Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

February 22, 2024

Administrator
Frazee Care Center
219 West Maple Avenue
Frazee, MN 56544

RE: CCN: 245299
Cycle Start Date: February 1, 2024

Dear Administrator:

On February 9, 2024, we informed you that we may impose enforcement remedies.

On February 13, 2024, the Minnesota Department(s) of Health and Public Safety completed a survey and it has been determined that your facility is not in substantial compliance. The most serious deficiencies in your facility were found to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

REMEDIES

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

- Mandatory Denial of Payment for new Mediare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective May 1, 2024

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective May 1, 2024. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective May 1, 2024.

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

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

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $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 May 1, 2024, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Frazee Care Center will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from May 1, 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:

LeAnn Huseth, RN, Unit Supervisor
Fergus Falls District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
1505 Pebble Lake Rd., Suite 300
Fergus Falls, Mn. 56537
Email: leann.huseth@state.mn.us
Office: (218) 332-5140 Mobile: (218) 403-1100

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 August 1, 2024 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 488.412 and § 488.456.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services

determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

APPEAL RIGHTS

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

Steven.Delich@cms.hhs.gov

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

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

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

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

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

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division

P.O. Box 64900
St. Paul, Minnesota 55164-0900

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

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

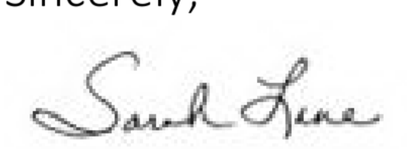
Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

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

Travis Z. Ahrens
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,



Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us

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February 22, 2024

Administrator
Frazee Care Center
219 West Maple Avenue
Frazee, MN 56544

Re: State Nursing Home Licensing Orders
Event ID: WXZZ11

Dear Administrator:

The above facility was surveyed on February 11, 2024 through February 13, 2024 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

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

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

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

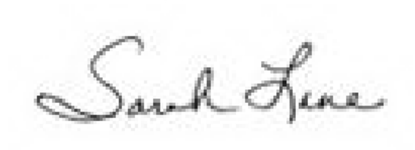
Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting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

LeAnn Huseth, RN, Unit Supervisor
Fergus Falls District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
1505 Pebble Lake Rd., Suite 300
Fergus Falls, Mn. 56537
Email: leann.huseth@state.mn.us
Office: (218) 332-5140 Mobile: (218) 403-1100

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

Please feel free to call me with any questions.

Sincerely,



Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245299	A. BUILDING _____ B. WING _____	C 02/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRAZEE CARE CENTER	219 WEST MAPLE AVENUE FRAZEE, MN 56544

(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 2/11/24 to 2/13/24, a survey for compliance with Appendix Z, Emergency Preparedness Requirements for Long Term Care facilities, §483.73(b)(6) was conducted during a standard recertification survey. The facility was NOT in compliance. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulation has been attained.	E 000		
E 041 SS=C	Hospital CAH and LTC Emergency Power CFR(s): 483.73(e) §482.15(e) Condition for Participation: (e) Emergency and standby power systems. The hospital must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section and in the policies and procedures plan set forth in paragraphs (b)(1)(i) and (ii) of this section. §483.73(e), §485.625(e), §485.542(e) (e) Emergency and standby power systems. The [LTC facility CAH and REH] must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section. §482.15(e)(1), §483.73(e)(1), §485.542(e)(1),	E 041		3/4/24

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

Electronically Signed | 03/01/2024

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

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E 041	Continued From page 1 §485.625(e)(1) Emergency generator location. The generator must be located in accordance with the location requirements found in the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5, and TIA 12-6), Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4), and NFPA 110, when a new structure is built or when an existing structure or building is renovated. 482.15(e)(2), §483.73(e)(2), §485.625(e)(2), §485.542(e)(2) Emergency generator inspection and testing. The [hospital, CAH and LTC facility] must implement the emergency power system inspection, testing, and [maintenance] requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code. 482.15(e)(3), §483.73(e)(3), §485.625(e)(3),§485.542(e)(2) Emergency generator fuel. [Hospitals, CAHs and LTC facilities] that maintain an onsite fuel source to power emergency generators must have a plan for how it will keep emergency power systems operational during the emergency, unless it evacuates. *[For hospitals at §482.15(h), LTC at §483.73(g), REHs at §485.542(g), and and CAHs §485.625(g):] The standards incorporated by reference in this section are approved for incorporation by reference by the Director of the Office of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may obtain the	E 041		

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E 041	Continued From page 2 material from the sources listed below. You may inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the Federal Register to announce the changes. (1) National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169, www.nfpa.org, 1.617.770.3000. (i) NFPA 99, Health Care Facilities Code, 2012 edition, issued August 11, 2011. (ii) Technical interim amendment (TIA) 12-2 to NFPA 99, issued August 11, 2011. (iii) TIA 12-3 to NFPA 99, issued August 9, 2012. (iv) TIA 12-4 to NFPA 99, issued March 7, 2013. (v) TIA 12-5 to NFPA 99, issued August 1, 2013. (vi) TIA 12-6 to NFPA 99, issued March 3, 2014. (vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011. (viii) TIA 12-1 to NFPA 101, issued August 11, 2011. (ix) TIA 12-2 to NFPA 101, issued October 30, 2012. (x) TIA 12-3 to NFPA 101, issued October 22, 2013. (xi) TIA 12-4 to NFPA 101, issued October 22, 2013. (xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009..	E 041		

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E 041	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to implement emergency and standby power system routine testing for generator safety checks. This deficient practice had the potential to affect all 33 residents residing in the facility. Findings include: On 2/12/2024 between 10:30 a.m. and 12:30 p.m., it was revealed by a review of available documentation that the facility failed to provide documentation of a 36-Month 4-hour generator load bank test having been completed. An interview with the Maintenance Director verified this deficient finding at the time of discovery. On 2/12/24, at 1:17 p.m. administrator reviewed the facility Emergency Preparedness plan with surveyor. Administrator confirmed a fire safety survey had been completed, and there were problems noted with the generator, the four hour bank test had not been documented as completed.	E 041	Immediate Corrective Action: Upon notification of the deficiency, the facility reached out to a vendor to conduct the required generator testing. Corrective action as it applies to others: On 2/22/24, the facility's vendor conducted the required 4 hour generator test. Interventions to prevent a recurrence: The facility has engaged in an agreement with a generator testing vendor to provide all required NFPA testing and maintenance. Compliance Date: Ongoing monitoring: - The Maintenance Director or designee will review records quarterly for compliance. A summary of the audit results will be reviewed with the IDT at the monthly QAPI meting for ongoing recommendations. This Deficiency is a copy of K918	
F 000	INITIAL COMMENTS On 2/11/24 to 2/13/24, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. In addition to the recertification survey, the	F 000		

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F 000	Continued From page 4 following complaint was reviewed. The following complaint was reviewed with no deficiency issued. H52999483C (MN00095442). The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure residents were assessed for the ability to self administer medications (SAM) for 1 of 3 residents (R3) reviewed for medication administration. Findings include: R3's significant change Minimum Data Set (MDS) dated 12/9/23, indicated R3 was cognitively intact. Identified R3 had diagnoses which	F 554	F 554 Immediate Corrective Action: R3 was assessed for the ability to safely self-administer medications, and an MD order was obtained to allow R3 to self-administer nebulized medications after set-up. Corrective Action as it Applies to Others: An audit was completed for other residents who receive nebulized	3/4/24

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F 554	Continued From page 5 included heart failure, anxiety and depression. Indicated R3 required moderate assistance of one staff with toileting and personal hygiene. Review of R3's electronic health record (EHR) revealed a SAM assessment had not been completed and R3 did not have an order for self administration of medications. R3's Physician's Telephone Orders dated 2/5/24, and signed 2/12/24, directed staff to administer DuoNeb (medication used to relax the muscles in the airways and increase air flow to the lungs) four times daily (QID) for seven days then as needed (PRN) for wheezing and shortness of breath (SOB). R3's Medication Administration Record (MAR) dated 2/1/24 to 2/9/24, indicated R3 was taking Ipratropium-albuterol inhalation solution (DuoNeb) 0.5-2.5 3 milligrams (mg) per 3 milliliters (ml). R3's order further indicated R3's order began on 2/5/24 at 8:00 p.m., and ended 2/12/24 at 4:00 p.m. R3's order for DuoNeb was changed to PRN following the physician's telephone order on 2/12/24. R3's care plan dated 12/21/23, indicated staff were to observe R3 for changes in cognition, level of alertness, confusion and forgetfulness. Identified staff were to reorient R3 as needed. During an observation on 2/12/24 at 11:33 a.m., registered nurse (RN)-A verified R3's DuoNeb order, retrieved the DuoNeb from the medication cart, locked the medication cart and walked to R3's room. RN-A knocked on R3's door, entered the room, explained the medication to R3, opened the DuoNeb and poured the solution into	F 554	medications to ensure those who self-administer have been assessed to do so and have a current MD to allow self-administration of medications. Prevent Recurrence: The policy and procedure for Self-administration of medications was reviewed and remains current. Staff will be educated on the policy by 3/4/2024. Date of Alleged Compliance: 3/4/2024. Ongoing Monitoring: Random chart review audits will be conducted to ensure that residents with orders for nebulized medications have current self-administration of medications assessments, and MD orders to allow SAM as indicated by the assessment findings. Audits will be conducted as follows: " 5x/week for 2 weeks " 3x/week for 2 weeks " 2x/week for 2 weeks " Weekly x 4 weeks A summary of the audit results will be reviewed by the IDT during the monthly QAPI meeting for further recommendations Monitored by: Don or Designee	

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F 554	Continued From page 6	F 554		

the nebulizer container. RN-A handed the nebulizer container to R3, turned the nebulizer machine on and informed R3 she would be back in ten minutes to shut the machine off. RN-A exited R3's room, returned to medication cart and signed off that the DuoNeb had been administered. RN-A stated "R3 is only taking this medication for seven days so she just does it by herself".

During an observation on 2/12/24 at 11:49 a.m., RN-A returned to R3's room, knocked on door, entered R3's room and shut the nebulizer machine off. RN-A took the nebulizer container from R3, disassembled the nebulizer container, washed it out in the sink and placed it on a wash cloth next to the nebulizer machine to dry.

During an interview on 2/13/24 at 8:59 a.m., R3 stated she she had been receiving DuoNeb treatments since she acquired an illness. R3 indicated she did not know how often she was receiving the medication. R3 stated she had not been taught how to use the nebulizer machine. R3 verified nursing staff did not remain in the room with her while the treatment was being administered. She stated nursing staff turned the nebulizer machine on, handed her the nebulizer and left the room right after handing it to her. R3 indicated nursing staff returned to her room once the nebulizer treatment was completed to turn the machine off.

During an interview on 2/13/24 at 9:27 a.m., RN-A verified R3's order for DuoNeb's for seven days. RN-A confirmed she set R3's nebulizer treatment up, handed the nebulizer container to R3, turned the nebulizer machine on and set her timer to return to R3's room when the treatment was

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F 554	Continued From page 7 finished. RN-A sated she had checked on R3 however did not stay in R3's room during the entire administration. RN-A confirmed R3 did not have a SAM assessment completed and did not have an order for self administration. RN-A stated if a resident did not have a SAM assessment or an order for self administration, staff were required to stay in the room during the entire administration. During an interview on 2/13/24 at 1:24 p.m., director of nursing (DON) confirmed the above findings and indicated staff should have been following the facility policy. DON stated her expectations were staff would assess residents for the ability to complete self administration of medications. DON indicated if the resident did not have a SAM assessment or physician's orders, staff were expected to remain with the resident during the entire administration. Facility policy titled Self Administration of Medications revised 1/23, indicated an individual resident may self-administer medication if the resident requested and the interdisciplinary team had determined that self-administration was clinically appropriate. Staff were to complete a self-administration of medication tool. If the team determined that self-administration was clinically appropriate, staff would obtain a physician's order for resident to self-administer each specific medication that the resident had been qualified to self-administer. In addition, staff would update the resident's care plan to indicate the resident's choice to self-administer medications.	F 554		
F 577 SS=C	Right to Survey Results/Advocate Agency Info CFR(s): 483.10(g)(10)(11)	F 577		3/4/24

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F 577	Continued From page 8 §483.10(g)(10) The resident has the right to- (i) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility; and (ii) Receive information from agencies acting as client advocates, and be afforded the opportunity to contact these agencies. §483.10(g)(11) The facility must-- (i) Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility. (ii) Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request; and (iii) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public. (iv) The facility shall not make available identifying information about complainants or residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure three years of survey results were readily accessible to residents and visitors. This deficient practice had the potential to affect all 33 residents currently residing in the facility. Findings include: During an observation on 2/12/24 at 10:00 a.m., a survey results book was located affixed to the wall in the main lobby of the facility, by the front	F 577	Immediate Corrective Action: The survey book was updated with the results from the 8/8/2023 complaint investigation. Corrective Actions as it Applies to Others: An audit of the survey book was conducted to ensure three years of survey results were readily accessible to residents and visitors. Prevent Recurrence:	

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F 577	Continued From page 9 door. The survey results book had survey results from the 2019, 2020, 2021, 2022, and 2023 recertification surveys. The survey results book lacked the deficiency from the 8/8/23, complaint investigation. During an interview on 2/12/24 at 10:23 a.m., assistant administrator (AA)-1 verified the 8/8/23, deficiency from the complaint investigation was not located in the survey book. During an interview on 2/12/24 at 10:31 a.m., administrator stated he was unaware the deficiencies from complaint investigations needed to be included in the survey results book for residents to review when requested. Review of a facility policy titled Examination of survey results dated May 2020, identified the three preceding years of surveys, certifications, and complaint investigations completed by the state and/or federal surveyors would be available for review.	F 577	The policy and procedure for Examination of Survey Results was reviewed and remains current. Staff will be educated on the policy by 3/4/2024. Date of Alleged Compliance: 3/4/2024. Ongoing Monitoring: Random weekly audits of the survey book will be conducted to ensure that three years of survey results are available and accessible to residents and visitors. Audits will be conducted as follows: " 3x/week for 2 weeks " 2x/week for 2 weeks " Weekly x 4 weeks A summary of the audit results will be reviewed by the IDT during the monthly QAPI meeting for further recommendations Monitored by: Administrator or Designee	
F 583 SS=E	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.	F 583		3/4/24

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F 583	Continued From page 10 §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure confidential information was not readily available for all residents, staff, and visitors to view for 17 of 17 residents (R26, R3, R21, R28, R86, R6, R11, R22, R5, R14, R27, R8, R31, R9, R30, R20 and R10) residing on the 100's wing whose confidential information was observed to be visible on two open computer screens and a resident care sheet in a common area. Findings include: During an observation on 2/12/24 at 11:26 a.m., a resident care sheet for the 100's unit was	F 583	Immediate Corrective Action: The EMARs were locked, and the resident care sheet was covered to prevent unauthorized individuals from viewing confidential resident information. Corrective Action as it applies to others: A visual audit was conducted to ensure that other EMAR screens were locked, and resident care sheets were safeguarded to prevent the unauthorized viewing of confidential resident information. Prevent recurrence:	

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F 583	Continued From page 11 observed on top of the medication cart with the sheet facing right side up and information visible to anyone walking by. Resident care sheet identified first and last names for R26, R3, R21, R28, R86, R6, R11, R22, R5, R14, R27, R8, R31, R9, R30, R20 and R10 , room numbers, vitals and medication notes. Registered nurse (RN)-A returned to the medication cart at 11:31 a.m., wrote on the resident care sheet, and kept the care sheet information right side up with the information still visible. RN-A opened electronic medical record (eMAR) documentation system, moved over to another medication cart and opened the eMAR documentation system. Resident information including names, room numbers and diagnoses from residents who resided in the 100's wing as noted above, were visible on the computer screen. RN-A walked away from both medication carts, entered the medication room behind the nurses's station and closed the door. The screen from the eMAR remained open and the care sheet remained visible to others who walked by. RN-A returned to the medications carts, walked around the front of both medication carts and down the hall into the therapy room while the screen from the computer and care sheet continued to be visible to others who walked by. RN-A returned to the medication carts at 11:36 a.m., reviewed the open eMAR documentation system on the medication cart.. RN closed the laptop on the medication cart. RN-A moved over to the other medication cart and started to dispense medications. RN-A dispensed medications, locked the laptop screen on the medication cart, placed a kleenex box over the care sheet and walked down the 100's hallway. Both medication carts were located in front of the nurses station at the end of the 100's wing hallway. Five unidentified staff and two	F 583	The policy for Resident Privacy and Confidentiality was reviewed and remains current. Staff will be educated on the policy by 3/4/2024. Date of Alleged Compliance: 3/4/2024. Ongoing Monitoring: Random visual audits will be conducted to ensure that EMAR screens are locked, and resident care sheets are safeguarded to maintain confidentiality. Audits will be conducted as follows: " 5x/week for 2 weeks " 3x/week for 2 weeks " 2x/week for 2 weeks " Weekly x 4 weeks A summary of the audit results will be reviewed by the IDT during the monthly QAPI meeting for further recommendations. Monitored by: DON or designee	

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F 583	Continued From page 12 visitors were observed passing the front of both medication carts during the observation. During an interview on 2/13/24 at 9:31 a.m., RN-A indicated she was unaware she had left the residents' care sheet visible and computer screens open when she walked away from the medication carts. RN-A confirmed she walked away from both carts to provide assistance elsewhere. RN-A revealed she used the resident care sheet to track residents' vitals and store information about medication administration. RN-A indicated it was important to ensure residents' personal information was not visible to others and RN-A would be more cautious with personal information. During an observation on 2/12/24 at 11:21 a.m., RN-B removed R10's medications from the medication cart located on the 200's wing. RN-B walked away from the medication cart while the computer screen remained open with R10's eMAR visible. RN-B went into the day room to administer R10's medications. During that time RN-B administered R10's medications, one resident wheeled up to the medication cart and had the potential to see R10's confidential eMAR information. During an observation on 2/12/24 at 11:26 a.m., RN-B removed R20's medication from the the medication cart. RN-B walked away from the mediation cart while R20's eMAR remained open. During the time R20's eMAR was open and unattended, one resident walked by the medication cart and had the potential to view	F 583		

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F 583	Continued From page 13 R20's confidential eMAR information. During an interview on 2/14/24 at 2:42 p.m., RN-B stated her normal process was to close the computer or lock the computer screen when she left the medication chart. RN-B verified she did not keep R10's and R20's eMAR information confidential when she left the computer screens open and visible and walked away. During an interview on 2/13/24 on 1:26 p.m., director of nursing (DON) confirmed the above findings and indicated due to Health Insurance Portability and Accountability Act of 1996,(HIPAA) computer screens should always be locked and care sheets should not be left visible. DON stated her expectations were staff would follow the policy for privacy. Review of facility policy titled Privacy and Confidentiality revised 11/16, identified the resident had a right to personal privacy and confidentiality of his or her personal and medical records. The resident had a right to secure and confidential personal and medical records. Resident records were limited to the use of the staff and would be safeguarded at all times to ensure confidentiality. Review of facility policy titled Medication Administration revised 11/22, identified staff were to place medication administration books or laptop/computer on top of cart; when unattended records should be closed for privacy.	F 583		
F 658 SS=E	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans	F 658		3/4/24

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F 658	Continued From page 14 The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to follow standards of practice related to medication administration for 1 of 1 resident (R6) observed to receive an inhalation medication, and 4 of 4 residents (R4, R13, R14, R15) observed for medication administration. Findings include: R6's quarterly Minimum Data Set (MDS) dated 11/24/23, identified R6 was cognitively intact, and had diagnoses which included: chronic obstructive pulmonary disease (COPD), respiratory failure and heart failure. Identified R6 received oxygen therapy. R6's comprehensive care plan dated 2/13/24, identified R6 required staff assistance with dressing, hygiene and transfers. Indicated R6 had diagnosis of COPD, with goals which included: would be free of serious complications related to respiratory disease and following doctor of medicine (MD) orders. R6's Order Summary Report signed 1/16/24, identified Fluticasone-Salmeterol (steroid) Aerosol Powder Breath Activated 250-50 microgram (MCG)/dose-1 puff inhale orally two times a day for COPD. Rinse mouth after each use. During an observation on 2/13/24 at 7:13 a.m.,	F 658	Immediate Corrective Action: A visual inspection was conducted to assess oral health for R6. RN-A received reeducation regarding the administration of medications in accordance with MD orders. RN-C received reeducation regarding the administration of resident medications in accordance with accepted standards of practice. Corrective Action as it applies to others: An audit was conducted for other residents that receive inhaled steroid medications to ensure the administration record directs staff to assist the resident to rinse mouth after each use. Prevent recurrence: The policy for Medication Administration was reviewed and remains current. Staff will be educated on the policy by 3/4/2024. Date of Alleged Compliance: 3/4/2024. Ongoing Monitoring: Random medication pass audits will be conducted to ensure staff assist or remind residents to rinse after the use of inhaled steroid medications, and to ensure staff prepare medications at the time of administration. Audits will be conducted	

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F 658	Continued From page 15 R6 was dressed in street clothes seated in her electric wheelchair in front of a table in her room. Registered nurse (RN)-A entered R6's room carrying an oxygen tank, which she applied to the back of R6's wheelchair. RN-A observed R6 take her oral medications from two paper medication cups, while taking sips of water. Nursing assistant (NA)-A entered the room and asked R6 if she needed anything. RN-A instructed R6 to take two inhalers, one which included the Fluticasone-Salmeterol inhaler R6 took the puffs of inhalers as prescribed. RN-A took the two inhalers and exited the room. R6 was not observed to rinse her mouth out and RN-A had not instructed R6 to rinse her mouth as ordered after taking the Fluticasone-Salmeterol inhaler. During an interview on 2/13/24 at 9:16 a.m., R6 indicated she received the Fluticasone-Salmeterol inhaler twice a day, which she had used at home prior to coming to the facility. R6 confirmed she had not rinsed her mouth after receiving the inhaler earlier that morning. R6 stated she was aware she was supposed to rinse her mouth after its use and had rinsed her mouth after using the inhaler once in a while at her home. R6 indicated she had not been reminded by facility staff to rinse her mouth out after the inhaler administration for a couple of years. During an interview on 2/13/24 at 9:43 a.m., RN-A confirmed she had not instructed R6 to rinse her mouth after receiving the Fluticasone-Salmeterol inhaler. RN-A stated she had not seen the order instructions to rinse mouth after use. RN-A indicated it was important to rinse the mouth after a steroid inhaler was received to prevent mouth sores.	F 658	as follows: " 5x/week for 2 weeks " 3x/week for 2 weeks " 2x/week for 2 weeks " Weekly x 4 weeks A summary of the audit results will be reviewed by the IDT during the monthly QAPI meeting for further recommendations. Monitored by: DON or designee	

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F 658	Continued From page 16 During a phone interview on 2/13/24 at 11:45 a.m., pharmacy consultant (PC)-A stated it was very important to rinse the mouth after using a Fluticasone-Salmeterol inhaler because it was a steroid. PC-A indicated it could cause Thrush, a fungal infection inside the mouth. PC-A stated the label on the Fluticasone-Salmeterol inhaler should include instructions to rinse after use. PC-A indicated it was her expectation that nursing staff would instruct the resident to rinse their mouth after use, and if they were unable to rinse their mouth, staff would use a toothette to cleanse their mouth after use. PC-A stated she would include reminders in her monthly report to the facility. During an interview and observation on 2/13/24 at 12:14 p.m., director of nursing (DON) confirmed R6's Fluticasone-Salmeterol inhaler label included instructions to rinse mouth after use. DON stated it was important for residents to rinse their mouth after use to prevent problems with their mouth. DON stated her expectation was for nursing staff to follow R6's orders. R6's Fluticasone-Salmeterol inhaler box instructions which included: to rinse your mouth with water after breathing in the medicine. Spit out the water. Do not swallow it. R6's Fluticasone-Salmeterol inhaler pharmacy label instructions included: to inhale 1 puff into lungs twice a day (BID), rinse mouth after use. The facility policy titled Medication Administration revised 11/22, identified it was the community's policy to administer all medications and treatments in a safe and effective manner. The policy procedure instructions included staff were	F 658		

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F 658	Continued From page 17 to read medication orders on the medication sheet and to compare the label with medication sheet. The policy lacked instructions for inhaled medication administration. In addition, the policy stated to proceed with the cart to the resident's room area, for solid medications, remove medication container (blister pack or bottle) and compare label with medication sheet. Place appropriate dosage into medication cup. Re-read label and medication sheet and return drug to its proper location (triple check). Administer medication to resident. Repeat procedure with each resident who was to receive medications. R4's physician order summary dated 1/31/24, identified the following medications were ordered: Antacid suspension 30 ml by mouth every six hours as needed. Cranberry tablet 400 mg by mouth daily. Dilaudid 2 mg by mouth twice daily. Doxepin 25 mg by mouth daily. Famotidine 20 mg by mouth twice daily. Fetzima 60 mg by mouth once daily. Haloperidol 2 mg by mouth once daily and 3 mg by mouth once daily. Levothyrozine 150 mcg by mouth once daily. Milk of Magnesia 30 cc	F 658		

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F 658	Continued From page 18 by mouth every 24 hours as needed. Miralax 17 gm by mouth once daily. Senna Plus one tablet by mouth twice daily. Seroquel 200 mg by mouth once daily and 100 mg by mouth once daily. Simethicone 125 mg by mouth every four hours as needed. Trazodone 150 mg by mouth once daily. Tylenol 650 mg by mouth twice daily and twice daily as needed. Vistaril 50 mg by mouth three times daily. R10's physician order summary dated 12/19/23, identified the following medications were ordered: Buspirone 7.5 mg by mouth twice daily. Depakote sprinkles 250 mg by mouth at bedtime daily. Donepezil 5 mg by mouth daily. Effexor XR 225 mg by mouth daily. Lactulose 30 ml by moth daily and every 24 hours as needed. Levothyroxine 225 mcg by mouth daily. Lyrica 150 mg by mouth twice daily. Milk of Magnesia 30 ml by mouth every 24 hours as needed. Miralax 17 gm by mouth twice daily. Morphine sulfate oral solution 2.5 mg buccally (placing the medication between the gum and cheek) every two hours as needed and three times a daily. Namenda 10 mg by mouth twice daily. Oyster Calcium 500 mg by mouth three times a day. Relafen 750 mg by mouth twice daily. Risperidone 0.25 mg by mouth once daily and 0.5 mg by mouth once daily. Senna-Plus two tablets by mouth twice daily. Tylenol 650 mg by mouth four times a day. Vitamin D 2000 mg by mouth daily. R13's physician order summary dated 2/9/24, identified the following medications wre ordered: Senna Plus two tablets by mouth as needed. Remeron 15 mg by mouth daily. Metoprolol 25 mg by mouth twice daily. Metamucil one packet by mouth as needed daily. Melatonin 6 mg by mouth daily at bedtime. Magnesium Oxide 400	F 658		

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F 658	Continued From page 19 mg by mouth daily. Magnesium Citrate 10 ounces by mouth as needed every seven days if no bowel movement. Fluoxetine 80 mg by mouth once daily. Robitussin Mucus plus Chest Congestion 10 ml by mouth every four hours as needed. Glycopyrrolate 1 mg by mouth every six hours as needed. Furosemide 40 mg by mouth once daily. Divalproex Sodium 500 mg by mouth once daily. Ferrous Sulfate 325 mg by mouth once daily-do not crush. Metronidazole 500 mg by mouth twice daily for three days beginning 2/9/24. Eliquis 5 mg by mouth twice daily. Ciprofloxacin 500 mg by mouth twice daily for three days beginning 2/9/24. Aspirin 81 mg by mouth once daily. R14's physician order summary dated 12/19/23, identified the following medications were ordered: Aspirin 325 mg by mouth daily. DocQLace 100 mg by mouth daily. I-Vite multi-vitamin by mouth twice daily. Keppra 500 mg by mouth in the morning and 750 mg by mouth in the evening. Lipitor 10 mg by mouth daily. Metformin 500 mg twice daily. Norvasc 10 mg by mouth daily. Proscar 5 mg by mouth daily. Tylenol 650 mg by mouth every six hours as needed. During an observation and interview on 2/11/24 at 4:09 p.m., RN-C unlocked medication cart, opened second drawer from top which revealed two white paper medication cups with multiple medications already present in both of them. The paper cups were located at the rear of the drawer, sliding back and forth when drawer opened and closed, and were labeled with black marker and was illegible. RN-C stated, "I am the only nurse on the 200 and 300 wing, you can watch my medication pass however I have many of them already dished up." RN-C stated the two paper medication cups were for R13 and R14.	F 658		

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F 658	Continued From page 20 RN-C indicated he was unable to verify what medications were in each residents pre-dished medication cups and, stated, "I would have to look up the residents medication orders to see what is ordered for the evening." In addition, RN-C indicated he was unable to verify what the black marker identified on the cups and stated, "there are certain residents that I always pre-dish medications early and will give the medications later when they are due to be given." One medication cup was observed to have crushed medications only. RN-C unlocked the controlled medication drawer on the right side of medication cart which revealed two paper medication cups with multiple medications in each cup. The cups moved around in the drawer when opened, were labeled with a black marker which was illegible. RN-C stated the medication cups were for R4 and R10 and locked in the controlled drawer due to having controlled substances ordered. When asked why medications were pre-dished, RN-C stated, "That's just how it is done in the nursing home." RN-C indicated he was unable to verify what medications were in each residents pre-dished medication cup without checking each residents medications orders. During an interview on 2/13/24 at 2:13 p.m., pharmacy consultant confirmed the standard of practice recommended not to dish up medications prior to administering them and medications should be given closest to the time ordered. During an interview and observation on 2/13/24 at 12:14 p.m., director of nursing (DON) confirmed R6's Fluticasone-Salmeterol inhaler label included instructions to rinse mouth after use. DON stated it was important for residents to rinse	F 658		

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F 658	Continued From page 21 their mouth after use to prevent problems with their mouth. DON stated her expectation was for nursing staff to follow R6's orders. During an interview on 2/13/24 at 2:43 p.m., DON stated the expectation for nursing staff was they would not setup medications ahead of time and would not dish up narcotics or crush medications ahead of time. The practice could result in medication errors including a resident receiving the wrong medication and possible injury. R6's Fluticasone-Salmeterol inhaler box instructions which included: to rinse your mouth with water after breathing in the medicine. Spit out the water. Do not swallow it. R6's Fluticasone-Salmeterol inhaler pharmacy label instructions included: to inhale 1 puff into lungs twice a day (BID), rinse mouth after use. The facility policy titled Medication Administration revised 11/22, identified it was the community's policy to administer all medications and treatments in a safe and effective manner. The policy procedure instructions included staff were to read medication orders on the medication sheet and to compare the label with medication sheet. The policy lacked instructions for inhaled medication administration. In addition, the policy stated to proceed with the cart to the resident's room area, for solid medications, remove medication container (blister pack or bottle) and compare label with medication sheet. Place appropriate dosage into medication cup. Re-read label and medication sheet and return drug to its proper location (triple check). Administer medication to resident. Repeat procedure with each resident who was to receive medications. Review of the facility policy titled medication	F 658		

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F 658	Continued From page 22 labeling and storage revised 11/22, lacked instructions on pre-dishing and storing medications in the medication cart prior to medication administration. Review of the facility policy titled medications-controlled revised 11/22, identified controlled substances were signed out upon dispensing of the medication.	F 658		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced	F 761		3/4/24

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F 761	Continued From page 23 by: Based on observation, interview, and document review, the facility failed to ensure insulin pens were accurately dated when opened for 2 of 3 residents (R11 and R136) who received insulin injections and insulin pens were disposed of past expiration date for 1 of 3 residents (R9) who received insulin injections. Further, the facility failed to ensure correct labeling on one refrigerated medication in 1 of 2 refrigerators reviewed for medication storage. Findings include: R11 R11's quarterly review Minimum Data Set (MDS) dated 12/21/23, indicated R11 had diagnoses which included diabetes mellitus (DM), malnutrition and anxiety. Indicated R11 required moderate assistance of one staff with toileting and personal hygiene. R11's signed physician's orders from 1/24/24 to 2/6/24, indicated R11 a physician's order for lantus (long acting insulin medication to control blood sugar) 10 units in the morning (AM) and 10 units at bedtime (HS) / evening (PM). R11's order audit report from 1/30/24, indicated R11's order was for Insulin Glargine Subcutaneous Solution 100 units/ml, inject 10 units subcutaneously two times a day for DM. R9 R9's significant change MDS dated 2/5/24, indicated R9 had diagnoses which included end stage renal disease (disease of the kidneys), DM	F 761	Immediate Corrective Action: The insulin pens for R11, R36 and R9, and the Mantoux solution were discarded. Corrective Action as it applies to others: An audit was conducted for other residents to ensure insulin pens were dated when opened and not beyond their expiration date. An audit of Medication storage areas, including refrigerated medications, was completed to ensure medications were labeled, dated, and stored in accordance with manufacturer□s recommendations. Prevent recurrence: The policy for Storage of Medications was reviewed and remains current. Staff will be educated on the policy by 3/4/2024. Date of Alleged Compliance: 3/4/2024. Ongoing Monitoring: Random medication storage audits will be conducted to ensure that medications are labeled, dated, and stored according to manufacturer□s recommendations. Audits will be conducted as follows: " 5x/week for 2 weeks " 3x/week for 2 weeks " 2x/week for 2 weeks " Weekly x 4 weeks A summary of the audit results will be reviewed by the IDT during the monthly QAPI meeting for further recommendations.	

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F 761	Continued From page 24 and anxiety. Indicated R9 required extensive assistance of one staff with toileting, transfers and personal hygiene. R9's signed physician's orders dated 1/16/24, lacked an order for Basaglar KwikPen Subcutaneous Solution 100 units/ml (long acting insulin medication to control blood sugar. R9's order audit report from 12/19/23, indicated R9's order for Basaglar KwikPen Subcutaneous Solution 100 units/ml, inject 7 unites subcutaneous one time a day for type 2 DM, hold and notify provider if blood sugar (BS) is below 80 had been discontinued. R136 R136's signed Order Summary Report dated 2/14/24, indicated R136 had a diagnosis of type 2 diabetes mellitus (DM) and had a physician's order for Insulin Glargine Subcutaneous Solution 100 units/ml (long acting insulin medication to control blood sugar, inject 25 units subcutaneously at bedtime for DM. During an observation and interview on 2/11/24 at 4:15 p.m., while completing medication storage of the medication carts with registered nurse (RN)-B, the top drawer of medication cart A1 contained an Insulin Glargine Subcutaneous Solution 100 units/ml insulin pen for R136 which was not dated. In the top drawer of medication cart A2, an Insulin Glargine Subcutaneous Solution 100 units/ml insulin pen for R11 was noted with no date and a Basaglar KwikPen Subcutaneous Solution 100 units/ml insulin pen for R9 which identified it had been opened on 12/15/23 and contained no expiration date. RN-B	F 761	Monitored by: DON or designee	

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F 761	Continued From page 25 confirmed the outdated insulin pen and undated insulin pens . RN-B stated R11, R9 and R136 had current orders for insulin and stated "yes we are giving them." RN-B indicated her usual process had been to open insulin pens and date them right away. RN-B stated she thought insulin pens were good for 30 days after opening and the facility used a cheat sheet do confirm expiration dates. During an interview on 2/13/24 at 2:13 p.m., pharmacy consultant (PC) indicated it was the responsibility of the facility to ensure all insulin pens were dated and discarded following manufacturer's recommendations. PC indicated Basaglar Solution Insulin pens, Lantus Solostar Solution Insulin pens and Insulin Glargine pens expired after 28 days being open at room temperature. PC stated her expectations were for the facility to have medications properly labeled with resident information and to follow manufacturer's recommendations for expiration dates. During an observation/interview on 2/11/24 at 4:55 p.m., registered nurse (RN)-C entered medication storage room, opened refrigerator and took out a box with a vial of Mantoux solution, (Tuberculin Purified Protein Derivative), verified the solution had been opened and accessed. RN-C confirmed the box and the vial did not have a date on them of when opened and placed into	F 761		

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F 761	Continued From page 26 use. RN-C verified a label on the box and the vial stated to date when opened and discard after being opened for 30 days. During an interview on 2/13/24 at 2:13 p.m., pharmacy consultant (PC) indicated it was the responsibility of the facility to ensure all insulin pens were dated and discarded following manufacturer's recommendations. PC indicated Basaglar Solution Insulin pens, Lantus Solostar Solution Insulin pens and Insulin Glargine pens expired after 28 days being open at room temperature. PC stated her expectations were for the facility to have medications properly labeled with resident information and to follow manufacturer's recommendations for expiration dates. In addition, pharmacy consultant indicated the pharmacy applied a label on the Mantoux box and vial as a reminder to staff to date once opened and discard after 30 days of being opened. Pharmacy consultant verified the expectation of nursing was to date the Mantoux solution once opened and discard after 30 days of being opened. Stated per manufacturer direction, the stability of tuberculin purified protein derivative was for 30 days after opened and would then be discarded. During an interview on 2/13/24 at 2:43 p.m., director of nursing (DON) confirmed the above findings and indicated her expectations were for staff to follow facility policy and manufacturer's recommendations. DON stated she would expect staff to date all insulin pens when they were opened and discard when they expired. DON indicated she would expect all nursing staff passing medications to review expiration dates during medication passes. DON stated the facility did not have a process in place to ensure	F 761		

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F 761	Continued From page 27 medications were being stored properly. In addition, DON verified the expectation of nursing staff would be to date the box and vial of Mantoux solution once opened. DON stated the solution would not be safe to use after 30 days of being opened. Review of facility policy titled Medication Labeling and Storage revised 11/22, medications were labeled in accordance with state and federal laws and include the expiration date when applicable. Labels included the residents name, drug name, dose, frequency, route instructions for use, and expiration date. Review of manufactures specifications for In-use Pen, store the pen you are currently using at room temperature [up to 86° Fahrenheit (F) (30°Celsius (C))] and away from heat and light. Throw away the pen you are using after 28 days, even if it still has insulin left in it. Review of manufacturer's specific for use, 3 ml single-patient-use SoloStar in use pen expires 28 days after opening. Review of manufacturer's specifications for use, 3 ml single-patient-use insulin glargine in use pen expires 28 days after opening. Review of facility policy titled, Drugs and Biological Storage-Labeling, dated 4/1/08, identified drugs and biologicals were to labeled in accordance with current accepted professional standards, including the appropriate accessory and cautionary instructions and the expiration data when applicable.	F 761		
F 851 SS=F	Payroll Based Journal	F 851		3/4/24

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F 851	Continued From page 28 CFR(s): 483.70(q)(1)-(5) §483.70(q) Mandatory submission of staffing information based on payroll data in a uniform format. Long-term care facilities must electronically submit to CMS complete and accurate direct care staffing information, including information for agency and contract staff, based on payroll and other verifiable and auditable data in a uniform format according to specifications established by CMS. §483.70(q)(1) Direct Care Staff. Direct Care Staff are those individuals who, through interpersonal contact with residents or resident care management, provide care and services to allow residents to attain or maintain the highest practicable physical, mental, and psychosocial well-being. Direct care staff does not include individuals whose primary duty is maintaining the physical environment of the long term care facility (for example, housekeeping). §483.70(q)(2) Submission requirements. The facility must electronically submit to CMS complete and accurate direct care staffing information, including the following: (i) The category of work for each person on direct care staff (including, but not limited to, whether the individual is a registered nurse, licensed practical nurse, licensed vocational nurse, certified nursing assistant, therapist, or other type of medical personnel as specified by CMS); (ii) Resident census data; and (iii) Information on direct care staff turnover and tenure, and on the hours of care provided by each category of staff per resident per day (including,	F 851		

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F 851	Continued From page 29 but not limited to, start date, end date (as applicable), and hours worked for each individual). §483.70(q)(3) Distinguishing employee from agency and contract staff. When reporting information about direct care staff, the facility must specify whether the individual is an employee of the facility, or is engaged by the facility under contract or through an agency. §483.70(q)(4) Data format. The facility must submit direct care staffing information in the uniform format specified by CMS. §483.70(q)(5) Submission schedule. The facility must submit direct care staffing information on the schedule specified by CMS, but no less frequently than quarterly. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to submit complete and accurate data for staffing information based on payroll during Quarter 4 (July 1st-September 30th, 2023) to the Centers for Medicare and Medicaid Services (CMS), according to specifications established by CMS. This deficient practice had the potential to affect all 33 residents residing in the facility. Finding include: Reviews of the Payroll-Based Journal Report (PBJ) Casper report 1705D Quarter 4 from 7/1/23-9/20/23, identified excessively low weekend staffing.	F 851	Corrective Action: A review of the policy for submitting PBJ data submission was reviewed and remains current. The Administrator, Director of Nursing, and Assistant Administrator were re-educated on the policy and requirements for the submission of complete and accurate direct care staffing information, including information for agency and contract staff, based on payroll and other verifiable and auditable data in a uniform format according to specifications established by CMS. Prevent Recurrence:	

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F 851	Continued From page 30 Review of the staffing timecards identified staff, their position, and total hours worked. During the review of time cards from 7/1/23-9/20/23, revealed a shortage on 7/23/23, from 3:20 p.m. to 6:54 p.m. On 2/12/24 at 2:47 p.m., the administrator provided a change of schedule slip for 7/23/23. The change of schedule slip identified the director of nursing (DON) came in to cover the shift for registered nurse (RN)-D. The change of schedule slip was signed by DON and RN-D on 7/23/23. A review of the facility's schedule slips and timecards identified discrepancies with the low weekend hours between facility schedules, timecards and the PBJ report. During an interview on 2/12/24 at 10:23 a.m., the administrator stated the DON covered the shift on 7/23/23. The DON received a salary and did not punch a time card when she worked. The administrator verified without the DON providing a timecard punch, the date submitted to the PBJ was inaccurate. Review of a policy titled PBJ-Payroll Based Journal dated May 2020, indicated the community would electronically submit the CMS complete and accurate direct care staffing information, including information for agency and contract staff, based on payroll and other verifiable and auditable data in a uniform format according to specifications established by CMS.	F 851	When administrative staff provide direct patient care services, administrative staff hours will be entered into the payroll system in accordance with CMS guidelines. Ongoing Monitoring: The administrator will audit the quarterly submission of Payroll Based Journal data. A summary of the audit results will be reviewed by the IDT during the monthly QAPI meeting for further recommendations Date of Alleged Compliance: 3/4/2024. Monitored by: Administrator or designee	
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)	F 880		3/4/24

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F 880	Continued From page 31 §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation,	F 880		

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F 880	Continued From page 32 depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure personal laundry and linen were transported in a manner that prevented risk of contamination for 3 of 3 hallways observed for linen transportation. In addition, the facility failed to ensure hand hygiene occurred during the laundry and linen distribution. Further, the facility failed to ensure infection prevention practices including hand hygiene were followed during wound cares for 1 of 1 residents (R13) observed for wound cares.	F 880	Immediate Corrective Action: HA-B and HA-A received reeducation on the process for transporting and handling linen in a manner to prevent the spread of infection including when to perform hand hygiene. RN-C received reeducation on the process for performing wound care in a manner to prevent the spread of infection and when to perform hand hygiene. Prevent Recurrence:	

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F 880	Continued From page 33 Findings include: Review of Centers for Disease Control (CDC) guidance, Appendix D - Linen and Laundry Management updated 5/4/23, identified linens must be sorted, packaged, transported, and stored in a manner that prevented risk of contamination by dust, debris, soiled linens or soiled items. Review of Centers for Disease Control (CDC) guidance titled Hand Hygiene in Healthcare Settings reviewed 4/28/23, identified hand hygiene protected residents receiving care and helped prevent the spread of germs. During an observation on 2/12/24 at 9:24 a.m., housekeeping aid (HA)-B took one pair of pants and one shirt out of the uncovered linen cart, brought into R30's room, placed in closet, brought two hangers out of the room and placed the hangers on the outside handle of the cart. HA-B pushed the uncovered linen cart down the 100's hallway, took one pair of pants, one shirt out of the linen cart, brought into R5's room, placed in closet, brought two hangers out of the room and placed them on the outside linen cart handle. HA-B pushed the uncovered linen cart down the hallway, took one shirt, one pair of pants out of the linen cart, brought into R22's room, placed in closet and walked back to the cart. HA-B pushed the uncovered linen cart down the hallway to the 200's rooms. HA-B took two shirts from the linen cart, entered R10's room, placed into the closet, grabbed two hangers from closet and placed on linen cart handle. HA-B entered R1's room, picked a pair of socks off the floor, placed them into the hamper in R1's room, grabbed two hangers from closet and placed them on the linen	F 880	The policies for linen handling and hand hygiene were reviewed and remain current. Facility staff will be reeducated on the policies by 3/4/2024. Date of Alleged Compliance: 3/4/2024. Ongoing Monitoring: Random hand hygiene and linen handling audits will be conducted to ensure ongoing compliance with proper infection control measures for linen handling and hand hygiene. Audits will be conducted as follows: " 5x/week for 2 weeks " 3x/week for 2 weeks " 2x/week for 2 weeks " Weekly x 4 weeks A summary of the audit results will be reviewed by the IDT during the monthly QAPI meeting for further recommendations. Monitored by: DON or designee	

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F 880	Continued From page 34 cart handle. HA-B continued to push the uncovered linen cart down the hallway past R24 in a wheelchair, grabbed one shirt, one pair of pants from linen cart, brought into R25's room and placed into closet. R24 entered R25's room in wheelchair, HA-B used both wheelchair handles and wheeled R24 out of R25's room into R24's room. HA-B exited R24's room, went to the linen cart, grabbed one shirt, one pair of pants out of the linen cart, brought into R24's room and put them in the closet. HA-B grabbed two hangers from R24's room, assisted R24 with her glasses, exited R24's room and placed the hangers on the handle of the linen cart. An unknown resident was pushed by the open linen cart in a bath chair while HA-B removed one blanket from the linen cart, placed on her knee, grabbed another blanket from the linen cart and placed under her left arm. HA-B walked down the hallway with both blankets, entered R7's room, placed one blanket in the chair, exited room, walked into R1's room, placed the blanket in the chair and exited the room. HA-B walked back to the linen cart, pushed the uncovered linen chart down the hallway. HA-B removed one shirt and walked back down the hall and placed R7's shirt in the closet. HA-B returned to the linen cart and pulled the uncovered linen cart down the hallway to the 300's rooms. HA-B grabbed one shirt, one pair of pants from the linen cart, entered R18's room, placed clothing in closet, grabbed two hangers from closet and placed them on the linen cart handle. HA-B moved the uncovered linen cart further down the hallway, grabbed one shirt, one pair of pants, brought into R20's room, placed them in closet, grabbed two hangers from closet and hung them on the linen cart handle. HA-B grabbed one shirt, one pair of pants, brought into R13's room, placed them in closet, removed two hangers from	F 880		

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F 880	Continued From page 35 closet and placed them on the linen cart handle. HA-B pulled the cover down over the cart and pushed the cart back to the laundry room. HA-B did not sanitize her hands and the cart remained uncovered during the entire observation. During an observation on 2/12/24 at 2:03 p.m., housekeeping supervisor (HA)-A was observed removing laundry from the laundry cart, delivered laundry to R2's room, placed laundry in R2's closet and exited R2's room. HA-A removed laundry from the cart, did not sanitize hands, delivered laundry to R4's room, placed laundry in R4's closet and exited R4's room. HA-A removed laundry from cart, knocked on R24's door, placed laundry in R24's closet and exited R24's room. HA-A returned to laundry cart in hall, removed laundry from cart, knocked on R25's door, placed laundry in R25's closet and exited R25's room. HA-A removed laundry from cart, delivered laundry to R29's room, placed laundry in R29's closet, assisted R29 to put glasses on, exited R29's room and returned to laundry cart without sanitizing hands. HA-A removed laundry from cart, knocked on R13's door, touched handles on R13's wheelchair to move out of way of closet, placed laundry in R13's closet and exited R13's room. HA-A removed laundry from cart, knocked on R7's door, placed laundry in R7's closet and exited R7's room. HA-A stopped in R1's room and visited with R1, exited R1's room with dirty laundry, returned to laundry cart and placed dirty linen on bottom shelf of laundry cart. HA-A removed laundry from cart, knocked on R23's door, opened door, placed laundry in R23's closet and exited R23's room. HA-A pushed laundry cart down hall, stopped at linen closet in hall,	F 880		

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F 880	Continued From page 36 opened linen door, delivered four pairs of gripper socks to shelf in closet, closed linen door and pushed laundry cart down hall. HA-A removed laundry from cart, knocked on R18's door, placed laundry in R18's closet, exited R18's room and went directly to R20's room with the rest of the laundry observed being carried. HA-A knocked on R20's door, opened door, placed laundry in R20's closet and exited R20's room. R18 asked HA-A why she had not received lunch and was hungry. HA-A entered R18's room, visited with R18, then went into the dining room toward the kitchen and returned a few minutes later to R18's room followed by a dietary staff who brought food. HA-A pushed laundry cart to the laundry room. HA-A did not sanitize her hands during the entire observation. During an interview on 2/12/24 at 2:10 p.m., HA-A verified she removed laundry from the cart, placed the laundry in the residents' closets and did not sanitize her hands. HA-A stated the purpose of completing hand hygiene was to prevent the spread of infection between residents. During an interview on 2/13/24 at 7:47 a.m., HA-B verified she did not keep the laundry cart covered the entire time while transporting the cart down the hallway for rooms in the 100's, 200's and 300's. She revealed she did not keep the cart covered because the hallways are not vacuumed and she did not want the dust going into the clean linens. HA-B stated she carried residents clothing from the cart to residents rooms, hung in closet and grabbed hangers from closets. HA-B confirmed she walked down the 200's hallway with one clean blanket in her hand and one clean	F 880		

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F 880	Continued From page 37 blanket tucked under the left arm to deliver to residents' rooms. HA-B indicated she only sanitized her hands at the beginning and then again at the end of the clothing pass. During a follow-up interview on 2/13/24 at 8:00 a.m., HA-B indicated she did not wear gloves when she collected soiled linen because she did not see the need to throw gloves away all the time. She stated she only sanitized her hands at the end of laundry pick-up and did not sanitize them in between residents. During an interview on 2/13/24 at 12:15 p.m., infection preventionist (IP) indicated she was not aware linen and laundry was being transported uncovered and staff did not sanitize their hands between residents. IP indicated her expectations were for staff to sanitize their hands between each resident during laundry distribution. IP stated she would expect staff to follow the rules and policies for laundry, handling laundry and dispensing laundry. IP stated she would expect staff to let someone in management know if they were unable to complete their jobs safely and while following infection prevention guidelines. During an observation on 2/11/24 at 5:53 p.m., R13 was observed laying in bed for wound care. Registered nurse (RN)-C entered R13's room for a scheduled wound dressing change. RN-C applied gloves, opened R13's dresser, removed saline solution and 4x4 gauze and placed onto bedside table. RN-C tore the top off three package's of 4x4 gauze. RN-C removed saline	F 880		

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F 880	Continued From page 38 bottle cover and poured saline into the 4x4 packages, removed the 4x4's from the packages and placed the 4x4's into a stack on R13's bedside table. RN-C pushed the bedside table that was near the dresser over to R13's bed. RN-C removed a soiled dressing from R13's right knee. R13's knee was observed to be bleeding. RN-C applied pressure to R13's right knee with the soiled gauze. RN-C removed the soiled gauze and a few drops of blood from the actively bleeding wound went onto the bed sheets. RN-C used wound cleanser and sprayed the open wound on R13's knee, approximately a silver dollar amount of blood was observed to spray onto R13's bed sheets. RN-C set the wound cleanser bottle on R13's bedside table, the bottle was observed to have numerous splatters of blood present on the spout, handle and front of bottle. RN-C opened an ointment of bacitracin with soiled gloves, put gloved finger on end of ointment tube and expelled ointment onto his gloved finger. RN-C put ointment on right knee which was still actively bleeding. RN-C set ointment on bedside table, removed backing from a foam dressing with adhesive edges and applied to R13's right knee. RN-C put gloved finger on ointment, expelled ointment onto gloved finger and applied ointment to R13's left knee that had three abrasions each approximately the size of a penny and were left open to air. RN-C lowered the head of the bed using electric hand control and assisted trained medication aide (TMA)-A to roll R13 onto his left side. RN-C retrieved the same wound spray bottle from bedside table, sprayed two wounds on R13's left buttock and one wound on R13's right buttock area. RN-C used one single 4x4 dry gauze to dry all three wounds, placed ointment on gloved finger and applied to all three wounds. RN-C applied the	F 880		

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F 880	Continued From page 39 three wet 4x4 gauze pads and placed one over each wound, opened two abdominal pad dressings and secured dressings with tape to buttocks. RN-C took gloves off, discarded into trash bin, picked up black marker from bedside table, dated and initialed R13's right knee dressing. RN-C assisted TMA-A to move R13 onto his back, put a blanket on R13 and raised the head of the bed using the electric hand control. RN-C set wound supplies on R13's dresser, left R13's room. RN-C was not observed to wash or sanitize hands when entering R13's room, during any of the wound cares, or prior to leaving R13's room. During an interview on 2/13/24 at 12:15 p.m., infection preventionist (IP) stated the expectation of nursing staff when completing wound cares was to practice good hand hygiene, remove gloves when needed and ensure the environment was sanitary. During an interview on 2/13/24 at 1:19 p.m., director of nursing (DON) indicated she was not aware laundry was being handled and transported as noted above. DON stated her expectations were for staff to be sanitizing or washing their hands before they entered a resident's room and when they left a resident's room. DON indicated staff were expected to follow the policies that had been put in place regarding transporting of linen and hand washing. Review of facility policy titled Linen Handling dated revised 11/2022, when handling, storing, processing, and transporting linens, facility personnel use procedures designed to prevent the spread of infection. Wash hands, apply gloves before handling soiled linen and hands are	F 880		

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F 880	Continued From page 40 washed after handling dirty laundry and prior to handling clean laundry. Review of facility policy titled Handwashing revised 11/2022, identified the facility required staff to wash their hands after each direct resident contact for which handwashing was indicated by accepted professional practice. As per recommendations from the CDC guidelines. Alcohol-based hand sanitizers were the most effective products for reducing the number of germs on the hands of healthcare providers.	F 880		

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	245299	A. BUILDING **01 - MAIN BUILDING** B. WING _____	**02/12/2024**

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K 000	INITIAL COMMENTS Fire Safety An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 02/12/2024. At the time of this survey, Frazee 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 | 03/01/2024

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245299	A. BUILDING **01 - MAIN BUILDING** B. WING _____	**02/12/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRAZEE CARE CENTER	**219 WEST MAPLE AVENUE** **FRAZEE, MN 56544**

(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 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. Frazee Care Center was constructed at three different times. The original building was constructed in 1971, is 1-story without a basement, and was determined to be of Type II(111) construction. In 1979 the north 200 wing addition was built. It is 1-story without a basement, was determined to be of Type II (000) construction, and is separated with 2- hour fire barriers from the main building. Additions to the	K 000		

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K 000	Continued From page 2 1979 building in 1993 include activities added to the west and the business/ main entrance addition to the east. These areas were determined to be Type V (111) construction, and the business / main entrance addition is separated from the apartment building with a 2- hour fire barrier. The facility is fully fire sprinkler protected and has a fire alarm system with smoke detection throughout the corridor system and in the common spaces that is monitored for automatic fire department notification. The facility has a capacity of 50 beds and had a census of 33 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 321 SS=D	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9	K 321		3/4/24

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K 321	Continued From page 3 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain hazardous storage room doors per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.2.1, and 19.3.2.1.3. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 02/12/2024 between 10:30 AM and 12:30 PM, it was revealed by observation patient room 103 has combustible storage in it and did not have a door closer on the door. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 321	Immediate Corrective Action: The combustible storage has been removed from the empty resident room. Corrective action as it applies to others: An Audit of resident rooms was conducted to ensure that resident rooms are free from hazardous combustible storage. Interventions to prevent a recurrence: Education will be provided to staff about combustible storage, and where it is appropriately stored throughout the facility. The policy for Hazardous Areas was reviewed and remains current. Compliance Date: Ongoing monitoring: The Maintenance Director or their designee will complete random audits as follows: 2x per week for 2 weeks 1x per week for 2 additional weeks, and	

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K 321	Continued From page 4	K 321	1x per month for 2 months A summary of the audit results will be reviewed with the IDT at the monthly QAPI meting for ongoing recommendations.	
K 353 SS=C	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation, a review of available documentation, and staff interview, the facility failed to inspect and maintain the fire sprinkler system per NFPA 101 (2012 edition), Life Safety Code, section 9.7.5, and NFPA 25 (2011 edition), Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, section 14.2.1. This deficient finding could have a widespread impact on the residents within the facility.	K 353	Immediate Corrective Action: Prior to receiving the tag, the facility had reached out to their fire safety company to schedule an inspection. Corrective action as it applies to others: The facility had the fire safety company complete the 5 year sprinkler inspection on 2/29/24.	3/4/24

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K 353	Continued From page 5 Findings include: On 02/12/2024 between 10:30 AM and 12:30 PM, it was revealed by review of available documentation and staff interview that the facility was overdue to have the 5-year internal inspection of sprinkler piping. The last 5-year inspection was conducted on 10/28/2018. An interview with the Maintenance Director verified this deficient finding.	K 353	Interventions to prevent a recurrence: The facility and the fire safety company has entered an agreement to provide maintenance and testing for all fire safety equipment including all NFPA testing requirements. Ongoing monitoring: The Maintenance Director or designee will review records quarterly for compliance. A summary of the audit results will be reviewed with the IDT at the monthly QAPI meting for ongoing recommendations.	
K 918 SS=C	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with	K 918		3/4/24

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K 918	Continued From page 6 NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to maintain generators per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.4.4.1.1.3, and NFPA 110 (2010 edition), Standard for Emergency and Standby Power Systems, sections 4.2, 8.4.9, 8.4.9.1 and 8.4.9.2. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 02/12/2024 between 10:30 AM and 12:30 PM, it was revealed by a review of available documentation that the facility failed to provide documentation of a 36-Month 4-hour generator load bank test having been completed. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 918	Immediate Corrective Action: Upon notification of the deficiency, the facility reached out to a vendor to conduct the required generator testing. Corrective action as it applies to others: On 2/22/24, the facility's vendor conducted the required 4 hour generator test. Interventions to prevent a recurrence: The facility has engaged in an agreement with a generator testing vendor to provide all required NFPA testing and maintenance. Compliance Date: Ongoing monitoring: - The Maintenance Director or designee will review records quarterly for compliance. A summary of the audit results will be reviewed with the IDT at the monthly QAPI meting for ongoing recommendations.	

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 2/11/24 to 2/13/24, a licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure and the following correction orders are issued.	2 000		

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2 000	Continued From page 1 In addition to the licensing survey, the following complaint was reviewed. The following complaint was reviewed with no licensing order issued. H52999483C (MN00095442). Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading	2 000		

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2 000	Continued From page 2 completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure personal laundry and linen were transported in a manner that prevented risk of contamination for 3 of 3 hallways observed for linen transportation. In addition, the facility failed to ensure hand hygiene occurred during the laundry and linen distribution. Further, the facility failed to ensure infection prevention practices including hand hygiene were followed during wound cares for 1 of 1 residents (R13) observed for wound cares. Findings include: Review of Centers for Disease Control (CDC)	21375	Corrected	3/4/24

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21375	Continued From page 3 guidance, Appendix D - Linen and Laundry Management updated 5/4/23, identified linens must be sorted, packaged, transported, and stored in a manner that prevented risk of contamination by dust, debris, soiled linens or soiled items. Review of Centers for Disease Control (CDC) guidance titled Hand Hygiene in Healthcare Settings reviewed 4/28/23, identified hand hygiene protected residents receiving care and helped prevent the spread of germs. During an observation on 2/12/24 at 9:24 a.m., housekeeping aid (HA)-B took one pair of pants and one shirt out of the uncovered linen cart, brought into R30's room, placed in closet, brought two hangers out of the room and placed the hangers on the outside handle of the cart. HA-B pushed the uncovered linen cart down the 100's hallway, took one pair of pants, one shirt out of the linen cart, brought into R5's room, placed in closet, brought two hangers out of the room and placed them on the outside linen cart handle. HA-B pushed the uncovered linen cart down the hallway, took one shirt, one pair of pants out of the linen cart, brought into R22's room, placed in closet and walked back to the cart. HA-B pushed the uncovered linen cart down the hallway to the 200's rooms. HA-B took two shirts from the linen cart, entered R10's room, placed into the closet, grabbed two hangers from closet and placed on linen cart handle. HA-B entered R1's room, picked a pair of socks off the floor, placed them into the hamper in R1's room, grabbed two hangers from closet and placed them on the linen cart handle. HA-B continued to push the uncovered linen cart down the hallway past R24 in a wheelchair, grabbed one shirt, one pair of pants from linen cart, brought into R25's room	21375		

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21375	Continued From page 4 and placed into closet. R24 entered R25's room in wheelchair, HA-B used both wheelchair handles and wheeled R24 out of R25's room into R24's room. HA-B exited R24's room, went to the linen cart, grabbed one shirt, one pair of pants out of the linen cart, brought into R24's room and put them in the closet. HA-B grabbed two hangers from R24's room, assisted R24 with her glasses, exited R24's room and placed the hangers on the handle of the linen cart. An unknown resident was pushed by the open linen cart in a bath chair while HA-B removed one blanket from the linen cart, placed on her knee, grabbed another blanket from the linen cart and placed under her left arm. HA-B walked down the hallway with both blankets, entered R7's room, placed one blanket in the chair, exited room, walked into R1's room, placed the blanket in the chair and exited the room. HA-B walked back to the linen cart, pushed the uncovered linen chart down the hallway. HA-B removed one shirt and walked back down the hall and placed R7's shirt in the closet. HA-B returned to the linen cart and pulled the uncovered linen cart down the hallway to the 300's rooms. HA-B grabbed one shirt, one pair of pants from the linen cart, entered R18's room, placed clothing in closet, grabbed two hangers from closet and placed them on the linen cart handle. HA-B moved the uncovered linen cart further down the hallway, grabbed one shirt, one pair of pants, brought into R20's room, placed them in closet, grabbed two hangers from closet and hung them on the linen cart handle. HA-B grabbed one shirt, one pair of pants, brought into R13's room, placed them in closet, removed two hangers from closet and placed them on the linen cart handle. HA-B pulled the cover down over the cart and pushed the cart back to the laundry room. HA-B did not sanitize her hands and the cart	21375		

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21375	Continued From page 5 remained uncovered during the entire observation. During an observation on 2/12/24 at 2:03 p.m., housekeeping supervisor (HA)-A was observed removing laundry from the laundry cart, delivered laundry to R2's room, placed laundry in R2's closet and exited R2's room. HA-A removed laundry from the cart, did not sanitize hands, delivered laundry to R4's room, placed laundry in R4's closet and exited R4's room. HA-A removed laundry from cart, knocked on R24's door, placed laundry in R24's closet and exited R24's room. HA-A returned to laundry cart in hall, removed laundry from cart, knocked on R25's door, placed laundry in R25's closet and exited R25's room. HA-A removed laundry from cart, delivered laundry to R29's room, placed laundry in R29's closet, assisted R29 to put glasses on, exited R29's room and returned to laundry cart without sanitizing hands. HA-A removed laundry from cart, knocked on R13's door, touched handles on R13's wheelchair to move out of way of closet, placed laundry in R13's closet and exited R13's room. HA-A removed laundry from cart, knocked on R7's door, placed laundry in R7's closet and exited R7's room. HA-A stopped in R1's room and visited with R1, exited R1's room with dirty laundry, returned to laundry cart and placed dirty linen on bottom shelf of laundry cart. HA-A removed laundry from cart, knocked on R23's door, opened door, placed laundry in R23's closet and exited R23's room. HA-A pushed laundry cart down hall, stopped at linen closet in hall, opened linen door, delivered four pairs of gripper socks to shelf in closet, closed linen door and pushed laundry cart down hall. HA-A removed laundry from cart, knocked on R18's door, placed laundry in R18's closet, exited R18's room and went directly to R20's room with the rest of the	21375		

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21375	Continued From page 6 laundry observed being carried. HA-A knocked on R20's door, opened door, placed laundry in R20's closet and exited R20's room. R18 asked HA-A why she had not received lunch and was hungry. HA-A entered R18's room, visited with R18, then went into the dining room toward the kitchen and returned a few minutes later to R18's room followed by a dietary staff who brought food. HA-A pushed laundry cart to the laundry room. HA-A did not sanitize her hands during the entire observation. During an interview on 2/12/24 at 2:10 p.m., HA-A verified she removed laundry from the cart, placed the laundry in the residents' closets and did not sanitize her hands. HA-A stated the purpose of completing hand hygiene was to prevent the spread of infection between residents. During an interview on 2/13/24 at 7:47 a.m., HA-B verified she did not keep the laundry cart covered the entire time while transporting the cart down the hallway for rooms in the 100's, 200's and 300's. She revealed she did not keep the cart covered because the hallways are not vacuumed and she did not want the dust going into the clean linens. HA-B stated she carried residents clothing from the cart to residents rooms, hung in closet and grabbed hangers from closets. HA-B confirmed she walked down the 200's hallway with one clean blanket in her hand and one clean blanket tucked under the left arm to deliver to residents' rooms. HA-B indicated she only sanitized her hands at the beginning and then again at the end of the clothing pass. During a follow-up interview on 2/13/24 at 8:00 a.m., HA-B indicated she did not wear gloves	21375		

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21375	Continued From page 7 when she collected soiled linen because she did not see the need to throw gloves away all the time. She stated she only sanitized her hands at the end of laundry pick-up and did not sanitize them in between residents. During an interview on 2/13/24 at 12:15 p.m., infection preventionist (IP) indicated she was not aware linen and laundry was being transported uncovered and staff did not sanitize their hands between residents. IP indicated her expectations were for staff to sanitize their hands between each resident during laundry distribution. IP stated she would expect staff to follow the rules and policies for laundry, handling laundry and dispensing laundry. IP stated she would expect staff to let someone in management know if they were unable to complete their jobs safely while following infection prevention guidelines. During an observation on 2/11/24 at 5:53 p.m., R13 was observed laying in bed for wound care. Registered nurse (RN)-C entered R13's room for a scheduled wound dressing change. RN-C applied gloves, opened R13's dresser, removed saline solution and 4x4 gauze and placed onto bedside table. RN-C tore the top off three package's of 4x4 gauze. RN-C removed saline bottle cover and poured saline into the 4x4 packages, removed the 4x4's from the packages and placed the 4x4's into a stack on R13's bedside table. RN-C pushed the bedside table that was near the dresser over to R13's bed. RN-C removed a soiled dressing from R13's right knee. R13's knee was observed to be bleeding. RN-C applied pressure to R13's right knee with the soiled gauze. RN-C removed the soiled gauze and a few drops of blood from the actively bleeding wound went onto the bed sheets. RN-C used wound cleanser and sprayed the open	21375		

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21375	Continued From page 8 wound on R13's knee, approximately a silver dollar amount of blood was observed to spray onto R13's bed sheets. RN-C set the wound cleanser bottle on R13's bedside table, the bottle was observed to have numerous splatters of blood present on the spout, handle and front of bottle. RN-C opened an ointment of bacitracin with soiled gloves, put gloved finger on end of ointment tube and expelled ointment onto his gloved finger. RN-C put ointment on right knee which was still actively bleeding. RN-C set ointment on bedside table, removed backing from a foam dressing with adhesive edges and applied to R13's right knee. RN-C put gloved finger on ointment, expelled ointment onto gloved finger and applied ointment to R13's left knee that had three abrasions each approximately the size of a penny and were left open to air. RN-C lowered the head of the bed using electric hand control and assisted trained medication aide (TMA)-A to roll R13 onto his left side. RN-C retrieved the same wound spray bottle from bedside table, sprayed two wounds on R13's left buttock and one wound on R13's right buttock area. RN-C used one single 4x4 dry gauze to dry all three wounds, placed ointment on gloved finger and applied to all three wounds. RN-C applied the three wet 4x4 gauze pads and placed one over each wound, opened two abdominal pad dressings and secured dressings with tape to buttocks. RN-C took gloves off, discarded into trash bin, picked up black marker from bedside table, dated and initialed R13's right knee dressing. RN-C assisted TMA-A to move R13 onto his back, put a blanket on R13 and raised the head of the bed using the electric hand control. RN-C set wound supplies on R13's dresser, left R13's room. RN-C was not observed to wash or sanitize hands when entering R13's room, during any of the wound cares, or prior to	21375		

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21375	Continued From page 9 leaving R13's room. During an interview on 2/13/24 at 12:15 p.m., infection preventionist (IP) stated the expectation of nursing staff when completing wound cares was to practice good hand hygiene, remove gloves when needed and ensure the environment was sanitary. During an interview on 2/13/24 at 1:19 p.m., director of nursing (DON) indicated she was not aware laundry was being handled and transported as noted above. DON stated her expectations were for staff to be sanitizing or washing their hands before they entered a resident's room and when they left a resident's room. DON indicated staff were expected to follow the policies that had been put in place regarding transporting of linen and hand washing. Review of facility policy titled Linen Handling dated revised 11/2022, when handling, storing, processing, and transporting linens, facility personnel use procedures designed to prevent the spread of infection. Wash hands, apply gloves before handling soiled linen and hands are washed after handling dirty laundry and prior to handling clean laundry. Review of facility policy titled Handwashing revised 11/2022, identified the facility required staff to wash their hands after each direct resident contact for which handwashing was indicated by accepted professional practice. As per recommendations from the CDC guidelines. Alcohol-based hand sanitizers were the most effective products for reducing the number of germs on the hands of healthcare providers. SUGGESTED METHOD OF CORRECTION: The	21375		

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21375	Continued From page 10 DON (Director of Nursing) or designee could review/revise facility policies to ensure they contain all components of an infection control program, including hand hygiene, wound care practices and linen/laundry transport. Then the DON or designee could educate staff and perform audits to ensure the policies are being followed. TIME PERIOD OF CORRECTION: Twenty-one (21) days.	21375		
21565	MN Rule 4658.1325 Subp. 4 Administration of Medications Self Admin Subp. 4. Self-administration. A resident may self-administer medications if the comprehensive resident assessment and comprehensive plan of care as required in parts 4658.0400 and 4658.0405 indicate this practice is safe and there is a written order from the attending physician. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure residents were assessed for the ability to self administer medications (SAM) for 1 of 3 residents (R3) reviewed for medication administration. Findings include: R3's significant change Minimum Data Set (MDS) dated 12/9/23, indicated R3 was cognitively intact. Identified R3 had diagnoses which included heart failure, anxiety and depression. Indicated R3 required moderate assistance of one staff with toileting and personal hygiene.	21565	Corrected	3/4/24

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21565	Continued From page 11 Review of R3's electronic health record (EHR) revealed a SAM assessment had not been completed and R3 did not have an order for self administration of medications. R3's Physician's Telephone Orders dated 2/5/24, and signed 2/12/24, directed staff to administer DuoNeb (medication used to relax the muscles in the airways and increase air flow to the lungs) four times daily (QID) for seven days then as needed (PRN) for wheezing and shortness of breath (SOB). R3's Medication Administration Record (MAR) dated 2/1/24 to 2/9/24, indicated R3 was taking Ipratropium-albuterol inhalation solution (DuoNeb) 0.5-2.5 3 milligrams (mg) per 3 milliliters (ml). R3's order further indicated R3's order began on 2/5/24 at 8:00 p.m., and ended 2/12/24 at 4:00 p.m. R3's order for DuoNeb was changed to PRN following the physician's telephone order on 2/12/24. R3's care plan dated 12/21/23, indicated staff were to observe R3 for changes in cognition, level of alertness, confusion and forgetfulness. Identified staff were to reorient R3 as needed. During an observation on 2/12/24 at 11:33 a.m., registered nurse (RN)-A verified R3's DuoNeb order, retrieved the DuoNeb from the medication cart, locked the medication cart and walked to R3's room. RN-A knocked on R3's door, entered the room, explained the medication to R3, opened the DuoNeb and poured the solution into the nebulizer container. RN-A handed the nebulizer container to R3, turned the nebulizer machine on and informed R3 she would be back in ten minutes to shut the machine off. RN-A exited R3's room, returned to medication cart and	21565		

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21565	Continued From page 12 signed off that the DuoNeb had been administered. RN-A stated "R3 is only taking this medication for seven days so she just does it by herself". During an observation on 2/12/24 at 11:49 a.m., RN-A returned to R3's room, knocked on door, entered R3's room and shut the nebulizer machine off. RN-A took the nebulizer container from R3, disassembled the nebulizer container, washed it out in the sink and placed it on a wash cloth next to the nebulizer machine to dry. During an interview on 2/13/24 at 8:59 a.m., R3 stated she she had been receiving DuoNeb treatments since she acquired an illness. R3 indicated she did not know how often she was receiving the medication. R3 stated she had not been taught how to use the nebulizer machine. R3 verified nursing staff did not remain in the room with her while the treatment was being administered. She stated nursing staff turned the nebulizer machine on, handed her the nebulizer and left the room right after handing it to her. R3 indicated nursing staff returned to her room once the nebulizer treatment was completed to turn the machine off. During an interview on 2/13/24 at 9:27 a.m., RN-A verified R3's order for DuoNeb's for seven days. RN-A confirmed she set R3's nebulizer treatment up, handed the nebulizer container to R3, turned the nebulizer machine on and set her timer to return to R3's room when the treatment was finished. RN-A sated she had checked on R3 however did not stay in R3's room during the entire administration. RN-A confirmed R3 did not have a SAM assessment completed and did not have an order for self administration. RN-A stated if a resident did not have a SAM assessment or	21565		

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21565	Continued From page 13 an order for self administration, staff were required to stay in the room during the entire administration. During an interview on 2/13/24 at 1:24 p.m., director of nursing (DON) confirmed the above findings and indicated staff should have been following the facility policy. DON stated her expectations were staff would assess residents for the ability to complete self administration of medications. DON indicated if the resident did not have a SAM assessment or physician's orders, staff were expected to remain with the resident during the entire administration. Facility policy titled Self Administration of Medications revised 1/23, indicated an individual resident may self-administer medication if the resident requested and the interdisciplinary team had determined that self-administration was clinically appropriate. Staff were to complete a self-administration of medication tool. If the team determined that self-administration was clinically appropriate, staff would obtain a physician's order for resident to self-administer each specific medication that the resident had been qualified to self-administer. In addition, staff would update the resident's care plan to indicate the resident's choice to self-administer medications. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review applicable policies and procedures to ensure residents' are assessed with self administration of oral medications; then provide staff education. The quality assurance committee could monitor for compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21565		

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21620	MN Rule 4658.1345 Labeling of Drugs Drugs used in the nursing home must be labeled in accordance with part 6800.6300. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure insulin pens were accurately dated when opened for 2 of 3 residents (R11 and R136) who received insulin injections and insulin pens were disposed of past expiration date for 1 of 3 residents (R9) who received insulin injections. Further, the facility failed to ensure correct labeling on one refrigerated medication in 1 of 2 refrigerators reviewed for medication storage. Findings include: R11 R11's quarterly review Minimum Data Set (MDS) dated 12/21/23, indicated R11 had diagnoses which included diabetes mellitus (DM), malnutrition and anxiety. Indicated R11 required moderate assistance of one staff with toileting and personal hygiene. R11's signed physician's orders from 1/24/24 to 2/6/24, indicated R11 a physician's order for lantus (long acting insulin medication to control blood sugar) 10 units in the morning (AM) and 10 units at bedtime (HS) / evening (PM). R11's order audit report from 1/30/24, indicated R11's order was for Insulin Glargine Subcutaneous Solution 100 units/ml, inject 10 units subcutaneously two times a day for DM.	21620	Corrected	3/4/24

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21620	Continued From page 15 R9 R9's significant change MDS dated 2/5/24, indicated R9 had diagnoses which included end stage renal disease (disease of the kidneys), DM and anxiety. Indicated R9 required extensive assistance of one staff with toileting, transfers and personal hygiene. R9's signed physician's orders dated 1/16/24, lacked an order for Basaglar KwikPen Subcutaneous Solution 100 units/ml (long acting insulin medication to control blood sugar. R9's order audit report from 12/19/23, indicated R9's order for Basaglar KwikPen Subcutaneous Solution 100 units/ml, inject 7 unites subcutaneous one time a day for type 2 DM, hold and notify provider if blood sugar (BS) is below 80 had been discontinued. R136 R136's signed Order Summary Report dated 2/14/24, indicated R136 had a diagnosis of type 2 diabetes mellitus (DM) and had a physician's order for Insulin Glargine Subcutaneous Solution 100 units/ml (long acting insulin medication to control blood sugar, inject 25 units subcutaneously at bedtime for DM. During an observation and interview on 2/11/24 at 4:15 p.m., while completing medication storage of the medication carts with registered nurse (RN)-B, the top drawer of medication cart A1 contained an Insulin Glargine Subcutaneous Solution 100 units/ml insulin pen for R136 which was not dated. In the top drawer of medication cart A2, an Insulin Glargine Subcutaneous	21620		

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21620	Continued From page 16 Solution 100 units/ml insulin pen for R11 was noted with no date and a Basaglar KwikPen Subcutaneous Solution 100 units/ml insulin pen for R9 which identified it had been opened on 12/15/23 and contained no expiration date. RN-B confirmed the outdated insulin pen and undated insulin pens . RN-B stated R11, R9 and R136 had current orders for insulin and stated "yes we are giving them." RN-B indicated her usual process had been to open insulin pens and date them right away. RN-B stated she thought insulin pens were good for 30 days after opening and the facility used a cheat sheet do confirm expiration dates. During an interview on 2/13/24 at 2:13 p.m., pharmacy consultant (PC) indicated it was the responsibility of the facility to ensure all insulin pens were dated and discarded following manufacturer's recommendations. PC indicated Basaglar Solution Insulin pens, Lantus Solostar Solution Insulin pens and Insulin Glargine pens expired after 28 days being open at room temperature. PC stated her expectations were for the facility to have medications properly labeled with resident information and to follow manufacturer's recommendations for expiration dates. During an observation/interview on 2/11/24 at 4:55 p.m., registered nurse (RN)-C entered medication storage room, opened refrigerator and took out a box with a vial of Mantoux solution, (Tuberculin Purified Protein Derivative), verified the solution had been opened and accessed. RN-C confirmed the box and the vial did not have a date on them of when opened and placed into use. RN-C verified a label on the box and the vial stated to date when opened and discard after being opened for 30 days.	21620		

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21620	Continued From page 17 During an interview on 2/13/24 at 2:13 p.m., pharmacy consultant (PC) indicated it was the responsibility of the facility to ensure all insulin pens were dated and discarded following manufacturer's recommendations. PC indicated Basaglar Solution Insulin pens, Lantus Solostar Solution Insulin pens and Insulin Glargine pens expired after 28 days being open at room temperature. PC stated her expectations were for the facility to have medications properly labeled with resident information and to follow manufacturer's recommendations for expiration dates. In addition, pharmacy consultant indicated the pharmacy applied a label on the Mantoux box and vial as a reminder to staff to date once opened and discard after 30 days of being opened. Pharmacy consultant verified the expectation of nursing was to date the Mantoux solution once opened and discard after 30 days of being opened. Stated per manufacturer direction, the stability of tuberculin purified protein derivative was for 30 days after opened and would then be discarded. During an interview on 2/13/24 at 2:43 p.m., director of nursing (DON) confirmed the above findings and indicated her expectations were for staff to follow facility policy and manufacturer's recommendations. DON stated she would expect staff to date all insulin pens when they were opened and discard when they expired. DON indicated she would expect all nursing staff passing medications to review expiration dates during medication passes. DON stated the facility did not have a process in place to ensure medications were being stored properly. In addition, DON verified the expectation of nursing staff would be to date the box and vial of Mantoux solution once	21620		

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21620	Continued From page 18 opened. DON stated the solution would not be safe to use after 30 days of being opened. Review of facility policy titled Medication Labeling and Storage revised 11/22, medications were labeled in accordance with state and federal laws and include the expiration date when applicable. Labels included the residents name, drug name, dose, frequency, route instructions for use, and expiration date. Review of manufactures specifications for In-use Pen, store the pen you are currently using at room temperature [up to 86° Fahrenheit (F) (30°Celsius (C))] and away from heat and light. Throw away the pen you are using after 28 days, even if it still has insulin left in it. Review of manufacturer's specific for use, 3 ml single-patient-use SoloStar in use pen expires 28 days after opening. Review of manufacturer's specifications for use, 3 ml single-patient-use insulin glargine in use pen expires 28 days after opening. Review of facility policy titled, Drugs and Biological Storage-Labeling, dated 4/1/08, identified drugs and biologicals were to labeled in accordance with current accepted professional standards, including the appropriate accessory and cautionary instructions and the expiration data when applicable. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON) and consulting pharmacist could review and revise policies and procedures for proper storage of medications. Nursing staff could be educated as necessary of the importance of labeling	21620		

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21620	Continued From page 19 medications properly. The DON or designee, along with the pharmacist, could audit medications on a regular basis to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21620		
21675	MN Rule 4658.1410 Linen Nursing home staff must handle, store, process, and transport linens so as to prevent the spread of infection according to the infection control program and policies as required by part 4658.0800. These laundering policies must comply with the manufacturer's instructions for the laundering equipment and products and include a wash formula addressing the time, temperature, water hardness, bleach, and final pH. This MN Requirement is not met as evidenced by: F880 SUGGESTED METHOD: The administrator or designee could develop/revise and implement policies and procedures for proper infection control measures were implemented for linen handling and educate staff on those policies. The quality assessment and assurance committee could perform random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21675	Corrected	3/4/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00730	A. BUILDING: _____ B. WING _____	C 02/13/2024

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21860	Continued From page 20	21860		
21860	MN St. Statute 144.651 Subd. 16 Patients & Residents of HC Fac.Bill of Rights Subd. 16. Confidentiality of records. Patients and residents shall be assured confidential treatment of their personal and medical records, and may approve or refuse their release to any individual outside the facility. Residents shall be notified when personal records are requested by any individual outside the facility and may select someone to accompany them when the records or information are the subject of a personal interview. Copies of records and written information from the records shall be made available in accordance with this subdivision and section 144.335. This right does not apply to complaint investigations and inspections by the Department of Health, where required by third party payment contracts, or where otherwise provided by law. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure confidential information was not readily available for all residents, staff, and visitors to view for 17 of 17 residents (R26, R3, R21, R28, R86, R6, R11, R22, R5, R14, R27, R8, R31, R9, R30, R20 and R10) residing on the 100's wing whose confidential information was observed to be visible on two open computer screens and a resident care sheet in a common area. Findings include: During an observation on 2/12/24 at 11:26 a.m., a	21860	Corrected	3/4/24

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21860	Continued From page 21 resident care sheet for the 100's unit was observed on top of the medication cart with the sheet facing right side up and information visible to anyone walking by. Resident care sheet identified first and last names for R26, R3, R21, R28, R86, R6, R11, R22, R5, R14, R27, R8, R31, R9, R30, R20 and R10 , room numbers, vitals and medication notes. Registered nurse (RN)-A returned to the medication cart at 11:31 a.m., wrote on the resident care sheet, and kept the care sheet information right side up with the information still visible. RN-A opened electronic medical record (eMAR) documentation system, moved over to another medication cart and opened the eMAR documentation system. Resident information including names, room numbers and diagnoses from residents who resided in the 100's wing as noted above, were visible on the computer screen. RN-A walked away from both medication carts, entered the medication room behind the nurses's station and closed the door. The screen from the eMAR remained open and the care sheet remained visible to others who walked by. RN-A returned to the medications carts, walked around the front of both medication carts and down the hall into the therapy room while the screen from the computer and care sheet continued to be visible to others who walked by. RN-A returned to the medication carts at 11:36 a.m., reviewed the open eMAR documentation system on the medication cart.. RN closed the laptop on the medication cart. RN-A moved over to the other medication cart and started to dispense medications. RN-A dispensed medications, locked the laptop screen on the medication cart, placed a kleenex box over the care sheet and walked down the 100's hallway. Both medication carts were located in front of the nurses station at the end of the 100's wing hallway. Five unidentified staff and two	21860		

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21860	Continued From page 22 visitors were observed passing the front of both medication carts during the observation. During an interview on 2/13/24 at 9:31 a.m., RN-A indicated she was unaware she had left the residents' care sheet visible and computer screens open when she walked away from the medication carts. RN-A confirmed she walked away from both carts to provide assistance elsewhere. RN-A revealed she used the resident care sheet to track residents' vitals and store information about medication administration. RN-A indicated it was important to ensure residents' personal information was not visible to others and RN-A would be more cautious with personal information. During an observation on 2/12/24 at 11:21 a.m., RN-B removed R10's medications from the medication cart located on the 200's wing. RN-B walked away from the medication cart while the computer screen remained open with R10's eMAR visible. RN-B went into the day room to administer R10's medications. During that time RN-B administered R10's medications, one resident wheeled up to the medication cart and had the potential to see R10's confidential eMAR information. During an observation on 2/12/24 at 11:26 a.m., RN-B removed R20's medication from the the medication cart. RN-B walked away from the mediation cart while R20's eMAR remained open. During the time R20's eMAR was open and unattended, one resident walked by the medication cart and had the potential to view R20's confidential eMAR information. During an interview on 2/14/24 at 2:42 p.m., RN-B stated her normal process was to close the	21860		

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21860	Continued From page 23 computer or lock the computer screen when she left the medication chart. RN-B verified she did not keep R10's and R20's eMAR information confidential when she left the computer screens open and visible and walked away. During an interview on 2/13/24 on 1:26 p.m., director of nursing (DON) confirmed the above findings and indicated due to Health Insurance Portability and Accountability Act of 1996,(HIPAA) computer screens should always be locked and care sheets should not be left visible. DON stated her expectations were staff would follow the policy for privacy. Review of facility policy titled Privacy and Confidentiality revised 11/16, identified the resident had a right to personal privacy and confidentiality of his or her personal and medical records. The resident had a right to secure and confidential personal and medical records. Resident records were limited to the use of the staff and would be safeguarded at all times to ensure confidentiality. Review of facility policy titled Medication Administration revised 11/22, identified staff were to place medication administration books or laptop/computer on top of cart; when unattended records should be closed for privacy. SUGGESTED METHOD OF CORRECTION: The DON could inservice staff regarding the importance of confidentiality and privacy of resident information displayed on the computer screen while staff were not present in the area and/or not utilizing the computer screen. An periodic audit could be conducted to ensure compliance and the findings could be communicated to the quality assurance	21860		

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21860	Continued From page 24 committee. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21860		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
March 28, 2024

Administrator
Frazee Care Center
219 West Maple Avenue
Frazee, MN 56544

RE: CCN: 245299
Cycle Start Date: February 1, 2024

Dear Administrator:

On February 22, 2024, we notified you a remedy was imposed. On March 15, 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 March 4, 2024.

As authorized by CMS the remedy of:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective May 1, 2024 did not go into effect. (42 CFR 488.417 (b))

In our letter of , in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from May 1, 2024 due to denial of payment for new admissions. Since your facility attained substantial compliance on March 4, 2024, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

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

Feel free to contact me if you have questions.

Sincerely,

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

March 28, 2024

Administrator
Frazee Care Center
219 West Maple Avenue
Frazee, MN 56544

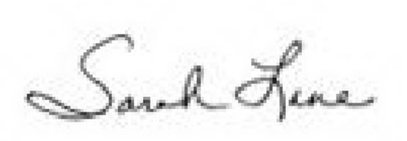
Re: Reinspection Results
Event ID: WXZZ12

Dear Administrator:

On March 21, 2024 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on February 13, 2024. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,



Sarah Lane, Compliance Analyst
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