:00 a.m. R92 was confused, only alert to self, tried to pull out trach, lips were bitten and bled and R92 was incontinent of urine. R92's eyes were closed throughout the morning shift. Approximately around 4:15 p.m. R94 had a seizure that lasted for two minutes, the NP was updated and R94 was sent to the emergency room. The progress notes lacked documentation the NP was notified at 10:00 a.m., when the initial change of condition occurred. Then, six hours and 15 minutes after the initial change of condition, R92 had a seizure. R92's occupational therapy (OT) notes identified: - 2/23/23 at 4:53 p.m., R92 was sitting in bed with head of bed (HOB) elevated in forward flexed position. R92 was not receptive to gesture cues, hand over hand (HOH) or verbal cues. R92 swatted staff's hand away. R92 was observed to	F 580	Corrections will be monitored by DON or designee	

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F 580	Continued From page 7	F 580		

have very swollen bottom lip with bloody and dried blood areas. R92 refused treatment. Vital signs assessed, nursing was notified and aware.

R92's Emergency Department (ED) to Hospital Admission summary dated 2/23/23, identified R92 was full code according to her POLST and arrived at the ED on 2/23/23 at 4:39 p.m., via ambulance due to a new onset witnessed seizure-like activity which lasted approximately two minutes. It was reported by the nursing home to the ED R92 had seizure like activity during an OT session and was unresponsive. R92's baseline was typically alert and oriented x 4 (person, place, time, situation). R92 was described on arrival to the ED as obtunded (only responds to physical stimulation). R92 was admitted to the intensive care unit (ICU) and then discharged back to the nursing home on 2/27/23.

During an interview on 4/26/23 at 8:19 a.m., the OT reviewed her therapy notes and stated she attempted to work with R92 on 2/23/23, however R92 was not receptive, swatted at her and had a bloody lip. The OT stated she ended the therapy session. The OT stated she then updated nursing whom said they were already aware. The OT stated this condition was "out of the ordinary" for R92. The OT stated she could not recall what actual time of the day she worked with R92, as the OT progress note was time stamped after R92 had left the facility in the ambulance. The OT stated nursing had not updated her on any change of condition prior to therapy session and would have expected to be.

During an interview on 4/26/23 at 8:44 a.m., the respiratory therapist (RT)-A stated she had worked with R92 routinely for ventilator cares and

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F 580	Continued From page 8	F 580		

recalled seeing R92 in bed on 2/23/23; RT-A stated the level of confusion she observed with R92 was "abnormal". RT-A stated she had updated the nurse and the nurse was already aware. RT-A could not recall what time she saw R92 that day.

During interview on 4/26/23 at 12:30 p.m., NP-A stated she saw R92 in the nursing home several times for regulatory visits and hospital follow up visits. NP-A stated especially for residents that were on ventilators she would expect to be notified immediately of a change in condition such as ongoing altered cognition which was not resolved with nursing interventions. NP-A stated she had no records of receiving a call regarding R92's change in condition. Upon review of progress notes NP-A agreed it looked like R92 had a change of condition 2/23/23, around 10:00 a.m., and NP-A was not notified until approximately 4:15 p.m. after R92 had seizure like activity.

During interview on 4/26/23 at 11:47 a.m., registered nuse (RN)-D stated providers should be updated immediately on change of condition. Upon review of progress notes RN-D agreed it looked like R92 had a change of condition 2/23/23 around 10:00 a.m., and NP-A was not notified until approximately six hours and 15 minutes later at 4:15 p.m. after R92 had seizure like activity.

During an interview on 4/26/23 at 9:56 a.m., RN-E stated new onset or persistent confusion in a resident that relied on a ventilator should be taken seriously, assessments done, and provider updated immediately if not resolved. RN-E stated confusion could be related to a metabolic or

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THE EMERALDS AT ST PAUL LLC	420 MARSHALL AVENUE SAINT PAUL, MN 55102

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F 580	Continued From page 9 respiratory concern. RN-E stated she worked with R92 on 2/23/23. RN-E stated R92 was "not good" for most of the day shift. RN-E stated she called the NP after R92 had seizure like activity. RN-E could not recall why the NP was not updated upon the original change of condition which was noted at 10:00 a.m. and the progress notes lacked a rationale for not notifying the provider. During an interview on 4/27/23 at 8:37 a.m., the director of nursing (DON) stated for a resident on a ventilator with a change of condition, the resident should be assessed, vital signs taken and the provider updated immediately if not able to resolve. The DON reviewed the progress notes and stated it appeared the change of condition occurred 2/23/23 at 10:00 a.m., and the provider was not notified until around 4:15 p.m. following R92's seizure. Facility policy Change in Resident Condition dated 6/2019, identified the facility should notify the physician/healthcare provider of changes in the resident's condition and/or status. The licensed nurses were directed to notify the physician/healthcare provider when there was a significant change in the resident's physical, emotional, or mental condition or if there was a pattern of refusal of treatment or medication (for example two or more times).	F 580		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.	F 584		6/7/23

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F 584	Continued From page 10 The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on interview, observation, and document review, the facility failed to ensure resident room walls were in good repair to create a home-like	F 584	Immediate Corrective Action: R9 scuff marks on the wall have been fixed. R79 scuff marks on wall, cracking	

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F 584	Continued From page 11 environment for 3 of 4 residents (R9, R79, and R88) reviewed for room environment. Findings include: R9's Admission Record form indicated R9 was his own representative. R9's quarterly Minimum Data Set (MDS) dated 3/14/23 indicated R9 had intact cognition. During interview and observation 4/25/23 at 9:31 a.m., R9's walls in his room contained scuff marks and R9 stated the marks on the walls bothered him. During interview and observation 4/27/23 at 9:31 a.m., nursing assistant (NA)-G verified the marks on the walls in R9's room and stated she would not want marks like that on her walls and the resident's rooms were supposed to be home-like and residents reported it bothered them. R79's admission MDS dated 2/20/23, indicated it was very important to R79 to take care of personal belongings or things. R79's significant change MDS dated 3/23/23, indicated R79 had intact cognition. During interview and observation 4/24/23 at 1:07 p.m., R79's walls in her room contained scuff marks and near the heater on the wall there was what appeared to be plaster cracking off. There were holes in the wall by the phone jack as well. R79 stated she was aware the building was an older structure, but would not have come here if she had known it looked like this.	F 584	plaster and hole, have been fixed. R88 scuff marks on the wall have been fixed. Corrective action as it applies to others: Full house audit completed to identify wall damage in resident rooms and work orders submitted. Facility has a plan in place to continue to work on any other identified rooms to remove scuffs or general repairs. Staff educated on submitting work orders through TELS. Date of completion: 6/7/2023 Reoccurrence will be prevented by: Audits weekly x4 and monthly x2 of 10 resident rooms to audit for wall damage. Results will be shared with facility QAPI committee for input on the need to increase, decrease, or discontinue audits. The correction will be monitored by: Maintenance director or designee	

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F 584	Continued From page 12 During interview on 4/27/23 at 8:34 a.m., NA-G stated she thought the room should have been fixed up before a new resident moved in and added the room looked unprofessional and thought the markings had been there a long time. R88's admission MDS dated 3/1/23, indicated R88 had intact cognition and it was very important to take care of personal belongings or things. During interview and observation 4/24/23 at 1:21 p.m., R88's room was observed to have scuff marks on the walls. R88 stated "I try not to look at it." R88 stated the marks bothered her and added maintenance was hoping to paint in the building soon however, that was a month or so ago. During interview on 4/27/23 at 8:31 a.m., R88 stated wall maintenance should have been completed before a new resident was admitted. NA-G agreed with R88 and stated the walls should be cleaned before a resident came in. During interview on 4/27/23 at 8:42 a.m., the maintenance director (MD) stated he was trying to get the first floor lobby and kitchen painted and was trying to paint two rooms a month and estimated the painting to be completed in six months to a year's time. During interview on 4/27/23 at 9:31 a.m., the director of nursing (DON) stated she would prioritize resident's rooms for painting. During interview and observation 4/27/23 between 12:03 p.m., and 12:06 p.m., the administrator verified the holes in the wall by the first floor elevator and stated maintenance was	F 584		

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F 584	Continued From page 13 going to paint the first floor, and verified the areas of concern in R79's room and stated the room would need to be painted. On 4/27/23, MD provided an e-mail correspondence dated 4/20/23 at 12:08 p.m., of a request to utilize a painter for the common area on the first floor and the lower half of the dining area indicating there were "lots of holes." Further indicated "Not really a priority, but I do get a lot of comments about both areas. Wanted to run it by ya!" A policy was requested, but the regional director of operations stated in an e-mail correspondence dated 4/27/23 at 12:01 p.m., they did not have a policy regarding home like environment.	F 584		
F 640 SS=D	Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4) §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death. (vi) Background (face-sheet) information, if there is no admission assessment. §483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the	F 640		6/7/23

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F 640	Continued From page 14 CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State. §483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following: (i)Admission assessment. (ii) Annual assessment. (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly assessment. (vi) Quarterly review. (vii) A subset of items upon a resident's transfer, reentry, discharge, and death. (viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment. §483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure a discharge Minimum Data Set (MDS) was completed for`1 of 2(R30) residents who discharged from the facility. Findings include: R30's admission MDS dated 11/7/22, indicated	F 640	Immediate Corrective Action R30 discharged 11/7/2022. Corrective Action as it applies to others Residents that discharge from the facility have the potential to be affected. Education with MDS Nurses completed on the facilities resident assessment policy	

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F 640	Continued From page 15 R30 was cognitively intact and had diagnoses of seizures and hypertension. R30's nursing progress note dated 11/7/22 at 4:25 p.m., indicated R30 discharged home with family. R30's medical record lacked evidence a discharge MDS was completed. When interviewed on 4/27/23 at 3:05 p.m., registered nurse (RN)-H verified a discharge MDS assessment for R30 was not completed. RN-H stated she was not sure if the discharge was unplanned and therefore not communicated to her. RN-H acknowledged the MDS was missed and further stated the assessment should have been completed in 14 days. When interviewed on 4/27/23, at 3:53 p.m. the Director of Nursing (DON) expected all MDS assessments to be completed on time. A facility policy for MDS assessments was not available.	F 640	and MDS completion/Submission Timeframes. Date of Compliance: 6/7/2023 Re-Occurrence will be prevented by: 5 Residents that have discharged from the facility will be reviewed within 14 days to ensure MDS has been submitted. Complete weekly x 4 weeks, then monthly x 2 months. The results of these audits will be reviewed at the facility QAPI meeting for input on the need to increase, decrease, or discontinue the audits Corrections will be monitored by DON or designee	
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure completed Minimum Data Set (MDS) assessments were accurate for 3 of 3 residents (R12, R25, R68) reviewed for resident assessment.	F 641	Immediate Corrective Action R12, R25 and R68 MDS assessments have been corrected. Diagnosis list updated as needed for R12 and R68	6/7/23

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F 641	Continued From page 16 Findings include: R12's annual MDS dated 3/23/23, indicated R12 was cognitively intact and had diagnoses of respiratory failure and had a tracheostomy. R12's MDS further indicated he had a current MDRO. R12's provider note dated 12/29/22, indicated R12 had a history of MRSA infection, but had no current MRSA infection. R25's quarterly Minimum Data Set (MDS) dated 3/8/23, indicated R25 was moderately cognitively impaired and required set up help for locomotion and eating, and extensive, one-person physical assistance with most other activities of daily living (ADL)s. The MDS indicated R25 had no broken or loosely fitting full or partial denture. R25's diagnoses included chronic obstructive pulmonary disease (COPD), respiratory failure, schizophrenia, bipolar disorder, insomnia, and diabetes. R25's annual MDS dated 12/7/22, indicated R25 did not have any oral or dental concerns. The MDS indicated R25 was not edentulous (no natural teeth) and had no oral or dental concerns. Dental care was not a triggered care area assessment. R25's care plan dated 5/18/21, indicated, "Has upper and lower dentures. My dentures are currently missing. Resident is f/u [follow up] with dentist to have it replaced. No oral pain or discomfort." During interview on 4/24/23 at 5:19 p.m., R25 stated the head nurse had lost her full set of	F 641	Care plans have been updated as needed. Orders have been updated as needed. Dental appointment scheduled for R25. Corrective Action as it applies to others Residents that reside in facility have the potential to be affected. Residents audited for oral/dental assessments MDRO tracking process revised and MDS nurses educated. Education completed with Nurse Managers on accurate and timely assessments. Oral dental evaluations will be reviewed during ARD and care plan to be updated as needed. Date of Compliance: 6/7/2023 Re-Occurrence will be prevented by: Complete audits on 5 new admissions weekly x 4 weeks, then monthly x 2 months. The results of these audits will be reviewed at the facility QAPI meeting for input on the need to increase, decrease, or discontinue the audits Corrections will be monitored by DON or designee	

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F 641	Continued From page 17 upper and lower dentures about a year ago and had not offered to replace them since. During interview on 4/26/23 at 2:31 p.m., R25 stated she no longer smoked and had been offered nicotine gum, but was not able to chew it very well since she did not have any teeth and the head nurse lost her dentures about a year ago. During interview on 4/27/23 at 9:30 a.m., registered nurse (RN)-A stated R25 did not have any teeth and therefore did not chew the nicotine gum but let it dissolve in her mouth. RN-A stated R25 used to have dentures but lost them two or three months ago. During interview on 4/27/23 at 11:51 p.m., nursing assistant (NA)-D stated R25 had been without dentures for over a year. During interview on 4/27/23 at 2:16 p.m., RN-H stated she used the oral/dental assessment normally completed by the nurse manager in the electronic health record (EHR) to code the MDS. RN-H stated R25's annual MDS indicated no oral/dental concerns and therefore did not trigger a care area assessment. During interview on 4/27/23 at 3:05 p.m. director of nursing (DON) stated oral/dental assessments were completed by the nurse managers and used to code the MDS. DON further stated the purpose of the assessments was to trigger care area assessments when appropriate which would then drive appropriate care.	F 641		

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F 641	Continued From page 18 R68's quarterly MDS dated 3/30/23, indicated R53 was cognitively intact and had diagnoses of respiratory failure and had a tracheostomy. R53's MDS further indicated R53 he had no MDRO. R68's provider note dated 3/27/23 at 12:00 a.m., indicated R68 had recent ESBL and MRSA, but had no active MRSA or ESBL infection and was colonized. R68's provider orders dated 9/13/22, direct staff to maintain contact precautions indefinitely for colonized Carbapenem Resistant Acinetobacter Baumanii (CRAB), a MDRO and must wear eye protection in addition to gown and gloves if anticipating splashing during procedures. When interviewed on 4/27/23 at 3:05 p.m., registered nurse (RN)-H stated when completing MDS assessments, she reviewed resident diagnoses, orders, assessments, outside hospital information and progress notes from nursing, therapy and providers. RN-H reviewed R12, R53, and R68's MDS assessments and identification of MDRO. RN-H further stated to code MDRO's the MDRO had to be an active infection with active treatment. R12 had MRSA as a diagnosis and RN-H assumed the MRSA was an active diagnosis. R68 had no diagnosis listed for a MDRO and verified she missed the treatment order for contact precautions and believed R68's MDS should have included MDRO. RN-H stated the process can be confusing and the notes and information can be a lot to get through. Typically, if a resident had a diagnosis of a MDRO infection, it would mean it was an active infection. When interviewed on 4/27/23, at 3:05 p.m. the director of nursing (DON) expected MDS	F 641		

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F 641	Continued From page 19 assessments to be accurate. Furthermore, the DON expected staff to use resources that include the regional office. Facility policy Resident Assessment Instrument dated September 2010, indicated an assessment coordinator was responsible for ensuring resident assessments were completed timely using an interdisciplinary assessment team. The policy indicated, "Information derived from the comprehensive assessment helps the staff to plan care that allows the resident to reach his/her highest practicable level of functioning."	F 641		
F 645 SS=D	PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3) §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services; or (ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State	F 645		6/7/23

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F 645	Continued From page 20 intellectual disability or developmental disability authority has determined prior to admission- (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability. §483.20(k)(2) Exceptions. For purposes of this section- (i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital. (ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual- (A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital, (B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and (C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services. §483.20(k)(3) Definition. For purposes of this section- (i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1).	F 645		

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F 645	Continued From page 21 (ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure a Level II Pre-admission Screening and Resident Review (PASARR) was conducted, documented and retained to ensure mental health needs were appropriately addressed or provided for 1 of 3 resident (R28) reviewed for PASARR. Findings include: R28's Medical Diagnosis form indicated diagnoses of schizophrenia and anxiety identified on 6/15/22, and post traumatic stress disorder (PTSD) identified on 7/18/22. R28's admission Minimum Data Set (MDS) dated 6/22/22, indicated R28 was not evaluated by Level II PASARR. R28's significant change MDS dated 2/14/23, indicated intact cognition, was independent for most activities of daily living (ADLs), and had a diagnoses of anxiety, schizophrenia, and PTSD. R28's Initial Pre-Admission Screening (PAS) Results dated 12/2/21, outlined a section labeled "Mental Illness" which concluded, "Based on the information provided for this nursing home stay, it appears this person meets the criteria for MI (mental illness) and needs to be referred to the lead agency for further evaluation. Please note final determination of the need for referral for	F 645	Immediate Corrective Action: R28 level 2 screening has been obtained. Corrective action as it applies to others: Full house PASARR audit completed to ensure all residents have PASARR completed per policy. Social services team reeducated on PASARR policy. Date of completion: 6/7/2023 Reoccurrence will be prevented by: Audits weekly x4 and monthly x2 of all new admissions to ensure PASARR was completed per facility policy and documented in resident EMR. Results will be shared with facility QAPI committee for input on the need to increase, decrease, or discontinue audits. The correction will be monitored by: Social services director or designee	

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F 645	Continued From page 22 further evaluation will be made by Senior LinkAge Line." A letter from the Senior LinkAge Line dated 12/9/21, indicated the PAS triggered for an OBRA (Omnibus Budget Reconsideration Act) Level II. The letter indicated OBRA Level II and level of care face-to-face assessments had to be completed prior to nursing home admission. R28's medical record was reviewed and lacked evidence a Level II PASARR was completed. During interview on 4/25/23 at 2:24 p.m., social worker (SW)-A stated the SW would notice if the screen hadn't been completed and the admission coordinator looks for the screens. Further stated their sister facility only sent the Level I. A Level II PASARR was required when a resident has a mental health diagnosis for treatment purposes and insurance billing was different. During interview on 4/25/23 at 2:34 p.m., the admission coordinator stated social services follows up on PASARRs. During interview on 4/25/23 at 2:39 p.m., the director of nursing (DON) stated the SW verifies the PASARR screens are completed along with the admission coordinator. DON stated she did not see a Level II PASARR for R28 who was admitted 6/15/22 and stated it should be completed prior to residents being admitted and it was not completed. A policy Pre-admission Screening (PAS) revised 4/2023, indicated social services would check for preadmission screening and OBRA level II requirements. Social services ensured the initial	F 645		

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F 645	Continued From page 23 pre-admission screening results indicate the resident meets level of care for purposes of medical assistance (MA) payment of long-term care prior to the resident being admitted to the facility. However, the policy lacked direction or information on how to ensure PAS' would be clarified or completed when the discrepancy was not level-of-care related but rather diagnosis' related or if other issues were identified.	F 645		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure routine personal hygiene was completed and provided for 1 of 1 resident (R52) reviewed for nail care. Findings include: R52's quarterly Minimum Data Set (MDS) dated 12/28/22, indicated impaired cognition, did not reject care, and required extensive assistance for personal hygiene and most activities of daily living (ADLs). R52's Medical Diagnosis form indicated the following diagnoses: memory deficit following cerebrovascular disease (a condition that affects blood flow to the brain) and type 2 diabetes mellitus. R52's care plan dated 6/27/22, indicated R52 had	F 677	Immediate Corrective Action R52 nails were cleaned and trimmed Corrective Action as it applies to others Activities of Daily Living Policy reviewed and remains current. Residents who are dependent on staff for ADL care have the potential to be affected. Residents audited for clean and trimmed nails Nursing staff will be educated on providing nail care. Date of Compliance: 6/7/2023 Re-Occurrence will be prevented by: Complete audits weekly x 4 weeks, then monthly x 2 months on 5 residents. The results of these audits will be reviewed at	6/7/23

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F 677	Continued From page 24 a self care deficit and an intervention included, "Assist with personal hygiene A1 [assist of one] with personal hygiene, A2 [assist of two] with check and change." A bath schedule located at the nursing station indicated R52 received baths a.m. on Mondays. During observation on 4/24/23 at 12:22 p.m., R52 was in a hospital gown and had brown debris under various fingernails. During observation on 4/25/23 at 8:29 a.m., R52 had brownish black colored debris under his fingernails. During observation 4/26/23 at 6:58 a.m., R52 was in bed and had debris under fingernails. During interview on 4/26/23 at 7:19 a.m., nursing assistant (NA)-H stated NA-F was assigned to R52 and was not going to get up today because he had dialysis the day before. During interview on 4/26/23 at 7:26 a.m., NA-F stated she had not completed cares but was going to wash his face and get him ready for breakfast and would check him to see if he needed to be changed after breakfast. During interview on 4/26/23 at 7:53 a.m., NA-F stated she typically provided R52 with his breakfast and then washed him and changed his brief and gown. During interview on 4/26/23 at 10:27 a.m., NA-F stated family wanted R52 cleaned so she provided cares. Observed R52 to have a fresh gown on and was clean shaven.	F 677	the facility QAPI meeting for input on the need to increase, decrease, or discontinue the audits Corrections will be monitored by DON or designee	

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F 677	Continued From page 25 During observation on 4/26/23 at 1:02 p.m., R52 had debris under his nails. During interview and observation on 4/26/23 at 1:52 p.m., NA-F verified R52's fingernails had debris under them and stated she did not clean under his nails because he was diabetic and did not know NA's could clean under finger nails if a resident was diabetic. During interview on 4/26/23 at 1:47 p.m., the director of nursing stated NA's could clean under nails of residents who had diabetes, but could not cut nails and expected nails to be cleaned on shower days and as needed. During interview on 4/26/23 at 1:54 p.m., licensed practical nurse (LPN)-B stated NA's could clean under nails, but could not trim a resident's nails who had diabetes. A policy, Activities of Daily Living (ADLs)/Maintain Abilities dated 3/31/23, indicated a resident who was unable to carry out ADLs would receive necessary services to maintain good nutrition, grooming, and personal and oral hygiene.	F 677		
F 684 SS=E	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered	F 684		6/7/23

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F 684	Continued From page 26 care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on interview, and document review the facility failed to perform skin assessments for 3 of 3 residents (R25, R37, R45) and failed to obtain physician ordered weights to monitor for weight loss for 2 of 4 residents (R29, R79) reviewed for quality of care. Findings include: R25's quarterly Minimum Data Set (MDS) dated 3/8/23, indicated R25 was moderately cognitively impaired and required extensive, one-person physical assistance with bed mobility and transfers. The MDS indicated R25 was at risk for skin breakdown. R25's diagnoses included chronic obstructive pulmonary disease (COPD), respiratory failure, schizophrenia, bipolar disorder, insomnia, and diabetes. R25's care plan dated 3/15/23, indicated R25 was at risk for skin breakdown due to incontinence and refusing showers. The care plan instructed staff to monitor skin for irritation and breakdown during cares and weekly skin assessments. R25's skin assessment dated 4/5/23, indicated, "Resident has redness on both legs and on the groin. No skin issue noted in other part of the body." R25's electronic health record (EHR) lacked evidence of more recent skin assessments. R25's April treatment administration record (TAR) indicated weekly skin inspections to be completed by a licensed nurse every day shift on Sundays	F 684	Immediate Corrective Action R25, R37 and R45 have had skin assessment completed. R29 and R79 have current weights. MD and dietitian have been updated. Corrective Action as it applies to others The facilities Weight Protocol policy and Skin Assessment and Wound Management policy have been reviewed and remain current. Residents that have physician ordered weights have the potential to be affected. Residents audited for skin assessments All residents audited for weights (monthly or as otherwise ordered) Nursing staff education to complete weights per physician order. Nursing staff education on completing weekly skin assessments along with completing skin assessments on readmission. Date of Compliance: 6/7/2023 Re-Occurrence will be prevented by: Complete audits weekly x 4 weeks, then monthly x 2 months of 5 residents. The results of these audits will be reviewed at the facility QAPI meeting for input on the need to increase, decrease, or discontinue the audits Corrections will be monitored by DON or designee	

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F 684	Continued From page 27 and every evening shift on Wednesdays to check skin integrity. The task was documented at completed on 4/2/23, 4/5/23, 4/9/23 and documented as refused on 4/12/23, 4/23/23, and 4/26/23. The task was documented as "other/see nurses note" on 4/19/23. R25's progress note dated 4/19/23 at 10:06 p.m. indicated, "Weekly skin inspection by licensed nurse. Complete MHM Weekly Skin Inspection in PCC [EHR]. Every evening shift every Wed for Skin integrity. Resident has precaution [Covid positive]." During interview on 4/26/23 at 2:31 p.m., R25 stated experiencing pain on her bottom and did not think a nurse ever looked at her bottom. During follow up interview on 4/27/23 at 9:12 a.m., R25 stated she was supposed to get a shower twice a week, but that was not happening. R25 further stated skin assessments were not being done either and she was not refusing them. During observation and interview on 4/27/23 at 9:48 a.m., nursing assistant (NA)-D entered R25's room to do incontinent care per R25's request. R25's bottom was reddened from coccyx to groin with the top layer of skin peeling off. NA-D stated R25's bottom had looked like this for a few days. During interview on 4/27/23 at 10:51 a.m., registered nurse (RN)-G stated she would do a skin assessment if scheduled during her shift. RN-G could not remember the last time she observed R25's bottom and was not aware of any skin breakdown or concerns.	F 684		

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F 684	Continued From page 28 During follow up interview on 4/27/23 at 11:51 a.m., NA-D stated provided R25 with a bed bath the previous evening (4/26/23). NA-D stated she informed the nurse, but did not witness a skin assessment. R37's annual Minimum Data Set (MDS) dated 2/7/23, indicated intact cognition with diagnoses of type II diabetes mellitus (a problem in the way the body regulates and uses sugar as a fuel.), end stage renal disease (kidney failure), and dependence on renal dialysis. R37 was independent with all activities of daily living (ADL) and was not at risk for pressure ulcers, however he has had pressure ulcers in the past. R37's physician's order dated 2/24/23, indicated weekly skin inspection by a licensed nurse, every evening shift (Friday). R37's care plan dated 3/15/23, indicated potential for alteration in skin integrity related to diabetes with end stage renal disease (ESRD). Stage 2 pressure ulcer on right buttock noted on 12/10/20, and healed on 12/24/20. It further indicated interventions to monitor skin integrity daily during cares, weekly skin inspection by the nurse, document on skin condition, and keep doctor informed of changes. R37's treatment administration record (TAR) for the month of March (2023) indicated, there were five skin checks that should have been completed. The documentation was as follows: -3/3/23, a 7 was documented and the key on the TAR indicated a 7 meant the resident was sleeping -3/10/23, a 2 was documented which meant R37 refused a skin check	F 684		

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F 684	Continued From page 29 -3/17/23, a 7 was documented -3/24/23, there was no documentation -3/31/23, a 2 was documented Therefore, R37 did not receive any skin assessments during the month of March. During an interview on 4/27/23 at 9:33 a.m., registered nurse (RN)-G stated nurses were responsible for completing weekly skin checks on all residents. RN-G further stated skin checks are important to determine if there was skin breakdown, open areas, and to prevent pressure ulcers. If a resident was unable to complete the skin check at a certain time or they refused, the nurse should reapproach at a different time and keep going back until the skin check was completed. During an interview on 4/27/23 at 9:45 a.m., the nurse manager RN-A stated nurses were responsibe for completing weekly skin assessments on all residents. RN-A further stated it was important to complete skin assessments to make sure the residents didn't have any skin breakdown or a pressure ulcer, "especially if they are diabetic, they are very prone to developing a wound." RN-A verified R37 had not received any skin assessments during the month of March (2023) and stated the resident sleeping wasn't a good reason to not complete a skin check. She stated "the patient wouldn't be sleeping [24 hours a day, 7 days a week] 24/7." She would expect the nurse to perfom the skin check by the end of the shift or inform the nurse on the next shift so they would be able to complete it. During interview on 4/27/23 at 12:01 p.m., RN-A stated skin assessments should be done weekly	F 684		

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F 684	Continued From page 30 to check for skin breakdown and were done in conjunction with the shower or bath. RN-A further stated that a resident could refuse the shower or bath, but the skin assessment should still be completed. RN-A stated a skin assessment should have been done the previous evening but confirmed in the EHR there was no evidence that it was completed nor was any new skin breakdown reported to her. During interview on 4/27/23 at 12:52 p.m., director of nursing (DON) stated skin assessment were to be completed by the nurse and documented on the TAR. DON further stated if a resident refused a shower, the skin assessment should still be completed, and NAs would report any new skin issues found during cares to the nurse right away. DON stated expectation was skin assessments would still be completed on residents regardless of the resident's precaution status. During an interview on 4/27/23 at 2:09 p.m., the director of nursing (DON) stated nurses were responsible for weekly skin assessments on all residents and skin assessments were important to detect any open areas, skin impairments, or wounds. The DON further stated if a resident was sleeping or unable to receive a skin assessment at a certain time, she would expect the nurse to reapproach later stating "You (nurse), should be able to get a skin assessment done in an eight hour shift." Staff should also be documenting refusals by entering a number 2 in the documentation on the TAR and the use of "NA" (not applicable) or an "X" is not acceptable documentation. The DON also stated if there was no documentation, then the task did not get completed.	F 684		

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F 684	Continued From page 31 Facility policy Skin Assessment and Wound Management dated 5/27/22, indicated, "Staff will perform routine skin inspections [with daily care]. Nurses are to be notified if skin changes are identified. A weekly skin inspection will be completed by licensed staff." R45's quarterly Minimum Data Set (MDS) dated 2/16/23 indicated intact cognition, did not reject cares and required extensive assist for most activities of daily living (ADLs), and was always incontinent of bowel and bladder. The MDS further indicated R45 was not at risk for developing pressure ulcers and did not have pressure ulcers or other wounds including moisture associated skin damage (MASD). R45's Medical Diagnosis form indicated R45 had the following diagnoses: acute respiratory failure, heart failure, type 2 diabetes mellitus, and protein calorie malnutrition. R45's care plan revised 2/17/23 indicated R45 had an alteration in skin integrity and an intervention included a weekly skin inspection to be completed by the nurse. R45's form NAR Guide provided 4/24/23 indicated R45 was incontinent of bowel and bladder and the NAR Guide was later updated to include an intervention to apply barrier cream on buttock after peri-cares. R45's progress note dated 4/3/23 indicated R45 was readmitted to the facility and completed antibiotics for pneumonia. The progress notes lacked documentation a skin assessment was completed.	F 684		

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F 684	Continued From page 32	F 684		

R45's MHM Readmit Data Collection form dated 4/5/23 indicated the form was in progress and skin condition had not been documented.

R45's progress note dated 4/22/23, indicated, "Weekly skin inspection by licensed nurse. Complete MHM Weekly Skin Inspection in PCC every evening shift every Sat" MHM Weekly Skin Inspection forms were reviewed and indicated the most recent form was dated 3/18/23 at 11:00 p.m. The form indicated it was the nurse's responsibility to evaluate the resident's skin at a minimum once a week to ensure skin integrity and R45 had a left great toe ulcer but other skin was intact. Another MHM Weekly Skin Inspection form dated 4/26/23 at 10:37 p.m. was later completed.

R45's R45's MHM Braden Scale form dated 10/4/22 indicated mild risk for skin impairment. R45's MHM Braden Scale form dated 4/27/23 at 8:01 a.m., indicated mild risk for skin breakdown and had IAD (incontinence associated dermatitis) to right buttock and had barrier cream to right buttock every shift.

R45's MHM Wound Evaluation forms dated 3/10/23, 3/16/23, 3/24/23, 3/30/23, 4/7/23, and 4/14/23 were reviewed, but did not indicate any measurements or description for wound to buttocks.

During interview 4/24/23 at 2:29 p.m., R45 stated she had a sore on her bottom due to incontinence. R45 stated the brief sticks to the wound and staff rub it with a wash rag.

During interview and observation 4/26/23 at 7:34 a.m., nursing assistant (NA)-H turned R45 on her

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F 684	Continued From page 33 left side. R45 had a white creamy substance coating her right buttocks cheek. NA-H cleaned buttocks and observed a scabbed area on right buttocks and a small area of redness surrounding the scab. NA-H stated she did not know how long R45 had the scabbed areas but stated it was there the day prior. R45 stated she had it since the second day after she returned from the hospital. During interview 4/26/23 at 12:26 p.m., NA-H stated she had been working on a different floor but stated R45 had the wound on her buttocks the day prior and had reported the wound to the nurse the day prior. During interview 4/26/23 at 12:30 p.m., registered nurse (RN)-B stated R45 had a wound on her left great toe and stated all wounds were measured and body audits were supposed to be done weekly, adding some people refused showers. RN-B stated she was only aware of a wound on R45's food and stated R45's last body audit was completed 3/18/23. RN-B further stated R45 refused a shower last week and refusals were supposed to be documented, however RN-B verified documentation lacked evidence R45 refused a shower or bath. RN-B stated when a resident has a wound, the nurse updates her and then RN-B contacts the wound provider. RN-B stated she expected documentation of measurements in the chart. RN-B stated the last Braden scale was completed on 10/4/22 and was considered at mild risk of skin breakdown and verified the MHM Readmit Data Collection form dated 4/5/23 had nothing was documented under skin and stated the note was not completed. RN-B stated she was waiting for the nurse to tell her the condition of R45's skin. RN-B stated	F 684		

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F 684	Continued From page 34 weekly body audits were important because skin could be fine, but three days later it could be a whole different story. During interview on 4/26/23 at 12:46 p.m. RN-H stated Braden Scale forms were done prior to the quarterly MDS and stated R45 had another quarterly MDS in February and should have had a Braden Scale completed for the February MDS. During interview 4/26/23 at 1:31 p.m. the director of nursing stated body audits were completed upon admission, weekly, and on re-admission and stated Braden Scale forms were completed quarterly. DON stated she was informed of the wound to buttocks the day prior and it was assessed on wound rounds. DON verified body audits should be completed weekly and if a resident refused, it would be documented on the treatment administration record (TAR) and verified the last body audit completed was on 3/18/23 and stated it was important to complete the body audits in order to catch any skin impairment. DON stated the wound to buttocks was incontinence associated dermatitis. During an interview on 4/27/23 at 2:09 p.m., the director of nursing (DON) stated nurses were responsible for weekly skin assessments on all residents and skin assessments were important to detect any open areas, skin impairments, or wounds. The DON further stated if a resident was sleeping or unable to receive a skin assessment at a certain time, she would expect the nurse to reapproach later stating "You (nurse), should be able to get a skin assessment done in an eight hour shift." Staff should also be documenting refusals by entering a number 2 in the documentation on the TAR and the use of "NA"	F 684		

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F 684	Continued From page 35 (not applicable) or an "X" is not acceptable documentation. The DON also stated if there was no documentation, then the task did not get completed. A policy, Skin Assessment and Wound Management dated 2/10/23 indicated a pressure ulcer risk assessment (Braden Scale) was completed per Monarch's assessment schedule/grid. A weekly skin inspection was to be completed by licensed staff. R29's significant change Minimum Data Set (MDS) dated 3/15/23, indicated severely impaired cognition and diagnoses of dementia (loss of cognitive function), dysphagia (difficulty swallowing), and protein calorie malnutrition (when the body doesn't get enough nutrients). R29 was totally dependent on staff for personal hygiene and locomotion on/off the unit, required extensive assistance with bed mobility, transfers, dressing, and toileting, and required supervision with eating. R29's physician's orders dated 3/1/23, indicated weekly weights one time a day (every Wednesday) for malnutrition. R29's care plan dated 4/24/23, indicated potential for alteration in nutrition due to being on a mechanically altered diet with history of cerebral vascular accident (stroke). Malnutrition diagnosis due to a history of inadequate oral intake as evidenced by a need for Remeron, supplements. Increased protein needs related to wound healing as evidenced by pressure ulcer. It further indicated an intervention to record weight at least monthly and more often as indicated.	F 684		

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F 684	Continued From page 36 R29's treatment administration record for the month of April (2023) indicated four times R29 should have been weighed. The results are as follows: -4/4/23 no documentation -4/11/23 116 pounds was documented -4/18/23 "NA" (not applicable) was documented -4/25/23 "X" was documented Therefore, R29 was only weighed one time during the month of April. R29's dietary progress note dated 4/25/23 indicated, "reviewed for pressure ulcer. Wound care notes dated (4/18/23) shows it deteriorated. Diet is mechanical soft with fair intakes averaging 75-100% of meals. He was added to Boost, prostat 1ounce daily and mighty shakes [twice a day] bid for weight loss last month. Current weight is at 116 pounds-alerted nursing to obtain updated weight. Will continue to follow resident status." R29's dietary progress noted dated 3/3/2023, indicated "WEIGHT WARNING: Value: 116.0 -10.0% change, reviewed for significant weight loss; also have RD [registered dietician] referral as well. Diet is mechanical soft with fair intakes averaging 75% of meals. He does trigger for significant weight. loss, down from 120s' [pounds] to now 116 pounds with {body mass index] BMI 21.9 [within normal limits] wnl. He was assessed by physician on 2/28 and added to mighty shake BID [twice a day] and weekly weights. He also has a pressure ulcer. RD met with resient this date, alerted him to his weight loss and asked him what was happening- he states "I'm not eating as much." When asked why, he says "I don't know." Writer asked if he's willing to take a supplement and he stated that would be	F 684		

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F 684	Continued From page 37 "wonderful." He prefers chocolate. Also encouraged resident to make sure he's eating his eggs, meats, and drinking his milk. No further interventions at this time- may consider changing supplements if resident not successful with weight gain and/or wound healing." During an interview on 4/27/23 at 11:53 a.m., registered nurse (RN)-C stated nursing assistants (NA) are responsible for weighing residents and the nurses are responsible for documenting it in the medical record. RN-C further stated it was important to weigh residents so they can tell if they've lost weight. She verified R29 was only weighed once during the month of April because "he was fighting them" and stated they should have documented a refusal. 4/27/23 12:28 p.m. Interview with the nurse manager RN-A stated NA's were responsible for weighing residents and the nurses were responsible for documenting it in the medical record. RN-A further stated R29 was supposed to be weighed weekly and it was impirtant to weigh residents to ensure they are not losing weight, especially with R29 because he has a wound and takes supplements for weight loss. RN-A verified R29 had not been weighed weekly stating "he refused those times and it should have been documented as a refusal not an NA (not applicable) or an X." During an interview on 4/27/23 at 10:31 a.m., the registered dietician (RD) stated R29 was on "supplements galore" due to weight loss and it was very important for staff to get R29's weight on a weekly basis. During an interview on 4/27/23 at 2:09 p.m., the	F 684		

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F 684	Continued From page 38 director of nursing (DON) stated nursing assistants were responsible for weighing the residents and the nurses were responsible for documenting it. The DON further stated it was important to weigh residents to track weight changes and because it was an indicator of poor nutrition. It was not acceptable documentation for the nurses to chart an "NA (not applicable) or an X" when documenting weights and refusals should have been documented. The DON also stated if there was no documentation on the treatment administration record (TAR) for a residents weight, then it wasn't done. R79's significant change MDS dated 3/23/23 indicated intact cognition, did not reject cares, required set up help for eating and had a diagnosis of unspecified protein calorie malnutrition. muscle wasting and atrophy to multiple sites, and a fracture of the mandible (a facial bone attached to muscles involved in chewing and other mouth movements). R79's weight was not recorded. R79's Profile form in the electronic medical record (EMR) indicated R79 was admitted 2/13/23. R79's discharge physician orders from HCMC Hospital dated 2/13/23, indicated an order for weights per facility protocol obtain weekly weights for four weeks, then monthly thereafter unless directed otherwise. R79's care plan dated 2/17/23 indicated R79 had inadequate oral intake due to poor appetite following a mandibular fracture as evidenced by a	F 684		

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BMI (Body Mass Index) of less than 18 (indicating underweight) and an intervention included obtain and record weights at least monthly, and more often as indicated by physician orders.

R79's Weight Summary form indicated two weights recorded. On 2/13/23, R79 was 101.6 pounds and on 2/20/23, R79 was 107.0 pounds, a weight gain of 5.31 percent in one week.

R79's MHM Clinical Nutrition Assessment form dated 3/31/23 indicated, current weight was 107 pounds on 2/20/23 and was going to request an updated weight for April. The note indicated to obtain weights per physician order.

R79's Clinical Physicians Orders form was reviewed and lacked orders for obtaining weights.

R79's April 2023 medication administration record (MAR) and treatment administration record (TAR) lacked orders to obtain weights.

During interview on 4/24/23 at 12:55 p.m., R79 stated she lost weight since being at facility. Reviewed weight records that indicated weight was 101.6 pounds on 2/13/22 and was 107.0 pounds on 2/20/23. The record lacked documentation a re-weight was completed.

During interview on 4/26/23 at 8:52 a.m. nursing assistant (NA)-F stated weights were completed monthly and on bath days and stated the nursing assistants completed weights.

During interview on 4/26/23 at 9:05 a.m., the director of nursing (DON) stated weights were done monthly unless otherwise ordered and were recorded in the Weight Summary form. DON

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F 684	Continued From page 40 verified the last weight recorded was 2/20/23. DON viewed the physician orders and TAR and stated it did not appear R79 received a weight in March. DON verified discharge physician orders indicated R79 was to be weighed weekly for four weeks and then monthly and stated the order was not put in for weekly weights for four weeks and stated she expected staff to monitor weights and added the dietician would also need to know resident's weights for monitoring. During interview on 4/26/23 at 9:18 a.m., registered nurse (RN)-B stated sometimes the aides wrote down weights on a piece of paper. At 9:21 a.m. RN-B brought a scale into R79's room with licensed practical nurse (LPN)-B. LPN-B asked RN-B what had happened to the other scale and RN-B stated it was broken. R79's weight was obtained on a digital step on style scale with a brand, Letsfit, and was 109.9 pounds. No additional weights were provided. During interview on 4/26/23 at 10:17 a.m. the diet tech stated she thought the protocol for obtaining weights was daily for three days following admission and added that it depended on the orders. During interview on 4/27/23 at 9:12 a.m. registered dietician stated residents who were at high risk nutritionally included residents on dialysis, residents with pressure ulcers, residents who required tube feeding, and residents who were under weight. The dietician stated she would reweigh residents if the weight did not make sense. A policy, Weight Protocol dated 10/12 indicated the facility would ensure nutrition parameters	F 684		

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F 684	Continued From page 41 were maintained within acceptable guidelines and all residents were weighed by nursing assistant staff at a minimum of daily upon admission for three days, then weekly for four weeks, and then monthly thereafter. Weights were taken utilizing consistent technique for example using the same scale, same time of day, wearing or not wearing prostheses etc. Weight changes of plus or minus three pounds warranted a re-weight within 24 hours by nursing assistant staff. Nursing assistant staff reported their weights to the charge nurse who entered the weights in the electronic chart. At the discretion of RN staff, in conjunction with the culinary services director, physician, and registered dietician, residents at high risk for nutritional compromise may be continued on more frequent weight readings. Signs that a resident may be deemed high risk may include, unintended weight loss or gain of five percent or more in one month, seven and a half percent change in three months.	F 684		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise;	F 692		6/7/23

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F 692	Continued From page 42 §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure a therapeutic diet that took into account a residents clinical condition for 1 of 1 resident (R79) Findings include: R79's significant change minimum data set (MDS) dated 3/23/23 indicated intact cognition, did not reject cares, required set up help for eating, and had a diagnosis of unspecified protein calorie malnutrition. muscle wasting and atrophy to multiple sites, and a fracture of the mandible (a facial bone attached to muscles involved in chewing and other mouth movements). R79's Profile form in the electronic medical record (EMR) indicated R79 was admitted 2/13/23. R79's Clinical Physician Orders form dated 2/15/23 indicated a regular diet, mechanical soft texture, (a diet designed for people who have trouble chewing and swallowing) and regular thin consistency diet for malnutrition. R79's care plan dated 2/17/23 indicated history of inadequate oral intakes related to poor appetite following a mandibular fracture as evidenced by a body mass index (BMI) less than 18.5, and adult	F 692	Immediate Corrective Action: R79 receives diet per doctor's orders. Corrective action as it applies to others: Audit of residents receiving therapeutic diet to ensure clinically appropriate, doctors order in place, and meal ticket correctly reflects doctors' order. Dietary and nursing staff educated on facility policy for therapeutic diet doctor's orders and following orders. Date of completion: 6/7/2023 Reoccurrence will be prevented by: Audits weekly x 4 and monthly x 2 of 5 residents receiving a therapeutic diet to ensure the food is prepared per doctor's order. Results will be shared with facility QAPI committee for input on the need to increase, decrease, or discontinue audits. The correction will be monitored by: Culinary Services Director or designee	

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F 692	Continued From page 43	F 692		

failure to thrive diagnosis. Interventions included providing diet per physician order.

R79's nutritional assessment dated 3/31/23 indicated R79's past medical history included severe protein calorie malnutrition, failure to thrive, and the goal was to consume greater than 50% of meals and 100% of supplements. The assessment indicated R79 had a regular, mechanical soft diet and the plan was to continue to offer diet as ordered.

During interview 4/24/23 at 12:55 p.m., R79 stated she fractured her jaw a while ago and the facility was supposed to provide food she could chew and stated she had turkey ala king and wasn't able to chew the turkey. R79 stated she lost weight since she had been at the facility. Weights were reviewed and on 2/13/23, R79 weighed 101.6 pounds standing and on 2/20/23 R79 weighed 107.0 pounds in a wheelchair. No other weights were recorded in the medical record.

During observation on 4/26/23 at 8:23 a.m., nursing assistant (NA)-F delivered breakfast to R79 in her room. At 8:24 a.m. NA-F left R79's room and heard R79 state "I can't eat this." R79 was sitting up in her bed with the head of the bed elevated.

During interview and observation on 4/26/23 at 8:26 a.m., R79 stated she did not know what this was (referring to her breakfast), adding she could not cut it or eat the food. R79 tried to cut the regular breakfast pizza with a fork in her right hand and tried to bring the food to her mouth and the fork was empty. At 8:30 a.m. R79's call light was activated. R79 stated staff were supposed to

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F 692	Continued From page 44 cut food for her. During interview and observation on 4/26/23 at 8:34 a.m., NA-F answered R79's call light and R79 stated she needed her food cut so she could eat. At 8:34 a.m., NA-F stated she could not give R79 the current meal because the meal ticket clearly indicated chopped. NA-F took R79's plate and left the room. R79's meal ticket indicated "CHP breakfast pizza, GND meat/soft. The top left corner of the meal ticket indicated Wednesday, April 26, 2023 breakfast Regular/NAS-MECH SOFT/GRD. At 8:44 a.m. NA-F brought in R79's breakfast that contained the breakfast pizza in a ground mechanical soft diet, however R79 stated it was cold. At 8:46 a.m., NA-F brought back R79's breakfast and R79 was able to use her fork and pick up the food on her plate. R79 stated she did not have pain in her jaw, but stated there was some discomfort. During interview on 4/26/23 at 8:52 a.m., NA-F stated the kitchen prepares the tray and the nursing assistants served the meals. NA-F stated they try to pay attention to make sure residents receive their ordered diet for choking purposes and stated R79 was supposed to have a mechanical soft diet so she could eat. During interview on 4/26/23 at 8:55 a.m., the speech therapist (ST)-K stated R79 had a mechanical soft diet and stated she thought R79 signed a risk and benefits form to receive regular foods and added she had pain with her jaw when she chewed and may have requested to go back to mechanical. ST-K stated R79 was not on her case load. During interview on 4/26/23 at 8:59 a.m., the	F 692		

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F 692	Continued From page 45 director of nursing (DON) stated if a resident signed a risks versus benefits form it would be scanned in or located in the paper chart. DON verified she did not locate a risk versus benefits form in the electronic medical record nor the paper chart and there was no documentation under education in the medical record. A risk versus benefits form was not provided. During interview on 4/26/23 at 9:05 a.m., DON stated R79 had a fall and fractured her jaw and was on a mechanical soft diet due to pain with chewing and stated she expected staff to follow the diet order. During interview on 4/27/23 at 9:12 a.m., registered dietician (RD)-I stated R79's food intakes were variable and it was concerning R79 received the wrong diet because she needed mechanical diet for malnutrition. A policy Diet Manual and Diet Orders indicated residents were provided with a diet that meets their daily nutritional and special dietary needs and may or may not include therapeutic and altered textured diets. Foods that must be pureed or ground will be done by the dietary department as indicated by the menu extensions. Foods that must be cut up for the resident will be done by nursing or other designated staff persons at the table.	F 692		
F 699 SS=D	Trauma Informed Care CFR(s): 483.25(m) §483.25(m) Trauma-informed care The facility must ensure that residents who are trauma survivors receive culturally competent, trauma-informed care in accordance with	F 699		6/7/23

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 699	Continued From page 46 professional standards of practice and accounting for residents' experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to comprehensively assess past trauma and implement care plan interventions utilizing a trauma-informed approach for 1 of 1 (R40) resident reviewed who had post-traumatic stress disorder (PTSD). Findings include: R40's admission Minimum Data Set (MDS) dated 7/14/22, identified intact cognition, required supervision with most activities of daily living (ADLs). Diagnoses included PTSD, mood disorder, and major depressive disorder. R40's care plan dated 7/8/22, lacked individualized trauma-informed approaches or interventions and lacked identification of triggers to avoid potential re-traumatization related to PTSD. R40's Associated Clinic of Psychology (ACP) note dated 9/13/22, identified diagnosis of PTSD resulting from being a victim of assault. During interview on, 4/24/23 at 2:14 p.m., R40 confirmed she had a diagnosis of PTSD and depression. R40 stated her depression kicks in every once and a while when she misses her kids and grandkids but was usually able to talk herself out of it. Resident stated she had a lot of traumas in her life but doesn't like or want to talk about it because it will bring it all back up again. Resident	F 699	Immediate Corrective Action: Trauma informed care plan completed for R40 to include individualized trauma informed approaches and interventions to identify triggers to avoid potential re-traumatization related to PTSD. R40 trauma informed care plan added to NAR resident care sheet. R40 TR evaluation and social history updated to reflect PTSD diagnosis. Corrective action as it applies to others: Audit care plans and NAR resident care sheets of residents who are trauma survivors to ensure their care plans include individualized trauma informed approaches and interventions to identify triggers to avoid potential re-traumatization. Social services team educated on facilities Trauma Informed Care policy. Nursing staff will be educated where they can locate individualized trauma informed approaches and interventions to identify triggers to avoid potential re-traumatization. Date of completion: 6/7/2023 Reoccurrence will be prevented by: Audits weekly x 4 and monthly x 2 of all new admissions to ensure care plans include individualized trauma informed	

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F 699	Continued From page 47 was unsure if staff were aware of her trauma. During observation and interview on 4/26/23 at 8:46 a.m., nursing assistant (NA)-B delivered meal tray to R40. NA-B stated he carries the NA care sheet which identified resident care needs. He stated R40 was independent with most everything, occasionally needing help with changing her incontinent brief. NA-B stated he was not aware of R40 having any past traumas or diagnosis of PTSD and that his interactions with her have been pleasant and doesn't recall her having any triggers that would cause behaviors. During interview on 4/26/23 at 12:46 p.m., NA-E stated she didn't think any of the residents had PTSD and was not aware of any triggers for R40 or any other residents. NA-E could not remember if she had received any training on trauma informed care. During interview on 4/26/23 at 12:53 p.m., licensed practical nurse (LPN)- A stated staff can look at any resident's face sheet to see if they have a diagnosis of PTSD. LPN-A stated if a resident has any behaviors that are triggered by PTSD, we would use our communication skills that we've learned to calm them down and redirect them. LPN-A stated any triggers for a resident would be listed in the resident's care plan and on the NA care sheets. LPN-A stated she wasn't aware of any current residents having a diagnosis of PTSD. During interview on 4/26/23 at 2:13 p.m., registered nurse (RN)-A stated staff can find out if a resident has a diagnosis of PTSD by looking at the resident's diagnosis list in their electronic health records (EHR). RN-A stated it would also	F 699	approaches and interventions to identify triggers to avoid potential re-traumatization. Additionally, staff will be asked where they can locate trauma informed approaches or interventions to identify triggers to avoid potential traumatization. Results will be shared with facility QAPI committee for input on the need to increase, decrease, or discontinue audits. The correction will be monitored by: Social services director or designee	

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F 699	Continued From page 48 be listed in the resident's care plan which would include the residents' triggers and interventions. RN-A confirmed R40 had a diagnosis of PTSD but wasn't aware of any specific triggers or interventions for R40. RN-A confirmed that R40's care plan lacked evidence of trauma triggers and interventions for her diagnosis of PTSD. During interview on, 4/27/23 at 8:39 a.m., licensed social worker (LSW)-B stated that one of the LSW meets with all new admission within 48 hours to gather information for the resident's care plan. LSW-B stated they address the following care plan areas: psychosocial, cognition, trauma, vulnerable adult, leave of absences and discharges. LSW-B stated if the resident has a diagnosis of trauma or PTSD, they complete the trauma questionnaire. This would then trigger us to add it to the resident's care plan. LSW-B stated the director of nursing (DON) or an RN would then add the trauma triggers and interventions to the resident's care plan. LSW-B stated she did was not as familiar with R40 but didn't think she had a diagnosis of PTSD. During interview on, 4/27/23 at 8:47 a.m., activity director (AD) stated on admission she completed the therapeutic recreation (TR) evaluation and social history assessment for the new admissions and trauma is an area of review in these assessments. If the resident has PTSD, it triggers more questions so we can care plan what triggers should be avoided for that resident. AD stated sometimes the resident doesn't want to talk about their trauma which we respect but we would still care plan that they have trauma, so staff are aware. AD stated she was not aware that R40 had a diagnosis of PTSD but stated she thought she had depression. AD stated R40's	F 699		

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F 699	Continued From page 49 participation in activities fluctuates due to her depression. AD states if she notices R40 is not participating as much in activities she adds her to the 1:1 visit list so that she is still receiving some sort of interaction with the activity team. R40's TR evaluation and social history dated 7/8/22, reviewed and lacked evidence of R40's PTSD diagnosis. During interview on 4/27/23 at 10:32 a.m., DON and regional nurse consultant (RNC), DON stated LSW completed the trauma questionnaire assessment for all new admissions. If a resident has PTSD or trauma, then a trauma focused area would be added to the resident's care plan. The care plan would include what the PTSD or trauma was, what the triggers were and what the staff should do for interventions. Staff are made aware of the resident's trauma and PTSD diagnosis by accessing the resident care plan, and it is listed on the NA care sheets. DON stated all staff receive education on trauma informed care via Healthcare Academy courses. Both the DON and RNC confirmed R40 had a diagnosis of PTSD and further confirmed R40 did not have a completed trauma questionnaire, the NA care sheet and resident's care plan lacked any specific triggers and interventions related to PTSD and past trauma. Facility policy titled Trauma Informed Care, revised on 2/24/23, identified residents that have a history of trauma will have goals and interventions added to their care plan to address potential triggers and approaches to minimize or eliminate the effect of the trigger on the resident.	F 699		
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On	F 756		6/7/23

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F 756	Continued From page 50 CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that	F 756		

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F 756	Continued From page 51 requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the consulting pharmacist (CP) identified or acted upon 1 of 1 resident (R53) reviewed for long term antibiotic use. Furthermore, the facility failed to ensure CP recommendations were addressed or acted upon for 1 of 5 residents (R25) reviewed for unnecessary medications. Findings include: R53 R53's admission MDS dated 2/23/23, indicated R53 had mild cognitive impairment and diagnoses of respiratory failure, kidney disease and a history of alcohol abuse. R53's provider order dated 2/17/23, indicated R53 required rifaximin (antibiotic) tablet 550 milligrams (mg) twice daily for pneumonia (respiratory infection). Furthermore, R53's rifaximin order had no stop date. R53's consultation pharmacist progress note dated 2/27/23 at 9:49 p.m., indicated no medication irregularities. R53's consultation pharmacist progress note dated 3/31/23 at 2:15 p.m., indicated no medication irregularities. When interviewed on 4/26/23 at 10:20 a.m., registered nurse (RN)-J stated R53 was not being treated for any current infection. RN-J verified R53 had been taking rifaximin since admission.	F 756	Immediate Corrective Action F53 reviewed pharmacist recommendation and orders/care plan have been updated as needed. R25 reviewed pharmacist recommendation and orders/care plan have been updated as needed. Corrective Action as it applies to others Residents that have a recommendation from the consulting pharmacist have the potential to be affected. Pharmacy recommendations have been reviewed and completed. Education completed with the nurse managers regarding completing Pharmacy Recommendations timely. Date of Compliance: 6/7/2023 Re-Occurrence will be prevented by: Complete audits weekly x 4, then monthly x 2 of 5 residents pharmacy recommendations. The results of these audits will be reviewed at the facility QAPI meeting for input on the need to increase, decrease, or discontinue the audits Corrections will be monitored by DON or designee	

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F 756	Continued From page 52 RN-J stated it was indicated for pneumonia, but there had been no antibiotic or active infection notes required. RN-J was unsure why R53 was on the antibiotic and why there was not an end date. When interviewed on 4/27/23 at 2:41 p.m., CP stated a review of resident medications was completed monthly. When a resident was actively taking antibiotics, a review of the dose and indication was completed to ensure the antibiotic was appropriate. CP verified R53's order for rifaximin had been ordered since admission. After CP furhter reviewed R53's medical record, CP stated R53's antibiotic was not for pneumonia, but likely treatment for R53's alcoholic liver disease. CP further stated further clarification was needed from the provider. CP verified irregularities were not indicated on R53's past two medication reviews, but CP had planned to follow up with the facility as documentation was required to support any long-term antibiotic use. R25's quarterly MDS dated 3/8/23, indicated R25 had moderate cognitive impairment, required extensive assistance with all activities of daily living (ADLs), and was independent with eating. The MDS indicated R25 received antipsychotic and antidepressant 5/7 days in look back period and hypnotics 6/7 days in look back period. Gradual dose reduction (GDR) was attempted on 1/7/22. R25's diagnoses included schizophrenia, major depressive disorder (MDD), insomnia, bipolar, and anxiety disorder. R25's provider order dated 4/4/22, and discontinued 3/3/23, indicated, ,"Zolpidem Tartrate Tablet 5 MG [milligram]. Give 10 mg by mouth at bedtime for trouble sleeping."	F 756		

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F 756	Continued From page 53 R25's CP recommendation to physician (CPRP) dated 10/13/22, indicated, "It appears [R25] has been receiving zolpidem 10mg po [by mouth] at bedtime for trouble sleeping since 4/4/2022 without a GDR this year ...If GDR is contraindicated a [sic] this time, please document clinical rationale below:" The bottom of the form lacked evidence of provider response or provider signature. R25's CPRP dated 11/25/22, indicated, "Reissued from pharmacy recommendation in October. It appears [R25] has been receiving zolpidem 10mg po at bedtime for trouble sleeping since 4/4/2022 without a GDR this year ...If GDR is contraindicated a [sic] this time, please document clinical rationale below:" The bottom of the form lacked evidence of provider response or provider signature. R25's CPRP dated 12/21/22, indicated, "Reissued from pharmacy recommendation in October. It appears [R25] has been receiving zolpidem 10mg po at bedtime for trouble sleeping since 4/4/2022 without a GDR this year ...If GDR is contraindicated a [sic] this time, please document clinical rationale below:" The bottom of the form lacked evidence of provider response or provider signature. R25's CPRP dated 1/31/23, indicated, "Reissued from pharmacy recommendation in December. It appears [R25] has been receiving zolpidem 10mg po at bedtime for trouble sleeping since 4/4/2022 without a GDR this year ...If GDR is contraindicated a [sic] this time, please document clinical rationale below:" The bottom of the form indicated, "Previous reduction unsuccessful, continues to have insomnia with increased	F 756		

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F 756	Continued From page 54 depression." Signed via telephone order on 2/3/23 by nurse practitioner (NP)-A and registered nurse (RN)-A. During interview on 4/27/23 at 12:01 p.m., RN-A stated the CP reviewed resident's medications monthly and when recommendations were identified, RN-A would print the CPRP and place it by the provider's workstation in the nurse manager's office to be addressed on the provider's next visit. RN-A could not explain why the zolpidem recommendation for R25 was not addressed for four months. During interview on 4/27/23 at 1:19 p.m., CP stated if a recommendation was not addressed it would be rerecommended the following month. CP stated, "Ideally, we would like to see the response from the provider more timely than four months." During interview on 4/27/23 at 1:46 p.m., nurse practitioner (NP)-A stated she would look for the CP recommendation forms sticking out of the resident's hard chart at the nurses station. NP-A stated she always addressed the recommendations when aware of them and if the CPRP was not signed by her, then she did not see it. During interview on 4/27/23 at 12:52 p.m., director of nursing (DON) stated the CPRP forms were printer out and reviewed by the provider and the nurse manger and should be addressed within 30 days of the recommendation. DON stated it should not have taken four months for the provider to address R25's CP recommendation regarding zolpidem.	F 756		

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F 756	Continued From page 55 Facility policy Consultant Pharmacist Reports dated August 2019, indicated, the CP performs a review of each resident's medication regimen at least monthly and reports findings with recommendations for improvement to the DON, attending physician, medical director, and administrator. The policy further indicated, "Recommendations are acted upon and documented by the facility staff and/or the prescriber. 1) Prescriber accepts and acts upon suggestion or rejects and provides an explanation for disagreeing."	F 756		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document	F 812	Immediate Corrective Action:	6/7/23

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F 812	Continued From page 56 review, the facility failed to maintain a clean and sanitary condition of the walk-in cooler, kitchen equipment, and kitchen floor to promote sanitation in the kitchen. This had the potential to affect 75 residents receiving food from the kitchen. Findings include: During the initial kitchen tour on 4/24/23 at 11:45 a.m., the walk-in cooler was observed. Upon entering, the floor was noted to be sticky. There was red jelly like substance on the floor near the shelves. The floor was scattered with food crumbs and debris. Upon the top shelf the following was observed; Heinz brand yellow mustard lid was loose with dried yellow drippings down the side of the container, Highland brand thousand island dressing had the cover partially in place with dried flaky drippings down the container onto the shelf, and Kemps brand cottage cheese was covered, but chunks of cottage cheese was spilt down the side of the container. Upon observation of the prep and cooking area food debris, crumbs, a half of hamburger bun and noodles were on the floor. A Vulcan brand convection oven had drips of dried substance on the doors, the top had visible grime, and the slight shelf by the corners of the doors had crumbs and debris. The Globe brand stand mixer had dried brown substance on the mixer and table it was sitting upon. The main stove which was cooking hamburgers had dried splatters of pale substance on the backsplash and smears of sticky residue down the front. When interviewed on 4/24/23 at 12:05 p.m., cook (C)-A verified the observations identified in the walk-in cooler. C-A further stated she hadn't	F 812	Deep clean of kitchen completed. Specifically, to include walk in cooler floor and shelving, prep and cooking area, floors, convection over, stand mixer, and main stove. Sanitation audit completed. Cleaning schedules posted in kitchen per facility process. Corrective action as it applies to others: Culinary staff educated on facilities kitchen cleaning policy and cleaning schedules. Date of completion: 6/7/2023 Reoccurrence will be prevented by: Audit daily Monday- Friday x4 weeks and monthly x2 of daily kitchen cleaning schedule and kitchen cleanliness to ensure daily cleaning is being completed and the schedules reflect this. Audit weekly x4 weeks and monthly x2 of kitchen cleanliness using sanitation audit. Results will be shared with facility QAPI committee for input on the need to increase, decrease, or discontinue audits. The correction will be monitored by: Culinary Director or designee	

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F 812	Continued From page 57 really noticed the items or the floor as she goes in to get or drop off items she needs and hadn't paid attention to the rest but acknowledged the cooler had to be cleaned. C-A further verified the observations made of the Vulcan oven and stand mixer. C-A stated she had not used that equipment today and was not sure when they were last used or cleaned. C-A verified the splatters of pale substance on the grill backsplash and the food and debris on the floor. CA-explained the splatter was likely from pancakes made for breakfast and she had not had a chance to clean in-between breakfast and lunch. C-A was not sure if there was a kitchen cleaning list posted. When interviewed on 9/28/23 at 9:38 p.m., C-B stated sometimes there was a cleaning list posted in the kitchen. C-A stated if there was one, it would be posted on the cabinet door. C-B further stated there was not one posted for this week. When interviewed on 9/28/23 at 10:05 a.m., the culinary director (CD) stated there are cleaning schedules for the kitchen. CD provided a book of cleaning schedules with no dates or months indicated. CD acknowledged kitchen cleaning had been a work in progress, and she had reformatted the cleaning lists to make it easier as there had been staff turnover and staff required reminders of daily cleaning. CD expected staff to maintain a clean kitchen to ensure food was prepared in a clean environment. A facility policy for kitchen cleaning was requested however was not received.	F 812		
F 880 SS=E	Infection Prevention & Control	F 880		6/7/23

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F 880	Continued From page 58 CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §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	F 880		

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	245295	A. BUILDING _____ B. WING _____	C 04/27/2023

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F 880	Continued From page 59 resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to identify multidrug resistant organism (MDRO) in 4 of 4 residents (R6, R12, R53, R68) reviewed for infections. The facility also failed to ensure proper personal protective equipment (PPE) was utilized for 1 of 1 residents (R68) reviewed for PPE. Furthermore, the facility failed to ensure current standards of practice for glove use and handwashing were being followed for 1 of 1 resident (R24), when	F 880	Immediate Corrective Action R6, R12, R53 and R68 reviewed for infections and plan of care updated for MDRO. R68 reviewed for PPE and plan of care updated. R24 standards of practice for glove use and handwashing when providing personal care Staff educated on Hand Hygiene and PPE	

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F 880	Continued From page 60 staff provided personal care. Findings include: Tracking R6's admission Minimum Data Set (MDS) dated 3/24/23, indicated R6 had moderate cognitive impairment and diagnoses of respiratory failure and had a tracheostomy (surgical airway placed in neck to aid in breathing). R6's hospital transfer orders dated 2/28/23, indicated R6 was colonized (bacteria is present in body without active infection) for Methicillin resistant staphylococcus aureus [(MRSA) a MDRO] and had a history of active MRSA pneumonia. R12's annual MDS dated 3/23/23, indicated R12 was cognitively intact and had diagnoses of respiratory failure and had a tracheostomy. R12's MDS further indicated R12 had MRSA. R12's provider note dated 12/29/22, indicated R12 had a history of active MRSA infection, but had no current MRSA infection and was colonized. R53's admission MDS dated 2/23/23, indicated R53 had mild cognitive impairment and diagnoses of spinal cord injury and had a tracheostomy. R53's hospital discharge note dated 2/17/23, indicated R53 had a history of active extended spectrum-eta-lactamase [(ESBL) a MDRO] pneumonia and MRSA.	F 880	Infection Preventionist educated on MDRO tracking MDRO tracking process revised Corrective Action as it applies to others Infection Prevention and Control Program Policy reviewed and remains current. Residents that have an MDRO have the potential to be affected. Residents that require PPE during cares have the potential to be affected Residents that reside in the facility that require assistance with personal care have the potential to be affected. Resident's medical records audited for MDROs Residents with MDROs audited to ensure orders, care plans and special instructions were updated Date of compliance: 6/7/2023 Re-Occurrence will be prevented by: Audits will be completed of 5 residents twice weekly for 4 weeks, then every week x 2 weeks. The results of these audits will be reviewed at the facility QAPI meeting for input on the need to increase, decrease, or discontinue the audits. Corrections will be monitored by DON or designee	

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F 880	Continued From page 61 R68's quarterly MDS dated 3/30/23, indicated R68 was cognitively intact and had diagnoses of respiratory failure and had a tracheostomy. R68's provider note dated 4/4/23 at 12:00 a.m., indicated R68 had a history of MRSA in a wound and a positive urine culture for ESBL and MRSA on 2/13/23. R68's provider orders dated 9/13/22, direct staff to maintain contact precautions indefinitely for colonized Carbapenem Resistant Acinetobacter Baumanii (CRAB), a MDRO and must wear eye protection in addition to gown and gloves if anticipating splashing during procedures. R68's care plan dated 9/13/22, indicated R68 was on isolation precautions related to CRAB and directed all staff to follow isolation precautions. An untitled, undated facility document provided on 4/25/26, was a facility list of residents with MDRO's in the facility and any precautions required. The list indicated R68 required enhanced barrier precautions for CRAB. The list lacked indication of R68's ESBL or MRSA history and R6's, R12's, or R53's MDRO history. When interviewed on 4/26/23, at 7:36 a.m., assistant director of nursing (ADON) stated upon admission or readmission to the facility, the admission paperwork would show any current or history of MDRO. The information was reviewed by the admission nurse or the infection preventionist (IP). RN-D verified R68 had CRAB in his sputum but had no other history of MDRO infections. RN-D further stated R6, R12 and R53 had no history of MDRO infections.	F 880		

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F 880	Continued From page 62 When interviewed on 4/26/23 at 10:33 a.m., the infection preventitionist (IP) stated she reviewed any admission or readmission paperwork for residents. This information could also be reviewed by the director of nursing (DON), the assistant director of nursing (ADON) or the admission nurse. Any information was found about current infections or history of MDRO, was communicated to me. IP acknowledged she was not aware of any history of MDRO infections for R6, R12, and R53. The IP was aware of R68's CRAB but was not aware of the positive urine cultures in 2/2023. IP was not sure if any of the residents MDRO's were active or if they have been cleared through any testing. IP was not sure if all MDRO's required tracking per the Centers for Disease Control (CDC) but acknowledged it was important to have awareness of residents MDRO history to ensure appropriate care and precautions were provided. When interviewed on 4/27/23, at 3:53 p.m., the DON stated there was a bed board system that was used for tracking and should include any type of MDRO. DON further stated this information was found in admission or readmission paperwork and it was important to understand if the resident was colonized or active to ensure correct placement and correct precautions are placed if needed. DON further stated understanding any history or active MDRO's was important to understand who is at risk for further infection. A facility policy on tracking MDROs was requested however was not provided. A policy titled Infection Prevention and Control Program revised 3/13/23, directed staff to utilize	F 880		

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F 880	Continued From page 63 surveillance tools to recognize the occurrence of infections and determine if they are community-acquired or facility acquired infections. Personal Protective Equipment R68's quarterly MDS dated 3/30/23, indicated R68 was cognitively intact and had diagnoses of respiratory failure and had a tracheostomy. R68's provider note dated 4/4/23 at 12:00 a.m., indicated R68 had a history of an active ESBL and MRSA urinary infection and a history of MRSA in a wound. R68's provider orders dated 9/13/22, direct staff to maintain contact precautions indefinitely for colonized CRAB and must wear eye protection in addition to gown and gloves if anticipating splashing during procedures. R68's care plan dated 9/13/22, indicated R68 was on isolation precautions related to CRAB and directed all staff to follow isolation precautions. An observation on 4/24/23 at 1:21 p.m., R68's door was slightly open. Outside the room was a cart with gowns and masks. On R68's door was a sign indicated, "Enhanced Precautions". The sign directed staff to wear gloves, gown, and mask for any high contact resident cares. Upon entering the room, R68 was in bed with the head of bed elevated into upright position. Speech therapist (SP) was standing to the side of R68 at the head of the bed. The SP had gloves and a mask but was not wearing eye protection or a gown.	F 880		

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F 880	Continued From page 64 When interviewed on 4/24/23 at 1:33 p.m., SP stated she had been working on building up R68's respiratory strength and to strengthen his ability to cough. SP verified the sign on the door and further explained that was due to R68's wound infection. SP stated she believed she was not performing any high contact cares and acknowledged she would wear gown and eye protection if the infection was in his secretions. SP was not aware of the order to wear eye protection and follow isolation precautions for CRAB. When interviewed on 4/24/23 at 1:45 p.m., registered nurse (RN)-J stated R68 had a wound infection and that was why there was enhanced barrier precautions. RN-J further stated a gown, gloves and mask were required for wound cares only and was not aware of any needs for eye protection. When interviewed on 4/25/23 at 8:51 a.m., R68 stated he had MRSA in his wound and further stated he also had something in his secretions but wasn't sure what it was. R68 stated he was not sure why gowning and gloving took place and further stated it was done mostly when wound cares were completed. When interviewed on 4/25/23 at 4:06 p.m., the IP stated the enhanced barrier sign directs staff what PPE was needed and for what cares. IP further stated staff were not always aware of where the infections were and were expected to follow the directions on the sign. IP acknowledged the sign had not indicated if eye protection was needed and stated staff should be wearing eye protection for cares which involved splatter of secretions.	F 880		

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F 880	Continued From page 65 When interviewed on 4/27/23 at 3:53 p.m., the DON stated staff were expected to follow the instructions on the enhanced precautions sign. DON stated the location of the infection was not relevant and if the sign was followed, the correct PPE was worn. DON further acknowledged further communication may be needed if eye protection was also required. A facility table Disease-specific Precautions revised 11/2017, had no listing for CRAB. The table had a listing for MDRO's which indicated for respiratory infections, gown, and gloves to be worn for those in direct contact of resident. Hand Hygiene R14's annual MDS assessment dated 3/3/23, indicated R14 had severe cognitive impairment and had diagnoses of respiratory failure, tracheostomy, and dementia. Furthermore, R14's MDS indicated R14 was incontinent and required assist of one for hygiene cares. An observation on 4/27/23 at 8:12 a.m., nursing assistant (NA)-I entered R14's room to provide cares. NA-I performed hand hygiene and donned gloves prior to starting incontinent care. NA-I unfastened R14's brief. R14's brief was wet. NA-I tucked under R14's wet brief and cleaned R14 from the front before turning R14 onto the right side. NA-I tucked R14's wet brief under and cleaned R14 from the back. A clean brief was placed and tucked under R14. NA-I then turned R14 to the left side, removed the wet brief and placed in the garbage. NA-I then finished cleaning R14 from the back before moving R14	F 880		

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F 880	Continued From page 66 onto her back. NA fastened R14's clean brief before obtaining a clean pad and the resident compression vest from the bedside. NA-I rolled the vest and pad up and placed next to R14 before assisting R14 to turn again from side to side to get the pad and compression vest under R14. NA-I took R14's pillows and adjusted them under R14's left leg, right lower extremity amputation site and left arm. The package of the cleansing wipes was closed before NA-I pulled open the side table drawer to put them away. R14's blankets were adjusted to cover her. NA-I then took R14's bed control and lowered R14's bed. NA-I then removed gloves and performed hand hygiene. NA-I had worn the same gloves from the start of NA-I's care until the end. When interviewed on 4/27/23 at 8:28 a.m., NA-I acknowledged she had used the same gloves for all R12's cares. NA-I further stated she should have removed soiled gloves, performed hand hygiene, and replaced with new gloves after handling R12's wet brief. NA-I further stated sometimes a step was missed, but not purposefully. When interviewed on 4/27/23 at 3:53 p.m., the DON stated staff were expected to remove gloves and perform hand hygiene when moving from soiled patient items to clean areas. DON further stated this was important to prevent the spread of bacteria. A policy titled Infection Prevention and Control Program revised 3/13/23, directed staff to be educated and adhere to proper techniques and procedures.	F 880		
F 881 SS=D	Antibiotic Stewardship Program	F 881		6/7/23

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F 881	Continued From page 67 CFR(s): 483.80(a)(3) §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to track and monitor the appropriate use of antibiotics use for 1 of 1 residents (R53) reviewed for antibiotic use. Findings include: R53's admission MDS dated 2/23/23, indicated R53 had mild cognitive impairment and diagnoses of respiratory failure, kidney disease and a history of alcohol abuse. R53's provider order dated 2/17/23, indicated R53 required rifaximin (antibiotic) tablet 550 milligrams (mg) twice daily for pneumonia (respiratory infection). Furthermore, R53's rifaximin order had no stop date. R53's provider note dated 2/22/23, lacked indication of why R53 was on rifaximin. R53's provider note dated 3/22/23, lacked indication of why R53 was on rifaximin. The facility infection and antibiotic tracking logs dated 2/2023- 4/2023, lacked indication of R53's	F 881	Immediate Corrective Action R53 antibiotic use reviewed. Order and plan of care updated. Infection Preventionist educated on Antibiotic Stewardship Antibiotic Stewardship Policy reviewed with medical providers Corrective Action as it applies to others Antibiotic Stewardship Program policy reviewed and remains current. Residents receiving an antibiotic have the potential to be affected. Communication process between the Infection Preventionist regarding antibiotics revised Date of compliance: 6/7/2023 Re-Occurrence will be prevented by Audits of 5 residents will be completed weekly for 4 weeks, then monthly x 2 months or until compliance is met. The results of these audits will be reviewed at the facility QAPI meeting for input on the	

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F 881	Continued From page 68 antibiotic use. When interviewed on 4/26/23 at 10:20 a.m., registered nurse (RN)-J stated R53 was not being treated for any current infection. RN-J had not realized R53 had been on an antibiotic and then verified R53 had been taking rifaximin since admission. RN-J stated it was indicated for pneumonia, but there had been no antibiotic or active infection notes required. RN-J was unsure why R53 was on the antibiotic and why there was not an end date. When interviewed on 4/26/23 at 3:23 p.m., Nurse Practitioner (NP)- A stated the indication for R53's rifaximin was incorrect and it was for R53's liver disease. NP-A further stated she was not sure how long R53 had been on the antibiotic as it was prescribed by R53's gastroenterologist (provider specializing in stomach, liver, intestine disorders) and likely was deemed beneficial for long term treatment. When interviewed on 4/26/23 at 10:33 a.m., the infection preventionist (IP) stated when a resident admitted on antibiotics, the IP would add them to the infection and antibiotic tracking log. Prophylactic antibiotics were always the providers decision. If the antibiotic was long term, the antibiotic would not need to be continually tracked. The IP acknowledged she was not aware of R53's antibiotic order and was not aware of any active infection. R53 was not added to the facility infection and antibiotic tracking log and further stated she would need to review R53's chart to determine why it was ordered. When interviewed on 4/27/23 at 3:53 p.m., the director of nursing (DON) expected all antibiotic	F 881	need to increase, decrease, or discontinue the audits Corrections will be monitored by DON or designee	

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F 881	Continued From page 69 use to be tracked and reviewed, including prophylactic use. The DON further stated it takes a team effort between nurses, pharmacy, and providers to ensure appropriateness and a rationale was documented. The DON stated monitoring antibiotic use was important to minimize any health risks of antibiotic overuse. A facility policy titled Antibiotic Stewardship Program revised 3/13/23, directed staff to review any antibiotic orders for residents who are newly admitted to the facility to ensure appropriateness of use. The policy also directed any pertinent documentation will be obtained for the medical record.	F 881		
F 919 SS=D	Resident Call System CFR(s): 483.90(g)(1)(2) §483.90(g) Resident Call System The facility must be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area from- §483.90(g)(1) Each resident's bedside; and §483.90(g)(2) Toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on interview, observation, and document review, the facility failed to ensure residents' call lights were functioning for 1 of 1 resident (R52) reviewed for call lights. Findings include: R52's quarterly Minimum Data Set (MDS) dated 12/28/22 indicated cognitive impairment, and	F 919	Immediate Corrective Action: R52's call light was replaced and functioning. Corrective action as it applies to others: Staff educated on facility call light policy and process to take if a call light is not working. Staff educated how to complete a	6/7/23

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F 919	Continued From page 70 required extensive assistance with most activities of daily living (ADLs). R52's Medical Diagnosis form indicated the following diagnoses: diabetes mellitus, memory deficit following cerebrovascular disease (a condition affecting blood vessels in the brain), complete traumatic amputation of left lower leg. R52's care plan revised 3/21/23 indicated R52 was at risk for falls related to confusion, recent left above the knee amputation, blindness in the left eye, and a cataract in the right eye which included an intervention to keep the call-light within reach. During observation on 4/24/23 at 12:22 p.m., R52's call light device was in the on position, however, the light above R52's room was not lit up. During observation on 4/24/23 at 1:47 p.m., R52's call light was in the on position. There was no call bell located near R52. During observation and interview on 4/26/23 at 7:53 a.m., R52 was in bed and nursing assistant (NA)-F stated R52 used his call light. At 7:56 a.m. the call light was turned on and NA-F stated the light should light up above R52's door. NA-F verified the light did not work above the door and had to try a couple times pushing the call light to get it to work. During observation on 4/26/23 at 1:02 p.m., R52 had his call light button pressed, but the light was not working outside the door. During interview on 4/26/23 at 1:54 p.m., licensed	F 919	maintenance work order in TELS. Full house call light audit preformed to ensure the facility is adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member from each resident beside and toilet and bathing facilities. Date of completion: 6/7/2023 Reoccurrence will be prevented by: Audit weekly x4 and monthly x2 – 10 resident bedside, toilet, and/or bathing call lights to ensure functionality. Results will be shared with facility QAPI committee for input on the need to increase, decrease, or discontinue audits. The correction will be monitored by: Maintenance director or designee	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245295	A. BUILDING _____ B. WING _____	C 04/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE EMERALDS AT ST PAUL LLC	420 MARSHALL AVENUE SAINT PAUL, MN 55102

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 919	Continued From page 71 practical nurse (LPN)-B stated maintenance was contacted if a call light was not working consistently and if the light works some of the time, staff should go to maintenance. During interview on 4/27/23 at 8:42 a.m., maintenance director stated there were no call light issues he was aware of and no open work orders for call lights. During interview and observation on 4/27/23 at 8:59 a.m., maintenance director verified R52's call light did not function when turned on and stated he is an amputee so it was critical to have the call light functioning and expected to be notified if a call light was not working consistently. During interview 4/27/23 at 9:31 a.m., the director of nursing (DON) stated she expected staff to put a TELS (a computer system used to notify maintenance when something needs fixed) order in and get the call light replaced or provide a bell if call lights didn't work. A policy, Call Light Policy dated 4/25/23 indicated if a call light system is identified as not operational at any time, the facility will take the following steps: the facility will provide residents with a means to call for help at the bedside and in toileting and bathing facilities through an audible or visual signal i.e. bell, walkie talkie, whistle, etc, the director of nursing and administrator will be notified of the system not functioning, the facility will keep a log of time the system was not functional and repair efforts made. Additionally, the policy indicated functioning properly was defined as; all portions of the system are functioning for example the system is not turned off at the nurses' station, the volume too low to be	F 919		

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F 919	Continued From page 72 heard, the light above a room or rooms is not working, no staff at nurses' station, and call are being answered.	F 919		
F 921 SS=D	Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i) §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to maintain sanitary equipment for 2 of 2 residents (R6, R14) reviewed for environmental cleanliness. Findings include: R6's admission Minimum Data Set (MDS) dated 3/24/23, indicated R6 had moderate cognitive impairment and diagnoses of respiratory failure and had a tracheostomy (surgical airway placed in neck to aid in breathing). R6's MDS further indicated R6 required tube feeding for nutrition. An observation on 4/24/23 at 5:35 p.m., R6's tube feeding pump was not running. The pump had multiple splattered light brown dried substance on it. There was also splattered light brown substances on the legs of the pole the pump was attached to. An observation on 4/26/23 at 7:11 a.m., R6's IV pump was infusing. The same spattered light brown substances remained splattered on the pump and pole.	F 921	Immediate Corrective Action: R6 and R 14's tube feeding equipment were cleaned. Corrective action as it applies to others: Full house audit of tube feeding equipment was completed to ensure functionality and cleanliness. Staff educated on facility policy Cleaning and Disinfection of Resident are Items and Equipment. Date of completion: 6/7/2023 Reoccurrence will be prevented by: Audit weekly x4 and monthly x2 – 5 tube feeding equipment to ensure functionality and cleanliness. Results will be shared with facility QAPI committee for input on the need to increase, decrease, or discontinue audits. The correction will be monitored by: Director of Nursing or designee	6/7/23

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F 921	Continued From page 73 When interviewed at 4/26/23 at 7:46 a.m., registered nurse (RN)-I verified the dried substance on R6's pump and stated it was likely tube feeding formula and stated spills sometimes happen. RN-I further stated housekeeping was responsible for cleaning equipment in resident rooms and they had not been in today. R14's annual MDS assessment dated 3/3/23, indicated R14 had moderately impaired cognition and diagnoses of dementia, respiratory failure and had a tracheostomy. Furthermore, R14's MDS indicated R14 required tube feeding for nutrition. An observation on 4/25/23 at 8:06 a.m., R14 was laying in bed with her tube feeding in place and running. F14's feeding pump had multiple areas of dried brown substance on the top and near the control buttons. When interviewed on 4/27/23 at 12:53 p.m., nursing assistant (NA)-I verified the brown dried substance on R14's tube feed pump as likley dried tube feed foumula. NA-I further stated she was not aware of how to clean them and nurses were responsible for cleaning the equiptment in the room. When interviewed on 4/26/23 at 8:26 a.m., housekeeper (HK)-A verified he worked on 2nd floor. HK-A further stated he did not clean any equipment in resident rooms and further stated nursing staff were responsible. When interviewed on 4/27/23 at 1:55 p.m., RN-D stated it was everyone's responsibility to ensure resident equipment was clean and sanitary.	F 921		

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F 921	Continued From page 74 Furthermore, RN-D stated whoever make the spills should clean it up. When interviewed on 4/27/23 at 3:53 p.m., the director of nursing (DON) expected staff to clean up spills on equipment pumps and poles. Furthermore, if the dirty equipment was noted, it should be cleaned. A facility policy titled Cleaning and Disinfection of Resident Care Items and Equipment revised 2018, directed staff to decontaminate reusable care equipment between resident use but did not direct staff on maintaining cleaning process during use.	F 921		

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	245295	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**04/25/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE EMERALDS AT ST PAUL LLC	**420 MARSHALL AVENUE** **SAINT PAUL, MN 55102**

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K 000	INITIAL COMMENTS FIRE SAFETY The Minnesota Department of Public Safety conducted an annual Life Safety recertification survey, State Fire Marshal Division on April 25,2023. At the time of this survey, The Emeralds at St.Paul was found in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, the Health Care Facilities Code. The Emeralds at St. Paul is a 4-story building with a partial basement. The building was constructed at 2 different times. The original building was constructed in 1968 and was determined to be of Type II(222) construction. In 1982, an addition was constructed to the East side of the building that was determined to be of Type II(222) construction. Because the original building and the addition meet the construction type allowed for existing buildings, the facility was surveyed as one building. The building is protected by a full fire sprinkler system. The facility has a fire alarm system with full corridor smoke detection and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 116 beds and had a census of 86 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is	K 000		

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

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

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