DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
December 20, 2023

Administrator
Avera Morningside Heights Care Center
300 South Bruce Street
Marshall, MN 56258

RE: CCN: 245228
Cycle Start Date: November 30, 2023

Dear Administrator:

On November 30, 2023, a survey was completed at your facility by the Minnesota Department(s) of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

REMEDIES

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

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective January 4, 2024.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective January 4, 2024. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective January 4, 2024.

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

This Department is also recommending that CMS impose:

• Civil money penalty (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $11,995; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by January 4, 2024, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Avera Morningside Heights Care Center will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from January 4, 2024. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions.

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

ELECTRONIC PLAN OF CORRECTION (ePOC)

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

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

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

- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

DEPARTMENT CONTACT

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

Nicole Osterloh, RN, Unit Supervisor
Marshall District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
1400 East Lyon Street, Suite 102
Marshall, Minnesota 56258-2504
Email: nicole.osterloh@state.mn.us
Office: 507-476-4230
Mobile: (507) 251-6264 Mobile: (605) 881-6192

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by May 30, 2024 if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and

1919(h)(3)(D) and Federal regulations at 42 CFR § 488.412 and § 488.456.

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

APPEAL RIGHTS

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

Steven.Delich@cms.hhs.gov

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

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

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

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

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

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

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

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245228	A. BUILDING _____ B. WING _____	C 11/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVERA MORNINGSIDE HEIGHTS CARE CENTER	300 SOUTH BRUCE STREET MARSHALL, MN 56258

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments On 11/27/23 through 11/30/23, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73 was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On 11/27/23 through 11/30/23, 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. The following complaints were reviewed with NO deficiencies cited: H5228036C (MN79089), H5228037C (MN80954), H52287392C (MN92437), H52287393C (MN92621), and H2287346 (MN97681). The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		12/27/2023

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	F 000		
F 641 SS=D	regulations has been attained. 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 the Minimum Data Set (MDS) assessment accurately reflected the status and needs for 1 of 1 resident (R48) reviewed for elopement. Findings include: R48's quarterly Minimum Data Set (MDS) dated 8/23/23, indicated the resident had moderate cognitive impairment and had a Wander Guard elopement bracelet to be used daily. The MDS further indicated diagnoses of Alzheimer's disease. R48's face sheet printed 11/30/23, included diagnoses of dementia with Lewy bodies (abnormal deposits of a protein in the brain causing sleep, behavior, cognition, and movement disorders) and psychotic disorder with delusions and hallucinations. R48's care plan dated 5/25/22, indicated R48 had a problem for elopement and was at risk for elopement related to dementia and ability to ambulate independently. R28 was not at risk for elopement at that time, which was also dated 5/25/22 with status of active and frequency listed	F 641	Elopement assessment for R48 completed on 12/6/23, the resident was not identified at risk for elopement. Wander guard was removed from the care plan 12/6/23. Aide care sheet was updated 12/6/23. LPN-A and Nurse Supervisor educated on elopement risk assessment, workflow, WanderGuard Policy and Wandering/Elopement Behavior Admission/Discharge Guidelines on 12/1/23 by DON. Chart audit of all residents with a WanderGuard on their care plan, and residents where a WanderGuard was removed within the last month, will be completed by January 4, 2024 to ensure that the elopement assessment, care plan, care sheets, and the MDS assessment are documented appropriately. WanderGuard Policy and Wandering/Elopement Behavior Admission/Discharge Guidelines policy will be reviewed at the mandatory long-term care skills fair scheduled for	1/4/24

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F 641	Continued From page 2 as PRN (as needed). R48's elopement assessment dated 5/3/23, indicated R48 was at low risk for elopement. R48's updated elopement assessment on 11/11/23, completed by licensed practical nurse (LPN)-A indicated R48 was then at risk for elopement and there was to be a Wander Guard in place and checked daily. A nursing aide care sheet, last revised 11/28/23, indicated R48 had dementia and a Wander guard. On interview and observation on 11/27/23 at 5:47 p.m., family member (FM)-A indicated R48 wanders a lot and at times is really confused. FM-A stated he is often here throughout the day and into the evening as he is concerned what could happen to R48. FM-A indicated they don't have a bracelet on her anymore. R48 did not have a Wander guard on her wrists, ankles, or wheelchair. During observations on 11/28/23 at 3:18 p.m., 11/29/23 at 8:10 a.m., and 11/30/23 at 8:10 a.m., R48 was observed to not have a Wander Guard on their person or wheelchair. On interview 11/30/23 at 8:14 a.m., trained medication assistant (TMA)-A indicated R48 used to wander around the facility frequently and try to go up the elevators or outside but hasn't tried to leave in a very long time. TMA-A indicated she no longer has a Wander guard on and thinks the nurse took it off at least a week ago. On interview 11/30/23 at 8:21 a.m., registered nurse (RN)-A, also identified as nursing	F 641	12/29/23 and 1/3/24. Staff unable to attend one of the scheduled trainings will have 1:1 training prior to working their next shift. Licensed nursing staff will send an email notification to the DON, Nurse Supervisors, and MDS Coordinator when a WanderGuard is put into use and when discontinued. Completion of an Elopement risk assessment will be added to the readmission checklist and to the significant change in condition checklist by January 4, 2024 Nurse Supervisor will complete an elopement assessment quarterly with the MDS assessment. Elopement risk assessment and WanderGuard use will be added to the care conference template to be discussed quarterly. DON will complete audit of completion of elopement risk assessment, WanderGuard documentation, and MDS assessment on all residents considered at risk for elopement. Audit to be completed weekly until 100% compliance x 4 weeks; then monthly x 3 months; if 100% compliance, decrease to 5 records quarterly x 2 quarters. Results of the audits will be reviewed at the facility QAPI meeting, regularly scheduled nurse meeting, and regularly scheduled aide meeting to review results and develop action plans as needed.	

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F 641	Continued From page 3 supervisor, indicated R48 has not tried to elope in a very long time and is not a high risk for elopement anymore. Upon review of recent elopement assessment dated 11/11/23, RN-A indicated the Wander guard was removed 5/3/23, when she was assessed as low elopement risk. RN-A indicated she doesn't believe the assessment on 11/11/23 was accurate because R48 has not made any attempts over the past six months to elope. RN-A added when R48 first came to the facility she was in a "different mental state" and has shown improvement since that time. On interview 11/30/23 at 9:25 a.m., the director of nursing (DON) indicated R48 was not physically able to wander around the facility anymore and agreed with RN-A that the 11/11/23 assessment was not accurate and R48 is not at high risk for elopement at this time. The DON stated when care plans are inactivated, like R48's, it says PRN (as needed) in the intervention. The DON stated the nursing assistant care sheet, care plan and assessment should all indicate R48's the same accurate status and interventions for elopement. On interview 11/30/23 at 10:19 a.m., LPN-A indicated she doesn't remember doing the assessment, but if her assessment indicated high risk and a Wander guard she would have verified the Wander guard was on R48's wrist, ankle or wheelchair. LPN-A indicated R48 does wander aimlessly on the ground floor but hasn't attempted to leave the facility or go on the elevators in a long time. A policy and procedure for assessments, care plans or elopement was requested, and none was received.	F 641	Date of correction: January 4, 2024 Responsible for correction: Director of Nursing	

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F 678 SS=D	Cardio-Pulmonary Resuscitation (CPR) CFR(s): 483.24(a)(3) §483.24(a)(3) Personnel provide basic life support, including CPR, to a resident requiring such emergency care prior to the arrival of emergency medical personnel and subject to related physician orders and the resident's advance directives. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure resident cardiopulmonary Resuscitation(CPR) orders were consistent throughout the medical record for 1 of 16 residents reviewed (R3) and ensure staff were knowledgeable as to where to identify documents in order to prevent discrepancies. Findings include: R3's current, November 2023, physician orders identified on 12/24/22, an order for Do Not Resuscitate (DNR) was entered. R3's current, undated face sheet also reflected the DNR status. R3's current, undated care plan identified R3 was a DNR as of 11/2/22. R3's current, Physician Orders for Life Sustaining Treatment (POLST) identified he was to receive CPR in an emergency. Interview on 11/27/23 at 3:57 p.m., with registered nurse (RN)-C, identified if R3's heart stopped she would start CPR "because I know from memory,...he is a full code (CPR)". RN-C reviewed chart and identified R3 is a DNR. RN-C then looked at the signed POLST and identified it	F 678	R3 s DNR/DNI status confirmed with spouse on 11/28/23. R3 had new POLST completed on 11/28/23 and signed by spouse and provider. New POLST will be scanned into chart after IT concerns with scanning has been resolved. POLST and code status order are consistent. Audit completed on 100% of current resident records on 12/26/23 for accuracy of POLST and code status order. Discrepancies identified will be corrected by 12/29/23. Nurse staff educated on the locations of the POLST in the EMR on 11/28/23 with additional education sessions scheduled for 12/29/23 and 1/3/24. Staff unable to attend one of the scheduled trainings will have 1:1 training prior to working their next shift. Admission checklist was revised on 12/26/23 to include verify code status and that the POLST was reviewed and scanned into the chart. This update will be reviewed at the mandatory staff education day on 12/29/23 and 1/3/24. Staff unable to attend one of the scheduled trainings	1/4/24

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F 678	Continued From page 5 said he was to have CPR. Interview on 11/27/23 at 4:15 p.m., with RN-B identified if R3's heart stopped she would check the face sheet for the code status order. RN-B identified she did not know how to pull up the signed POLST or advanced directive in the medical record. Interview on 11/28/23, director of nursing (DON) agreed that the medical record and the POLST did not match, and she was not sure why. She identified that she could not determine what the correct code status order should be, and she would have to follow up with the family to find out what their wishes were and get a new POLST completed and signed by the physician. Review of the facility's September 2023, Code Status/Resuscitation policy identified they would periodically review CPR status with the resident or responsible representative at least quarterly and with any significant change in the resident's condition.	F 678	will have 1:1 training prior to working their next shift. Code status is discussed and reviewed at care conferences. Social worker/designee includes any follow-up items in the care conference note. Care conference follow-up added to the daily huddle board to ensure the follow-up items are completed. The social worker/designee will complete audits on all admissions and readmissions weekly. Once at 100% compliance for 4 consecutive weeks, audits will transition to monthly. Once at 100% compliance with monthly x 3, 30 charts will be audited per quarter for 3 quarters. Results of the audits completed will be reviewed at the facility QAPI meeting and regularly scheduled nurses meeting to review results and develop action plans as needed. Date of correction: January 4, 2024 Responsible for correction: Director of Nursing	
F 686 SS=G	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure	F 686		1/4/24

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F 686	Continued From page 6 ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to identify and implement interventions to prevent new pressure ulcer (PU) development for 1 of 1 resident (R61) who was at risk for PU upon admission. This caused actual harm when the facility failed to identify interventions to prevent new PU's to R61's heels and hip. Findings include: R61's: 1) 7/6/23, admission Minimum Data Set (MDS) assessment identified R61's cognition was severely impaired. R61 was dependent on staff for bed mobility, transfers, and toileting. R61 was identified as at risk for pressure ulcer (PU) development with no pressure ulcers present at that time. R61 had no venous or arterial ulcers, however, did have a skin tear. R61's skin and ulcer treatment included application of a nonsurgical dressing other than on their feet and application of ointment/medication other than on their feet. R61's diagnosis included atrial fibrillation, arthritis, osteoporosis, heart failure, hypertension, dementia, malnutrition or at risk for malnutrition, anxiety, depression, and psychotic disorder. 2) 9/27/23, quarterly MDS identified R61 continued to be dependent on staff for bed	F 686	R61 s repositioning schedule increased to hourly on 12/23/23. Braden assessment completed 12/23/23 with treatment plan in place inclusive of repositioning schedule, supplements, boot, air mattress, and cradle on bed, specialty cushion for chair. RN-A educated on 11/29/23 regarding the Pressure Injury Development process map included in the Skin Condition Identification and Prevention Program policy. All residents skin will be assessed for breakdown and skin risk assessment (Braden scale) completed. Findings will be documented in the EMR with interventions implemented based on resident skin risks. All care plans will be reviewed for accuracy and current skin prevention interventions. Completed on 12/29/23. Licensed nursing staff will email the wound team with identification of new wounds. Nurse will email the wound team when a resident scores 14 or less on the Braden scale on admission, readmission, and significant change of condition	

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F 686	Continued From page 7 mobility, transfers, and toileting. R61 was identified as having a stage I or greater PU. R61 was at risk for PU development. R61 had an unhealed PU, and 1 unstageable PU. R61's skin and PU treatment included a pressure reducing device in chair, PU care, and application of ointment/medication, other than on their feet. R61's diagnoses included peripheral vascular disease (lack of blood flow to extremeties), atrial fibrillation (abnormal heart rhythm that affects blood circulation), congestive heart failure, degenerative joint disease, heart valve inadequacies (regurgitation), history of facial cancer, and knee and hip replacements. Observation on 11/28/23 at 12:10 p.m., R61 was seated in Broda wheelchair reclined with her feet elevated and a heel boot on her left foot. At 2:59 p.m., R61 was noted to be laying down in her bed positioned on her back side. At 5:06 staff entered room and assisted R61 up out of bed and back into her recliner. R61's facility wound assessments identified: 1) On 8/9/23, the left foot 2nd toe appeared as dried dark black/brown scab that measured 0.6 centimeters (cm) length x 1 cm width x 0.6 cm area and was classified as a PU, unstageable with wound bed eschar (dead tissue) at 100%, surrounding tissue noted to be dry, with brown staining, and a small amount of drainage. Staff were to apply a wound dressing and notify the physician (MD). Staff noted details of left 2nd toe remained the same on 8/16/23, 8/23/23, 8/30/23, 9/6/23, and 9/12/23. There was no mention of interventions put into place to prevent further skin breakdown as R61 was identified at risk for skin breakdown and now had additional heightened risk for other PU related to identified skin	F 686	checklists. The wound team consists of the DON, Nursing Managers, Dietician, Dietary Manager, MDS Coordinator, Therapy Manager and Quality Coordinator. Skin inspection/measure assessment and weekly skin risk assessment (Braden scale) will be completed x 4 weeks with readmissions and significant change in condition. Readmission checklist and significant change in condition checklist will be updated with this new process. Assessment for tissue tolerance at time of admission, significant change in condition, upon hospital return, and annually. Repositioning schedule, as well as other preventative measures, will be based on results of tissue tolerance testing. Findings of tissue tolerance testing will be documented in the EMR. Repositioning schedule will be documented in the EMR and care plan. Wound assessments are scheduled to be completed every Tuesday on first floor and Thursdays on Ground Floor. Will revise the weekly wound documentation audit tool to include if the wound is improving, worsening, or unchanged. Continue weekly wound documentation audits. The audit findings will be emailed to long-term care leaders for follow-up. Nurse Supervisors will bring any significant change to a resident's skin assessment to the leader daily huddle which consists of the Administrator, DON,	

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F 686	Continued From page 8 breakdown on left 2nd toe. 2) On 9/27/23, staff noted R61's left 2nd toe appeared as brown, measured 0.2 cm x 0.1 cm x 0.02 cm. Staff noted it was a PU, unstageable, with the wound bed 100% eschar. The surrounding tissue was dry, and had a scant amount of drainage. Wound dressings were to be applied. 3) On 10/3/23, the left 2nd toe had 2 areas. The top portion of 2nd toe measured 0.7 cm x 0.5 cm and the bottom portion of the 2nd toe measured 0.6 cm x 0.9 cm x 0.54 cm. They appeared as intact brown, yellow, unstageable PU, with the wound bed 40% slough and 60% granulated (healthy tissue). The surrounding tissue was noted to be dry, red, was boggy but had no drainage. Wounds were cleansed with betadine and dressing applied and secured with medical tape. There was no documentation R61's physician had been updated with the change in status of the left second toe or interventions were reviewed for appropriateness or additional interventions were identified for the remainder of R61's feet. 4) On 10/10/23, the left 2nd toe had 1 area that measured 0.8 cm x 0.5 cm x 0.40 cm. Staff did not document the appearance or stage of the PU, however, the surrounding tissue was noted to be dry and intact. A wound cleanser was used and the dressing changed to a debriding type dressing (alginate). Details of the left 2nd toe remained the same on the 10/17/23, 10/22/23, and 10/24/23. 5) On 10/21/23, staff identified an additional area of concern as R61 had a rash to their right upper shoulder, starting along the backside of the right side of the neck and down the right upper arm. The rash was not causing R61 discomfort and was to be re-assessed the next day. On 10/22/23, the rash had gotten larger with blisters present.	F 686	Provider, MDS Coordinator, Nurse Supervisors, Therapy Manager, Activities Coordinator and Dietary Manager. Education will be provided to the licensed nursing staff on pressure ulcer prevention interventions, special equipment available, Skin Condition Identification and Prevention Program Policy and process maps at the mandatory long-term care education days on 12/29/23 and 1/3/24. Staff unable to attend one of the scheduled trainings will have 1:1 training prior to working their next shift. An education plan related to skin condition, wound treatment, and assessment skills will be created for calendar year 2024 to provide ongoing education to licensed nursing staff and aides. Orientation of new staff will include skin assessment and pressure injury process maps for licensed nursing staff; and identification of skin injury for aides. DON/designee will audit the resident's skin risk assessment (Braden score) and preventative interventions in place for all admissions, readmission, and residents with a significant change in condition weekly x 4 weeks; if 100% compliance x 4 weeks, reduce auditing to monthly x 3; if 100% compliance, decrease auditing to 5 records quarterly x 2 quarters. Quality Coordinator will complete weekly audits of completion of pressure injury	

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F 686	Continued From page 9 Staff contacted R61's MD and the resident was seen via video with a diagnosis of shingles and medication was ordered. (R61 was placed into isolation in their room). 6) On 10/24/23 at 4:23 p.m., staff identified the left 2nd toe was a dry scab, measuring 0.5 cm x 0.6 cm x 0.30 cm, and the wound bed was 100% eschar. This measurement indicated a decrease in size from the morning measurement. No other interventions were placed at that time to protect R61's feet from new PU. 7) On 10/29/23, new bilateral heel wounds (PU) were identified. A right heel wound was noted that appeared dark reddish purple and measured 2.7 cm length x 2.7 cm width x 7.29 cm area. No drainage was noted. Staff placed an adhesive bandage on the right heel for protection and placed booties on heel and were to float the heels. The left heel was identified to have a wound that measured 2.7 cm x 2.7 cm x 7.29 cm also with a adhesive bandage placed on that heel for protection. Staff contacted R61's MD for a referral to wound care. Staff now began new interventions of booties on heels and were to ensure R61's heels were floated while in bed or a chair. R61 was noted as having displayed discomfort with the dressing change. 8) On 10/30/23, the right heel was identified as healed, however staff noted the area remained fragile and heel protectors were to still be in place. The left heel showed redness with purple area in the middle that measured 2.5 cm x 1.4 cm x 3.50 cm. The left heel was identified as a pressure wound a stage 2, with an Optifoam dressing to be applied and ensure heel protectors were in place. Staff noted redness on R61's left heel and measured the PU at 5 cm x 4 cm with a purple area in center of red area that measured 2.5 cm x 1.4 cm. R61's MD was updated on the	F 686	assessment documentation and admission skin assessments with audit tool emailed to LTC nurse leaders weekly. Audit weekly x 4 weeks; if 100% compliance for 4 weeks, decrease frequency to monthly x 3; if 100% compliance, decrease auditing to 5 records quarterly x 2 quarters. Results of the audits completed will be reviewed at the facility QAPI meeting, regularly scheduled nurse meetings, and regularly scheduled aide meetings to review results and develop action plans as needed. Date of correction: January 4, 2024 Responsible for correction: Director of Nursing	

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F 686	Continued From page 10 new stage 2 pressure ulcer noted to the left heel, with a question if hospice referral would be appropriate. On 10/31/23, the provider responded R61 was not "quite at a hospice level yet". 9) On 11/1/23, R61's left heel measurements remained the same. The left 2nd toe was identified as having 2 areas a scab below the right side of the 2nd toenail and a scab on the knuckle of the 2nd toe. The measurement was 0.4 cm x 0.3 cm x 0.12 cm, unstageable, with the wound bed 100% eschar, and a scant amount of drainage. The dressing applied was a Polymem dressing. R61 was noted as having displayed discomfort with the dressing change. A scab below 2nd toenail measured 0.4 cm x 0.5 cm. Another new area on the left side of foot was noted to be pink measuring 1 cm x 0.7 cm x 0.7 cm, classified as a stage 1 PU, and a Polymem dressing was applied. The facility reached out to wound care for assessment and treatment of R61's left 2nd toe, with an appointment made for 11/2/23. Review of wound care progress notes from nurse practitioner (NP)-G identified on: 1) 11/2/23, NP-G assessed R61's left foot wounds and identified a stage IV PU on R61's left 2nd toe and pressure injury of deep tissue to the left heel. NP-G noted R61 had a Polymem dressing to the left 2nd toe wound and an Optifoam dressing to the left heel. R61 was noted to have had a heel protector on. Following debridement NP-G identified the underlying tissue was consistent with a stage IV PU (full thickeness with muscle and bone exposure) noted to the dorsal (top) aspect of the left second toe that measured 0.9 cm x 1.0 cm x 0.1 cm. probing into the bone. The wound bed was 50% slough and 50% necrotic tissue. NP-G noted a deep tissue	F 686		

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F 686	Continued From page 11 PU of the left heel. R61's skin was intact with non-blanchable (lack of blood flow) purple discoloration, measuring at 1.0 cm x 1.5 cm. NP-G's plan revealed R61 did have a stage IV pressure injury to left second toe with some bone exposed and surrounding redness. NP-G would need to order an MRI to further assess for potential osteomyelitis (sever bone infection). Treatment for second left toe was to be a debriding dressing of calcium alginate as a primary dressing covered with a Polymem dressing. The left heel was not open. She would continue to cover this area with Optifoam dressing and change the dressing every 2-3 days. R61 was to continue to use heel protectors and staff were to ensure regular pressure offloading practices. 2) On 11/15/23, NP-G re-assessed R61's non-healing foot wounds. Family was present and significantly concerned with the non-healing nature of the wounds. R61 was scheduled to see the infectious disease team later that day. NP-G noted a full thickness ulcer on R61's left second toe that measured 2.3 cm x 1.4 cm x 0.1 cm with deep probing to the bone. The wound bed is 100% necrotic tissue. NP-G also noted a full thickness wound to left heel that measured 2.5 cm x 3.0 cm x 0.1 cm. Necrotic tissue was covering the wound bed. R61 had moderate sanguineous (yellowish)drainage. NP-G had a discussion with the family the possibility of vascular (blood flow) studies however, family was unsure they wanted to move forward with that given her advanced age and demented status. There was concern for underlying osteomyelitis or worsening infection and NP-G noted R61 may be better off treated by the infectious disease team with an antibiotic. R61's family was more willing to accept the potential risks of antibiotic therapy	F 686		

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F 686	Continued From page 12 versus any surgical procedure. It was explained to the family by NP-G that without proper treatment, there was a possibility the wounds could become worse, and they could certainly could lead to a life threatening infection (sepsis). R61 was fitted for a heel suspension boot to be used at all times to offload the heel wound and written instructions were provide for the facility. 3) On 11/20/23, NP-G assessed R61's left foot wounds. R61 had been seen last week by podiatry and infectious disease. The family decided to move forward with symptomatic treatment at this time and forgo any aggressive management. R61's left second toe PU measured 2.3 cm x 1.4 cm x 0.1 cm deep and was probing to the bone. The wound bed was 100% necrotic (dead) tissue. R61's left heel full thickness PU wound measured 2.5 cm x 3.0 cm x 0.1 cm deep. Dry necrotic tissue covered the wound bed. There were two new areas of non-blanchable, deep red discoloration areas noted to her outer and inner ankle. NP-G's plan was to continue with betadine to the left second toe and the left heel as well with an Optifoam dressing to the left heel after the betadine wash dried. Staff were to continue with R61's heel suspension boot and offloading practices like floating the heels. Further review of R61's wound assessments identified on: 1) 11/7/23, R61's left side of the foot was noted as "healed". The left heel identified the center of wound was purple, and was boggy. The left heel measured 1 cm x 1.5 cm x 1.5, and an Optifoam dressing was applied. The left 2nd toe was identified as "moist", measuring 1 cm x 0.7 cm x 0.7 cm, stage 4, with 25% of the wound bed as slough and 75% of wound bed being eschar. The	F 686		

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F 686	Continued From page 13 surrounding tissue was macerated (white from moisture) with a small amount of drainage. Calcium alginate was applied followed by a Polymem dressing. R61 was noted to have discomfort with the dressing change. R61 was followed by wound care. 2) On 11/16/23, identified no assessment of left toe or left heel. Staff did note a new potential PU area on right lateral hip and it measured 0.9 cm x 0.3 cm x 0.27 cm. Staff classified the wound as a stage 2 PU. Dressing applied was Optifoam 4 x 4. An air mattress was now to be applied to R61's bed. 3) On 11/22/23, R61's right lateral hip had a scab that measured 0.5 cm x 0.2 cm x 0.10 cm. Staff noted the wound to be a stage 2 PU which they felt was improving. The left heel center of the wound was purple, and its edges were noted to be separating. The appearance was pink, purple, and boggy. The heel measured 3.5 cm x 3 cm x 10.5 cm and was classified as a stage 2 PU with small amount of drainage. An Optifoam dressing was applied. The left 2nd toe appeared moist, and measured 1 cm x 0.7 cm x 0.7 cm. and was noted to be a stage 4 PU. A small amount of drainage was seen. R61 had discomfort with the dressing change and was to be followed by wound care. R61's routine Skin Inspections dated 9/23/23, 10/14/23, 10/21/23, 10/28/23, 11/4/23, 11/11/23 and 11/27/23 had no identification of R61's wounds. R61's progress notes identified on: 1) 9/28/23, R61 was at risk for skin breakdown and had a unstageable pressure ulcer to her left 2nd toe. A barrier was applied as a preventative and now a cushion was to be used in R61's	F 686		

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F 686	Continued From page 14 wheelchair. 2) 10/29/23, progress note identified communication to the provider that nursing noted areas on both of R61's heels that resemble deep tissue injury. The areas measured approximately 2.7 cm x 2.7 cm and were dark red/purple in color. Nursing requested a referral to wound care. The noted identified Optifoam had been placed on bilateral heels for protection, and booties were to be placed on heels and feet heels were to be floated on pillows. 3) 11/15/23, progress note identified the director of nursing (DON) spoke with family members who requested therapy to evaluate R61 for a different wheelchair, and they also requested a foot board for the wheelchair to support R61's legs. A fentanyl (narcotic pain patch) was requested to help with foot pain, and an air mattress was now to be placed on R61's bed. There was no indication the DON had identified preventative measures should have been placed to prevent other new or worsening pressure ulcers before they occurred. 4) 11/17/23, progress note identified R61 was on contact precautions related to MRSA culture from wound to the bone and being treated for osteomyelitis. R61's current care plan identified on: 1) 6/30/23, staff were to reposition R61 every 2 hours. The care plan lacked identification of the 8/9/23, of R61's unstageable pressure ulcer identified on R61's left second toe that was documented in the wound assessment section of the medical record, along with interventions to prevent worsening of that wound or prevention of additional PU. 2) 10/30/23, the care plan was updated and identified heel protectors were implemented to	F 686		

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F 686	Continued From page 15 both heels while in bed and staff were to offload and float heels when able. There was no indication of interventions to prevent heel PU prior R61 acquiring their heel PU. 3) 11/13/23, the care plan was updated to include staff implemented contact precautions related to methicillin resistant staphylococcus aureus (antibiotic resistant organism) (MRSA) in R61's left 2nd toe. 4) 11/16/23, a care plan updated identified an air mattress was implemented due to R61's high risk for skin breakdown. There was no indication the facility proactively attempted to identify and implement interventions to prevent R61's heel and hip PU, nor how routine repositioning every 2 hrs was adequate to ensure R61 had properly offloaded their weight to ensure pressure reduction. R61's Tissue Tolerance assessments revealed on: 1) 6/30/23, the assessment identified after 2 hours of lying supine redness was noted on the coccyx with the intervention of repositioning put into place. The care plan identified repositioning every 2 hours however, the assessment had no mention how the facility determined a routine 2 hour repositioning was appropriated for a resident already at risk, nor if staff had identified the need for increased monitoring or repositioning. 2) 7/1/23, the assessment identified after 2 hours of lying supine areas of pressure had been observed on the coccyx with the same intervention of repositioning identified. The care plan remained the same with repositioning every 2 hours. There was no indication staff had identified increased repositioning was required as R61's 2 hour repositioning had not been adequate to prevent the area of pressure	F 686		

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F 686	Continued From page 16 identified on the coccyx from occurring. 3) On 7/2/23, the assessment identified after 3 hours lying supine an area of pressure had been observed with redness noted on the coccyx with an intervention put in place to elevate with pillow and reposition. There was no mention of what staff were to elevate with a pillow. Interview on 11/27/23 at 4:28 p.m., with family member (FM)-E and FM-F reported R61 was admitted to the facility at end of June 2023, with no skin issues. By the end of August, R61 had developed a PU on her left second toe. FM-F stated they "did not understand" how R61 could come into the facility with no skin issues then develop a pressure ulcer. FM-E reported the facility "did not do or have any treatments in place" until November 2023. R61 had not seen podiatry or wound care until the wound "turned almost black". At that time, the infectious disease (ID) physician extended R61's current antibiotic order until 12/15/23 and then planned to reassess. The ID physician advised the family the next step was amputation. FM-E and FM-F did not feel it was in R61's best interest to have the amputation. FM-F had met with the director of nursing (DON) at beginning of November 2023 and requested a foot cradle for the bed, a different wheelchair as R61's did not even have foot pedals and an air mattress for the bed. FM-F felt all of those interventions "should have been done a couple months ago". FM-F and FM-E were concerned if R61 was actually being repositioned when family was not present. FM-E reported they had asked the facility about R61's left toe PU was getting worse and they were told when R61 had shingles she was not eating and her immune system was compromised, and that was the reason for the decline in her PU status.	F 686		

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	245228	A. BUILDING _____ B. WING _____	C 11/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVERA MORNINGSIDE HEIGHTS CARE CENTER	300 SOUTH BRUCE STREET MARSHALL, MN 56258

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F 686	Continued From page 17 FM-F added if they had not spoken to the DON and had made suggestions for prevention of PU, R61 would not have the air mattress, foot cradle, or a new wheelchair. Interview on 11/28/23 at 3:38 p.m., with nursing assistant (NA)-D identified R61 came back from the local hospital yesterday with padded boots and white pads on her ankles. R61 was not to have the blankets touch her feet. NA-D was unsure how R61 developed her PU's but reported they had "gotten worse". She had heard staff speak about her getting an amputation but was unsure if that was going to happen. NA-D reported if R61 was laying down staff were to only reposition her every 2 hours. She confirmed staff were to reposition R61 even if family was visiting. Observation and interview on 11/29/23 at 11:00 a.m., with registered nurse (RN)-C completing wound care treatments identified R61 was combative with the 2 nursing assistants, yelling and attempting to hit out. RN-C first removed a dressing from R61's buttocks and observed was a PU on R61's left buttocks cheek. RN-C cleaned the PU with normal saline, and measured it as 0.3 centimeters (cm) x 0.4 cm. RN-C then applied a new Optifoam dressing. RN-C reported R61's dressing changes typically occur in the evening, so she was unable to state if she felt the wound had improved or not. The right buttocks cheek was observed to have no reddened areas. The left second toe was cleaned with normal saline, measured as 2.3 cm x 1.3 cm. RN-C then applied betadine to the area and reported that the left second toe was to be left open to air. The right hip was observed to have a small scab that measured 0.3 cm x 0.6 cm. RN-C had cleaned the area and stated it would be left open to air.	F 686		

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F 686	Continued From page 18 The left heel dressing was removed with a small amount of yellowish drainage noted on dressing. RN-C cleaned the area and measured the area as a whole measuring 4.3 cm x 3.4 cm. The inner opened area measured 0.6 cm x 2.4 cm. There was also an unstageable part covered in eschar measuring 3.9 cm x 2.9 cm. RN-C applied betadine and let that dry and applied another Optifoam dressing. RN-C identified on the left great toe a small scab that measured 0.3 cm x 0.4 cm. The right back side of R61's ankle had what appeared to be reddened skin resembling a rug burn or shearing that measured 0.2 cm x 0.6 cm. The left top portion of R61's ankle had a dressing RN-C removed. RN-C reported that this "must be new". The area appeared to be reddened skin that measured 1.8 cm x 1.4 cm. Interview on 11/29/23 at 1:53 p.m., with director of nursing identified she was unable to find documentation that R61's MD had been update after the left 2nd toe status changed on 10/3/23 or that the care plan had been reviewed for appropriate interventions or needed revisions to prevent worsening of the current pressure ulcer or to prevent additional skin breakdown. She confirmed that the air mattress to R61's bed had not been implemented until 11/16/23 and that she had ordered a support device for R61's wheelchair however, that had not come in yet. She reported that she felt it was important to note that R61 had shingles diagnosed on 10/22/23, that potentially contributed to her decline. She confirmed that the facility should be communicating with R61's MD when a decline in wound status was identified and the resident's care plan should have been reviewed and revised as necessary. She revealed R61's tissue tolerance assessment identified concerns after 2	F 686		

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	245228	A. BUILDING _____ B. WING _____	C 11/30/2023

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F 686	Continued From page 19 hours and that the facility implemented an every 2 hour repositioning when R61 first arrived. She further revealed if the tissue tolerance assessment identified after 1 hour a resident was red then staff should have reposition R61 hourly. She revealed the heel protectors were implemented on 10/30/23, the heel suspension boots on 11/15/23, a foot cradle for the bed was implemented and stated "I don't know what else we could do". Interview on 11/30/23 at 8:45 a.m., with trained medication aid (TMA)-E identified R61 had never walked since admission. R61 was unable to move herself in her wheelchair and needed extensive assistance of staff since admission. TMA-E identified preventative measures in place for skin breakdown were reposition and toileting. TMA-E reported they thought R61 developed the heel ulcer after she had shingles in October 2023. Observation on 11/30/23 at 8:45 a.m., R61 was in bed sleeping, foot cradle in place, and was positioned with pillows on her left side facing the doorway. It was unknown if R61's heel boots were on or heels were floated in bed as she was covered up. Interview and observation on 11/30/23 at 8:54 a.m., with licensed practical nurse (LPN)-B in R61's room where R61 was lying in bed on her back slightly leaning more towards her left side. LPN-B identified wound rounds were completed weekly with measurements. R61 was known to be combative with cares. R61 used to use a standing lift but had further declined and now uses a total body lift. R61 then instructed LPN-B to leave her room. R61 was observed moving her feet up and down rubbing them while in her bed.	F 686		

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F 686	Continued From page 20 Upon leaving the room, LPN-B reported that was how she believed R61 got her heel wound. Interview on 11/30/23 at 9:11 a.m., with nurse practitioner (NP)-G identified R61 was first seen on 11/2/23 for a stage 4 pressure ulcer on left second toe and a deep tissue injury on her left heel. NP-G reported the development of deep tissue PU's depended on each resident and their co-morbidities. R61 did not have good vascular status (blood flow to her limbs) and that increased her risk of acquiring a PU. NP-G reported R61 had even developed a new wound between weekly visit confirming she was prone to skin breakdown. When residents are at risk for skin breakdown, she typically recommended heel suspension boots. She reported there were concerns for osteomyelitis (bone infection) however, R61's family did not want to pursue aggressive measures related to her not being a good surgical candidate. Family also felt R61 would not tolerate a PICC line (IV line used to get antibiotics directly into the blood stream near the heart). NP-G reported there were "definitely things [interventions]" that should have been put in place prior to R61 acquiring new PU. The family was made aware that R61 could become septic (life threatening infection if not treated) related to not wanting to do any interventions other than oral antibiotics. NP-G revealed that every 1 to 1.5 hour repositioning would be ideal as every 2 hour repositioning for a resident who was a known PU risk was not appropriate. She agreed the facility should have anticipated R61's needs and identified and implemented interventions to try and lower her risk of new PU development. Observation and interview on 11/30/23 at 10:46	F 686		

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F 686	Continued From page 21 a.m., of R61 who was seated in recliner, reclined with feet elevated and heel boot on. FM-E reported there have been multiple times when FM-E had to request staff to reposition R61. FM-E further reported that R61 did not receive a boot to suspend her heel until she was seen by podiatry and reported R61 did not have any foot pedals for her wheelchair for the first 5 months until occupational therapy finally assessed her for wheelchair positioning. R61's 11/22/23, occupational therapy evaluation identified a referral was made for an evaluation for optimal positioning while in recliner and wheelchair for skin integrity and comfort. The therapy note identified R61 was found to have a ROHO cushion that was flat noted in wheelchair. A replacement cushion, low profile was provided. Therapy also provided a dycem cushion for recliner. There was no indication that therapy had been consulted for positioning upon admission or when PU had been discovered. R61's 11/15/23, Infectious Disease (ID) visit note identified left second toe with osteomyelitis with associated cellulitis (skin infection). Family was present and discussed the chances of a "cure" might be hampered by "multiple variables" including poor vascular supply and age. A discussion on side effects of antibiotic and after a full explanation of the clinical scenario a decision was made to proceed with antibiotic therapy. The left foot medial heel ulcer was assessed also. R61's case was extensively discussed with family members. A MRI, vascular study was offered but declined by family and decision to only treat with antibiotic was made given her advanced age and dementia. A follow up appointment on 11/27/23, identified a concern for osteomyelitis with a	F 686		

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F 686	Continued From page 22 recommendation for MRI or bone scan to evaluate. It was noted that family declined the desire to have R61 go through a MRI, vascular studies or source control (e.g.. amputation). the ID planned to treat R61 with Docycycline (antibiotic) 100 mg twice a day until 12/13/23 then follow up in 2 weeks as an outpatient. Review of June 2023, Skin Condition Identification and Prevention Program policy identified residents would be assessed for risk of pressure ulcer development or presence of pressure ulcers upon admission. The facility will implement interventions to prevent pressure ulcer development and/or treat current pressure ulcers. For residents who have been identified as having a pressure ulcer upon admission interventions will be implemented to promote healing. Residents who develop a pressure ulcer after admission, the facility will reevaluate prevention intervention for appropriateness of preventative measures. The facility was to document pressure ulcers weekly by the type of injury, the stage, measurements, describe the wound bed, describe the wound edges, any drainage, any pain and progress towards healing. There was no indication PU should be assessed more frequently as needed to ensure worsening did not occur. If a resident has a pressure ulcer not showing evidence of progress within 2-4 weeks the resident and interventions should be reassessed. The facility was to implement a baseline care plan within 48 hours that included preventative measures based or the residents risks and needs that were identified such as repositioning, pressure relieving devices, moisture barriers, and nutritional needs with measurable goals identified. The policy further provided references for prevention, assessing, staging, and types of	F 686		

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F 686	Continued From page 23 interventions the facility could use. The pressure ulcer development reference identified the provider and the wound care team should be notified of a new pressure ulcer development for an assessment. The facility was to notify the MD if no evidence of healing occurred in 2-4 weeks. The policy references included performing a tissue tolerance test and how to conduct the test. For example if a resident that had remained in the same position for 2 hours developed any areas of redness the test should be stopped as the resident would require repositioning at an interval of every hour.	F 686		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 1 of 1 resident	F 688	R16 was reevaluated by OT on 11/29/23 and will continue to receive OT services	1/4/24

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F 688	Continued From page 24 (R16) received assistance with hand splints to prevent worsening of contractures. Findings include: R16's Diagnosis Report printed 11/29/23, included diagnosis of vascular dementia (problems in the blood supply to the brain leading to tissue death), and rheumatoid arthritis (chronic inflammatory disease that affects the joints). R16's quarterly Minimum Data Set (MDS) dated 11/1/23, identified R16 had a Brief Interview for Mental Status (BIMS) score of 9 indicating moderate cognitive impairment. The MDS further identified R16 required partial to moderate assist with transfers, and was dependent on staff for toileting and dressing. The MDS also included functional limitation of range of motion with impairment on one side upper extremities. R16's care plan dated 1/2/20, indicated R16 requires assistance with most of her activities of daily living and uses adaptive equipment. Interventions included R16 is to wear a brace on right arm, hand and wrist after range of motion. R16 is to wear orthotic (brace) for 2-3 hours at a time as she tolerates. Check for any redness or pain while she has orthotic on. R16's Nursing Assistant Care Sheet, last revised 11/17/23, indicated use of EZ Stand (strap/stand device used to lift someone from a seated position) but did not include use of a splint or orthotic device. An occupational therapy treatment encounter dated 12/28/22, by certified occupational therapy assistant (COTA)-B indicated R16 had orthotic on	F 688	twice a week. Worklist/care plan will be updated to reflect current treatment plan by 12/29/23. OT evaluations will be ordered for all residents with a brace/splint order. Evaluations will be completed and worklist updated accordingly by January 4, 2024. All aide care sheets will be reviewed and revised as necessary to accurately reflect current resident brace/splint order by January 4, 2024. Physical Therapy Assessment policy to be reviewed and revised to include assessment for change in range of motion and plan for use of orthotics as appropriate. All licensed nursing staff and aides will receive education on brace/splint use, appropriate document in the EMR, and ROM. This will be completed at the mandatory long-term care education days on 12/29/23 and 1/3/24. Staff unable to attend one of the scheduled trainings will have 1:1 training prior to working their next shift. Admission and readmission checklists will be revised to add resident's brace/splint to the worklist by January 4, 2024. Nurse Supervisors will complete audits of brace/splint use documentation in the EMR on all residents with a brace/splint weekly. Once at 100% compliance with documentation for 4 consecutive weeks,	

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F 688	Continued From page 25 for 2.5+ hours this morning per staff. COTA educated staff on ensuring patient has no redness or pain during and after wearing the brace. Staff and patient agreeable to completing range of motion and orthotic wear schedule. Staff agreeable to check for redness/pain and to encourage patient to wear for 2-3 hours at a time as patient tolerates. Patient will be discharged. During observation and interview on 11/17/23 at 4:58 p.m., R16 had a visibly contracted (shortening and hardening of muscle) right 4th and 5th finger with the 2 fingers bent straight downwards towards her wrist. There was no splint on her right hand. R16 stated she is unable to move her 4th and 5th fingers and she once wore a splint but doesn't anymore. R16 indicated she isn't sure why they quit putting the splint on her right hand. R16 stated she spent months trying to get her fingers to work again, but she just can't move them now and stated "they are stuck". A splint was present in a basket holder in her room window on the ledge. During observation on 11/28/23 at 12:49 p.m., R16 was in the dining room getting assistance with eating. No splint was present on her right hand. During observation and interview on 11/28/23 at 2:20 p.m., registered nurse (RN)-B indicated R16 used to have a splint for her right hand and is unsure if R16 is refusing or if staff are not putting it on. R16 did not have a splint on her right hand. RN-B asked R16 to move her right 4th and 5th fingers and R16 stated "they don't move" and was unable to move them. R16 indicated she wasn't sure if a splint would work on her hand as she can't move her fingers. RN-B pointed towards	F 688	audits will transition to monthly. Once at 100% compliance with monthly audits for 3 months, 5 charts will be audited per quarter for 2 quarters. Results of the audits completed will be reviewed at the facility QAPI meeting, regularly scheduled nurse meetings, and regularly scheduled aide meetings to review results and develop action plans as needed. Date of correction: January 4, 2024 Responsible for correction: Director of Nursing	

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F 688	Continued From page 26 R16's window and indicated the splint is in the basket holder on the ledge. During interview on 11/28/23 at 2:23 p.m., trained medication aide (TMA)-B indicated she tries to put the splint on R16's right hand but some days she gets upset and doesn't allow staff to put it one. TMA-B indicated she refused today and was yelling at staff earlier. TMA-B indicted she generally will try a couple times every day and if R16 refuses she documents refused. TMA-B added R16 can not use her right hand to grasp the EZ-stand handles. During observation on 11/29/23 at 7:52 a.m., R16 remained in bed. No splint was present on R16's right hand. Splint remained in basket holder on window ledge. During interview on 11/29/23 at 8:20 a.m., TMA-C indicated R16 will sometimes wear her splint and other times she refuses. TMA-C indicated they complete range of motion to her R16's hand daily. Brace documentation included: (documentation was completed 1-2 times daily) June 1-30, 2023: no documentation 10 times. Brace on 13 times and brace off 21 times. Refusals documented 0 times July 1-31, 2023: no documentation 11 times. Brace on 13 times, brace off 34 times. Refusals documented 0 times. August 1-31, 2023: no documentation 9 times. Brace on 15 times, brace off 35 times. Refusals documented 0 times. September 1-30, 2023: no documentation 9 times. Brace on 19 times, brace off 24 times. 1 refusal due to pain documented. October 1-31, 2023: no documentation 14 times.	F 688		

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F 688	Continued From page 27 Brace on 18 times, off 19 times. Refusal 2 times. November 1-28, 2023: no documentation 12 times. Brace on 12 times, off 22 times. Refusal 1 time. During observation and interview on 11/29/23 at 1:08 p.m., registered nurse (RN)-A, also identified as supervisor, assessed R16's right hand. RN-B indicated she hasn't seen it for awhile but R16 had a stroke that affected her right side but she doesn't believe the fingers have changed since she last evaluated her right hand. R16 did not have a splint on her right hand and splint remained in basket holder on window ledge. During interview on 11/29/23 at 1:34 p.m., the director of nursing (DON) indicated if R16 refuses to wear the splint it should be documented as refused. The DON confirmed the plan of care for R16's splint has not been documented as R16 wearing the splint but was unsure if she has been actually wearing the splint or not. The DON indicated she will request an occupational therapy evaluation. During interview on 11/29/23 at 2:49 p.m., occupational therapist (OT)-A indicated she was seen by OT in December 2022 for assessment and treatment for her right hand and fingers. OT-A indicated R16 was to wear her splint 2 to 3 hours per day, check for redness and then put splint back on. OT-A indicated she received a request from DON to assess R16 fingers and right hand which she assessed as "tighter" than previous but was able to move R16's fingers and get them stretched to normal position. OT-A indicated if R16 is refusing to wear her right wrist brace, OT should be notified, which OT-A confirmed has not occurred.	F 688		

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F 688	Continued From page 28 A OT evaluation and plan of treatment dated 11/29/23, for R16 included at baseline R16 has limited wrist extension and tightness for MP (medial phalangeal), PIP (proximal inter-phalangeal joint) and DIP (distal inter-phalangeal joints), (hinge joints between the phalanges {digital bones in the hands} of the finger that provide flexion towards the palm of the hand). R16 within 4 weeks will demonstrate improved tolerance to wear orthotic for a least 4-6 hours per day monitoring for redness for maintaining joint mobility. On 11/29/23, passive range of motion (PROM) was completed but orthotic unable to be assessed today due to patient leaving for another appointment. An OT note dated 11/29/23, at 3:03 p.m. included: Evaluation for R16's right upper extremity, use of orthotics and reported decreased ability to participate in feeding and drinking when when she is drowsy but can do it independently when she is alert. She had previous care provider plan completed for use of Comfy orthotic 2-3 hours at a time during the day checking for redness and use of sheepskin palm protector at night with exercises. Staff reported that they have attempted to put on orthotic but she declines. At this time, skilled OT services are warranted for PROM, orthotic use and wearing. OT provided gentle PROM with tightness present. The use of the Comfy orthotic was not attempted today as R16 left for another appointment. A policy and procedure was requested for splint/orthotic use and none was received.	F 688		
F 689 SS=E	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)	F 689		1/4/24

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F 689	Continued From page 29 §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure the hot steam table was separated from the resident's area in 1 of 3 kitchenettes observed (Gardens resident dining area) placing residents at risk for potential burns. Findings include: Review of current resident's roster residing in the Gardens wing of the facility identified 19 resident total, with 14 residents identified with cognitive impairment and 2 at risk for wandering with Wander Guard devices in place. Observation on 11/27/23 at 12/21 p.m., in the Gardens kitchenette dining area identified a steam table used to hold food at a hot holding temperature while serving residents was against the wall. The steam table and surrounding area lacked any barrier between it and the residents. Observation on 11/27/23, at 12:44 p.m., dietary aid (DA)-A shut off steam table and left area, no other staff were present. Steam table remained very hot to touch. The Garden's dining area was open to resident common areas lacking any barrier or door to ensure resident could not	F 689	Gardens Neighborhood steam table was immediately taken out of service and placed in storage on 11/27/23. The steam table was returned to the Gardens unit on 11/30/23 with temporary barrier placed. All other units were assessed, and the same risk was identified in the Horizons unit. A temporary barrier was put into place around the steam table on 11/27/23. Evaluation of options for steam tables in Horizons and Gardens Neighborhoods will be completed by dietary manager, LTC leadership, and Plant on 12/28/23; with follow-up as per the results of the evaluation. Dietary manager to review/revise the Nutrition Plan of Care and Assessment policy. Staff educations completed with individuals scheduled to work on 11/27/23 in the Horizons unit and on 11/30/23 in the Gardens unit was completed. Dietary manager to review and revise the	

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F 689	Continued From page 30 wander into the area. Interview on 11/27/23 at 1:15 p.m., with DA-A identified that he had not received any special instructions or training related to safety with residents and the hot steam table. He said the nursing assistants watch the residents during mealtime to make sure they don't get to close to the steam table. The other dining rooms have a barrier between residents and the steam table, and he was not sure why they did not have one in the gardens dining room but thought it might be the lack of space. DA-A identified that he always makes sure to shut off the steam table before he leaves, and he agreed that it takes a while for it to cool off. Interview on 11/29/23 at 1:57 p.m., administrator agreed with the above finding and agreed the lack of a barrier between residents and the steam table places residents at risk for being burned. He identified that going forward he would always expect a barrier be in place to ensure the safety of residents. A policy was requested related to steam tables but none was provided.	F 689	Nutrition Plan of Care and Assessment policy to include steam table safety in LTC. Steam table safety and education reviewed at daily huddles with dietary staff until all staff have received the education. Dietary orientation binder has been updated to include education on steam table safety. Education of all nursing staff and aides related to steam table safety to be completed during mandatory education days scheduled for 12/29/23 and 1/3/24. Staff unable to attend one of the scheduled trainings will have 1:1 training prior to working their next shift. Dietary manager will audit the Gardens and Horizons steam table staffing and temporary barrier use 3 times a week for 4 weeks. Once at 100% compliance for 4 consecutive weeks, audit frequency will be decreased to monthly x 3; if 100% compliance, decrease auditing to 5 audits quarterly x 2 quarters. Results of the audits completed will be reviewed at the facility QAPI meeting and at the regularly scheduled dietary staff meeting held to review results and develop action plans as needed. Date of Correction: January 4, 2024 Responsible for correction: Dietary Manager	

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F 812	Continued From page 31	F 812		
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 and interview the facility failed to ensure the steam table where resident meals were served had a sneeze guard to protect food from being contaminated by nearby staff. This had the potential to effect all 12 residents who ate in the Gardens dining area. Findings include: Observation on 11/27/23 at 12:21 p.m., in the Garden dining area identified a steam table against the wall. The steam table lacked a sneeze guard to help reduce the risk of contamination from nearby staff or residents, and there was no separation device used to keep staff	F 812	Gardens neighborhood steam table was immediately taken out of service and placed in storage on 11/27/23. The steam table was returned on 11/30/23 to Gardens unit with temporary barrier in place. All staff to wear a mask when handling food from the steam tables on all units. Dietary manager to review/revise the Nutrition Plan of Care and Assessment policy. Evaluation of options for steam	1/4/24

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F 812	Continued From page 32 or residents any distance away. Dietary aide (DA)-A was observed facing the steam table and dishing food onto plates and placing on a cart, either he or a nursing assistant would take the cart and pass to the residents. Other staff were observed standing near the steam table while DA-A was dishing food. Interview on 11/29/23 at 1:57 p.m., with administrator identified he was not aware that they needed a sneeze guard but agreed that this could pose a risk for contamination. He identified that going forward they would ensure a steam table with a sneeze guard would be used. Review of the 10/17/22, facility provided LTC Food Safety and Sanitation Policy identified the facility would establish and maintain sanitary standards of cleanliness and food handling practices. They would evaluate practices of food handling to meet sanitary standards.	F 812	tables/sneeze guards in Gardens Neighborhood will be completed by dietary manager, LTC leadership, and Plant on 12/28/23; with follow-up as per the results of the evaluation. Staff education provided at daily huddles starting 12/26/23 and will be repeated until all staff have received the education. This will also be reviewed at the next staff meeting in February as these meetings are held quarterly. Dietary orientation binder for new employees updated with information related to sneeze guard and use of mask. Dietary manager will audit staff members on all units to ensure staff are wearing masks when serving from steam table 3 times a week for 4 weeks. Once at 100% compliance for 4 consecutive weeks, audit frequency will be decreased to monthly x 3; if 100% compliance, decrease auditing to 5 audits quarterly x 2 quarters. Results of the audits completed will be reviewed at the facility QAPI meeting and at regularly scheduled dietary staff meetings to review results and develop action plans as needed. Date of Correction: January 4, 2024 Responsible for correction: Dietary Manager	
F 867 SS=F	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii)	F 867		1/4/24

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F 867	Continued From page 33 §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement. §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor performance indicators. §483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation. §483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events.	F 867		

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F 867	Continued From page 34 §483.75(d) Program systematic analysis and systemic action. §483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained. §483.75(d)(2) The facility will develop and implement policies addressing: (i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems; (ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and (iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained. §483.75(e) Program activities. §483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care. §483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility.	F 867		

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F 867	Continued From page 35 §483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e). Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section. §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility's Quality Assurance and Performance Improvement (QAPI) committee failed to have evidence of a Performance Improvement Project (PIP) which identified facility specific high risk or problem-prone areas, develop an action plan to	F 867	QAPI meeting agenda template to be revised to include opportunity to create PIPs as identified through completion of post event analyses, notification trending, or VA reports.	

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F 867	Continued From page 36 correct the identified areas of concern, and to ensure the committee participated in the development and oversight of the systems. This had the potential to affect the quality of care and quality of life for all 72 residents in the facility. Findings include: Interview and record review of minutes with the Quality Assurance (QA) coordinator, for the last 3 quarters; March 16, 2023; April 20, 2023; May 18, 2023, June 15, 2023, July 20, 2023; September 21, 2023, and October 19, 2023, identified the facility had failed to identify facility specific problems or areas of concern, develop action plans, and implement systems with documented QAPI committee oversight. Interview on 11/28/23 at 2:15 p.m., with the QA coordinator reported QA education is provided to all staff annually by online education related to generic QAPI programs and not to the faciliy's QAPI program itself. Managers were "encouraged" to take facility specific QAPI information from the score card to their staff meetings and it was also available to staff online in the facility SharePoint document. She reported there was no documentation to identify if information had been provided by the department managers to their staff. Interview on 11/28/23 at 3:30 p.m., with the director of nursing (DON) reported she included QAPI as an agenda item on her monthly staff meetings. She reported she reviewed any areas of concern she was aware of but did not have any information on PIPS or areas of concern outside of the nursing department.	F 867	QAPI meeting agenda template to be revised to expand the PIP section to include more detail related to action plans, PIP committee meeting minutes and attaching PIP meeting minutes to the QAPI meeting minutes. Mentoring/coaching provided by quality coordinator to administrative assistant regarding writing of QAPI meeting minutes. Process Improvement Project initiated regarding pressure injuries. Staff to be educated on initiation of PIP through use of Story board. Annual nursing home quality plan to be reviewed at staff meetings on an annual basis. Quality scorecard and process improvement projects to be a standing agenda item for all nurse and aide staff meetings. QAPI meeting minutes to be attached to the meeting planner for nurse and aide staff meetings for staff to review prior to the meeting. QAPI meeting minutes to be distributed to all nursing and aide staff with staff meeting minutes QAPI meeting minutes to be audited by the quality coordinator after each meeting to determine accuracy of minutes and ensure loop closure.	

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F 867	Continued From page 37 Interview on 11/29/23 at 9:30 a.m. with registered nurse (RN)-C reported there was some review of QAPI at staff meetings, but there had not been specific discussion on PIP projects, facility identified areas of concern or action plans put in place. Interview on 11/29/23 at 3:46 p.m., with the QA coordinator and the interim administrator reported she had spoken with other supervisors about the process used for taking minutes and there needed to be more detail on areas of discussion and any projects put into place. The QA coordinator reported the facility developed a plan at the beginning of the physical year and then items could be added as they were identified. She voiced agreement there was no documented evidence of the process included in the QAPI minutes and facility specific concerns along with the action plan should be identified. When asked about the alleged incident of drug diversion she confirmed the incident had not been brought to QAPI as an area of concern and it should have been with development of an action plan with QAPI oversight. The interim administrator reported his agreement that work needed to be done to ensure identified areas of concern were discussed with development of a plan of action and documentation in the QAPI minutes. Review of the QAPI Plan 2023 - 2024, approved by the Quality Committee of the Board of Directors August 28, 2023, identified the facility would put in place systems to monitor care and services, drawing data from multiple sources. It included performance indicators to monitor a wide range of care processes and outcomes and review findings against benchmarks/goals the facility had established for performance. It	F 867	Date of Correction: January 4, 2024 Responsible for correction: LTC Administrator	

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F 867	Continued From page 38 included tracking, investigating, and monitoring adverse events each time they occurred, with development of action plans implemented. Targets for performance in areas being monitored were to be set by the QAPI team, with monitoring of the facility's progress. The QAPI team was to organize a PIP team who was entrusted to investigate a problem area and produce plans for correction and/or improvement to be implemented. The progress and results of the PIP teams work was to be reported to the QAPI committee on a regular basis.	F 867		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;	F 880		1/4/24

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F 880	Continued From page 39 §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review.	F 880		

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F 880	Continued From page 40 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 follow manufacture's instructions for cleaning and disinfecting 2 of 2 Master Care Air Jetted tubs located on the First floor. This had the potential to affect 24 of 34 residents, (R1, R3, R4, R5, R8, R11, R12, R13, R15, R17, R18, R21, R23, R24, R27, R33, R35, R36, R37, R41, R46, R47, R51, and R60) who utilized the two tubs. The facility also failed to ensure staff followed policy and procedure for donning and doffing personal protective equipment (PPE) following use with a resident who was on precautions and failed to sanitize a Hoyer lift following use with a resident on contact precautions. Findings include: WHIRLPOOL TUB Observation and interview on 11/29/23 at 10:44 a.m., with trained medication aid (TMA)-D who performed cleaning and disinfection the Master Care Aire Jet tub following completion of a resident bath. TMA-D reported she had completed her last bath for the day and would complete the cleaning and disinfection process. She then pointed to the instruction sheet posted on the side of the mirror across from the tub and pointed out a competency form posted on the wall beside the tub and stated she followed the directions. TMA-D applied gloves, and goggles, went to the side of the tub unit, picked up the sprayer located on the front of tub and sprayed the interior surface of tub and the surfaces of the bath chair with Master Care Classic cleanser and	F 880	DON provided real-time education to the staff involved in the tub cleaning on 11/29/23. All licensed nursing staff and aides will complete a tub cleaning competency, PPE donning/doffing competency, and mechanical lift sanitization competency at the mandatory long-term care education days on 12/29/23 and 1/3/24. Staff unable to attend one of the schedule trainings will have 1:1 training prior to working their next shift. New hires will complete a tub cleaning competency and donning/doffing of PPE within the first 30 days of hire. The DON/designee will complete 8 tub cleaning observations a week. Once at 100% compliance with 8 observations a week for 4 consecutive weeks, observations will transition to 4 a month. Once at 100% compliance with the 4 observations a month for 3 months, 8 tub cleanings will be observed per quarter for 2 quarters. The DON/designee will complete 8 PPE observations a week. Once at 100% compliance with 8 observations a week for 4 consecutive weeks, the observations will decrease to 4 a month. Once at 100% compliance with the 4 observations a month for 3 months, 8 observations will be	

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	245228	A. BUILDING _____ B. WING _____	C 11/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 880	Continued From page 41 disinfectant. After she sprayed the solution over the interior surfaces of the tub and chair, she closed the drain and turned on the water to fill the tub. She then picked up a long handled scrub pad and brushed the tub and chair as the tub was filling with water to the level covering the seat of the bath chair. TMA-D did not add more of the Master Care Classic solution and reported it was on the surface of the tub and chair and mixed with the water to disinfect the surfaces. She turned on the tub jets at 10:48 a.m. and reported they were allowed to run for 10 minutes to disinfectant all surfaces. Two black jets were noted in the bottom of the tub and circulated the water over the interior surfaces of the tub and chair. TMA-D continued to brush surfaces of tub for another minute and then removed pad and disposed into the trash. She reported a new pad was used each time the tub was cleaned. TMA-D removed her gloves, washed her hands and continued to put away supplies in room and stated she had to wait for 10 minutes to allow the tub to be disinfected. At 10:55 a.m., TMA-D turned off the jets and opened the drain and allowed the water and disinfectant to drain from tub. When asked about the amount of disinfectant and water in the tub she reported she was not aware of how much disinfectant she had sprayed in the tub as she didn't measure it, and she was not aware of how much water the tub held, or the amount of water needed to cover the seat of the bath chair. Review of the Master Care direction sheet with TMA-D located on the wall identified 2 ounces of disinfectant was to be diluted in 1-2 gallons of water and then brushed over all surfaces and allowed to remain wet for 10 minutes. TMA-D reported there was a lot more water in the tub than the 1-2 gallons and she thought there was "probably 2 ounces of	F 880	completed per quarter for 2 quarters. The DON/designee will complete 8 mechanical lift sanitizing observations a week. Once at 100% compliance with 8 observations a week for 4 consecutive weeks, observations will transition to 4 a month. Once at 100% compliance with the 4 observations for 3 months, 8 mechanical lift sanitizing observations will be completed per quarter for 2 quarters. Results of the audits completed will be reviewed at the facility QAPI meeting, regularly scheduled nurse meetings, and regularly scheduled aide meetings to review results and develop action plans as needed. Date of Correction: January 4, 2024 Responsible for correction: Director of Nursing	

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F 880	Continued From page 42 disinfectant" because she had sprayed everything well. She reported she had been trained to clean and disinfectant the tub as she had demonstrated, but agreed the ratio of water to disinfectant was not as directed on the instruction sheet. Interview on 11/29/23 at 10:19 a.m., with nursing assistant (NA)-C reported she also provided tub baths in the jetted tubs and utilized the same process for spraying disinfectant on the interior surfaces and chair, scrubbing the surfaces with the pad, then filling the tub with water to cover the bath chair seat. NA-C reported she was not aware of the recommended dilution that was listed on the Master Care direction sheet and identified she was not aware of how much disinfectant/cleaner was sprayed into the tub, but confirmed filling the tub to the level of the bath chair seat was more than the 1-2 gallons directed. Interview on 11/29/23 at 2:52 p.m. with the infection preventionist reported her expectation for staff to follow manufacture recommendations for the dilution ratio of disinfectant to water for cleaning/disinfection of the jetted tubs. Reported she was aware of staff completing a competency for providing tub baths and that included cleaning and disinfection. She reported she was not aware the manufacture's directions were not being followed and was an infection control concern she would need to follow up on. Interview on 11/30/23 at 10:15 a.m., with the director of nursing (DON), identified her expectation for the manufacture's recommendations for tub cleaning and disinfection to be followed and voiced agreement	F 880		

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F 880	Continued From page 43 that filling the tub over the level of the bath chair seat was much more than the recommended 1-2 gallons of water. Review of the Master Care MB-80 R operation manual identified the tub capacity was 45 gallons of water and water level covering the seat of the bath chair came half way up surface of the tub. The directions for disinfection listed to add 2 ounces of disinfectant solution per gallon water, wet all surfaces thoroughly, and allow to remain wet for 10 minutes and then remove excess liquid. Review of the Master Care Integrity Bath cleaning and disinfecting competency form identified, when there was approximately one gallon of water and disinfectant in the foot well, shut off dispensing by turning knob upright. Use the long handed brush, to thoroughly scrub the inside surfaces of the bath, transfer chair, belts and pads.. Open the drain and allow the disinfectant to remain for full contact time of 10 minutes per manufacture recommendations. Once the contact time was reached, turn on flush water (turn knob left) to run water through the disinfecting lines in the dispensing box and thoroughly rinse all cleaned components of the tub and transfer chair. A policy for use of the Master Care jetted tub was requested but not provided.	F 880		

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F 880	Continued From page 44 PPE Observation and interview on 11/28/23 at 5:32 p.m., of nursing assistant (NA)-A and NA-B who donned gloves and yellow gowns before entering R61's room. R61 had a sign on the door that identified contact precautions. NA-A and NA-B reported that R61 had an infection in a wound and that staff had to don personal protective equipment (PPE) when performing cares. NA-A and NA-B transferred R61 with a mechanical Hoyer lift (full body lift) into the bed to check and change incontinent product. R61 was incontinent of bowel. R61 was combative with the staff during the task. NA-A removed the soiled incontinent product, cleaned R61's peri area and placed a new incontinent product on R61 without changing gloves. NA-A and NA-B then transferred R61 into her recliner in her room with NA-A still wearing the same gloves. NA-B removed the garbage bag from the trash can that contained the soiled incontinent product and replaced with a new bag before exiting the room. NA-A pushed the mechanical Hoyer lift out of the room and down the hall to a small alcove and parked it all while wearing the same gloves and the yellow gown. NA-A then walked farther down the hall still wearing the yellow gown and soiled gloves to the nurse's station where she removed the gown and soiled gloves. NA-A then used hand sanitizer on her hands and walked into the dining area. NA-A reported that she did not take her soiled gloves nor her yellow gown off in the room because NA-B had just changed the garbage and she did not want to put her dirty gown and gloves in there. NA-A confirmed that she had not sanitized the mechanical Hoyer lift after parking it in the small alcove. NA-A agreed that her PPE should have been removed prior to leaving the room and that	F 880		

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F 880	Continued From page 45 the mechanical lift should have been disinfected immediately after use with someone on contact precautions.	F 880		
F 881 SS=E	Antibiotic Stewardship Program 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 perform antibiotic stewardship to include antibiotic use protocols and a system to monitor antibiotic usage and determine if the prescribed antibiotics resolved the identified infectious process for 22 of 72 sampled residents (R2, R6, R7, R10, R11, R13, R21, R22, R28, R36, R37, R38, R43, R47, R53, R61, R167, R267, R268, R269, R270, and R271) identified in the facility's infection control surveillance. This had the potential to affect all 72 residents who were or may receive antibiotic therapy in the future. Findings include: Review of the September, October, and November 2023 infection control (IC) surveillance identified for the month of: 1). September 2023, 8 residents were receiving antibiotic treatment (R10, R13, R22, R167, R268,	F 881	Starting on 12/27/2023 all residents currently on an antibiotic will be reviewed for 72-hour time out completion and charting for antibiotic completion including specific infection assessment for use of the antibiotic. Residents on antibiotics will be added to the facility daily huddle board and unit huddle boards. All licensed nursing staff will be reeducated on the daily charting expectations for residents on antibiotics, 72-hour time out, and final note once antibiotics are completed for the completion of resolution of symptoms/infection at the mandatory long-term care education days on 12/29/23 and 1/3/24. Staff unable to attend one of the scheduled trainings will	1/4/24

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F 881	Continued From page 46 R269, R270 and R271). R167 was identified as receiving an antibiotic but there was no additional information included. There was no indication staff had re-assessed the resident's following completion of the therapy or notified their physicians to identify if symptoms had resolved or there was a need to change the medication or continue treatment for a specific period. 2). October 2023, 4 residents were identified as receiving antibiotic treatment (R6, R37, R53, and R267), R267 was listed on the tracking form as "infectious Disease" but there was no follow up or documentation to identify the source of infection. There was no indication staff had re-assessed the resident's following completion of the therapy or notified their physicians to identify if symptoms had resolved or there was a need to change the medication or continue treatment for a specific period. 3). November 2023, 10 residents were identified on the tracking as receiving antibiotic therapy ((R2, R7, R11, R21, R28, R36, R38, R43, R47 and R61). There was no indication staff had re-assessed the resident's following completion of the therapy or notified their physicians to identify if symptoms had resolved or there was a need to change the medication or continue treatment for a specific period. Interview and document review on 11/27/23 at 1:02 p.m. with the infection control practioner (IP) reported she received a daily report of any new antibiotics started within the last 3 days and utilized (Theradoc-a computer-based resource that identified labs, antibiotic orders, etc. and populated to a surveillance dashboard for review). The IP reported she looked at antibiotic initiation to determine if it met Loeb criteria and documented on her spreadsheet. According to	F 881	have 1:1 training prior to working their next shift. Infection preventionist will continue to audit the 72-hour time out on all residents with antibiotic orders. DON/designee will audit all residents that have completed antibiotics for the completion of documentation of resolution of symptoms/infection until at 100% for one month. Once at 100% compliance for a month, will transition to 20% of residents with completed antibiotics per quarter for 3 quarters for continued compliance audit. Results of the audits completed will be reviewed at the facility QAPI meeting and regularly scheduled nurse meetings to review results and develop action plans as needed. Date of Correction: January 4, 2024 Responsible for correction: Director of Nursing	

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F 881	Continued From page 47 the IP Employee illness was monitored by a nurse at another facility who screened and determined the appropriate action based on signs and symptoms (S/S) reported. She received a report via email to update on the action taken with the employee. When asked about the incidents of Sepsis the IP reported she was aware of the occurrence and the facility had a form Situation, Background, Assessment and Recommendation (SBAR) staff were to complete and fax to the doctor when a resident was having S/S, but she identified staff were not consistent with completion of the form. Completion of the form caused a trigger on the electronic system to perform an assessment and notify the provider but that was not consistently completed. Interview on 11/29/23 at 8:53 a.m., with the Quality Assurance Coordinator (QA) identified she felt it would be appropriate to have documentation of resolution of a person who had been receiving antibiotic treatment regardless of whether the course of treatment was initiated in the facility or in the hospital. Interview on 11/29/23 at 9:30 a.m., with registered nurse (RN)-C reported when an antibiotic was started on the unit, she notified the director of nursing (DON), and a 48-hour time out would be completed and documented in the record. The facility also performed a 72 hour hold with the hope the culture/sensitivity (C/S) had returned and at that time the MD or NP was notified for any updates or changes in orders. RN-C reported when a resident returned from a hospitalization, she made certain there was an end date for the antibiotic, but relied on the MD or NP to make any documentation related to resolution of the condition that indicated the need for antibiotic	F 881		

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F 881	Continued From page 48 treatment. RN-C identified nursing did not do any routine follow up or documentation unless the antibiotic was started in the facility. Interview on 11/30/23 at 10:30 a.m. with the DON identified her expectation for antibiotic stewardship to be followed according to the policy and documentation should be complete to identify all areas on the spread sheet. She also identified all antibiotics should be tracked regardless of initiation in or out of the facility. Review of the November 2023 Long Term Care Antibiotic Stewardship policy identified outcomes were to be monitored related to the use of antibiotics was to include tracking multi-drug resistant organisms and Clostridiums difficile. Review the list of antibiotics ordered for residents to determine if treatment guidelines were followed. Track antibiotic use in the facility monthly to review for patterns of use, days of therapy and to determine the impact of antibiotic stewardship interventions. Reporting of antimicrobial use as well as resistance was to be reported to the Quality Assurance and Performance Improvement (QAPI) committee quarterly. Education was to be provided to nursing and clinical staff at least annually with the goal of antibiotic stewardship interventions.	F 881		

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	245228	A. BUILDING **02 - NEW BUILDING AND RENOVATED EXISTING BLD** B. WING _____	**11/28/2023**

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 11/28/2023. At the time of this survey, Avera Morningside Heights Care Center was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		12/27/2023

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

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K 000	Continued From page 1 Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. Avera Morningside Heights Care Center was constructed as follows: The original building was constructed in 1963, it is two-stories in height, has no basement, is fully fire sprinkler protected and was determined to be of Type II(111) construction; The 2004 Addition is two-stories in height, has no basement, is fully fire sprinkler protected and was determined to be of Type II(111) construction . The facility has a capacity of 76 beds and had a	K 000		

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K 000	Continued From page 2 census of 72 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 923 SS=D	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full	K 923		1/10/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245228	A. BUILDING **02 - NEW BUILDING AND RENOVATED EXISTING BLD** B. WING _____	**11/28/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVERA MORNINGSIDE HEIGHTS CARE CENTER	**300 SOUTH BRUCE STREET** **MARSHALL, MN 56258**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 923	Continued From page 3 cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain correct oxygen cylinder storage per NFPA 99 (2012 edition), Health Care Facilities Code, sections 11.3.1, 11.3.2, 11.3.3, 11.3.4, and 11.6.5. This deficient finding could have a isolated impact on the residents within the facility. Findings include: On 11/28/2023, at 12:30 PM, it was revealed by observation that in the O2 Transfer Room, there was mixed storage of empty/full cylinders. There was no identified storage areas for full and/or empty cylinders. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 923	A larger rack to store oxygen cylinders will be ordered from Northwest Respiratory Signage will be added to the wall in the storage room to indicate empty and full All licensed nursing staff and aide staff will receive education on gas equipment – cylinder and container storage at the mandatory long term care education days on 12/29/23, 1/3/24, and 1/5/24. Orientation checklist/binders will be revised to include education on cylinder and container storage DON/designee will audit oxygen storage room twice a week for 4 weeks to ensure appropriate storage of oxygen cylinders. Once 100% compliance x 4 weeks, will decrease auditing to 4 observations per month x 3 months; if 100% compliance decrease auditing to 6 observations per quarter x 2 quarters. Results of audits completed will be reviewed at the facility QAPI meeting and regularly scheduled nurse and aide meetings to review results and develop action plans as needed. Date of Correction: January 10, 2024 Responsible for correction: Director of Nursing	

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
January 19, 2024

Administrator
Avera Morningside Heights Care Center
300 South Bruce Street
Marshall, MN 56258

RE: CCN: 245228
Cycle Start Date: November 30, 2023

Dear Administrator:

On December 20, 2023, we notified you a remedy was imposed. On January 4, 2024 the Minnesota Departments of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of January 10, 2024.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective January 4, 2024 be discontinued as of January 10, 2024. (42 CFR 488.417 (b))

In our letter of December 20, 2023, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from January 4, 2024. This does not apply to or affect any previously imposed NATCEP loss.

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Health Regulation Division
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Email: Kamala.Fiske-Downing@state.mn.us