Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

April 26, 2023

Administrator
Highland Operations, LLC
2319 West Seventh Street
Saint Paul, MN 55116

RE: CCN: 245028
Cycle Start Date: April 6, 2023

Dear Administrator:

On April 6, 2023, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be 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.

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Pete Cole, RN Unit Supervisor
Metro Team C District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: peter.cole@state.mn.us
Office/Mobile: (651) 249-1724

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

If substantial compliance with the regulations is not verified by July 6, 2023 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by October 6, 2023 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

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

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

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

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

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Phone: 651-201-4384
Email: holly.zahler@state.mn.us

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 245028	MULTIPLE CONSTRUCTION A. BUILDING: ______ B. WING ______	DATE SURVEY COMPLETE: 4/6/2023
NAME OF PROVIDER OR SUPPLIER **HIGHLAND OPERATIONS LLC**	STREET ADDRESS, CITY, STATE, ZIP CODE **2319 WEST SEVENTH STREET SAINT PAUL, MN**		

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 623	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address

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and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.

§483.15(c)(6) Changes to the notice.
If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.

§483.15(c)(8) Notice in advance of facility closure
In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l).
This REQUIREMENT is not met as evidenced by:
Based on interview and document review, the facility failed to ensure a written notice of transfer was provided for 2 of 2 residents (R32, R55) reviewed for hospitalization.

Findings include:

R32's quarterly Minimum Data Set (MDS) dated 11/7/22, indicated intact cognition and required extensive assist with transferring, bed mobility, toileting, and hygiene, occasionally had bladder incontinence, and did not reject cares.

R32's Admission Record form in the electronic medical record (EMR) indicated R32 was his own representative.

R32's Medical Diagnosis form in the electronic medical record (EMR) indicated R32 had the following diagnoses: Crohn's disease (an inflammatory disease that affects the digestive tract), muscle weakness, and difficulty walking.

R32's nursing progress note dated 11/26/22, indicated R32 was found on the floor about 5:45 a.m. lying on left side and was trying to walk to the bathroom and fell. The progress note indicated R32 rated pain a seven out of 10 and was unable to raise his left arm and the nurse practitioner (NP) and the administrator were notified.

R32's nursing progress note dated 11/27/22 at 10:45 p.m., indicated R32 had a fall the previous day and an x-ray had been ordered and further assessment indicated R32 was in "dire" pain guarding his arm screaming his arm was broken, 911 was called at 8:00 a.m. and was sent to the hospital.

R32's nursing progress note dated 12/8/22 at 5:30 a.m., indicated R32 was sent to the hospital for uncontrolled pain, possible delirium and malnutrition and the provider was aware.

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R32's progress notes were reviewed and lacked information the resident and representative were provided a transfer form for either hospitalization.

An email was sent to the ombudsman on 4/5/23 at 7:58 a.m. who later replied 4/11/23 at 12:00 p.m., that she did not receive any discharge notices for R32 regarding hospitalizations 11/27/22 and 12/8/22.

During interview on 4/5/23 at 8:10 a.m. R32 did not recall receiving a bed hold.

During interview on 4/5/23 at 9:03 a.m. licensed practical nurse (LPN)-G stated she was not aware of any kind of checklists to use when a resident goes to the hospital and stated she has sent residents to the hospital many times and has never sent a bed hold policy or a transfer form.

During interview on 4/6/23 at 7:58 a.m., registered nurse (RN)-D stated when a resident goes to the hospital, a face sheet and med list is sent and stated they are supposed to sign a bed hold and this information should be documented and after reviewing progress notes, RN-D stated she did not remember sending a bed hold. RN-D did not mention a transfer form.

R55's quarterly MDS dated 2/16/23 indicated intact cognition, had the following diagnosis: chronic kidney disease, and had an indwelling catheter..

A nursing progress note dated 3/30/23, indicated R55 was admitted to the hospital for sepsis and a signed bed hold, transfer sheet and medication list was sent to Fairview hospital.

During interview on 4/6/23 at 8:44 a.m., R55 stated she did not recall receiving a bed hold, and did not mention if she received a transfer form.

During interview 4/6/23 at 8:50 a.m., the assistant director of nursing stated she sent R55's face sheet, bed hold, and POLST (physician order for life sustaining treatment), the administration record and an order summary and stated she was not aware of any checklists or paperwork to send when a resident transfers to the hospital and was not aware of a specific transfer form.

During interview on 4/6/23 at 10:11 a.m. the director of nursing stated when a resident is sent to the hospital, the face sheet, orders, progress notes, and recent labs are sent and added they do not do a transfer form and if a bed hold was not sent along, they would fax it and it would be documented.

A policy, Transfer or Discharge, Emergency dated 11/30/21, indicated if it was necessary to make an emergency transfer or discharge to the hospital, the facility would prepare a transfer form to send with the resident.

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	245028	A. BUILDING: ____ B. WING ____	4/6/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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Notice of Bed Hold Policy Before/Upon Trnsfr
CFR(s): 483.15(d)(1)(2)

§483.15(d) Notice of bed-hold policy and return-

§483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies-
(i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility;
(ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any;
(iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and
(iv) The information specified in paragraph (e)(1) of this section.

§483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section.
This REQUIREMENT is not met as evidenced by:
Based on interview and document review the facility failed to provide a written bed hold notice prior to transfer to the hospital for 1 of 1 resident (R32) reviewed for hospitalization.

Findings include:

R32's quarterly Minimum Data Set (MDS) dated 11/7/22, indicated intact cognition and required extensive assist with transferring, bed mobility, toileting, and hygiene, occasionally had bladder incontinence, and did not reject cares.

R32's Admission Record form in the electronic medical record (EMR) indicated R32 was his own representative.

R32's Medical Diagnosis form in the electronic medical record (EMR) indicated R32 had the following diagnoses: Crohn's disease (an inflammatory disease that affects the digestive tract), muscle weakness, and difficulty walking.

R32's nursing progress note dated 11/27/22 at 10:45 p.m., indicated R32 had a fall the previous day and an x-ray had been ordered and further assessment indicated R32 was in "dire" pain guarding his arm screaming his arm was broken, 911 was called at 8:00 a.m. and was sent to the hospital.

R32's nursing progress note dated 12/8/22 at 5:30 a.m., indicated R32 was sent to the hospital for

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uncontrolled pain, possible delirium and malnutrition and the provider was aware.

The progress notes were reviewed and lacked information that a notice of bed hold was provided.

During interview on 4/5/23 at 8:10 a.m., R32 stated he did not recall receiving a bed hold notice prior to going to the hospital.

During interview on 4/5/23 at 9:03 a.m., licensed practical nurse (LPN)-G stated she was not aware of any kind of checklists to use when a resident goes to the hospital and stated she has sent residents to the hospital many times and has never sent a bed hold policy.

During interview on 4/6/23 at 7:58 a.m., registered nurse (RN)-D stated when a resident goes to the hospital, a face sheet and med list is sent and stated they are supposed to sign a bed hold and this information should be documented and after reviewing progress notes, RN-D stated she did not remember sending a bed hold.

During interview on 4/6/23 at 8:50 a.m., the assistant director of nursing (ADON) stated she knew from previous work experience to send a copy of the bed hold, but was not aware of a check list for the staff and added she was aware they needed a process for floor staff for when a resident transferred to the hospital.

During interview on 4/6/23 at 10:11 a.m., the director of nursing stated when a resident is sent to the hospital, the face sheet, orders, progress notes, and recent labs are sent and added they do not do a transfer form and if a bed hold was not sent along, they would fax it and it would be documented.

A policy Notice of Bed-Hold Policy undated indicated the notice of Bed-Hold Policy is provided to the resident/financially responsible party upon admission and at the time of leave.

F 640

Encoding/Transmitting Resident Assessments
CFR(s): 483.20(f)(1)-(4)

§483.20(f) Automated data processing requirement-
§483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility:
(i) Admission assessment.
(ii) Annual assessment updates.
(iii) Significant change in status assessments.
(iv) Quarterly review assessments.
(v) A subset of items upon a resident's transfer, reentry, discharge, and death.
(vi) Background (face-sheet) information, if there is no admission assessment.

§483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility

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must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State.

§483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following:
(i)Admission assessment.
(ii) Annual assessment.
(iii) Significant change in status assessment.
(iv) Significant correction of prior full assessment.
(v) Significant correction of prior quarterly assessment.
(vi) Quarterly review.
(vii) A subset of items upon a resident's transfer, reentry, discharge, and death.
(viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment.

§483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS.
This REQUIREMENT is not met as evidenced by:
Based on interview and document review, the facility failed to ensure a discharge return not anticipated (DRNA) Minimum Data Set (MDS) was completed and transmitted to the Centers for Medicare and Medicaid (CMS) in a timely manner for 1 of 4 residents (R15) reviewed for MDS accuracy.

Findings include:

R15's Census listing, printed 4/6/23, identified R15 admitted to the nursing home on 10/21/22, and R15 discharged the nursing home on 12/16/22, with dictation present, "STOP BILLING."

However, R15's MDS listing, printed 4/6/23, identified the last completed MDS was a Medicare 5-Day MDS completed on 10/28/22. There was no indication the facility had completed and transmitted the required DRNA MDS to CMS despite R15 having discharged the nursing home over three months prior.

On 4/5/23 at 1:32 p.m., the assistant director of nursing (ADON) was interviewed. ADON explained the facility currently did not have an MDS coordinator in-house so, as a result, the MDS' were being outsourced to a "third party" located out of State. ADON stated getting all the MDS(s), and their corresponding assessments, had been "a little bit of a struggle" as a result.

On 4/6/23 at 2:05 p.m., registered nurse (RN)-A was interviewed, and they verified they were currently completing the MDS' for the nursing home while out of State. RN-A verified they had reviewed the medical record and explained R15 was a planned discharge back to the community and, as a result, a DRNA MDS

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should have been completed but was not. RN-A stated they would immediately complete one to help "close the chart" and ensure better continuity of care.

A facility' policy on MDS completion and transmission was requested, however, none was provided.

F 641

Accuracy of Assessments
CFR(s): 483.20(g)

§483.20(g) Accuracy of Assessments.
The assessment must accurately reflect the resident's status.
This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and document review, the facility failed to ensure the completed Minimum Data Set (MDS) was accurately coded to reflect actual restraint use for 1 of 4 residents (R24) reviewed for MDS accuracy.

Findings include:

The Centers for Medicare & Medicaid Services (CMS) Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual, dated 10/2018, outlined a section labeled, "SECTION P: RESTRAINTS AND ALARMS," which directed to record the frequency a resident was restrained by any of the listed devices during the seven day look-back period. A definition of physical restraint was provided which outlined, "Any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily, which restricts freedom of movement or normal access to one's body."

R24's quarterly MDS, dated 3/4/23, identified R24 severe cognitive impairment, required limited assistance with transfers, and had functional limitations in range of motion on both sides of their upper and lower body. Further, the MDS contained section, "P0100. Physical Restraints," which was marked, "D. Other," and, "2. Used Daily."

On 4/3/23 at 7:39 a.m., R24 was observed in the doorway of her room while seated in her wheelchair. R24 had no visible restraints (i.e., lap belt, wrist restraints) present or on at this time. R24's bed was visible from the hallway, which had a visible one-quarter grab bar attached on the left side in the 'raised' position.

When interviewed on 4/3/23 at 7:45 a.m., nursing assistant (NA)-H stated R24 did not use any restraints to their knowledge.

On 4/6/23 at 2:35 p.m., a subsequent observation of R24 was made. R24 was laying in her bed in her room with the same one-quarter grab bar in place and raised up. When interviewed at this same time, NA-A explained R24 had used the grab bar for an extended period of time and the attached, raised bar did not

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restrict R24's ability to get up from the bed. R24 agreed with this when asked.

R24's medical record was reviewed and lacked evidence R24 had any restraint(s) applied during the quarterly MDS (dated 3/4/23) ARD period to justify coding use of such devices.

On 4/6/23 at 2:05 p.m., registered nurse (RN)-A was interviewed, and they verified they were currently completing the MDS' for the nursing home while out of State. RN-A explained the MDS was coded to reflect restraint use as R24 used a grab bar on their bed to increase their mobility and, since it was a grab bar and not an actual side rail, they coded it as, "Other." RN-A acknowledged grab bars used for mobility were not typically coded as a restraint, however, the nurses on-site had told them the bar was "fixed" and "cannot be moved." Further, RN-A reiterated a grab bar was typically not coded as a restraint; however, they had been directed to code it as such by one of the regional nurses.

A facility' policy on MDS completion was requested, however, none was received.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245028	A. BUILDING ______ B. WING ______	C 04/06/2023

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments On 4/3/23 to 4/6/23, a survey for compliance with Appendix Z, Emergency Preparedness Requirements for Long Term Care facilities, §483.73 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 025 SS=C	Arrangement with Other Facilities CFR(s): 483.73(b)(7) §403.748(b)(7), §418.113(b)(5), §441.184(b)(7), §460.84(b)(8), §482.15(b)(7), §483.73(b)(7), §483.475(b)(7), §485.625(b)(7), §485.920(b)(6), §494.62(b)(6). [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:]	E 025		5/12/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed — TITLE — (X6) DATE: 05/05/2023

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

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	245028	A. BUILDING _______ B. WING _______	C 04/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLAND OPERATIONS LLC	2319 WEST SEVENTH STREET SAINT PAUL, MN 55116

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E 025	Continued From page 1 *[For Hospices at §418.113(b), PRFTs at §441.184,(b) Hospitals at §482.15(b), and LTC Facilities at §483.73(b):] Policies and procedures. (7) [or (5)] The development of arrangements with other [facilities] [and] other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of services to facility patients. *[For PACE at §460.84(b), ICF/IIDs at §483.475(b), CAHs at §486.625(b), CMHCs at §485.920(b) and ESRD Facilities at §494.62(b):] Policies and procedures. (7) [or (6), (8)] The development of arrangements with other [facilities] [or] other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of services to facility patients. *[For RNHCIs at §403.748(b):] Policies and procedures. (7) The development of arrangements with other RNHCIs and other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of non-medical services to RNHCI patients. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to develop and document written agreements with other providers that included pre-arranged written agreements with other facilities to receive residents in the event of limitations or cessation of operations to maintain continuity of services to facility residents. This had the potential to affect all 58 residents and the staff of the facility.	E 025	E 025 A facility contract agreement was established with Southview Acres Nursing and Rehabilitation on 5/10/2023. This agreement was placed in the master emergency preparedness binder. Quarterly, the facility contract for transfer will be reviewed and documented on the QAPI meeting minutes. The IDT team will be in-serviced on the	

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E 025	Continued From page 2 Findings include: On 4/5/23 at 3 p.m., review of the facility's Emergency Preparedness Program (EEP) with a revised date of 2/28/23, documented EPP plans for in the case of evacuation to transfer residents to a local community center but failed to include written pre-arranged agreements to receive residents in the event of limitation or cessation of operations to maintain the continuity of services. During interview on 4/6/23 at 10:05 a.m., administrator confirmed the EPP did not include pre-arranged written agreement with the facility identified to receive residents in the event of limitations or cessation of operations to maintain the continuity of services to facility residents. Administrator did not list how all aspects of continutity of care for all the resident population could be continued at a community center. Administrator stated facility had a signed transfer agreement and would look for it. A copy of pre-arranged written agreements with other facilities was requested but was not provided.	E 025	Coordinated EMA□s Emergency Management Agency Policy with emphasis on item #1 that the facility will establish and maintain relationships with agencies to coordinate responses in emergency situations and item #5 that coordination will include providing coordinating agencies with a copy of the facility response plan, participating in agency meetings to discuss emergency provisions, and participating in training exercises and drills. Executive Director and/or designee will be responsible for compliance. Audits on facility contract agreements will begin monthly x 2 months then quarterly to ensure compliance. Audit results will be reviewed by the Executive Director and the Executive Director will take audit results to QAPI for review and recommendation. Compliance: 5/12/2023	
E 036 SS=C	EP Training and Testing CFR(s): 483.73(d) §403.748(d), §416.54(d), §418.113(d), §441.184(d), §460.84(d), §482.15(d), §483.73(d), §483.475(d), §484.102(d), §485.68(d), §485.542(d), §485.625(d), §485.727(d), §485.920(d), §486.360(d), §491.12(d), §494.62(d). *[For RNCHIs at §403.748, ASCs at §416.54, Hospice at §418.113, PRTFs at §441.184, PACE	E 036		5/12/23

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E 036	Continued From page 3 at §460.84, Hospitals at §482.15, HHAs at §484.102, CORFs at §485.68, REHs at §485.542, CAHs at §486.625, "Organizations" under 485.727, CMHCs at §485.920, OPOs at §486.360, and RHC/FHQs at §491.12:] (d) Training and testing. The [facility] must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. *[For LTC facilities at §483.73(d):] (d) Training and testing. The LTC facility must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually. *[For ICF/IIDs at §483.475(d):] Training and testing. The ICF/IID must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at	E 036		

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E 036	Continued From page 4 least every 2 years. The ICF/IID must meet the requirements for evacuation drills and training at §483.470(i). *[For ESRD Facilities at §494.62(d):] Training, testing, and orientation. The dialysis facility must develop and maintain an emergency preparedness training, testing and patient orientation program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training, testing and orientation program must be evaluated and updated at every 2 years. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to develop and maintain an emergency preparedness training and testing program that is based on the emergency plan, risk assessment, policies, and procedures. This had the potential to affect all 58 residents currently residing in the facility, as well as their families and/or representatives. See E0037: The facility failed to provide staff emergency preparedness training at least annually which was based on the facility emergency preparedness plan (EPP), with a revised date of 2/28/23. See E0039: The facility failed to provide staff emergency preparedness test at least twice annually which was based on the facility EPP.	E 036	E 036 Facility staff will have emergency preparedness training and testing courses completed by 05/09/2023. All new employees will have emergency preparedness training and testing upon orientation and annually. The facility risk assessment and emergency policies and procedures will be reviewed and updated as needed. Annually, the emergency preparedness plan, risk assessment and all emergency policies and procedures will be reviewed and updated as needed. The IDT team will be in-served on the Emergency Management Plan with emphasis on item #19 that the plan will be reviewed and updated at a minimum annually to ensure its accuracy. Administrator and/or designee is responsible for compliance. Audits on emergency plan review will	

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E 036	Continued From page 5	E 036	begin 1x month then quarterly to ensure sustained compliance Audit results will be reviewed by the Executive Director and the Executive Director will take audit results to QAPI for review and recommendation. Compliance: 5/12/2023	
E 037 SS=C	EP Training Program CFR(s): 483.73(d)(1) §403.748(d)(1), §416.54(d)(1), §418.113(d)(1), §441.184(d)(1), §460.84(d)(1), §482.15(d)(1), §483.73(d)(1), §483.475(d)(1), §484.102(d)(1), §485.68(d)(1), §485.542(d)(1), §485.625(d)(1), §485.727(d)(1), §485.920(d)(1), §486.360(d)(1), §491.12(d)(1). *[For RNCHIs at §403.748, ASCs at §416.54, Hospitals at §482.15, ICF/IIDs at §483.475, HHAs at §484.102, REHs at §485.542, "Organizations" under §485.727, OPOs at §486.360, RHC/FQHCs at §491.12:] (1) Training program. The [facility] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the [facility] must conduct training on the updated policies and	E 037		5/12/23

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E 037	Continued From page 6 procedures. *[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles. (ii) Demonstrate staff knowledge of emergency procedures. (iii) Provide emergency preparedness training at least every 2 years. (iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others. (v) Maintain documentation of all emergency preparedness training. (vi) If the emergency preparedness policies and procedures are significantly updated, the hospice must conduct training on the updated policies and procedures. *[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) After initial training, provide emergency preparedness training every 2 years. (iii) Demonstrate staff knowledge of emergency procedures. (iv) Maintain documentation of all emergency	E 037		

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E 037	Continued From page 7 preparedness training. (v) If the emergency preparedness policies and procedures are significantly updated, the PRTF must conduct training on the updated policies and procedures. *[For PACE at §460.84(d):] (1) The PACE organization must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, contractors, participants, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Demonstrate staff knowledge of emergency procedures, including informing participants of what to do, where to go, and whom to contact in case of an emergency. (iv) Maintain documentation of all training. (v) If the emergency preparedness policies and procedures are significantly updated, the PACE must conduct training on the updated policies and procedures. *[For LTC Facilities at §483.73(d):] (1) Training Program. The LTC facility must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency	E 037		

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E 037	Continued From page 8 procedures. *[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following: (i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment. (v) If the emergency preparedness policies and procedures are significantly updated, the CORF must conduct training on the updated policies and procedures. *[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following: (i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at	E 037		

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E 037	Continued From page 9 least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the CAH must conduct training on the updated policies and procedures. *[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least every 2 years. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to provide staff emergency preparedness training at least annually which was based on the facility Emergency Preparedness Plan (EPP). This had the potential to affect all 58 residents currently residing in the facility, as well as staff, and visitors at the facility. Findings include: During an interview on 4/6/23 at 11:08 a.m., nursing assistant (NA)-E stated they had worked at the facility for several years. NA-E stated the facility conducts fire drills but when specifically asked about the facility's Emergency Preparedness Program, (NA)-E stated she was not aware of it.	E 037	E 037 The facility failed to provide staff emergency preparedness training at least annually which was based on the facility emergency preparedness plan (EPP). Upon hire, newly hired employees will have emergency preparedness education annually and training exercises bi-annually per facility policy. All staff will be in-serviced on the Disaster Training Plan with emphasis on item #4 that training exercise drills will be conducted at least bi-annually to test the emergency preparedness plan and education on emergency preparedness yearly. Administrator and/or designee is	

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E 037	Continued From page 10 During interview on 4/6/23 at 11:21 a.m., nursing assistant (NA)-F stated we "do fire drills training". When asked about the Emergency Preparedness Program, (NA)-F stated she didn't recall recieving training on the facility EPP. During interview on 4/6/23 at 11:26 a.m., registered nurse (RN)-D stated she had worked at the facility for three years and did not recall an annual emergency preparedness training. RN-D stated "but we do fire drills." During interview on 4/6/23 at 11:44 a.m., nursing assistant (NA)-G stated she had worked at the facility for five years and she is not aware of any plans for evacuation and did not recall ever recieving training on the facility EPP. During an interview on 4/6/23 at 11:50 a.m., nursing assistant (NA)-A stated she had worked at facility for five months and she had only received education about fire and weather emergencies and had not been trained on the facility's EPP. During interview on 4/6/23 at 11:53 a.m., dietary aid (DA)-A stated she had worked at facility for two years and had received training about abuse, fire emergencies. NA-A stated she was unaware of a an emergency preparedness training. During an interview on 4/6/23 at 1:26 p.m., the director of nursing stated she had received training about the emergency preparedness plan as part of her new employee orientation. During an interview on 4/6/23 at 2:10 p.m., the administrator was unable to provide	E 037	responsible for compliance. Audits on employee training on emergency preparedness education and training will begin 1x week for 4 weeks the monthly to ensure sustained compliance. Audit results will be reviewed by the Executive Director and the Executive Director will take audit results to QAPI for review and recommendation. Compliance: 5/12/2023	

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E 037	Continued From page 11 documentation of the facility's EPP training during the last year. The administrator stated going forward EPP training will be part of all employees annual training.	E 037		
E 039 SS=C	EP Testing Requirements CFR(s): 483.73(d)(2) §416.54(d)(2), §418.113(d)(2), §441.184(d)(2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2), §483.475(d)(2), §484.102(d)(2), §485.68(d)(2), §485.542(d)(2), §485.625(d)(2), §485.727(d)(2), §485.920(d)(2), §491.12(d)(2), §494.62(d)(2). *[For ASCs at §416.54, CORFs at §485.68, REHs at §485.542, OPO, "Organizations" under §485.727, CMHCs at §485.920, RHCs/FQHCs at §491.12, and ESRD Facilities at §494.62]: (2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following: (i) Participate in a full-scale exercise that is community-based every 2 years; or (A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or (B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event. (ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is	E 039		5/12/23

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 039	Continued From page 12 not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed. *[For Hospices at 418.113(d):] (2) Testing for hospices that provide care in the patient's home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the following: (i) Participate in a full-scale exercise that is community based every 2 years; or (A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full scale community-based exercise or individual facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following:	E 039		

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E 039	Continued From page 13 (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (3) Testing for hospices that provide inpatient care directly. The hospice must conduct exercises to test the emergency plan twice per year. The hospice must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual facility-based functional exercise; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospice is exempt from engaging in its next required full-scale community based or facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop led by a facilitator that includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.	E 039		

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E 039	Continued From page 14 (iii) Analyze the hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the hospice's emergency plan, as needed. *[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):] (2) Testing. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the [PRTF, Hospital, CAH] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.	E 039		

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E 039	Continued From page 15	E 039		

Continued From page 15

(iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the [facility's] emergency plan, as needed.

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

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E 039	Continued From page 16 maintain documentation of all drills, tabletop exercises, and emergency events and revise the PACE's emergency plan, as needed. *[For LTC Facilities at §483.73(d):] (2) The [LTC facility] must conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The [LTC facility, ICF/IID] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. (B) If the [LTC facility] facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required a full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [LTC facility] facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [LTC facility] facility's emergency plan, as needed.	E 039		

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E 039	Continued From page 17 *[For ICF/IIDs at §483.475(d)]: (2) Testing. The ICF/IID must conduct exercises to test the emergency plan at least twice per year. The ICF/IID must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or. (B) If the ICF/IID experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID is exempt from engaging in its next required full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the ICF/IID's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID's emergency plan, as needed. *[For HHAs at §484.102] (d)(2) Testing. The HHA must conduct exercises to test the emergency plan at least annually. The HHA must do the following:	E 039		

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E 039	Continued From page 18 (i) Participate in a full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise every 2 years; or. (B) If the HHA experiences an actual natural or man-made emergency that requires activation of the emergency plan, the HHA is exempt from engaging in its next required full-scale community-based or individual, facility based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the HHA's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the HHA's emergency plan, as needed. *[For OPOs at §486.360] (d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following:	E 039		

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E 039	Continued From page 19 (i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. If the OPO experiences an actual natural or man-made emergency that requires activation of the emergency plan, the OPO is exempt from engaging in its next required testing exercise following the onset of the emergency event. (ii) Analyze the OPO's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. *[RNCHIs at §403.748]: (d)(2) Testing. The RNHCI must conduct exercises to test the emergency plan. The RNHCI must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the RNHCI's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the RNHCI's emergency plan, as needed. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to conduct a full-scale community based exercise, or a facility-based table top exercise to test their emergency preparedness program twice per year or to document activation	E 039	E 039 The facility will conduct a mock disaster training drill tentatively schedule for 05/25/2023. For future training, the facility will conduct mock drills annually per	

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E 039	Continued From page 20 of their emergency preparedness plan or incident command system in response to an actual emergency event the facility experienced during the last year. This had the potential to affect all 58 residents who currently resided in the facility, along with staff who work in the facility. Findings include: Review of the facilities emergency preparedness plan (EPP) binder did not include exercises performed during the last year. During an interview on 4/6/23 at 10:05 a.m., the administrator stated no community-based exercise was completed for all the staff since the facility started to operate under new owners in July 2022. The administrator was unable to present any documentation of facility's staff participation in a full-scale community-based exercise during the last year.	E 039	facility policy. The IDT team will be in-serviced on the Disaster Training policy (updated 5/9/2023) with emphasis on #4 that training exercise drills will be conducted at least bi-annually to test the emergency preparedness plan and identify opportunities for improvement. Administrator and/or designee is responsible for compliance. Audits on mock disaster training will begin 1x week for 4 weeks the monthly to ensure sustained compliance. Executive Director and/or designee will be responsible for compliance. Audits on will begin weekly x 4 weeks then monthly to ensure compliance. Audit results will be reviewed by the Executive Director and the Executive Director will take audit results to QAPI for review and recommendation. Compliance: 5/12/2023	
F 000	INITIAL COMMENTS On 4/3/23 to 4/6/23, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was not in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. In addition to the recertification survey, the following complaints were reviewed with no deficiencies issued: H5028152C (MN82276) H5028153C (MN80170) H5028154C (MN82151)	F 000		

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F 000	Continued From page 21 H50289948C (MN83138) H50289949C (MN83630) H50289950C (MN86253) H50289951C (MN91482) H50289953C (MN91901) H50289955C (MN92087) H50289957C (MN92300) H50289958C (MN86039) H50289959C (MN86234) H50281008C (MN91569) and The following complaints were reviewed with a deficiency issued at F565: H50289952C (MN91701) H50289954C (MN92059) H50289956C (MN92102) The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 553 SS=E	Right to Participate in Planning Care CFR(s): 483.10(c)(2)(3) §483.10(c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not	F 553		5/12/23

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F 553	Continued From page 22 limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iii) The right to be informed, in advance, of changes to the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care. §483.10(c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must- (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care. This REQUIREMENT is not met as evidenced by: Based on interview, and document review, the facility failed to ensure resident and/or resident representatives participated in the resident care planning process and subsequent development of interventions for 4 of 4 residents (R31, R49, R29, R162) reviewed for participation in care planning. Findings include:	F 553	F 553 R 31 discharged from the facility. R 49 will have a care conference on 05/09/2023. R 29 had a care conference on 05/02/2023. R 162 discharged from the facility on 04/28/2023. All existing resident care conferences will be scheduled with the resident and/or resident representative	

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F 553	Continued From page 23 R31's significant change Minimum Data Set (MDS) dated, 3/22/23, identified R31 required extensive assistance with two plus staff for bed mobility, transfers, and extensive assistance with assist of one for personal hygiene and dressing. Diagnoses includes morbid obesity, atrial fibrillation, heart failure, and history of venous thrombosis and embolism (blood clots). R31's hospital after visit summary printed 9/28/22 stated, "General info for SNF for Length of Stay Estimate: Short Term Care: Estimated # of Days <30". R31 progress note dated 12/16/22, by facility social worker (SW)-B stated "Met with [R31], Here in TCU on short term recovery from fall and broken elbow and shoulder. Scheduled Care Conference for Tuesday at 1:00pm". R31 progress note titled "Care Conference" dated 2/22/23 at 9:29 a.m., by SW-A stated "Note Text: Contacted [R31's] [family member] to arrange a Care Conference, [family member][FM-(A)] stated that he will give me a call back." During interview with R31 on 4/3/23 at 10:38 a.m., R31 stated facility "has not had a care conference since my admission", which was on 9/28/22. During interview with administrator on 4/3/23 at 11:26 a.m., administrator stated expectation that care conference notes from the social worker can be viewed in the resident's electronic medical record (EMR) under progress notes and/or assessments tab. "I don't see it in there". Administrator stated expectation was SW-A was	F 553	during the MDS review period. Initial care conferences will be conducted per facility policy. Facility Social Service Designee was in-serviced on the Resident Care Conference/Care Plan review with emphasis on item #2 that initial care conferences will be held within 72hrs of a resident□s admission and quarterly care conference will be scheduled during the MDS assessment reference period. Administrator and/or designee will be responsible for compliance. Audits on will begin weekly x 4 weeks then monthly to ensure compliance. Audit results will be reviewed by the Executive Director and the Executive Director will take audit results to QAPI for review and recommendation. Compliance: 5/12/2023	

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F 553		F 553		

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told and "she should be doing this".

During interview with SW-A on 4/3/23 at 1:39 p.m., SW-A stated "We have not had a care conference yet since admission" for R31. SW-A stated care conferences are expected to be done within 48 hours of admission and quarterly. SW-A stated care conference notes are expected to be found in the progress note of EMR.

During interview with director of nursing (DON) on 4/5/23 at 1:01 p.m., DON stated expectation of care conferences to be done and documented by facility at resident admission, quarterly and as needed. DON verified R31 care conference was not done since admission on 9/28/23. "I don't see one documented. There should be."

During interview with R31's emergency contact, (FM-A) on 4/5/23 at 1:58p.m., FM-A stated no care conferences have been scheduled for R31 since admission to facility. FM-A stated he has "not been notified about anything" since his mother was admitted to facility. FM-A stated he had called the facility twice to discuss discharge planning for R31, but facility has not responded to him. FM-A stated "if they are saying they are calling me they are not telling the truth. I expect to be included in the care conferences". FM-A stated R31 "lives with my [family member]" and "no has talked to me or anyone in our family including my mother about discharge planning".

Facility policy titled Resident Care Conference/Care Plan Review updated 03/30/2021 stated "The overall care conference goal process will aid in better resident care outcomes for our long-term and safe discharge to the community for our short-term residents".

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R49's face sheet dated 4/6/23, indicated R49 admitted to the facility on 2/24/23.

R49's significant change Minimum Data Set (MDS) dated 3/21/23, indicated R49 had severe cognitive deficits.

R49's electronic medical record (EMR) indicated R49's diagnoses included a stroke resulting in one-sided paralysis, encephalopathy (disorder or disease affecting the brain), coronary artery disease (CAD, increased plaque in the arteries of the heart), cardiomyopathies (diseases affecting the heart muscle), history of clostridium difficile (C-Diff a bacterial infection of the intestine that can lead to death), heart failure, malnutrition, obstructive sleep apnea (the cessation of breathing during sleep), atrial fibrillation (irregular heart rhythm increasing the incidents of blood clots), high blood pressure, shortness of breath, dysphagia (difficulty swallowing), and second-degree burn to left lower limb.

R49's Care Area Assessment (CAA) dated 3/21/23, indicated R49 triggered for cognitive loss/dementia, communication, activities of daily living (ADL) function, urinary incontinence, falls, pressure ulcers, and pain.

R49's care plan dated 2/27/23, indicated R49 had a goal for his preferences to be honored while at the facility. R49 was also on hospice with the goal to remain comfortable related to his hospice care. Interventions included coordinating R49's care with the hospice services and other end of life cares.

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Review of R49's progress notes lacked indication of a care conference or documentation of efforts to coordinate a care conference since R49's admission on 2/24/23.

R49's responsible party was unavailable for interview.

During an interview on 4/3/23 at 11:35 a.m., the social services director (SSD)-A stated residents were to have a care conference within 48 hours of admission and then every quarter. SSD-A verified R49 has not had a care conference since his admission on 2/24/23, and she had not contacted R49's responsible party to schedule one.

R29's significant change Minimum Data Set (MDS), dated 2/23/23, indicated R29 had short-term and long-term memory problems with severely impaired cognitive skills for decision making, needed extensive assistance with bed mobility, transfers, toileting use, personal hygiene, and supervision with eating. The MDS further indicated medical diagnoses to include metabolic encephalopathy (a problem in the brain caused by a chemical imbalance in the blood which can lead to personality changes), binge eating disorder (frequently consuming unusually large amounts of food in one sitting and feeling that eating behavior is out of control), venous insufficiency (a condition in which the veins have problems sending blood from the legs back to the heart), major depressive disorder (a mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life), obstructive sleep apnea (Intermittent airflow blockage during sleep causing decreased oxygen

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F 553	Continued From page 27 saturation or arousal from sleep), and schizoid personality disorder (a condition in which people avoid social activities and interacting with others). During interview on 4/4/23 at 8:28 a.m., R29 stated he had never been invited to or attended a care conference since being admitted to the facility on 2/9/23. Review of R29's electronic medical record (EMR) lacked evidence of any interdisciplinary team meetings or a care conference being held since admission to the facility on 2/9/23. During interview on 4/6/23 at 9:53 a.m., the director of nursing (DON) confirmed there was no evidence of a care conference in R29's medical record. The DON stated the expectation would be for care conferences to be help within the first 72 hours of admission and quarterly. The DON further stated every care conference should be documented in progress notes. The five day, in progress, Minimum Set Data (MDS) dated 3/30/23, indicated R162 was severely cognitive impaired, easily distracted, incoherent, needed extensive assistance with bed mobility, transfers toileting, ambulation, dressing, eating and hygiene. The MDS further indicated medical diagnoses to include aphasia (loss of ability to understand or express speech), cerebral infarction (area of damaged tissue on the brain), epilepsy (brain disorder that causes recurring, unprovoked involuntary movement), pain in right leg, pulmonary hypertension (a type of blood pressure that affects arteries in the lungs and in	F 553		

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F 553	Continued From page 28 the heart), schizophrenia (mental disorder that affects how a person thinks, acts and expresses emotions) and diabetes mellitus, During interview on 4/3/23 at 8:01 a.m., R162 was sitting at the edge of the bed and was calling for help to use the bathroom. R162 was able to answer simple concrete yes and no questions but R162 was unable to answer questions related to his stay at the facility and goals of care. During interview on 4/3/23 at 3:45 p.m., R162's family member stated she had not participated on a care conference to revise R162's care plan or therapy program. Regarding R162's discharge planning, family member (FM)-A stated that R162 would return home with her. During interview on 4/5/23 at 10 a.m., social worker (SW)-A stated admission care conferences were scheduled within 48 hours of admission. Thereafter, care conferences are scheduled every three months, annually and with significant changes. SW-A stated documentation of care conferences should be noted on R162's progress notes or under assessments. SW-A stated a care conference was not done for R162. During interview with director of nursing (DON) on 4/5/23 at 1:02 p.m., DON stated expectation of care conferences to be done and documented by facility at resident admission, quarterly and as needed. DON verified R162's care conference was not done since admission.	F 553		
F 554 SS=E	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer	F 554		5/12/23

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F 554	Continued From page 29 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 medications were securely stored for 4 of 4 residents (R5, R9, R30, R48) who had medications left in their rooms and did not have an order to self-administer medications. In addition, the facility failed to assess 1 of 1 residents (R48) who wanted to self-administer her medications. Findings include: R5 R5's admission Minimum Data Set (MDS) dated 2/23/23, indicated R5 had intact cognition, was independent with eating and required extensive assistance with all other activities of daily living (ADLs). R5's electronic medical record (EMR) indicated R5's diagnoses included seborrheic dermatitis (a condition causing red, flaky, itchy skin), sequelae poliomyelitis (post-polio syndrome affecting nerve function and occurring decades after initial exposure), diabetes, adjustment disorder with anxiety and depression, chronic hepatitis C, and erythema intertrigo (inflammation due to skin-to-skin friction). R5's Care Area Assessment (CAA) dated 2/23/23, indicated R5 triggered for ADL function and psychotropic drug use. R5's care plan dated 3/29/23, indicated R5 was	F 554	F 554 R 5, R 9, R 30, and R 48 had a risk management incident created and for all, each incident will be thoroughly investigated, and root cause identified. R 48 had a self-administration of medication assessment completed on 5/4/23 and determined resident can self-administer medications. The IDT along with the MD/NP will review documents to determine if resident is capable of self-administering medication. All existing residents will have their rooms audited for ointment and medications and these items will be relocated to the appropriate medication/treatment cart. In addition, existing residents will have their self-administration assessment reviewed and updated and any self-administration requested will be initiated as warranted. Future residents will have treatments and medications stored on the appropriate medication/treatment cart and residents who request to self-administer their medications will have an assessment completed and IDT team along with MD input per facility policy. Licensed nurses will be in-serviced on the self-administration of medication policy with emphasis on item # 3 that residents who are deemed safe and appropriate for self-administration of medication, it will be documented in the medical record and a care plan initiated. Licensed nurses will	

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F 554	Continued From page 30 dependent on staff for all intellectual, social, emotional, and physical needs. R5 had ADL self-care needs, was non-ambulatory and used a trapeze device for bed mobility. R5 was at risk for behaviors related to post traumatic stress syndrome (PTSD), depression, and anxiety. Interventions included administering R5's medications as ordered. R5's physician orders indicated staff were to cleanse R5's coccyx (tailbone) wound with wound cleanser and apply Santyl (ointment) to the wound bed. Clobetasol Propionate ointment (a corticosteroid) was to be applied to R5's face and neck, trolamine salicylate cream to both knees, hydrocortisone cream to affected skin, and capsaicin cream to both knees and a diphenhydramine oral tablet 25 milligrams (mg) every evening. R5's Self Administration of Medication (SAM) assessment dated 2/14/23, indicated R5's preference to self-administer medications was "no/unable to determine." R5's Associated Clinic of Psychology (ACP) progress note dated 3/30/23, indicated R5 had "some emotional distress effecting overall well-being." The note also indicated R5 had "some or much difficulty with ADLs." During an observation and interview on 4/3/23 at 7:44 a.m., R5 was in bed. A bottle of ketoconazole shampoo in a plastic bag with a prescription label for vancomycin (an antibiotic) indicated "discard by 2/1/23", a bottle of Vashe wash (wound cleanser), with R5's prescription labels were on R5's dresser. A clear plastic drinking cup was also on R5's dresser with	F 554	also be in-serviced on the Medication Storage Policy with focus on item #1 that drugs must be stored in locked compartments. Director of Nursing and/or designee will be responsible for compliance. Audits on Self-administration assessments, resident request for self-administration and medication storage will begin 2x week x 2 weeks, weekly x 4 weeks then monthly to ensure compliance. Audit results will be reviewed by the Executive Director and the Executive Director will take audit results to QAPI for review and recommendation. Compliance: 5/12/2023	

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approximately one inch of an unknown white powdery substance. R5 stated he thought the powder was an antifungal.

During an interview on 4/3/23 at 8:03 a.m., trained medical assistant (TMA)-A stated staff had been leaving the shampoo and wound cleanser in the room for convenience and although TMA-A stated the medications should have been locked in the nurse's cart, did not remove them from R5's room. TMA-A stated she believed the white powder was an antifungal that should not have been left in an unmarked cup in R5's room and removed the cup to dispose of the substance. TMA-A further stated R5 was not safe to self-administer medications.

During an observation on 4/4/23 at 9:07 a.m. R5 was in bed and the bottle of shampoo and wound cleanser were on R5's dresser.

During an observation on 4/5/23 08:44 a.m., R5 was in bed, the shampoo and wound cleanser were on his dresser in addition to a tube of ketoconazole ointment, and a tube of mupirocin ointment.

During an observation and interview on 4/6/23 at 11:46 a.m. R5 was in bed. The shampoo, wound cleanser, and a tube of diclofenac ointment were on his dresser. Registered nurse (RN)-F stated prescription medications including shampoos, cleanser, and ointment were not to be left in a resident's room unless the resident had completed a SAM and the physician approved it. RN-F further verified R5 did not have an order to self-administer any medications and removed the medications from R5's room.

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R9
R9's quarterly MDS dated 3/10/23, indicated R9's cognitive assessment was incomplete. R9 was independent with eating, required extensive assistance with toileting, dressing and personal hygiene, and total assistance for transfers and bed mobility.

R9's admission MDS dated 10/28/22, indicated R9 had intact cognition.

R9's face sheet indicated R9's diagnoses included a traumatic amputation of the lesser toe, osteomyelitis (bone infection) of the right foot and ankle, malnutrition, kidney failure, and systemic sclerosis (autoimmune disease-causing excessive collagen in the skin and internal organs).

R9's CAA dated 12/2/22, indicated R9 triggered for falls, nutritional status, and incontinence.

R9's care plan dated 11/16/22, indicated R9 was dependent on staff for emotional, intellectual, physical, and social needs. R9 had a communication deficit related to hearing loss and was on an anticoagulant (blood thinner). Interventions included giving medications as ordered and monitoring for side effects and effectiveness. R9 also had a potential for impairment to skin integrity. Interventions included using barrier cream after each incontinent episode.

R9's physician orders dated 3/29/23, indicated R9 had betadine (antimicrobial solution) applied to her right foot wound daily and calamine-menthol-petrolatum-zinc paste as needed for dry skin.

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R9's SAM dated 3/1/23, indicated R9's preference to self-administer medications was "no/unable to determine."

During an observation on 4/3/23, at 10:00 a.m., R9 was asleep in bed. A bottle of iodine povidone and an uncapped tube of diphenhydramine zinc ointment with R9's prescription label were on R9's dresser.

During an observation on 4/3/23, at 1:54 p.m. R9 was in a wheelchair watching TV in her room. The bottle of iodine and uncapped tube of ointment were on R9's dresser.

During an observation on 4/4/23 at 8:52 a.m. R9 was asleep in bed. The bottle of iodine and uncapped tube of ointment were on R9's dresser.

During observation on 4/5/23, at 9:18 a.m., R9 was asleep in bed. The bottle of iodine and uncapped tube of ointment were on R9's dresser.

During an observation and interview on 4/6/23 at 11:50 a.m. R9 was sitting in a wheelchair in her room. RN-F verified the R9 did not have an order to self-administer medications and removed the bottle of iodine and uncapped tube of ointment from her room stating medications needed to be locked in the nurse's cart for the resident's safety.

R30
R30's quarterly MDS dated 2/22/23, indicated R30 had mild cognitive deficits, required supervision of one staff for toileting and was independent with all other ADLs.

R30's EMR indicated R30 had diagnoses

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F 554	Continued From page 34 including a stable burst fracture of the spine (thoracic vertebra T11-T12), muscle weakness, alcoholic cirrhosis of the liver, high blood pressure, major depression, morbid obesity, sciatica (pain in the sciatic nerve from the lower back down one or both legs) and hepatic (liver) failure. R30's CAA dated 11/22/22, indicated R30 triggered for ADL function, falls, and psychotropic drug use. R30's care plan dated 7/15/22, indicated R30 was Cuban and dependent on staff for meeting his emotional, intellectual, physical, and social needs. R30 was dependent on alcohol and may have impaired judgement while intoxicated. Interventions included to assess and adjust medications as needed and encouraging R30 to drink in moderation. R30 was also at risk for falls due to gait/balance problems and had chronic pain related to his spinal fracture. Interventions included anticipating R30's need for pain relief and responding immediately to any complaint of pain. R30's physician orders dated 2/8/22, indicated R30 had capsagel (Capsaicin) gel for pain to his right Achilles tendon (ankle). R30's SAM dated 2/22/23, indicated R30's preference to self-administer medications was "no/unable to determine." During an observation and interview 4/6/23 at 11:48 a.m. R30 was in the dining room. The tube of prescription Capsaicin was tucked between R30's mattress and grab bar alongside a new tube of Capsaicin ointment with no prescription	F 554		

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label. RN-F stated the ointments should not be left in R30's room because he did not have an order to self-administer medications and removed them from R30's room.

R48
R48's significant change MDS dated 12/24/22, lacked indication of R48's cognitive status. R48 required supervision for bed mobility and toileting and was independent with all other ADLs.

R48's quarterly MDS dated 11/26/22, indicated R48 had intact cognition.

R48's hospital discharge summary dated 12/9/21, indicated R48 had diagnoses including respiratory failure with hypoxia (low oxygen) resulting in a tracheostomy (artificial airway place in the throat) due to COVID-19, morbid obesity, diabetes, chronic kidney disease, high blood pressure, low thyroid, and depression with a suicide attempt due to adjustment disorder.

R48's CAA dated 12/24/22, indicated R48 triggered for falls, incontinence, and pressure ulcers.

R48's care plan dated 9/1/22, indicated R48 was independent for meeting her emotional, intellectual, physical, and social needs and wished to discharge to an assisted/independent living community. R48 had diabetes and an altered cardiovascular (heart) status due to high blood pressure. Interventions included monitoring R48 for signs of coronary artery disease (CAD) such as chest pain, heartburn, shortness of breath, and nausea or vomiting and giving medications as ordered.

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R48's physician orders dated 12/21/22, indicated R48 received 120 milligrams (mg) thyroid tablet once daily for low thyroid, two 25 mg (50mg) carvedilol twice a day for high blood pressure, and 2.5 mg amlodipine besylate in the morning for high blood pressure.

R48's SAM dated 3/24/23, indicated R48's preference to self-administer medications was "no/unable to determine."

During an observation and interview on 4/3/23 at 10:26 a.m., R48 was sitting in her wheelchair after dressing herself and self-transferring out of bed. R48 stated she had to take her thyroid pill 30 minutes prior to or two hours after eating. R48 stated some staff would bring her thyroid pill then leave her other medications on her meal tray to be taken after she got herself up and ate breakfast; however, R48 further stated some staff told her they were not allowed to leave the medications which confused R48. R48 stated she had never been asked if she would like to self-administer her medications and that it would be "so much easier."

During an observation on 4/4/23 at 8:54 a.m., R48 was in bed with her bipap (a mask used to treat sleep apnea) on. R48's breakfast tray was on the bedside table and a medication cup with three pills was on her meal tray. R48 stated she received her thyroid pill at 8:00 a.m. and the medications in the cup were her carvedilol and amlodipine.

During an interview on 4/4/23 at 8:59 a.m., licensed practical nurse (LPN)-A stated residents had to have a SAM assessment completed and a physician's order to self-administer medications.

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HIGHLAND OPERATIONS LLC	**2319 WEST SEVENTH STREET SAINT PAUL, MN 55116**

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LPN-A stated R48 was alert and oriented but was unsure if she had a SAM assessment. LPN-A then verified R48's SAM indicated her preference for self-administration of medications was "no/unable to determine" LPN-A stated she did not know why R48's SAM indicated "no" because R48 always took her thyroid medication early, and her high blood pressure medications later. The was "normal" for her.

During an interview and observation on 4/5/23 at 9:20 a.m. R48 was in bed with her bipap mask on. R48 stated she did not receive her thyroid pill until 9:00 a.m. and would need to wait to eat her breakfast until 9:10 a.m. R48's breakfast was on the bedside table with a medication cup containing two medications.

During an interview on 4/5/23 at 9:23 a.m. LPN-D stated she gave R48 her thyroid medication and left a medication cup with two other medications on R48's meal tray for her to take later. LPN-D was unaware if R48 had a SAM assessment.

During an interview on 4/6/23 at 3:00 p.m., the director of nursing (DON) stated staff should watch residents take their medications unless the resident had a SAM assessment that indicated they were able to safely self-administer medications and a provider had written an order approving it. The DON also stated any medicated shampoo and creams were also to be locked in the nurse's cart and not left in a resident's room without a SAM assessment and provider's order. The DON further stated the assistant DON (ADON) and herself completed the SAM assessments.

During an interview on 4/6/23 at 4:39 a.m., the

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F 554	Continued From page 38 ADON stated R48 had not mentioned wanting to self-administer her medications during her quarterly assessment on 3/24/23, and she was unaware staff had been leaving R48's medications for her to take later. The ADON further stated she would re-address the issue with R48. The facility Administering Medications policy dated 12/13/21, indicated medications were to be administered in accordance with prescriber orders. Medication administration would honor resident choices and preferences. Residents may self-administer medication only if the attending physician and interdisciplinary team have determined the resident has the decision-making capacity to do so safely.	F 554		
F 565 SS=E	Resident/Family Group and Response CFR(s): 483.10(f)(5)(i)-(iv)(6)(7) §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such	F 565		5/12/23

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F 565	Continued From page 39 groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to ensure an ongoing grievance/complaint about long call light wait times, brought up during resident council meetings was addressed for 5 of 5 residents (R9, R18, R26,R30, and R48) interviewed about resident council. Findings include: The facility's Resident Council Minutes identified concerns with long call light wait times for residents. 10/10/22, Old Business: Call light not being answered for a very long time (DON [director of nursing] to audit call lights). New Business: Call lights still an ongoing issue (F/U [follow up] with Nursing department). 11/12/23, [11/12/22] Old Business: Call lights still an ongoing issue	F 565	F 565 The administrator and social service designee met with R 9, R 18, R 26, R 30, and R 48 on resident council concerns regarding the call light wait times. A grievance form will be completed for this meeting and the resident response to facility plan will be recorded. All existing residents will be notified of the facility plan to decrease call light wait times will be presented at the next resident council meeting tentatively scheduled for 5/11/23. Facility staff will be in-serviced on the Call light Policy with emphasis on the policy purpose that timely response to resident needs and requests immediately. In addition, the facility staff will be in-serviced on the grievance policy and procedure process with emphasis on who is to receive the grievance, the grievance log and facility policy response	

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F 565	Continued From page 40 (F/U with Nursing department). 1/12/23, Old Business: Call lights still an ongoing issue (F/U with Nursing department). 2/9/23, New Business: Call light not being answered on time. (F/U with management). 3/9/23, Old Business: Call light not being answered on time. (F/U with management). R9 R9's quarterly Minimum Data Set (MDS) dated 3/10/23, indicated R9's cognitive assessment was incomplete. R9 was independent with eating, required extensive assistance with toileting, dressing and personal hygiene, and total assistance for transfers and bed mobility. R9's diagnoses included a traumatic amputation of the lesser toe, osteomyelitis (bone infection) of the right foot and ankle, malnutrition, kidney failure, and systemic sclerosis (autoimmune disease-causing excessive collagen in the skin and internal organs). R9's admission MDS dated 10/28/22, indicated R9 had intact cognition. R9's CAA dated 12/2/22, indicated R9 triggered for falls, nutritional status, and incontinence. R9's care plan dated 3/15/23, indicated R9 was dependent on staff for her emotional, intellectual, physical, and social needs. R9 was a vulnerable adult with a risk for abuse related to altered cognition. Interventions included anticipating and meeting R9's needs. R9 also had a potential for impaired skin integrity. Interventions included applying barrier cream after each episode of	F 565	timeframes. Social Service designee will be responsible for compliance. Audits on call light wait times and grievance resolution and grievance log entries will begin 2x week for 2 weeks, weekly x 4 weeks then monthly to ensure compliance. Audit results will be reviewed by the Executive Director and the Executive Director will take audit results to QAPI for review and recommendation. Compliance: 5/12/2023	

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incontinence. The care plan also indicated R9 had episodes of shortness of breath related to low oxygen and would have not complications related to shortness of breath.

During an interview on 4/3/23 at 2:01 p.m. R9 stated sometimes it took staff an hour to answer her call light. R9 stated she worried if there was a "crisis" they would not be there. R9 also stated she left her door open so she could watch for staff to walk by and call out for help.

During an interview on 4/5/23 at 2:35 p.m. R9 stated she put her call light on the previous evening during dinner to request salad dressing; however, staff did not answer her call light until 8:00 p.m. R9 stated she had often waited hours for staff to answer her call light and would occasionally check the electronic display at the end of the hall to ensure it was working.

Review of R9's call light log from 3/22/23 at 12:00 a.m., to 4/4/23 at 12:01 a.m., indicated the following:
4/4/23
-3:20 p.m. 344 minutes (min)
4/2/23
-9:12 p.m. 42 min
3/31/23
-9:25 p.m.
-5:39 p.m. 78 min

R18
R18's quarterly MDS dated 2/10/23, indicated R18 had intact cognition, was independent with eating, required supervision for transfers and extensive assistance for all other ADLs. R18 had diagnoses including polyosteoarthritis (pain, swelling, and stiffness in multiple joints), high

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blood pressure, dysphagia (difficulty swallowing), obesity, chronic pain, pulmonary embolism (a clot in the lung), spondylosis (degeneration) of the lower spine, and asthma.

R18's CAA dated 5/11/22, indicated R18 triggered for urinary incontinence, falls, and pressure ulcers.

R18's care plan dated 8/16/22, indicated R18 was dependent on staff for her emotional, intellectual, physical, and social needs. R18 had ADL self-care needs related to limited mobility and was a moderate risk for falls related to gait/balance problems. Interventions included ensuring R189's call light was accessible and staff responded promptly to all R18's requests for assistance. R18 also had a safety risk with a potential for abuse. Interventions included anticipating R18's needs and assisting her to complete her treatment plan. The care plan also indicated R18 had potential/actual impairment to her skin integrity. Interventions included applying barrier cream after every incontinent episode.

During an interview on 4/3/23 at 10:03 a.m., R18 stated she had waited "for a couple of hours" for staff to answer her call light. R18 was concerned if she had an emergency, the staff would not respond fast enough. R18 activated her call light on 4/5/23, for assistance transferring to her wheelchair so she could attend a facility meeting; however, the staff took an hour to respond causing R18 to miss the meeting. R18 stated the resident council met monthly with the activities director (AD) who filled out grievances regarding their concerns. R18 further stated, although long call light response times had been an ongoing complaint during resident council meetings, it had

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not been addressed.

Review of R18's call light log from 3/22/23 at 12:00 a.m., to 4/4/23 at 12:01 a.m., indicated the following:
4/1/23
-8:35 p.m. 80 min

R26
R26's significant change MDS dated 1/20/23, 12/8/22, and 11/28/22, lacked indication of R26's cognitive status.

R26's admission MDS dated 8/31/22, indicated R26 was cognitively intact, was independent with eating, required limited assistance with dressing and extensive assistance with all other ADLs. R26's diagnoses included chronic obstructive pulmonary disease (COPD, causing difficulty breathing), obstructive sleep apnea (the cessation of breathing periodically during sleep), morbid obesity, high blood pressure, diabetes, anxiety, failure to thrive, and peripheral venous insufficiency (decreased ability to circulate blood and fluid from the lower extremities resulting in fluid retention).

R26's CAA dated 1/20/23, indicated R26 triggered for urinary incontinence, falls, nutrition, and psychotropic drug use.

R26's care plan dated 2/20/23, indicated R26 was dependent on staff for his emotional, intellectual, social, and physical needs. R26 had an altered respiratory status and difficulty breathing related to sleep apnea, obesity, and COPD.

During an interview on 4/3/23 at 8:09 a.m., R26 stated he had his call light on for one and a half to

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two hours and staff would "just walk by." R26 stated he had waited so long he soiled his bed.

Review of R26's call light log from 3/22/23 at 12:00 a.m., to 4/4/23 at 12:01 a.m., indicated the following:
4/4/23
-3:17 p.m. 413 min
-1:24 p.m. 34 min
-12:27 p.m. 30 min
-10:11 a.m. 39 min
4/3/23
-8:39 a.m. 31 min
4/2/23
-3:45 a.m. 29 min
4/1/23
-12:36 p.m. 62 min
3/31/23
-11:14 a.m. 56 min

R30
R30's quarterly MDS dated 2/22/23, indicated R30 had mild cognitive deficits, required supervision of one staff for toileting and was independent with all other ADLs. R30 had diagnoses including a stable burst fracture of the spine (thoracic vertebra T11-T12), muscle weakness, alcoholic cirrhosis of the liver, high blood pressure, major depression, morbid obesity, sciatica (pain in the sciatic nerve from the lower back down one or both legs) and hepatic (liver) failure.

R30's CAA dated 11/22/22, indicated R30 triggered for ADL function, falls, and psychotropic drug use.

R30's care plan dated 7/15/22, indicated R30 had ADL self-care needs due to limited range of

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motion. R30 had chronic pain due to a spinal fracture. Interventions indicated anticipating R30's need for pain relief and responding immediately to any complaint of pain. R30 was dependent on alcohol which could cause impaired judgement while intoxicated. R30 was also a high risk for falls related to gait/balance problems. Interventions included ensuring R30's call light was within reach and responding promptly to R30's requests for assistance.

During an interview on 4/5/23 at 8:48 a.m., R30 stated he has had to wait two hours for staff to answer his call light and had to "do everything for myself."

Review of R30's call light log from 3/22/23 at 12:00 a.m., to 4/4/23 at 12:01 a.m., indicated R30 did not activate his call light during that period.

R48
R48's significant change MDS dated 12/24/22, lacked indication of R48's cognitive status. R48 required supervision for bed mobility and toileting and was independent with all other ADLs.

R48's quarterly MDS dated 11/26/22, indicated R48 had intact cognition.

R48's hospital discharge summary dated 12/9/21, indicated R48 had diagnoses including respiratory failure with hypoxia (low oxygen) resulting in a tracheostomy (artificial airway place in the throat) due to COVID-19, morbid obesity, diabetes, chronic kidney disease, resistant hypertension (blood pressure that remains high despite the use of 3 antihypertensive medications), low thyroid, depression, and obstructive sleep apnea.

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R48's CAA dated 12/24/22, indicated R48 triggered for falls, incontinence, and pressure ulcers.

R48's care plan dated 9/1/22, indicated R48 had ADL self-care needs and would maintain her current level of function. Interventions included limited assistance by staff for walking. R48 also had diabetes and an altered cardiovascular status related to high blood pressure with goals to remain free from complications related to the diagnoses. R48 also had chronic kidney disease. Interventions included staff assisting R48 with ADLs and ambulation as needed and monitoring R48 for changes in mental status including seizures. The care plan also indicated R48 had urge bladder incontinence. Interventions included ensuring R48 had an unobstructed path to the bathroom and reminding R48 to use the bathroom upon waking.

During an interview on 4/3/23 at 10:26 a.m., R48 stated staff had taken hours to respond to her call light or had not responded at all. R48 stated they (the residents) had complained "multiple times" about long call light response times; however, "nothing happens."

Review of R48's call light log from 3/22/23 at 12:00 a.m., to 4/4/23 at 12:01 a.m., indicated the following:
4/4/23
-11:10 a.m. 56 min
4/3/23
-7:50 p.m. 43 min
4/2/23
-7:18 a.m. 45 min
3/31/23
-6:22 p.m. 35 min

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F 565	Continued From page 47 11:03 a.m. 88 min During an interview on 4/6/23 at 4:54 p.m., the activity director (AD) stated she would fill out a grievance form for resident concerns brought up during the monthly resident council meetings. The AD stated call light response times had been a concern and the AD had filled out grievance forms regarding the complaint; however, the AD was unable to provide any grievance forms. During an interview on 4/6/23 at 4:44 p.m., the administrator stated the AD would fill out a grievance form regarding concerns brought up during the monthly resident council meetings and give them to him to distribute to the appropriate department. The administrator stated he was unaware residents had been complaining about long call light response times and had not received any grievance forms from the AD regarding the concern. The facility Answering the Call Light policy dated 10/18/22, indicated staff were to answer resident call lights immediately. If the resident's request can be fulfilled by the responding staff, complete the task within five minutes or as soon as possible. If the responding staff is/are unable to fulfill the resident's request, staff were to ask the nurse supervisor for assistance. The facility Resident Council policy dated 4/7/23, indicated a Grievance Form would be used to track resident council issues and resolutions and the department related to any issue would be responsible for addressing the concern. The quality assurance and performance improvement (QAPI) committee would review information and feedback from the resident council and issues	F 565		

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F 565	Continued From page 48 documented on resident council response forms may be referred to the QAPI committee (if the issue is a serious concern or a pattern). The facility Grievances/Complaints, Recording and Investigating policy dated 10/28/21, indicated all grievances and complaints filed with the facility would be investigated and corrective actions would be taken. The Grievance Officer would begin an investigation into the complaint upon receiving the grievance. All complaints and grievances would be recorded on the "Resident Grievance Complaint Log" including the disposition of the grievance. The resident or their representative would be informed of the investigation and any corrective actions recommended within five working days of the filing of the grievance/complaint and the Grievance Log would be filed with the Administrator within five working days of the incident. A copy of the Grievance Log would also be filed with the business office.	F 565		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489,	F 578		5/12/23

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F 578	Continued From page 49 subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure a Physician's Orders for Life Sustaining Treatment (POLST) was acted upon and completed in a thorough manner to reflect resident' wishes for emergency, and potential prolonged care needs, for 1 of 1 resident (R43) reviewed who had an incomplete POLST in the medical record. Findings include:	F 578	F 578 R 43 had the POLST updated on 5/2/23 and a copy was uploaded to the resident electronic medical record. All existing residents were audited for their POLST and any missing POLST forms identified will be completed. Future residents who admit to the facility will have a POLST completed and signed by the physician and or physician designee. The IDT team will be in-serviced on the	

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F 578	Continued From page 50 R43's significant change in status Minimum Data Set (MDS), dated 3/13/23, identified R43 had intact cognition, demonstrated no rejection of care behaviors, and required extensive assistance to complete most late-loss activities of daily living (ADLs). Further, the MDS outlined R43 had several medical conditions including progressive neurological conditions, high blood pressure, and Parkinson's Disease. R43's medical record was reviewed. A POLST, undated, was located in the scanned electronic medical record (EMR) which had several sections to be completed and labeled "A" through "E", respectively. The scanned POLST had R43's name, date of birth (DOB), and one single 'checkmark' placed next to directions under section "A" which read, "Attempt Resuscitation / CPR (Note: selecting this requires selecting "Full Treatment" in Section B)." The remainder of the POLST contained these sections and corresponding medical intervention wishes for both emergency and/or prolonged care needs: Section "B" was labeled, "Medical Treatments," and outlined the medical interventions, assumed the patient had a pulse or was breathing. It provided three options to be selected to reflect the patient wishes for care including, "Full Treatment," and, "Selective Treatment," and, "Comfort-Focused Treatment (Allow Natural Death)." However, there were no visible markings or checkmarks placed to either of these options and the section was left blank. Section "C" was labeled, "Documentation of Discussion," and outlined directions to select who was involved in the discussion of the POLST (i.e., resident, family, surrogate). There was also	F 578	Advanced Directive Policy with focus on the entire policy with emphasis on if the resident has or does not have advanced directive established. The IDT team will also be in-serviced on the Scanning Documents Procedure with focus on documents must have a signature before being uploaded to the resident electronic medical record. Director of Nursing and/or designee will be responsible for compliance. Audits on will begin weekly x 4 weeks then monthly to ensure compliance. Audit results will be reviewed by the Executive Director and the Executive Director will take audit results to QAPI for review and recommendation. Compliance: 5/12/2023	

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F 578	Continued From page 51	F 578		

provided spacing for the patient or surrogate to sign. However, again, there were no visible markings, checkmarks, or signatures on the POLST to demonstrate this information had been reviewed with R43 or their responsible parties, if applicable. The entire section was left blank.

Section "D" was labeled, "Signature of Physician / APRN / PA," and provided spacing for the medical provider to sign the document and instill it as a current physician order for care. These individual spaces (i.e., name, license type) each had bolded print which outlined, "Required." However, there were no signatures or markings present and the entire section was left blank and not completed.

Section "E" was labeled, "Additional Patient Preferences (Optional)," which provided options to place a marking or checkmark next to desire treatment options including artificial nutrition, antibiotic use, and any other treatments as desired. However, again, the entire section was left blank and not completed. Further, the spacing provided for the health care provider who prepared the document (i.e., facility staff) to sign was also left blank and not completed.

R43's medical record was reviewed and lacked evidence these items had been discussed with R43 to facilitate person-center care planning for medical treatments in the event R43 sustained an emergency medical event (i.e., cardiac arrest) which could require emergency intervention or prolonged medical treatment (i.e., dialysis, tube feedings).

On 4/5/23 at 10:31 a.m., R43 was interviewed. R43 recalled the staff asking them if they wanted

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F 578	Continued From page 52 CPR or not, however, didn't recall the other information on the POLST (i.e., antibiotics, tube feeding) having been discussed with them, at least not "in that much detail [i.e., what they'd like done]." R43 explained, "I don't want to be a vegetable." R43 decided they would like the staff to attempt CPR and, if not successful, ensure their tissues get donated to the University of Maryland which had been pre-arranged. R43 stated such was "important" to them. Further, R43 expressed they would be open to IV medications or tube feedings but only if there was "some hope" of a full recovery and reiterated, "I don't want to be a vegetable." When interviewed on 4/5/23 at 10:36 a.m., licensed practical nurse (LPN)-C explained the social worker usually completed the POLST with a resident upon admission; however, at times, they would "have us [nurses] do it." LPN-C reviewed R43's EMR and verified the 'banner' for the EMR directed CPR should be initiated. LPN-C reviewed R43's scanned POLST and verified it was not completed adding most of the information was "not in there," and LPN-C verified R43 did not have a "hard chart" which could contain more information as everything should be scanned into the EMR. LPN-C explained R43 was "[their] own person" and, if a situation happened emergently and R43 was unable to speak for themselves, they would call the nurse manager or director of nursing (DON) for direction on how to proceed. LPN-C added the current POLST "doesn't tell me much," and needed to be completed. On 4/5/23 at 1:25 p.m., the assistant director of nursing (ADON) was interviewed. ADON explained the nursing home used hospital	F 578		

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F 578	Continued From page 53 discharge orders for a resident' code status (i.e., CPR / DNR) until the nursing home had a change to "complete the POLST." ADON reviewed R43's POLST and verified it had not been completed. ADON explained R43 had admitted to the nursing home when it was owned by a previous management group, however, expressed staff should be checking the POLST on a quarterly basis to see if the document "needs to be redone" or not. ADON verified the medical record lacked evidence the staff had identified and acted upon to resolve the incomplete POLST and stated such action should have happened so there wasn't discrepancy in R43's wishes should he suffer an acute medical event. A provided Advance Directive policy, dated 10/2022, identified residents' had the right to formulate advanced directives and they would be honored in accordance with state law and facility policy. The policy outlined the interdisciplinary team (IDT) would assess decision-making capacity and if an advanced directive was not previously on file, then staff would offer to make and establish one. Further, the policy outlined the information on the advanced directive would be reviewed on an annual basis with the resident.	F 578		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention;	F 580		5/12/23

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F 580	Continued From page 54 (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations	F 580		

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F 580

Continued From page 55

under §483.15(c)(9).
This REQUIREMENT is not met as evidenced by:
Based on interview and record review the facility failed to immediately consult with the provider following a fall with injury for 1 of 1 resident (R32).

Findings include:

R32's quarterly Minimum Data Set (MDS) dated 11/7/22, indicated intact cognition and required extensive assist with transferring, bed mobility, toileting, and hygiene, occasionally had bladder incontinence, and did not reject cares.

R32's Medical Diagnosis form in the electronic medical record (EMR) indicated R32 had the following diagnoses: Crohn's disease (an inflammatory disease that affects the digestive tract), muscle weakness, and difficulty walking.

R32's medication administration record (MAR) dated November 2022 indicated an order for acetaminophen 1000 milligrams (mg) by mouth three times a day for pain with a start date of 5/3/22, pregabalin (a medication for nerve pain) 25 mg twice daily for pain management with a start date of 5/2/22, and oxycodone (a narcotic for pain management) 5 mg every four hours as needed for pain management with a start date of 5/4/22. The oxycodone was documented on the MAR as given one time in November on 11/26/22 at 12:09 p.m.

R32's nursing progress note dated 11/26/22, indicated R32 was found on the floor about 5:45 a.m. lying on left side and was trying to walk to the bathroom and fell. The progress note indicated R32 rated pain a seven out of 10 and

F 580

F 584
The outside area around R 39□s window was cleaned 04/11/2023. The call light volume was adjusted near R 50□s room. R 50 ventilation duct was cleaned 04/06/2023. Existing residents were educated on 04/12/2023 of smoking in the designated area resident ventilation duct cleaning will be scheduled per unit. Future residents who smoke will be educated on the facility smoking policy. Ventilator duct cleaning will be added to the Maintenance schedule for routine cleaning.
Maintenance Director will be in-serviced on the Homelike Environment Policy and procedure with emphasis on item 2a that resident rooms must be clean, sanitary and orderly environment. In addition, ventilation duct cleaning will be recorded in the facility electronic maintenance system to ensure scheduled cleaning occurs. Residents and staff will also be educated on designated smoking areas and where to extinguish their cigarettes.
Executive Director and/or designee will be responsible for compliance.
Audits on ventilation vents and outside environment will begin weekly x 4 weeks then monthly to ensure compliance.
Audit results will be reviewed by the Executive Director and the Executive Director will take audit results to QAPI for review and recommendation.
Compliance: 5/12/2023

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F 580	Continued From page 56 was unable to raise his left arm and, "NP and administrator notified." The progress note lacked information on the outcome of the consultation with the nurse practitioner (NP). R32's Incident Audit Report form dated 11/26/22, indicated R32 was found on the floor and under the heading immediate action taken, rated pain a seven out of 10, was unable to raise left arm and was lifted up with two assist to the toilet and put back to bed. A progress note dated 11/26/22 at 4:43 p.m., indicated R32 was seen and assessed by medical doctor (MD) and a new order was written for left upper arm and shoulder x-ray due to pain and not using after fall. R32's physician progress note from medical doctor (MD)-K indicated R32 was seen on 11/26/22 and had severe pain with passive range of motion of the left upper extremity and shoulder and an apparent left upper extremity injury and an x-ray was ordered for the left upper arm and shoulder. R32's nursing progress note dated 11/27/22 at 10:45 p.m., indicated R32 had a fall the previous day and an x-ray had been ordered and further assessment indicated R32 was in "dire" pain guarding his arm screaming his arm was broken, 911 was called at 8:00 a.m. and was sent to the hospital. R32's hospital discharge summary indicated R32 was hospitalized 11/27/22 through 12/3/22 for a humerus fracture (upper arm bone) and acute hypoxic respiratory failure.	F 580		

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F 580 | F 580

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During interview on 4/5/23 at 9:36 a.m., licensed practical nurse (LPN)-F stated when a resident falls, the nurse determines what happened, and stated you have to get ahold of the doctor and document what their response was under the progress notes. LPN-F stated R32 was not able to lift his arms which could indicate that something happened and stated she left a message for NP after the fall, but could not recall if NP called back and stated R32 was having pain. LPN-F verified if a resident was having pain and difficulty moving their arm the provider should be notified right away. LPN-F added she recalled updating MD-K when he came to the facililty on the afternoon shift 11/26/22.

During interview on 4/5/23 at 9:03 a.m. LPN-G stated if a resident falls the nurse must determine what happened and if there is an injury, the nurse must talk to a provider and added you can't leave a voicemail.

During interview on 4/6/23 at 1:56 p.m. NP-C stated if a resident fell and had pain staff should call and talk to her right away and document whether or not there were any recommendations.

During interview on 4/5/23 at 3:01 p.m. the assistant director of nursing stated if a resident fell and complained of pain or was injured, the provider must be called and expected staff to keep calling the provider until they received a response and document the provider's response.

During interview on 4/6/23 at 10:11 a.m. director of nursing (DON) stated she expected staff to contact her and speak with a provider when a resident falls and is injured.

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F 584	Continued From page 58	F 584		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to	F 584		5/12/23

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F 584	Continued From page 59 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on interview, observation, and document review, the facility failed to ensure a home-like environment was provided for rooms that were free of odors for 1 of 1 resident (R39) and room vents were maintained in a clean manner and sound levels were at a comfortable level due to call light system for 1 of 1 resident (R50). Findings include: R39's clinical resident profile in the electronic medical record (EMR) indicated R39 was their own representative. R39's progress note dated 2/10/23, indicated a BIMS score of 15 (cognitively intact). During interview and observation on 4/5/23 at 12:15 p.m., R39 stated staff and residents constantly smoke outside his bedroom window and yelled at them not to smoke. R39 added he could not stand the smell from the cigarettes that came in to his room from the window. The ground outside R39's window was covered with cigarette butts. R39 stated the admission brochure indicated people were supposed to smoke in designated areas and the second hand smoke should not bother other residents and added someone was smoking outside his window last night. During interview on 4/5/23 at 12:32 p.m., the director of nursing (DON) stated staff and	F 584	F 584 The outside area around R 39□s window was cleaned 04/11/2023. The call light volume was adjusted near R 50□s room. R 50 ventilation duct was cleaned 04/06/2023. Existing residents were educated on 04/12/2023 of smoking in the designated area resident ventilation duct cleaning will be scheduled per unit. Future residents who smoke will be educated on the facility smoking policy. Ventilator duct cleaning will be added to the Maintenance schedule for routine cleaning. Maintenance Director will be in-serviced on the Homelike Environment Policy and procedure with emphasis on item 2a that resident rooms must be clean, sanitary and orderly environment. In addition, ventilation duct cleaning will be recorded in the facility electronic maintenance system to ensure scheduled cleaning occurs. Residents and staff will also be educated on designated smoking areas and where to extinguish their cigarettes. Executive Director and/or designee will be responsible for compliance. Audits on ventilation vents and outside environment will begin weekly x 4 weeks then monthly to ensure compliance. Audit results will be reviewed by the Executive Director and the Executive Director will take audit results to QAPI for review and recommendation.	

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F 584	Continued From page 60 residents were supposed to smoke in the front of the building in the gazebo. DON verified there were cigarette butts all over the ground and the smell could go in R39's window and added her expectation was staff should redirect people to the front of the building. R50's annual Minimum Data Set (MDS) dated 2/17/23, indicated a diagnosis of hemiplegia (paralysis on one side of the body) and hemiparesis (weakness on one side of the body) following cerebral infarction (stroke) affecting the right side, and had adequate hearing. R50's nursing progress notes dated 3/20/23, indicated R50 was able to shake his head yes or no during interview. R50's care plan dated 8/21/22, indicated R50 had expressive aphasia (a condition where a person can comprehend speech, but has difficulty speaking) and interventions included: ask yes or no questions if appropriate, and allow adequate time to respond. During interview and observation on 4/3/23 at 10:45 a.m., R50 was laying in bed in his room and the call light display outside had audible beeps. R50 nodded yes when asked if the sound bothered him. The white colored ventilation duct above the doorway contained a visible black debris. During interview and observation on 4/5/23 at 11:45 a.m. R50 was in bed smiling and nodded head yes when asked if the call light system noise bothered him. The ventilation duct contained black debris.	F 584	Compliance: 5/12/2023	

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F 584	Continued From page 61 During interview and observation on 4/5/23 at 12:07 p.m., licensed practical nurse (LPN)-C stated the call light system noise could be annoying if it kept going off and observed the black debris on the ventilation duct adding she thought it was dust and looked like it had been there a while. LPN-C asked R50 if the call light system bothered him and R50 nodded head indicating yes. LPN-C asked R50 if he could still hear the noise if the door was closed and R50 again nodded head indicating yes. LPN-C stated maybe the call light system could be moved and added it would be easier to see if it was closer to the nursing station. During interview on 4/5/23 at 1:08 p.m., the maintenance director (MD)-I indicated the ventilation on the ceilings were cleaned every three to four months. MD-I produced documentation R50's ventilation duct was cleaned 7/28/22, and stated the ducts were also cleaned in December, but did not have documentation to verify ventilation ducts were cleaned. During interview on 4/6/23 at 10:57 a.m., the administrator stated he expected documentation when ventilation ducts were cleaned, verified he would have to look at the call light system, and expected staff and residents to smoke under the pavilion. A policy, Homelike Environment dated 12/8/21, indicated residents were provided a safe, clean, comfortable and homelike environment and encouraged to use their personal belongings to the extent possible. The facility staff and management maximized, to the extent possible, the characteristics of the facility that reflect a	F 584		

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F 584	Continued From page 62 personalized, homelike setting. These characteristics include: comfortable sound levels, pleasant neutral scents, and a clean, sanitary and orderly environment. A policy, Resident Smoking Policy dated 7/1/22, indicated the goal of the policy was to allow residents to safely smoke while ensuring non-smoking residents were able to be free from second-hand smoke. The designated smoking area is the gazebo in the front of the building, located outside the main entrance.	F 584		
F 636 SS=D	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence.	F 636		5/12/23

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F 636	Continued From page 63 (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts. §483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.) (iii)Not less than once every 12 months. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to complete multiple significant change in status (SCSA) Minimum Data Set	F 636	F 636 R 31 has since discharged from the facility. R 26 MDS dated 4/8/2023, all	

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F 636	Continued From page 64 (MDS) in a thorough and accurate manner to ensure cognitive and mood needs were comprehensively evaluated for 2 of 4 residents (R31, R26) reviewed for MDS accuracy. Findings include: The Centers for Medicare & Medicaid Services (CMS) Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual, dated 10/2018, outlined, "The SCSA is a comprehensive assessment for a resident that must be completed when the IDT [interdisciplinary team] has determined that a resident meets the significant change guidelines for either major improvement of decline." A section labeled, "SECTION C: COGNITIVE PATTERNS," identified the items reviewed in the section were, " ... intended to determine the resident's attention, orientation and ability to register and recall new information. These items are crucial factors in many care-planning decisions." A subsequent section labeled, "SECTION D: MOOD," identified the items reviewed in the section, " ... address mood distress ... It is particularly important to identify signs and symptoms of mood distress among nursing home residents because these signs can be treatable." R31's SCSA MDS, dated 3/11/23, identified R31 admitted to the nursing home in September 2022 from an acute care hospital. The MDS' section labeled, "Section C: Cognitive Patterns," however, had no data at all entered, with most fields not even having a "-" symbol demonstrating the item had been dashed. In addition, the section labeled, "Section D: Mood," had all the items to be assessed or addressed completed	F 636	assessments were completed timely. For existing residents, the assessment schedule was updated to coincide with the MDS schedule. Future resident assessments will continue to auto populate for completion during the MDS look back assessment period. Licensed nurses will be in-serviced on the Admission and Quarterly assessment schedule with emphasis on when and which assessments that must be completed for the resident MDS category. Director of Nursing and/or designee will be responsible for compliance. Audits on timely completion of resident assessments will begin weekly x 4 weeks then monthly to ensure compliance. Audit results will be reviewed by the Executive Director and the Executive Director will take audit results to QAPI for review and recommendation. Compliance: 5/12/2023	

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with a " - " mark and no other data entered.

R31's medical record, and the completed MDS, lacked evidence these items had been assessed within the assessment reference date (ARD) as directed by the RAI manual to ensure a full evaluation of the resident.

R26's SCSA MDS, dated 1/20/23, identified R26 admitted to the nursing home in August 2022 from an acute care hospital. The MDS' section labeled, "Section C: Cognitive Patterns," however, had no data at all entered, with most fields not even having a "-" symbol demonstrating the item had been dashed. In addition, the section labeled, "Section D: Mood," had all the items to be assessed or addressed completed with a " - " mark and no other data entered.

R26's medical record, and the completed MDS, lacked evidence these items had been assessed within the ARD as directed by the RAI manual to ensure a full evaluation of the resident.

On 4/5/23 at 1:32 p.m., the assistant director of nursing (ADON) was interviewed. ADON explained the facility currently did not have an MDS coordinator in-house so, as a result, the MDS' were being outsourced to a "third party" located out of State. ADON stated getting all the MDS(s), and their corresponding assessments, had been "a little bit of a struggle" as a result and explained there had been instances when themselves and the director of nursing (DON), whom were responsible to complete those corresponding assessments (i.e., BIMS), were not told of ARD(s) so it resulted in the assessments not getting completed timely for the MDS.

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F 636	Continued From page 66 On 4/6/23 at 2:05 p.m., registered nurse (RN)-A was interviewed, and they verified they were currently completing the MDS' for the nursing home while out of State. RN-A explained the items left blank on the MDS or which were 'dashed' were "not assessed" so they couldn't be coded on the MDS. RN-A stated the corresponding assessments (i.e., BIMS, PHQ-9) should have been completed so the MDS(s) could be accurately completed, adding with them there was "no data to pull [to the MDS]." A facility' policy on MDS completion was requested, however, none was received.	F 636		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable.	F 655		5/12/23

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F 655	Continued From page 67 §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure a copy of the baseline care was provided to ensure knowledge of care and promote person-centered care planning or 1 of 1 residents (R59) reviewed for care plans. Findings include: R59's five-day, Minimum Data Set (MDS) dated 3/10/23, identified R59 had moderate cognitive impairment and required extensive assistance with most activities of daily living. In addition, R59 had diagnoses of metabolic encephalopathy (a problem in the brain manifested as an alteration in consciousness), heart failure (heart is unable to	F 655	F 655 R 59 has since discharged from the facility. Existing residents admitted from survey exit until present will have their baseline care plan presented and signed by the resident or resident representative. Future resident will have their baseline care plan initiated and presented per facility policy. The IDT and licensed nurses will be in-serviced on the Care Conference Guideline with emphasis on items 5 and 7 that the initial care conference should occur within 72 hours of admission and that the baseline care plan must be	

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F 655	Continued From page 68 pump blood as well as it should), acute on chronic respiratory failure with hypoxia (low levels of oxygen in the blood that causes difficulty breathing), polyneuropathy (damage to peripheral nerves which can cause pain), and osteomyelitis (inflammation of bone caused by infection) of right femur. R59's physician orders dated 2/20/23, included orders for oxygen, nebulizer treatments, and fluid restrictions. R59's care plan dated 2/21/23, identified focus areas included activities of daily living (ADLs), safety and abuse risk, elopement risk, diabetes mellitus, risk of falls, nutrition and hydration, risk for skin breakdown, acute/chronic pain, and care directives. R59's care plan did not identify his cardiac or respiratory conditions. A progress note dated 2/20/22 at 9:50 p.m., indicated resident was admitted to facility with orders for fluid restriction, had a PICC (peripheral intravenous catheter) line, intact skin, right leg amputation above the knee and audible lung wheezes. A progress noted dated 2/22/23 at 11:35 p.m., indicated R59 was sent to the hospital due to shortness of breath, anxiety, and pain. R59's progress note dated 2/28/23 at 5:00 p.m. indicated R59 was readmitted after a hospitalization for respiratory distress. R59 was alert, oriented, and continued to be on oxygen at five liters via nasal canula. R59's order summary report, identified a new order dated 2/28/23, for scheduled Albuterol inhaler(Bronchodilator- it works by relaxing and opening air passages to the lungs to make breathing easier) four times a day and atorvastatin (cholesterol lowering medication) one tablet at bedtime.	F 655	signed by those who attended. Director of Nursing and/or designee will be responsible for compliance. Audits on baseline care plan completion will begin weekly x 4 weeks then monthly to ensure compliance. Audit results will be reviewed by the Executive Director and the Executive Director will take audit results to QAPI for review and recommendation. Compliance: 5/12/2023	

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Progress note dated 3/2/23 at 8:50 a.m., indicated R59 reported difficulty breathing. R59 called 911 and was transported and admitted to the hospital. Progress note dated 3/7/23 at 2:09 pm indicated R59 returned to the facility via emergency medical transportation in a wheelchair and had oxygen at 6 liters via nasal canula. R59's order summary report, identified a new order on 3/7/23 for daily weights and instructed staff to notify provider if his weight increased by two pounds in 24 hours or five pounds in seven days.

R59's progress note dated 3/1/23 at 2:41 p.m., indicated R59 was conversing with friends that were not there, and documented oxygen saturations were at 80% when he removed his oxygen. The NP was updated, and she ordered an urinalysis. A progress note dated 3/2/23 at 11:56 a.m., indicated NP was updated of R59's transfer to the hospital. A progress note dated 3/15/23 at 12:10 p.m., indicated R59 requested a stronger pain medication for headaches and informed NP about R59's refusal to check his blood glucose level.

Provider encounter note, titled Nursing Home Visit, dated 3/9/23, indicated a visit to R59's to follow up R59's hospitalization and his readmission to the facility's TCU (transitional care unit). Encounter note indicated R59 was hospitalized from 3/2/23 to 3/7/23 for acute on chronic congestive heart failure. Provider note indicated R59 underwent IV diuresis (receiving a medication intravenously to eliminate excessive fluid from the blood) and was treated for hospital acquired pneumonia. Nursing staff reported concerns about R59's lethargy and shortness of breath. Provider note, indicated R59 was dyspneic (difficulty breathing, shortness of

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breath), he had intercostal muscle use for respirations and was lethargic. NP indicated lab work was drawn in the morning and chest X-ray findings were consistent with congestive heart failure. NP indicated that R59 was offered palliative care and a hospice consult but he declined them. NP ordered Metolazone (reduces fluid retention caused by heart failure) 5 milligrams (mg) daily 30 minutes prior to Bumex (treats fluid retention) for three days, scheduled albuterol nebulizer twice a day for three days and ordered to send R59 to the hospital if his respirations did not improve.

Provider encounter note, titled Nursing Home Visit, dated 3/13/23, identified R59's weakness, physical deconditioning, heart failure and kidney failure. NP indicated R59 stated he was fine, he was vague during conversation and denied any concerns. NP made no changes to R59's medication regimen.

R59's progress note dated 3/19/23 at 3:55 a.m., stated R59 was found unresponsive by staff and CPR was initiated. R59 was transported to the hospital where he expired.

During interview on 4/6/23 at 9:13 a.m., registered nurse (RN)-C indicated that R59 was alert and able to make his needs known. RN-C stated R59's chief problem was hypoxia (low levels of oxygen in the blood that causes difficulty breathing). R59 was on continuous oxygen, was non-ambulatory and sometimes R59 was non-complaint with cares. RN-C stated, R59 was sent several times to the hospital due to shortness of breath.

During interview on 4/6/23 at 10:50 a.m., DON

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F 655	Continued From page 71 stated, R59 was originally admitted on 2/20/23 with respiratory issues, on oxygen, fluid restrictions, blood glucose monitoring, and antibiotics. R59 refused cares and didn't do well with therapies. R59 declined hospice services and said he wanted to continue with therapies. R59 continued to have respiratory issues, had episodes of confusion but came out of his room. DON stated care plans are initiated by the managers, the assistant director of nursing or herself. R59's care plan was initiated on 2/21/23 by the DON. The DON verified R59's care plan did not address his respiratory or heart condition. Facility policy titled, Care Plans, Comprehensive Person-centered revised 11/30/2, indicated a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. The carte plan also indicated, the assessments of residents are ongoing and care plans are revised as information about the residents and the resident's condition change. In addition, the policy also directed the interdisciplinary team to review and update the care plan when the resident has been readmitted to the facility from a hospital stay. Based on interview and document review, the facility failed to ensure a copy of the baseline care was provided to ensure knowledge of care and promote person-centered care planning or 1 of 1 residents (R59) reviewed for care plans.	F 655		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and	F 656		5/12/23

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F 656	Continued From page 72 implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.	F 656		

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F 656	Continued From page 73 §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure a comprehensive care plan was developed and maintained for 1 of 1 resident who was hard of hearing (R8), 1 of 1 resident that was on an anticoagulant (a blood thinning medication) (R47), and 1 of 1 resident (R32) who was incontinent. Findings include: R32's quarterly Minimum Data Set (MDS) dated 11/7/22, indicated intact cognition and required extensive assist with transferring, bed mobility, toileting, and hygiene, occasionally had bladder incontinence, and did not reject cares. R32's significant change MDS dated 1/21/23, indicated R32 required extensive assist with toileting and personal hygiene, had not had a trial toileting program and was occasionally incontinent of urine. R32's Admission Record form in the electronic medical record (EMR) indicated R32 was his own representative. R32's Medical Diagnosis form in the electronic medical record (EMR) indicated R32 had the following diagnoses: Crohn's disease (an inflammatory disease that affects the digestive tract), muscle weakness, and difficulty walking.	F 656	F 656 R 8 had a hearing care plan initiated on 5/3/23. All existing residents who are hard of hearing will have their care plan reviewed and updated as needed. Future residents will have a hearing care plan initiated during the care plan comprehensive review period. R 47 has since discharged from the facility. Existing residents who are on Coumadin will have their care plans reviewed and updated as needed. Future residents will have a Coumadin care plan initiated during the base line care plan creation period. R 32 had an incontinent care plan focus initiated on 5/3/23. All other existing residents who are incontinent care plans will be reviewed and updated as needed. Future residents who are incontinent will have their comprehensive care plan created during the comprehensive review period and interventions initiated. IDT team was in-serviced on the Care Plans Comprehensive policy with focus on item #8 that the comprehensive care plan includes all services and specialized services and the resident goals to enhance the optimal functioning of the resident. Director of Nursing and/or designee will be responsible for compliance. Audits on completion of the	

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F 656	Continued From page 74 R32's form Care Area Assessment (CAA) Worksheet dated 1/21/23 indicated R32 was occasionally incontinent and there were modifiable factors that contributed to incontinence which included environmental factors, additionally other factors that contributed to incontinence included urinary urgency and need for assistance in toileting, depression, and medications including: anticholinergics, antipsychotics, antidepressants, and sedative hypnotics. The CAA did not identify the type of incontinence. The CAA indicated the urinary incontinence would be addressed in the care plan with the objective of slowing or minimizing decline, and minimizing risks. R32's nursing progress note dated 11/26/22, indicated R32 was found on the floor about 5:45 a.m. lying on left side and was trying to walk to the bathroom and fell. R32's care plan was reviewed and lacked a urinary incontinence care plan. Additionally, the activity of daily living (ADL) of self care needs care plan dated 7/15/22 lacked any interventions related to toileting. R32's skin integrity care plan dated 7/15/22, indicated barrier cream could be applied after each incontinence episode. R32's Toilet Use task form from 3/7/23 through 4/5/23, indicated R32 was mostly independent with toilet use, but required supervision on one occasion, limited assistance on six occasions, and extensive assistance on four occasions. The task indicated R32 did not refuse task. R32's Bladder Elimination task form from 3/7/23 through 4/5/23, indicated R32 was mostly continent, but had four episodes of incontinence.	F 656	comprehensive care plan with measurable goals and interventions will begin weekly x 4 weeks then monthly to ensure compliance. Audit results will be reviewed by the Executive Director and the Executive Director will take audit results to QAPI for review and recommendation. Compliance: 5/12/2023	

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F 656	Continued From page 75 The task indicated R32 did not refuse this task. During interview and observation on 4/5/23 at 8:10 a.m., R32 was in his room and stated staff don't remind him to use his call light and added he can push the button and wait for hours. During interview on 4/5/23 at 8:31 a.m., nursing assistant (NA)-A stated R32 did not allow cares and added R32 went to the bathroom and wiped him self, dressed self and if he was in a gown, they let him stay in a gown and added he was not incontinent unless he was sick. During interview on 4/5/23 at 9:03 a.m., licensed practical nurse (LPN)-G stated they were supposed to have continence programs and added she was told to take residents to the bathroom and ask if they needed assist and if a resident could not tell they would go in and offer, and their toileting needs or program was reflected on the care plan. LPN-G stated she thought R32 was on a program of offering to toilet every two hours. During interview on 4/5/23 at 3:01 p.m., the assistant director of nursing (ADON) verified there was no incontinence care plan and in the month had four episodes of incontinence and was aware of concerns of lack of care planning. During interview on 4/6/23 at 10:11 a.m., the director of nursing (DON) stated they had a third party person completing the MDS. R8's quarterly Minimum Data Set (MDS), dated 3/4/23, indicated R8 was cognitively intact and needed extensive assistance with bed mobility,	F 656		

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transfers, dressing, toilet use, personal hygiene and was non ambulatory. The MDS indicated R8 wore bilateral hearing aids.

R8's electronic medical record (EMR) medical diagnoses list included chronic kidney disease with heart failure and unspecified quadriplegia (condition where both the arms and legs are paralyzed) which were both present on admission to the facility on 8/25/22.

R8's care plan, dated 8/31/22, indicated R8 needed extensive assistance with personal hygiene, however lacked any indication R8 wore hearing aides or how to communicate with R8.

During interview on 4/4/23 at 8:50 a.m., R8 stated he was hard of hearing and staff were not appropriately communicating with him. R8 stated he preferred staff to speak slow and loud and had asked numerous staff to communicate with him this way, however, "they do not and I cannot understand them." R8 further stated staff would often talk at him and immediately leave the room before he could ask for clarification which caused him to be confused on his plan of care.

During interview and observation on 4/5/23 at 8:41 a.m., the nurse practitioner (NP)-A stated R8 was very hard of hearing and his hearing deficit caused him to be confused. NP-A was observed explaining R8's wound care to him and needed to yell and repeat herself multiple times to be heard and understood by R8.

During an interview on 4/5/23 at 9:26 a.m., nursing assistant (NA)-D stated the NAs used the care plans to know how to care for a resident. NA-D stated she was aware that R8 used hearing

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aids, however, how to communicate with R8 was not on the care plan. NA-D stated they often had to repeat themselves when they were trying to communicate with R8.

During an interview on 4/5/23 at 9:31 a.m., licensed practical nurse (LPN)-A stated communicating with R8 was very challenging because of R8's hearing loss. LPN-A further confirmed there were no interventions on the care plan directing staff how to communicate with R8.

During an interview on 4/5/23 at 2:21 p.m., the director of nursing (DON) stated she was aware R8 was hard of hearing, and it would be expected to have interventions on the care plan for how to communicate with a resident who was hard of hearing.

R47's admission MDS, dated 3/7/23, indicated R47 had mild cognitive impairment and needed extensive assistance with bed mobility, transfers, dressing, toileting, and personal hygiene. The MDS further indicated R8 received an anticoagulant on all seven days of the look back period.

R47's medical diagnoses list included hemiplegia (paralysis on one side of the body) following cerebral infarction (stroke) affecting the left non dominant side which was present upon admission to the facility on 2/28/23.

R47's physician orders, dated 2/28/23, indicated R47 had the following order: Xarelto (an anticoagulant which can cause an increased risk of bleeding) 20 milligrams (mg), one tablet via gastrostomy tube one time a day related to

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hemiplegia affecting left non-dominant side.

R47's entire electronic medical record (EMR) including progress notes and care plan lacked evidence that medication side effects for Xarelto were being monitored which may include blood tinged or red blood in urine, black tarry stools, dark or bright red blood in stools, sudden severe headaches, nausea, vomiting, diarrhea, muscle joint pain, lethargy, bruising ,blurred vision, shortness of breath, loss of appetite, sudden changes in mental status, significant or sudden changes in vital signs.

During an interview on 4/6/23 at 8:33 a.m., registered nurse (RN)-D stated some medications, such as antipsychotics, prompted the nurse to monitor for side effects before giving the medication, however, there were no prompts to monitor for side effects prior to administering anticoagulants.

During an interview on 4/6/23 at 9:32 a.m., the DON stated it would be expected to have interventions to monitor for anticoagulant side effects on the resident's care plan and any concerns would be documented as a progress note.

A policy Care Plans, Comprehensive Person-Centered dated 11/30/21 indicated care plan interventions were derived from a thorough analysis of the information gathered as part of the comprehensive assessment. The comprehensive, person-centered care plan will incorporate identified problem areas, incorporate risk factors associated with identified problems, reflect treatment goals, timetables, and objectives in measurable outcomes, aid in preventing or

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F 656	Continued From page 79 reducing decline in the resident's functional status and/or functional levels. In addition, the policy identified a comprehensive care plan will be developed for each resident within 7 days of the MDS completion date. A policy Urinary Continence and Incontinence-Assessment and Management dated 11/1/21 indicated the physician and staff would provide appropriate services and treatment to help residents restore or improve bladder function and prevent urinary tract infections to the extent possible. As part of its assessment nursing staff would seek and document details related to incontinence which included types of incontinence and would identify risk factors for becoming incontinent.	F 656		
F 660 SS=D	Discharge Planning Process CFR(s): 483.21(c)(1)(i)-(ix) §483.21(c)(1) Discharge Planning Process The facility must develop and implement an effective discharge planning process that focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions. The facility's discharge planning process must be consistent with the discharge rights set forth at 483.15(b) as applicable and- (i) Ensure that the discharge needs of each resident are identified and result in the development of a discharge plan for each resident. (ii) Include regular re-evaluation of residents to identify changes that require modification of the discharge plan. The discharge plan must be updated, as needed, to reflect these changes.	F 660		5/12/23

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F 660	Continued From page 80 (iii) Involve the interdisciplinary team, as defined by §483.21(b)(2)(ii), in the ongoing process of developing the discharge plan. (iv) Consider caregiver/support person availability and the resident's or caregiver's/support person(s) capacity and capability to perform required care, as part of the identification of discharge needs. (v) Involve the resident and resident representative in the development of the discharge plan and inform the resident and resident representative of the final plan. (vi) Address the resident's goals of care and treatment preferences. (vii) Document that a resident has been asked about their interest in receiving information regarding returning to the community. (A) If the resident indicates an interest in returning to the community, the facility must document any referrals to local contact agencies or other appropriate entities made for this purpose. (B) Facilities must update a resident's comprehensive care plan and discharge plan, as appropriate, in response to information received from referrals to local contact agencies or other appropriate entities. (C) If discharge to the community is determined to not be feasible, the facility must document who made the determination and why. (viii) For residents who are transferred to another SNF or who are discharged to a HHA, IRF, or LTCH, assist residents and their resident representatives in selecting a post-acute care provider by using data that includes, but is not limited to SNF, HHA, IRF, or LTCH standardized patient assessment data, data on quality measures, and data on resource use to the extent the data is available. The facility must ensure that	F 660		

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F 660	Continued From page 81 the post-acute care standardized patient assessment data, data on quality measures, and data on resource use is relevant and applicable to the resident's goals of care and treatment preferences. (ix) Document, complete on a timely basis based on the resident's needs, and include in the clinical record, the evaluation of the resident's discharge needs and discharge plan. The results of the evaluation must be discussed with the resident or resident's representative. All relevant resident information must be incorporated into the discharge plan to facilitate its implementation and to avoid unnecessary delays in the resident's discharge or transfer. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide ongoing, comprehensive discharge planning to a lower level-of-care for 1 of 2 residents (R14) reviewed who wished to discharge from the nursing home. Findings include: R14's admission Minimum Data Set (MDS), dated 4/5/22, identified R14 admitted to the nursing home from the acute hospital. The MDS listed a section, "Q0300," which was answered, "Expects to be discharged to the community." R14's most recent quarterly Minimum Data Set (MDS), dated 1/6/23, identified R14 had no neurological disorders (i.e., dementia) and was independent with most activities of daily living (ADLs). However, the section to record R14's cognition (i.e., BIMS) was left blank and not completed. Further, the MDS outlined, under section "Q0400. Discharge Plan," that an active	F 660	F 660 R 14 met with the Social Service Designee on 05/04/2023. R 14 discharge care plan will be reviewed and updated as needed. R 14 will be provided with a list of facilities and each facility will be contacted and a status note will be recorded in the resident chart. All existing residents will be interviewed for discharge potential and their care plans will be reviewed and updated. For future residents, discharge planning will be discussed upon admission, quarterly and as needed throughout the resident stay. Social Service designee will be in-serviced on the Community Health Services policy indicating that agencies will be kept for resident use and the designee will also be in-serviced on the Discharge Prep Process from AHRQ which will provide a checklist of items to ensure residents have a successful	

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F 660	Continued From page 82 discharge plan was not in place for R14 to return to the community, and no referrals to the local agencies had been made. R14's care plan, dated 7/15/22, identified R14 "wishes to be discharged to Assisted Living Facility," with a goal reading, " ... will be able to verbalize required assistance post-discharge and the services required to meet needs before discharge." The care plan listed only one intervention to meet this goal which read, "Evaluate and discuss with the resident/family/caregivers the prognosis for independent or assisted living. Identify, discuss and address limitations, risks, benefits and needs for maximum independence." On 4/3/23 at 9:23 a.m., R14 was interviewed. R14 explained they admitted to the nursing home about a year prior from the hospital where they had been due to medication mis-management which caused them to fall. The hospital then "sent me here [nursing home]" and she wanted to discharge to an assisted living facility as they "don't really need help" with most care. However, R14 explained, the nursing home had several social workers resign and further discharge planning never seemed to happen adding, "I don't feel like they're dealing with it." R14's medical record was reviewed and a single progress note was identified which discussed R14's discharge planning and subsequent plan. The note, dated 10/20/22, identified the social worker spoke with R14 and R14 said the assisted living facility (ALF) was "out of the area she wants to be in." R14 desired to be more in the Inver Grove Heights area and they had a friend who lived there whom assisted R14 with	F 660	transition into the community. Executive Director and/or designee will be responsible for compliance. Audits on resident discharge care planning with follow up progress notes will begin weekly x 4 weeks then monthly to ensure compliance. Audit results will be reviewed by the Executive Director and the Executive Director will take audit results to QAPI for review and recommendation. Compliance: 5/12/2023	

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transportation. The note concluded, "SW [social worker]: will continue to look for an ALF for Resident." The medical record lacked any further evidence R14 had ongoing, comprehensive discharge planning happening despite R14 wanting to leave the nursing home which had been identified in the medical record and their care plan.

When interviewed on 4/5/23 at 9:31 a.m., nursing assistant (NA)-A described R14 as "very independent" with their cares who would often leave the campus and go offsite to their friends house. The NA staff really just "get [them] water" and if R14 asked for anything, they would help but reiterated R14 was "very independent." NA-A stated they were unsure what, if any, discharge planning was happening for R14 and expressed they were unsure why R14 resided at the nursing home but added, "I think she likes it here."

On 4/5/23 at 12:49 p.m., the current social services designee (SSD) was interviewed. SSD explained they had only worked at the nursing home for "a month and a half" now, however, verified they were responsible to facilitate and coordinate discharges. SSD stated they were aware R14 wanted to discharge as R14 had approached them a few weeks prior expressing such desire and, as a result, SSD sent some information to two assisted living facilities. However, SSD added, "That is it so far." SSD stated both the facilities had not yet responded to the information and she had not attempted to contact them since "early last week." SSD stated nobody from the nursing home, including the previous social worker staff members, had expressed R14 wanted to discharge to the lesser level-of-care facilities. SSD stated any progress

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on discharge planning should be recorded in the progress notes so there was "proof you did it," adding they had not documented their activities thus far, either, due to them being "fairly new" and "still getting the hand into it." Further, SSD stated R14 was not the only person to express frustration with a lack of discharge planning due to social worker turn-over and expressed R14 maybe didn't keep voicing it as "maybe [R14] got sick of repeating the story over and over to people in this position."

On 4/5/23 at 2:52 p.m., the administrator was interviewed. They explained R14 was someone who "wasn't on our radar as someone to discharge," and acknowledged the discharge planning process had somewhat struggled with the social worker turn-over. However, the administrator expressed they felt the issue was not "too big of an issue," and they were actively working to discharge several others who had expressed a desire to leave. The administrator verified any discharge planning items should be recorded in the progress notes and include what items are being worked on and what was still needed. This planning process, for a long-term care person, should happen and include "more a quarterly conversation," and outline "what's the plan" or issue(s) holding up the discharge process. The administrator expressed they expected the progress notes to outline the discharge planning process and a lack of documentation made it difficult to ensure continuity of care.

A facility' policy on comprehensive discharge planning was requested, however, none was received.

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F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure routine personal hygiene (i.e., nail care) was completed and provided for 2 of 4 residents (R43, R50) reviewed for activities of daily living (ADLs) and who were dependent on staff for their care. Findings include: R43's significant change in status Minimum Data Set (MDS), dated 3/13/23, identified R43 had intact cognition, demonstrated no rejection of care behavior, and required extensive assistance from staff to complete personal hygiene. Further, the MDS identified R43 was not diabetic. R43's care plan, dated 3/20/23, identified R43 had ADL self care needs due to musculoskeletal impairment. The care plan listed several interventions for this including, "PERSONAL HYGIENE/ORAL CARE: The resident requires extensive assistance of 1." The care plan lacked any indication how often nail care would be attempted or provided, or if R43 had any preferences for their nails (i.e., longer or short). On 4/3/23 at 11:38 a.m., R43 was observed seated in a wheelchair in his room. R43 had visibly long, some of them being several millimeters in length, fingernails present on both	F 677	F 677 R 43 received nail care on 4/5/23 & 4/13/23 and 5/5/2023. R 43 nail care plan preference was reviewed and updated as needed. R 50 received nail care on 4/5/23, 4/10/23, & 4/24/23 and 5/5/2023. R 50 nail care plan preference was reviewed and updated as needed. All existing residents care plans were reviewed and updated for nail care preference. Future residents will receive nail care per their care plan preferences. Nursing staff will be in-serviced on the ADL Support Policy and Procedure with emphasis on item #2 that appropriate care and services will be rendered for residents who are unable to carry out ADL□s independently. The nursing staff will also be in-serviced on the Fingernail/toenail Care Policy and procedure that details daily cleaning and regular trimming to prevent infections. Assistant Director of Nursing and/or designee will be responsible for compliance. Audits on grooming with emphasis on nail care per resident preference will begin weekly x 4 weeks then monthly to ensure compliance. Audit results will be reviewed by the	5/12/23

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	245028	A. BUILDING ______ B. WING ______	C 04/06/2023

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HIGHLAND OPERATIONS LLC	2319 WEST SEVENTH STREET SAINT PAUL, MN 55116

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F 677	Continued From page 86 hands with black debris present under various ones. R43 was interviewed and expressed "clipping the nails hasn't happened in quite awhile," which R43 voiced had been "several weeks" at least. R43 stated they did not always agree to take their scheduled showers as their room was cold, however, reiterated they wanted their nails clipped adding, "Yes, I would." R43 stated they would have attempted to clip them on their own, however, they didn't have a clippers. R43's completed Weekly Bath Audit 020919 - V2, dated 2/8/23, identified R43 received a shower. However, the audit lacked any information or indication if nail care had been offered, completed or attempted. R43's next completed Weekly Bath Audit 020919 - V2, dated 3/30/23, identified R43 received a bed bath. However, the audit lacked any information or indication if nail care had been offered, completed or attempted. There was no other completed weekly audits identified in the medical record between 2/8/23 and 3/30/23. R43's progress note, dated 3/9/23, identified R43 refused their shower despite multiple attempts. However, the note lacked information on if nail care was offered, attempted, or provided. R43's progress note, dated 3/16/23, identified R43 had refused their bed bath as it was "too cold." R43 had no skin issues though, however, again, the note lacked information on if nail care was offered, attempted, or provided. R43's progress note, dated 3/23/23 (nearly two weeks prior), identified, "Nails clipped and feet OK." R43's medical record was reviewed and lacked	F 677	Executive Director and the Executive Director will take audit results to QAPI for review and recommendation. Compliance: 5/12/2023	

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evidence R43 had nail care attempted, offered, or provided since 3/23/23, despite having visibly long nails present and desiring them to be clipped.

On 4/5/23 at 8:29 a.m., nursing assistant (NA)-B was interviewed. NA-B explained R43's level of care seemed to "depends on his mood" as sometime they were able to care for themselves and other times not. NA-B stated R43 was typically accepting of care offered, and expressed R43 had a scheduled bath for every Thursday according to the posted bath schedule. NA-B stated nail care could be completed on the scheduled bath day or "if you see it [needs to be]" but added such was "just my opinion." NA-B then observed R43's nails at the surveyors request and verified they were long and soiled adding, "We can get them clipped down a little bit." Further, NA-B stated any attempts to complete nail care, including a refusal, should be recorded in the medical record.

When interviewed on 4/5/23 at 10:42 a.m., licensed practical nurse (LPN)-C stated nail care should be completed on a weekly basis during the assigned "shower day." LPN-C observed R43's nails and verified their length adding they "should be trimmed." LPN-C stated R43 was not diabetic and, as a result, the NA(s) could clip them and document such action in the "POC charting." LPN-C verified any attempt, including a refusal, should be documented.

R50's annual MDS, dated 2/17/23, identified R50 and unclear speech and required extensive assistance with ADL(s). However, the section to record R50's cognition (i.e., BIMS) was left blank

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and not completed.

R50's care plan, dated 3/20/23, identified R50 had an ADL self-care deficit and listed several interventions including, "PERSONAL HYGIENE/ORAL CARE: dependent ax1 [assist of one]." The care plan lacked any indication how often nail care would be attempted or provided, or if R43 had any preferences for their nails (i.e., longer or short).

R50's progress note, dated 3/23/23, identified, "Nail and toes trimmed. Skin is good."

On 4/3/23 at 10:45 a.m., R50 was observed laying in bed while in his room. R50 did not verbally respond to the surveyor' questions, however, would smile at times. R50 had visibly long fingernails present on both hands with several nails having a black debris present under the nail bed. Later, on 4/3/23 at 1:21 p.m., R50 continued to have long fingernails with the black-colored debris present underneath several of them.

R50's most recent Weekly Bath Audit 020919 - V2, dated 4/3/23, identified R50 had a bed bath completed and R50 was not resistive. However, the audit lacked any information or indication if nail care had been offered, completed or attempted despite R50 having visibly long fingernails observed on the same day (4/3/23).

On 4/5/23 (two days later) at 8:23 a.m., R50 was again observed laying in bed while in his room. R50 continued to have visibly long fingernails present on both hands with the same black-colored debris present under several of the nail beds. R50 remained non-verbal and unable

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F 677	Continued From page 89 to answer questions when asked. R50's medical record was reviewed and lacked evidence R50 had nail care attempted, offered, or provided since 3/23/23, despite having visibly long nails present and evidence of bathing being completed on 4/3/23. On 4/5/23 at 9:53 a.m., nursing assistant (NA)-A was interviewed. NA-A explained R50 was totally dependent on staff for care and cares for them, including bathing, were "not that hard." NA-A stated they had noticed R50's fingernails were long "a month ago or so" so they clipped them, however, was not sure when it was last done since. NA-A observed R50's nails and verified their length and condition. NA-A stated R50's nails should be cleaned and clipped when staff "see they're longer," adding when they had clipped them last time (about a month prior) the nails then were even "way longer than this." NA-A expressed they had noticed some cares, including nail care, not be completed recently and reiterated R50's nails should have been clipped as R50 will scratch at himself at times. Further, NA-A stated any nail care completed, or attempted, should have been recorded in the medical record. On 4/5/23 at 1:20 p.m., the assistant director of nursing (ADON) was interviewed and explained nail care should be completed on a weekly basis with the scheduled bathing. ADON stated they had noticed a few weeks ago the nails "are a problem" for several residents and, as a result, they used an extra nurse to clip them which explained the progress notes on 3/23/23 for R43 and R50. ADON stated "going forward" the nail care would be closer reviewed on the completed	F 677		

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F 677	Continued From page 90 bath audits to ensure it was done and documented. A provided Fingernails/Toenails, Care of policy, dated 2/2022, identified nail care included daily cleaning and regular trimming. The policy outlined, "Proper nail care can aid in the prevention of skin problems around the nail bed," and, "Trimmed and smooth nails prevent the resident from accidentally scratching and injuring his or her skin." A procedure of how to complete nail care was provided, and the policy directed the provided nail care should be recorded in the medical record, including if it was refused despite being offered/attempted.	F 677		
F 684 SS=E	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to comprehensively assess and develop interventions to address behavioral needs for 1 of 1 resident (R43) identified to horde balloons and inflatables; failed to comprehensively assess and develop an ongoing, comprehensive treatment plan with a develop skin condition for 1 of 1 resident (R50) observed to have dry skin on their face; and failed	F 684	F 684 Behavioral: R 48 will be scheduled by Social Service to receive consultation to facility contracted behavioral health organization for review and recommendation. R 48 will also be assessed by OT for room order. R 48 will meet with nursing leadership and will discuss and implement new	5/12/23

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to obtain blood pressures according to physician orders for 2 of 2 residents (R26, R48) reviewed who consumed diuretic and anti-hypertensive medications.

Findings include:

BEHAVIORAL ASSESSMENT:

R43's significant change in status Minimum Data Set (MDS), dated 3/13/23, identified R43 had intact cognition, demonstrated no hallucinations, delusions or rejection of care behaviors, and required extensive assistance with most activities of daily living (ADLs). Further, the MDS outlined a Behavioral Symptoms Care Area Assessment (CAA) was not triggered during the MDS review.

On 4/3/23 at 10:20 a.m., a housekeeper (HK)-B approached the surveyor and said aloud, "You from the State?" HK-B then lead the surveyor to R43's room and opened the doorway while saying aloud, "You need to do something [with this room]," as it was impossible to clean. Inside the room, R43 was laying in bed which was positioned in the middle of the room with the headboard against the wall opposite the doorway entrance. The room was filled with numerous inflatable-type balloons and items (i.e., pool inflatable) along with various debris (i.e., mail, letters, spilled drink or food items, boxes, etc.) present which covered a majority of the floor. The amount of inflatables was enough to occlude nearly one-half of the room' floor. HK-B stated the room had been in such condition for "months and months and months" and needed to be addressed, however, the management had not acted upon it to ensure it was cleaned up adding, "Nobody doing anything [about it]." At 10:22 a.m.,

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interventions to maintain/declutter resident room. R 48 will have a behavioral care plan initiated with measurable goals and interventions. All existing residents with behaviors will have their behavior care plan reviewed and updated as needed. Future residents identified for behaviors will have a referral to behavioral health and a behavioral care plan initiated.
Social Services Designee along with the IDT team will be in-serviced on the Behavioral Health Policy and procedure that behavioral health services are available and should be conducted by qualified and competent on behavioral health and trauma.
Social Service designee will be responsible for compliance.
Audits on behavioral health services request and behavioral health care plans will begin weekly x 4 weeks then monthly to ensure compliance.
Audit results will be reviewed by the Executive Director and the Executive Director will take audit results to QAPI for review and recommendation.
Skin:
R 50 was assessed by the NP on 5/4/23 and treatment orders were implemented. R 50 skin care plan was reviewed and updated. R 50 received a weekly bath, and the bath audit was completed on 5/4/23 and resident□s skin showed dry skin on face and lips. All existing residents with skin conditions, their skin was assessed, and care plans along with treatment orders and random weekly bath audits were reviewed and updated as needed. Future residents who admit to

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F 684	Continued From page 92 R43 awoke while in bed and expressed they had lived at the nursing home for "20 years" now. When asked about the room condition, R43 just responded, "I'm a mess." During subsequent interview, on 4/3/23 at 11:31 a.m., R43 explained they wanted to keep their room more organized and "wanted to clear out some [of the items and debris] but not all." R43 stated they "have a thing about balloons" and enjoyed ordering them online. R43 stated they had spoken with staff who repeatedly just attempt to clean the items out and never help them go through the items reiterating "something's I don't want to give up." However, R43 expressed, none of the staff take time to help him go through the items and decide what to keep or discard. R43's care plan, dated 4/4/23, identified R43 had an ADL self-care deficit and required extensive assistance to complete most ADLs. The section included an intervention, dated 4/4/23, which identified R43 preferred to keep their room filled with inflatables and, "Resident has sexual preferences with balloon like items that he orders online ... prefers to keep room unkept, resident will respond positively to staff requests to deflate and declutter room at times." However, the care plan lacked any evidence of this identified behavioral symptom and/or condition prior to 4/4/23; nor any evidence of what, if any, interventions had been attempted in the past or what the plan to address the room condition going forward (i.e., treatment plan, behavioral management plan) would be to ensure R43 remained safe in the room. On 4/5/23 at 8:29 a.m., nursing assistant (NA)-B was interviewed. NA-B explained they had	F 684	the facility will have weekly skin assessments recorded in the bath audit and skin conditions will be treated per MD order. Nursing staff was in-serviced on the newly created Skin Care Policy and Procedure dated 04/29/2023 with emphasis on item #3 that residents with skin concerns will be referred to the appropriate health professional and that skin check will occur weekly and skin treatments will be performed per MD order. Director of Nursing and/or designee will be responsible for compliance. Audits on weekly bath audit responses to skin concerns will begin weekly x 4 weeks then monthly to ensure compliance. Audit results will be reviewed by the Executive Director and the Executive Director will take audit results to QAPI for review and recommendation. Blood Pressure Monitoring: R26 physician was contacted, and frequency of vitals sign order was initiated. R 48 physician was notified that resident blood pressure frequency was not followed. The physician response will be documented in the resident electronic medical record. There were no adverse effects from this deficient practice. Licensed nurses will be in-serviced on Medication Treatment Order Policy and Procedure with emphasis on 9f that any requirements for monitoring or follow-up will occur per MD order. Director of Nursing and/or designee will be responsible for compliance. Audits on vital sign parameter orders frequency and physician notification as	

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F 684	Continued From page 93 worked at the nursing home for "a few weeks" and R43 had their room filled with balloons "since I've been here." R43 needed varying assistance to complete cares which NA-B expressed "depends on his mood maybe." NA-B stated they were unsure what, if any, interventions were in place to address R43's hoarding and room condition adding they had never been told or directed to offer to clean it or sort it before. On 4/5/23 at 9:42 a.m., NA-A was interviewed. NA-A explained R43 seemed to "like to be on the floor" and "likes to lay on his balloons." NA-A stated the staff try to clean up the room from time to time; however, in the past, R43 would become upset and tell staff they paid for the room and "can do what the [explicative] he wants" with the space. NA-A stated the room was a hazard which had also been explained to R43 and elaborated R43 had even, prior, sustained falls in the room due to the debris and balloons being scattered around the room. NA-A stated they were unaware what, if any, other interventions were done or in place to help organize and keep the room safe aside from just trying to clean it "often as we can." R43's medical record was reviewed and lacked evidence the behavior had been comprehensively assessed or had individualized interventions attempted or considered despite R43 hoarding these items for an extended period of time and, at times, having sustained falls as a result of the behavior. There was no indication in the record the facility had worked with R43 to determine what, if any, goals for behavioral care or what, if any, sustainable and ongoing interventions (i.e., weekly sorting) could be done to ensure R43 was allowed personal items, within reason, which did not impact their safety or the safety of others.	F 684	needed will begin weekly x 4 weeks then monthly to ensure compliance. Audit results will be reviewed by the Executive Director and the Executive Director will take audit results to QAPI for review and recommendation. Compliance: 5/12/2023	

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On 4/5/23 at 10:42 a.m. licensed practical nurse (LPN)-C was interviewed. LPN-C expressed they were aware of R43's room condition and stated staff had just "fixed his room yesterday [4/4/23];" however, R43 would often just mess it back up. This had been an issue for several months now. LPN-C stated they were unaware what, if any, interventions or dedicated approaches were being done with R43 and this hoarding-type behavior adding "none that I know of."

When interviewed on 4/5/23 at 1:49 p.m., the assistant director of nursing (ADON) stated R43 would, at times, allow staff to remove some of the items from the room but it seemed to only "stir him" to then go online and order more. ADON explained R43 had Parkinson's Disease and a resulted cognitive and communication deficit. However, ADON acknowledged the medical record lacked any assessment or individualized interventions for the behavior adding, "Obviously, there isn't one." ADON stated they could review and consider maybe some approaches on shower days with approaching R43 in a "what can we help you organize" manner. ADON stated the behavior needed to be assessed and appropriately care planned to help "let the record show" what worked and didn't work to keep the room better organized and help keep R43 safe.

A provided Behavioral Assessment, Intervention and Observing policy, dated 10/2021, identified the nursing home would provide behavioral health services as needed to attain or maintain the highest level of functioning in accordance with the comprehensive assessment and plan of care. A section labeled, "Assessment," directed the initial assessment of behavior would include the

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nursing staff would evaluate usual patterns of cognition, mood, and behavior; the resident's method for communicating items like pain, hunger; and the resident's typical or past responses to stress, fatigue and other triggers. The care plan would then incorporate those findings and be consistent with current standards of practice.

SKIN CONDITION NOT ACTED UPON:

R50's annual Minimum Data Set (MDS), dated 2/17/23, identified R50 had severely impaired cognitive skills for daily decision making and required extensive assistance to complete most activities of daily living (ADLs).

R50's care plan, dated 3/13/23, identified R50 had a potential or actual skin impairment due to fragile skin, immobility, and need for assistance. A goal was listed which read, " ... will maintain or develop clean and intact skin by the review date," along with several interventions including barrier cream applied after incontinence episodes, keep skin clean and dry, and lotioning dry skin.

On 4/3/23 at 10:45 a.m., R50 was observed laying in bed while in their room. R50 did not verbally respond to the surveyor when conversed with them, however, did smile at times. R50 had several areas of scaled, dry skin present on the face including forehead, cheeks, and around the mouth.

R50's Weekly Bath Audit 020919 - V2, dated 3/27/23, identified a bed bath was completed. A section labeled, "Skin Status," outlined there were no new alterations identified. The completed audit

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lacked evidence R50 had any dry skin concerns.

R50's most recent Weekly Bath Audit 020919 - V2, dated 4/3/23, identified a bed bath was again completed, and the section for R50's skin again identified no new alterations were identified. The completed audit lacked evidence R50 had any dry skin concerns despite scaled, dry skin being present on several areas of their face on the same date.

During subsequent observation, on 4/5/23 (two days later) at 8:23 a.m., R50 continued to have visible areas of white, scaled dry skin present on their face and around their mouth.

On 4/5/23 at 9:53 a.m., nursing assistant (NA)-A was interviewed. NA-A explained R50 required total assistance with care and did not verbally communicate. NA-A observed R50's face and verified the condition stating it appeared to be "dry skin." NA-A stated R50 had issues with it "since he's been here," so they had asked the family to bring in some cocoa butter lotion, however, nobody had as of yet. NA-A stated they tried to put lotion on R50's face when they notice the dry skin, however, when questioned on what ongoing treatment plan was in place, NA-A responded some nurses follow through with things (i.e., treatment plans) and others do not adding, "Nothin' ever gets done." NA-A stated they had never been directed or told to apply lotion or any other creams to R50's developed skin issue and expressed they were "not sure" what other staff, including nurses or NA(s), were doing for it, either.

R50's Medication Administration Record (MAR) and Treatment Administration Record (TAR),

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dated 4/2023, identified R50's current physician-ordered medications and treatments with their subsequent administration documentation. This lacked evidence of a current medicated treatment plan for R50's developed dry skin. Further, R50's medical record was reviewed and lacked evidence R50's facial dry skin had been comprehensively assessed, including for causative factors, and an ongoing treatment plan placed despite R50 having this condition present for an extended period of time as described by the direct care staff.

On 4/5/23 at 10:56 a.m., licensed practical nurse (LPN)-C was interviewed. LPN-C stated they had just "today" noticed R50's dry skin on their face while giving medication to them; however, verified R50 had no current treatment plan or orders to manage this. LPN-C stated none of the aides had reported it before and, if they had, she would have assessed the situation and updated the medical provider to get a treatment plan in place. LPN-C stated the skin condition looked like severe dry skin and reiterated it should be addressed.

When interviewed on 4/5/23 at 1:45 p.m., the assistant director of nursing (ADON) explained R50 did have a care planned intervention to apply lotion on dry skin, however, there were no other treatment plans they could locate to address the developed skin issue. ADON stated staff likely needed "to stay on top of the lotion," and R50's skin would improve. ADON verified the medical record lacked evidence the skin condition had been comprehensively assessed or acted upon adding, "not that I found," and expressed it should have been with staff potentially not recognizing "dry skin" as a skin alteration. ADON stated staff

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education was needed.

A facility policy on non-pressure related skin conditions, including the assessment of such and corresponding treatment process, was requested; however, none was received.

BLOOD PRESSURE MONITORING:

R26

R26's face sheet indicated R26 admitted to the facility on 8/24/22.

R26's significant change MDS's dated 1/20/23, 12/8/22, and 11/28/22, lacked indication of R26's cognitive status.

R26's admission MDS, dated 8/31/22, indicated R26 was cognitively intact, was independent with eating, required limited assistance with dressing and extensive assistance with all other ADLs.

R26's electronic medical record (EMR) indicated R26's diagnoses included chronic obstructive pulmonary disease (COPD, causing difficulty breathing), obstructive sleep apnea (the cessation of breathing periodically during sleep), morbid obesity, high blood pressure, diabetes, anxiety, failure to thrive, and peripheral venous insufficiency (decreased ability to circulate blood and fluid from the lower extremities resulting in fluid retention).

R26's CAA dated 1/20/23, indicated R26 triggered for urinary incontinence, falls, nutrition, and psychotropic drug use.

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R26's care plan dated 2/20/23, indicated R26 was dependent on staff for his emotional, intellectual, social, and physical needs. R26 had an altered respiratory status and difficulty breathing related to sleep apnea, obesity, and COPD. Interventions included monitoring the effectiveness and side effects of medications and monitoring for increased respirations, decreased or increased pulse. R26's care plan lacked indication of R26's cardiovascular status or history of high blood pressure or use of a diuretic.

R26's medication administration record (MAR) dated April 2023, indicated R26 took the following medications:
-amlodipine 10 milligrams (mg) for high blood pressure
-furosemide 40 mg (a diuretic) for high blood pressure
-losartan potassium 50 mg for high blood pressure

R26's MAR lacked an order indicating the frequency for taking R26's vital signs.

R26's blood pressure log dated 4/5/23, indicated R26's blood pressure was taken since his admission on 8/24/22, as follows:
-8/24/22
-10/28/22
-12/5/22
-12/10/22
-1/30/23
-2/2/23
-3/1/23
-3/13/23

R48

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R48's significant change MDS, dated 12/24/22, lacked indication of R48's cognitive status. R48 required supervision for bed mobility and toileting and was independent with all other ADLs.

R48's quarterly MDS dated 11/26/22, indicated R48 had intact cognition.

R48's hospital discharge summary dated 12/9/21, indicated R48 had diagnoses including respiratory failure with hypoxia (low oxygen) resulting in a tracheostomy (artificial airway place in the throat) due to COVID-19, morbid obesity, diabetes, chronic kidney disease, resistant hypertension (blood pressure that remains high despite the use of 3 antihypertensive medications), low thyroid, depression, and obstructive sleep apnea.

R48's Care Area Assessment (CAA) dated 12/24/22, indicated R48 triggered for urinary incontinence, falls, and nutrition.

R48's care plan dated 3/24/23, indicated R48 had altered cardiovascular (heart) function. Interventions included monitoring and documenting any signs or symptoms of coronary artery disease, observing R48's vital signs and reporting abnormalities to the provider. R48 also had diabetes. Interventions included monitoring/documenting/reporting increased heart rate. R48 had renal (kidney) insufficiency related to kidney disease. Interventions included observing R48 for shortness of breath, increased heart rate, elevated blood pressure, skin temperature, peripheral pulses (wrists and ankles) and breath sounds for crackles (fluid in the lungs).

R48's physician orders dated 3/23/23, indicated

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R48 received 120 milligrams (mg) thyroid tablet once daily for low thyroid, two 25 mg (50mg) carvedilol twice a day for high blood pressure, and 2.5 mg amlodipine besylate in the morning for high blood pressure. The orders also indicated staff were to take R48's vitals daily.

R48's blood pressure log dated 4/5/23, indicated from 3/23/23 to 4/5/23, R48's blood pressure was not taken on the following dates:

-3/23/23
-3/24/23
-3/25/23
-3/28/23
-3/29/23
-3/30/23
-4/1/23-4/5/23

During an interview on 4/3/23 at 10:26 a.m., R48 stated staff were supposed to take her vitals daily; however, they often forget and had not taken her vitals yet that morning. R48 also stated she would prefer staff take them at the same time every morning so she could track their consistency.

During an interview on 4/4/23 at 8:54 a.m., R48 stated staff brought her morning medications but had not taken her vitals.

During an interview on 4/6/23 at 2:52 p.m., licensed practical nurse (LPN)-E stated R48's vitals should have been completed daily, according to her orders, especially because she was taking so many cardiac medications. LPN-E further stated she did not know what the policy was if a resident did not have an order to indicate how frequently their vitals were to be taken but

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F 684	Continued From page 102 believed it was at least once a week, possibly on their bath day. During an interview on 4/6/23 at 3:00 p.m. the director of nursing (DON) stated staff should have been taking R48's vitals, including her blood pressure, daily. The DON verified R48's vitals including her blood pressure were not recorded daily in her EMR. The DON further stated resident vital signs including blood pressure should be taken according to their orders. During an interview on 4/7/23 at 8:09 a.m. the consulting pharmacist (PH) stated it was important for staff to be monitoring his vitals, including his blood pressure, more often than once a month because R26 was on a diuretic. During an interview on 4/6/23 at 1:27 p.m., the nurse practitioner (NP)-A stated residents should have their vital signs, including blood pressure, taken according to the facility standing orders if there were no provider orders to indicate their frequency. The NP further stated R26 should have had his vitals taken at least once a month. The facility Standing Orders for Skilled Nursing Facilities: Minnesota Association of Geriatric Inspired Clinicians (MAGIC), alliance for Clinical Excellence (ACE) policy dated April 2022, indicated upon admission to a long-term care facility, residents were to have vitals, including blood pressures, taken weekly unless otherwise directed.	F 684		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents.	F 689		5/12/23

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F 689	Continued From page 103 The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to implement individualized interventions to mitigate risk for falls following a fall with a fracture for 1 of 1 resident (R32). Findings include: R32's quarterly Minimum Data Set (MDS) dated 11/7/22 indicated intact cognition and requirement of extensive assist with transferring, bed mobility, toileting, and hygiene, occasionally had bladder incontinence, and did not reject cares. R32's significant change MDS dated 1/13/23, indicated intact cognition, did not reject cares, required extensive assist with bed mobility, transfers, dressing, toileting, personal hygiene, and had a balance problem when moving from seated to standing, walking, and during transfer between bed , chair, and wheelchair. The MDS indicated R32 was occasionally incontinent. R32's Medical Diagnosis form in the electronic medical record (EMR) indicated R32 had the following diagnoses: Crohn's disease (an inflammatory disease that affects the digestive tract), muscle weakness, and difficulty walking. R32's falls care plan dated 7/15/22 indicated the	F 689	F 689 R 32 remains a resident at the facility. Upon return to the facility R 32 had a new fall, pain assessment and care plan was reviewed and updated. All existing resident falls from survey exit until present will be thoroughly reviewed, root cause identified (if able) and care plans will be reviewed and updated as needed. Future residents who fall will have a resident centered fall prevention plan and interventions based on assessment information. IDT and Nursing staff will be in-serviced on the Fall Management Policy and Procedure with emphasis on category Resident Centered Approaches with emphasis on identifying the root cause of a fall and place a plan to reduce and/or avoid a fall. Assistant Director of Nursing and/or designee will be responsible for compliance. Audits on root cause analysis and resident centered interventions will begin weekly x 4 weeks then monthly to ensure compliance. Audit results will be reviewed by the Executive Director and the Executive Director will take audit results to QAPI for	

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F 689	Continued From page 104 following interventions created on 7/15/22: be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed, the resident needs prompt response to all requests for assistance, and physical therapy to evaluate and treat as ordered or as needed. The care plan was revised on 4/4/23, to update the goal that R32 would be free of falls through the review target date of 4/21/23. R32's Resident Fall Risk form dated 11/1/22 indicated intermittent confusion, was ambulatory but incontinent, had a balance problem while walking and decreased muscular coordination and gait problems. The form also indicated R32 took one or two medications that included antipsychotics, antianxiety agents, antidepressants, hypnotics, cardiovascular medications, diuretics, narcotic analgesics, neuroleptics, or other medications that caused lethargy or confusion, and had predisposing diseases. The form had a score of 16 indicating a high risk for falls. R32's Resident Fall Risk form dated 12/6/22, indicated intermittent confusion, a history of one or two falls in the past three months, was ambulatory but incontinent, had a balance problem while standing, walking and required an assistive device. The form also indicated R32 took one or two medications that included antipsychotics, antianxiety agents, antidepressants, hypnotics, cardiovascular medications, diuretics, narcotic analgesics, neuroleptics, or other medications that caused lethargy or confusion, and had predisposing diseases. The form had a score of 19 indicating a high risk for falls.	F 689	review and recommendation. Compliance: 5/12/2023	

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F 689	Continued From page 105 R32's Resident Fall Risk form dated 12/14/22, indicated disoriented at all times, had one to two falls in the past three months, was chair bound and required assist with elimination, had a balance problem with standing and walking. The form also indicated R32 took one or two medications that included antipsychotics, antianxiety agents, antidepressants, hypnotics, cardiovascular medications, diuretics, narcotic analgesics, neuroleptics, or other medications that caused lethargy or confusion, and had predisposing diseases. The form had a score of 13 indicating a high risk for falls. R32's Resident Fall Risk form dated 1/5/23 indicated R32 was alert, had one to two falls in the past three months, was ambulatory but incontinent, had gait problems. The form also indicated R32 took one or two medications that included antipsychotics, antianxiety agents, antidepressants, hypnotics, cardiovascular medications, diuretics, narcotic analgesics, neuroleptics, or other medications that caused lethargy or confusion, and had predisposing diseases. The form had a score of 12 indicating a high risk for falls. R32's Resident Fall Risk form dated 1/13/23 indicated R32 was alert, had a history of one to two falls in the past three months, was ambulatory and continent, and required an assistive device. The form also indicated R32 took one or two medications that included antipsychotics, antianxiety agents, antidepressants, hypnotics, cardiovascular medications, diuretics, narcotic analgesics, neuroleptics, or other medications that caused lethargy or confusion, and had predisposing diseases. The form had a score of eight,	F 689		

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indicating a moderate risk for falls.

R32's nursing progress note dated 11/26/22, indicated R32 was found on the floor about 5:45 a.m. lying on left side and was trying to walk to the bathroom and fell.

R32's Incident Audit Report form dated 11/26/22, indicated R32 was found on the floor in his room on his left side. He tried to walk to the bathroom and fell. Under the heading immediate action taken, R32 was assessed, rated pain a seven out of ten, was unable to raise his left arm, and was lifted up with two assist to the toilet and back to bed. The form indicated the type of injury was R32's left shoulder, predisposing factors included weakness, and under other information "diarrhea" was documented.

R32's nursing progress note dated 11/27/22 at 10:45 p.m., indicated R32 had a fall the previous day and an x-ray had been ordered and further assessment indicated R32 was in "dire" pain guarding his arm screaming his arm was broken, 911 was called at 8:00 a.m. and R32 was sent to the hospital.

R32's hospital discharge summary indicated R32 was hospitalized 11/27/22 through 12/3/22 for a humerus fracture (upper arm bone) and acute hypoxic respiratory failure.

R32's Care Area Assessment Worksheet form dated 1/21/23, indicated an actual problem for falls and indicated R32 took antipsychotics, antidepressants, and hypnotics, had diagnoses related to his heart, and neuromuscular, and psychiatric or cognitive and the form indicated falls would be addressed in the care plan to slow

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F 689	Continued From page 107 or minimize decline. R32's Toilet Use task form from 3/7/23 through 4/5/23 indicated R32 was mostly independent with toilet use, but required supervision on one occasion, limited assistance on six occasions, and extensive assistance on four occasions. The task indicated R32 did not refuse this task. R32's Bladder Elimination task form from 3/7/23 through 4/5/23, indicated R32 was mostly continent, but had four episodes of incontinence. The task indicated R32 did not refuse this task. During interview and observation on 4/5/23 at 8:10 a.m., R32 stated he still felt pain to his shoulder and stated staff don't remind him to use his call light, he sometimes pushes the call button and waits for hours. During interview on 4/5/23 at 8:31 a.m., nursing assistant (NA)-A stated R32 does not allow you to take care of him adding he goes to the bathroom and is able to wipe and dress himself. NA-A stated R32 was only incontinent when he is ill. During interview on 4/5/23 at 2:26 p.m., licensed practical nurse (LPN)-F stated when a resident falls they try to determine the cause and document in a risk management report. During interview on 4/5/23 at 3:01 p.m., the assistant director of nursing (ADON) stated R32's fall risk assessment was completed in January and was categorized as a moderate risk for falls. ADON stated the interventions on R32's care plan were not specific to his prior fall and added that every fall has to have an intervention and be specific to the fall and R32 did not have specific	F 689		

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F 689	Continued From page 108 interventions following his fall. ADON stated Associated Clinic of Psychology (ACP) spoke with resident 3/30/23 and mentioned R32 would benefit from more assist with his activities of daily living and expected interventions to be in place on the care plan to prevent falls. During interview on 4/6/23 at 10:11 a.m., the director of nursing (DON) stated R32 was at at risk for falls and stated fall prevention interventions for R32 would include to encourage the use of the walker, answer the call light, assist to toilet after meals, assure call light is in reach, and the walker should be within reach. DON added the interventions should be assumed, but could be on the care plan. A policy, Fall Risk Assessment dated 10/4/21 indicated the nursing staff, in conjunction with the attending physician, consultant pharmacist, therapy staff, and others, would seek to identify and document resident risk factors for falls and establish a resident-centered falls prevention plan based on relevant assessment information. A policy, Care Plans, Comprehensive Person-Centered dated 11/30/21, indicated the interdisciplinary team must review and update the care plan when the desired outcome is not met.	F 689		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is	F 690		5/12/23

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 690	Continued From page 109 not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure developed bowel incontinence was comprehensively assessed and interventions developed to promote continence for 1 of 1 resident (R43) who complained of loose, incontinent stools. Findings include:	F 690	F 690 R43 had a new comprehensive bowel assessment completed, a medication review and the MD notified of new onset of incontinence and from this assessment a bowel plan and care plan will be implemented and evaluated. All other residents who are incontinent of bowel will be reviewed and their bowel care plan will	

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F 690	Continued From page 110 R43's significant change in status Minimum Data Set (MDS), dated 3/13/23, identified R43 was cognitively intact and required extensive assistance with toileting care. Further, the MDS outlined R43 as being frequently incontinent of bowel, however, was not being managed on a bowel toileting program. R43's most recent Continence Evaluation Review - V2, dated 12/7/22, identified a section labeled, "Continence History," with a subsection named, "Bowel." This identified R43 had no bowel incontinence, had a daily bowel movement, and, would occasionally need laxative or suppository aide for regulation. The evaluation continued and provided sections to record pertinent medical diagnoses, medication consumption, and potential contributing factors to incontinence. The evaluation concluded with a section labeled, "Treatment Options," which outlined prompted voiding, incontinence products, and offering toileting in the morning, bedtime, and with cares throughout waking hours would be beneficial for R43's bladder incontinence adding, "[R43] is continent of bowel but occasionally incontinent of bladder." R43's care plan, dated 3/14/23, identified R43 was incontinent of bladder and listed a goal which read, " ... will remain free from skin breakdown due to incontinence and brief use through the review date," along with several interventions including cleaning the peri-area after incontinence episodes, ensuring an unobstructed path to the bathroom, and checking frequently and as required for incontinence. The care plan lacked evidence, or subsequent interventions, for any bowel incontinence.	F 690	be reviewed and updated as needed. Future residents who admit to the facility will have a bowel and bladder screening along with a comprehensive assessment per facility policy. Nursing staff will be in-serviced on the Bowel Disorder Clinical Protocol with emphasis on item #3 that the nurse must access and document/report any changes in amount and frequency of bowel movements and consistency. Director of Nursing and/or designee will be responsible for compliance. Audits on new onset of bowel incontinence in residents will begin weekly x 4 weeks then monthly to ensure compliance. Audit results will be reviewed by the Executive Director and the Executive Director will take audit results to QAPI for review and recommendation. Compliance: 5/12/2023	

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F 690	Continued From page 111 On 4/3/23 at 11:47 a.m., R43 was observed seated in a wheelchair in their room, and had no odors (i.e., suggesting incontinence) present at this time. R43 was interviewed and expressed they had been having multiple issues with loose stools and bowel incontinence. R43 felt it was diet related and, as a result, was taking Imodium (medication used to treat diarrhea) when needed. R43 stated they were unaware if they were on a bowel management program but added the nursing home wasn't good about proactively addressing issues, including their bowel concerns, adding "it's only reactive [here]." R43 reiterated the bowel incontinence and, at times, loose stools were embarrassing. R43's POC (point of care) History Response, printed 4/6/23, identified the past 30 days worth of bowel continence as recorded by the nursing assistant (NA) staff. This identified R43 had a total of eight (8) recorded episodes of bowel incontinence in the past 30 day period. When interviewed on 4/5/23 at 9:42 a.m., NA-A explained R43 was incontinent bladder and, as a result, does "wet the bed a lot." NA-A stated R43 was "sometimes" incontinent of bowel, too, and explained it was an "on and off thing with him" it seemed; however, R43 had some level of bowel incontinence for the past several months now to her recall. NA-A verified R43 was not currently on a toileting program for bowel incontinence but expressed R43 would "ring his light" if needed help with the toilet. R43's medical record was reviewed and lacked evidence R43's bowel incontinence, including contributing factors such as medication use, had been comprehensively reassessed and	F 690		

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F 690	Continued From page 112	F 690		

interventions developed to promote more continence since he had been assessed on 12/7/22, where he was recorded as being continent of bowel.

On 4/5/23 at 10:42 a.m., licensed practical nurse (LPN)-C was interviewed. LPN-C explained R43 needed help to complete most cares but "for the most part" was generally accepting of help and care. LPN-C stated they were aware R43 was "occasionally" incontinent of bowel and had been for several weeks now. LPN-C reviewed R43's medical record, including the continence evaluation, and expressed the director of nursing (DON) or someone else usually completed those assessments adding they themselves "haven't done one [ever]." LPN-C acknowledged the medical record lacked further assessment or care planning of R43's developed bowel incontinence and expressed it should have been assessed and acted upon.

On 4/5/23 at 1:32 p.m., the assistant director of nursing (ADON) was interviewed. ADON reviewed R43's medical record and verified the continence evaluation (dated 12/7/22) outlined R43 as being continent of bowel, and R43 had, apparently, since developed bowel incontinence as was charted by the NA(s) in the POC charting. ADON stated themselves and the DON were both currently working to complete such assessments and evaluations, and they explained a bowel incontinence assessment would include a review of medication use, mobility, medical complications and other factors which could contribute to incontinence. However, ADON verified R43 had not been comprehensively reassessed for their bowel incontinence despite the recorded episodes of incontinence adding, "It

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F 690	Continued From page 113 should have been done." A facility policy on bowel management was requested, however, none was received.	F 690		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure ongoing weight gain was identified timely, comprehensively assessed, and acted upon to meet resident wishes (i.e., weight loss) and reduce the risk of complication (i.e., heart disease) for 1 of 1 resident (R14) reviewed who voiced they had gained significant weight since they admitted to	F 692	F 692 R 14 will have a reweight completed, the facility dietitian will meet with R 14 for review of current diet order and weight loss plan and a new nutritional assessment completed. R 14 MD will assess the resident health status and a care plan will be implemented with	5/12/23

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F 692	Continued From page 114 the nursing home. Findings include: R14's quarterly Minimum Data Set (MDS), dated 1/6/23, identified R14 was independent with eating, was 66 inches tall, and weighed 179 pounds (lbs). Further, the MDS outlined R14 had not sustained any weight loss or gain (i.e., 5% or more in the last month; 10% or more in the last six months). However, the section used to record R14's cognition was left blank and not completed. R14's most recent Nutrition Data (Quarterly) MNA - V2, dated 1/6/23, identified R14 was determined to be at risk for malnutrition and listed their weight as, "189 [lbs]," with a Body Mass Index (BMI) recorded as, "BMI 23 or greater." A section labeled, "Summary Note," outlined R14 demonstrated no significant weight changes, consumed a regular diet, weight changes were not expected, and the registered dietician would follow-up per the MDS cycle or as needed. However, the completed assessment lacked evidence R14 had been asked or queried on what, if any, goals they had for their weight (i.e., loss). R14's care plan, dated 1/6/23, identified R14 had a nutritional problem and listed a goal which read, " ... will maintain adequate nutritional status as evidence by maintaining weight within 5% of 190#, no s/sx of malnutrition, and consuming at least 50% of meals." The care plan listed several interventions including obtaining weights per policy, and providing R14's diet as ordered. On 4/3/23 at 9:42 a.m., R14 was interviewed and expressed concerns about having gained too	F 692	resident centered interventions. All other existing residents will have their weights from survey exit until present and weight losses/gains will be reported to the facility dietitian and MD for further recommendations. Future residents will have weights performed per policy and any undesired weight gains or losses will be reported to the MD and Dietitian. Licensed nurses will be in-serviced on the Weight Assessment policy with emphasis on item #3 that weight change of 5% a reweight will be obtained and if accurate, the dietitian will be notified. The dietitian will be in-serviced on the Nutritional Assessment with emphasis on item #1 that a nutritional assessment will be conducted for each resident and item #3 that each component will include review of weight, intake, appetite, and any resident weight goals. Dietary Manager and/or designee will be responsible for compliance. Audits on resident monthly weights for accuracy, notification to the dietitian for weight losses/gains and nutritional interventions for weight losses or gains will begin weekly x 4 weeks then monthly to ensure compliance. Audit results will be reviewed by the Executive Director and the Executive Director will take audit results to QAPI for review and recommendation. Compliance: 5/12/2023	

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F 692	Continued From page 115 much weight since they admitted to the nursing home. R14 explained they had "not weighed this much" for several years and acknowledged they needed to do more exercise to help lose weight, but reiterated concern for having gained weight over the past several months. R14 expressed their usual body weight, prior to admitting to the nursing home, was around 150 to 160 pounds (lbs), however, the last time they weighed themselves at home, on a leave of absence, was "about 210 [lbs]." R14 stated nobody from the nursing home had reviewed or discussed the weight gain with her but expressed they wished someone would adding, "I'm having a heck of a time trying to lose it." On 4/5/23 at 8:10 a.m., R14 was seated on their bedside in their room. Nursing assistant (NA)-B knocked and entered R14's room with a meal tray which contained a white-colored menu slip. This outlined R14's name, diet order, and a section labeled, "Special Instructions," which included, "*LARGE PORTIONS," and, "*NO SAUSAGE GRAVY." R14 was served scrambled eggs, 1 piece of buttered toast, a single slice of ham, and a small dish of fruit cocktail. Later, at 9:07 a.m., R14 remained on their bedside and their meal tray had been removed. R14 stated they had "pretty much" ate everything provided, however, the servings provided were not "the normal amount I usually get," which R14 expressed made they feel "so very blessed" due to wanting to lose weight. R14's Weight Summary, printed 4/6/23, identified R14's collected and recorded weights since admission to the nursing home. This included: 4/1/22 - 179.0 lbs.	F 692		

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Continued From page 116

6/16/22 - 188.0 lbs.

10/20/22 - 193.6 lbs.

3/3/23 - 195.0 lbs (a 8.94% gain since admission).

On 4/5/23 at 9:31 a.m., nursing assistant (NA)-A was interviewed. NA-A explained R14 was "very independent" with their own cares and often would leave the nursing home to go out with her significant other to their home. NA-A stated she had noticed R14 had "gained a little weight" over the past few months as R14 had been "skinny when [they] first came here." NA-A stated R14 had never reported concerns to them about their weight; however, reiterated they had noticed weight gain adding R14 had, in the past, been complaining staff were giving her "too much food." NA-A stated they were unsure if the nurses or dietary department was aware R14 had gained weight and could not explain why R14's menu slip had 'large portions' listed on it.

R14's medical record was reviewed and lacked evidence R14's continued, unplanned weight gain had been comprehensively assessed to determine what, if any, modifications could be made to help R14 lose weight and/or not gain weight despite R14 having sustained a nearly 10% weight gain since admission and direct care staff observing R14 having visibly gained weight since admission to the nursing home.

On 4/5/23 at 1:10 p.m., the assistant director of nursing (ADON) was interviewed and explained weights were collected on a monthly basis unless a specific physician order directed otherwise.

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F 692	Continued From page 117 ADON stated the registered dietician (RD) did make rounds at the facility, however, they were not sure of their process or how someone would be triggered for them to review adding, "I don't know what [RD] routine is." However, ADON stated the nursing department was responsible to identify and report any observed weight changes, including weight gain, to the RD and should, themselves, be checking for "those trends." ADON stated R14 had not specifically mentioned any concerns to them about their weight, however, expressed she had just noticed R14 appeared to have gained weight from her medical record photo adding, "[R14] is skinny in that picture." ADON reviewed R14's medical record and verified R14 had gained weight since admission to the nursing home and expressed the dietary department maybe needed to revise the menu slip and R14's nutrition goals. ADON expressed they would review for long-term trends (i.e., admission to current), however, was unsure what others, including the RD, do with their assessment process but added it was part of a new "IDT process" they were hoping to implement to allow staff to "look at the whole picture." When interviewed on 4/5/23 at 2:35 p.m., the RD explained they had just that day (4/5/23) visited with R14 for a routine MDS interview where R14 reported they "want to lose weight." RD explained to R14 some approaches for such would include being more active to which R14 expressed they often get bored with physical activity unless outdoors. RD stated R14 had reported the "exact same numbers" of usual body weight to their current weight (i.e., 150-160, 210) as they reported to the surveyor just days prior. RD explained their review of weights was based mostly from clinically significant change to which	F 692		

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F 692	Continued From page 118 R14 didn't meet the threshold. RD stated they were usually more informed and involved with residents for weight loss instead of weight gain, however, if concerns were present, regardless, they would want to reassess the situation and converse with the resident to "see what their concerns are." RD stated nobody had reported any concerns to him about R14's weight gain and there were options to address it including reducing the meals to "regular portion sizes" and providing education on weight loss. Further, RD stated they did long-range weight modeling (i.e., admission to current) "to a certain extent," however, more often just reviewed from the past 180 days (six months) to current for their assessment process. A provided Nutritional Assessment policy, dated 12/2021, identified the RD would conduct a nutritional evaluation for each resident upon admission and as indicated by a change in condition which placed the resident at risk for impaired nutrition. The assessment would include several components including usual body weight, usual intake and appetite, and clinical conditions which could impact the nutritional status. The nutritional care plan would then address the causes of impaired nutrition, resident' personal preferences, and any goals or benchmarks for improvement. However, the policy lacked specific information on how or when weight gain would be assessed or addressed.	F 692		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who	F 695		5/12/23

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F 695	Continued From page 119 needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure oxygen orders were received and tubing was changed and dated timely for 1 of 1 resident (R29) reviewed for respiratory care. Findings include: R29's significant change Minimum Data Set (MDS), dated 2/23/23, indicated R29 had short-term and long-term memory problems with severely impaired cognitive skills for decision making, needed extensive assistance with bed mobility, transfers, toileting use, personal hygiene, and supervision with eating. The MDS further indicated medical diagnoses to include metabolic encephalopathy (a problem in the brain caused by a chemical imbalance in the blood which can lead to personality changes), binge eating disorder (frequently consuming unusually large amounts of food in one sitting and feeling that eating behavior is out of control), venous insufficiency (a condition in which the veins have problems sending blood from the legs back to the heart), major depressive disorder (a mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life), obstructive sleep apnea (Intermittent airflow blockage during sleep causing decreased oxygen saturation or arousal from sleep), and schizoid	F 695	F 695 R 29 had oxygen orders and tubing was changed on 4/21/23. R 29□s care plan was reviewed and updated as needed. All existing residents who utilize oxygen will have their orders reviewed, tubing assessed, and care plan reviewed and updated as needed. Future residents will have oxygen orders entered and tubing changed per facility policy. Licensed nurses were in-serviced on the Oxygen Policy that a physician order and care plan is required and the Department of Respiratory Policy that changes in tubing and canula is changed every 7 days and as needed. Director of Nursing and/or designee will be responsible for compliance. Audits on oxygen orders, care plans and tubing changes will begin weekly x 4 weeks then monthly to ensure compliance. Audit results will be reviewed by the Executive Director and the Executive Director will take audit results to QAPI for review and recommendation. Compliance: 5/12/2023	

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F 695	Continued From page 120	F 695		

personality disorder (a condition in which people avoid social activities and interacting with others).

During observation on 4/4/23 at 8:13 a.m., R29 was wearing oxygen via nasal cannula (a lightweight tube which on one end splits into two prongs which are placed in the nostrils). The oxygen tubing and humidification bottle were not labeled or dated. R29 stated he was unsure if staff were changing the oxygen tubing.

During observation on 4/5/23 at 1:39 p.m., R29 was observed wearing oxygen via nasal cannula. The tubing and humidification bottle remained unlabeled and undated.
R29's entire medical record was reviewed, including R29's care plan, physician orders, medication and treatments records and tasks, and all lack orders or interventions for oxygen therapy.

R29's progress notes since admission on 2/9/23 were reviewed. The only mention of R29's oxygen tubing being changed was a nursing note dated 3/24/23 which indicated R29 received new oxygen tubing which was labeled and dated.

During an interview on 4/6/23 at 8:29 a.m., registered nurse (RN)-D stated the documentation tasks for oxygen therapy are either in the medication administration record (MAR) or in physician orders and stated, "that is how we know what tasks to do." RN-D confirmed there were no orders for oxygen in R29's chart and was unable to confirm what oxygen liter flow R29 should be on.

During an interview on 4/6/23 at 0932 a.m., the director of nursing (DON) stated the expectation

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 695	Continued From page 121 for oxygen therapy was for the liter flow rate to be in physician orders and for the oxygen tubing and humidification bottle to be changed and dated weekly and documented in a progress note. A facility policy titled Oxygen Administration, reviewed 11/1/21, indicated staff should verify there is a physician order for oxygen therapy prior to placing oxygen on a resident.	F 695		
F 697 SS=D	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure physician-recommended interventions for pain management were accurate, acted upon, and implemented to promote comfort and reduce pain for 2 of 2 residents (R14, R30) reviewed for pain management. Findings include: R14's quarterly Minimum Data Set (MDS), dated 1/6/23, identified R14 was independent with most activities of daily living (ADLs) and received no scheduled, as-needed, or non-pharmacological interventions for pain management. However, the sections provided to record R14's cognition (i.e., Section C) and the corresponding pain interview were left blank and not completed.	F 697	F 697 R 14 and R 30 had a new pain assessment, and the MD was contacted for review of current pain medications. R 14 and R 30 pain care plans were reviewed and updated as needed. The NP will be notified that the orders given for pain gel for R 14 were not implemented. The NP response will be recorded in the resident electronic medical record. All existing residents will have their pain medications reviewed for effectiveness and pain care plan reviewed and updated as needed. Existing residents will have pain medications administered and monitored for effectiveness per physician order. Licensed nurses and nurse aides will be	5/12/23

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F 697	Continued From page 122 R14's most recent Nurse Pain Tool Observation, dated 1/3/23, identified several sections to be completed to assess for pain. These sections included pain location, quality of the pain, and effects of the pain (i.e., limiting day-to-day activities). However, all of these sections were left blank and not completed. The tool concluded with a section labeled, "Pain Summary," which only outlined, " [R14] denies any pain." R14's care plan, dated 12/31/22, identified R14 received pain medication for chronic pain. A goal was listed which read, "The resident will be free of any discomfort or adverse side effects from pain medication," and listed several interventions for R14 including providing analgesic medications as ordered and monitoring for potential side effects. On 4/3/23 at 9:49 a.m., R14 was interviewed. R14 expressed she had "bad arthritis" in her knees which, at times, caused them both to "hurt me real bad." R14 stated she used ibuprofen (an anti-inflammatory medication) to help control the pain, however, it was not always effective. R14 stated staff were aware of her pain, and she had even spoken to the nurse practitioner (NP) about getting something else for pain a month or so prior, however, there had been no follow-up on it since then. R14 expressed she felt more needed to be done for her pain management. R14's Encounter - Nursing Home Visit note, dated 3/1/23, was completed by nurse practitioner (NP) which outlined a chief complaint of, "Knee Pain." R14 reported having bilateral knee pain which " ... [R14] feels they are so painful she can't do as much as she normally	F 697	in-serviced on the Pain Clinical Policy with focus on identifying resident signs and symptoms of pain and notifying the nurse of resident signs and symptoms for further assessment and MD/NP notification. Director of Nursing and/or designee will be responsible for compliance. Audits on resident�s pain medication, effectiveness and pain care plan will begin 2x week for 2 weeks, weekly x4 weeks then monthly to ensure sustained compliance. Audit results will be reviewed by the Executive Director and the Executive Director will take audit results to QAPI for review and recommendation. Compliance: 5/12/2023	

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F 697	Continued From page 123	F 697		

does," and was wondering if more treatment could be completed. The note listed an assessment, and subsequent plan, for this which included obtaining x-rays of the knees, providing Voltaren 1% gel (a topical pain cream) to bilateral knees three times a day, and referring R14 back to the orthopedic surgeon who replaced her knees several years prior.

On 4/5/23 at 8:09 a.m., a subsequent interview with R14 was held. R14 stated she had just visited with the NP, again, the day prior (4/4/23) where she voiced her knees were "really getting bad." The NP responded they would "put something through" and possibly consider cortisone injections to R14's knees. R14 stated they were unaware the NP had provided recommendations from the 3/1/23 visit, and verified no x-rays or Voltaren gel or orthopedic referral had been discussed or offered to her. R14 stated such interventions were "worth a try," and expressed the lack of follow-up, and subsequent missed interventions and ongoing pain issues, was frustrating. R14 added, "Nobody does here [follow-up]."

R14's Medication Administration Record (MAR), dated 4/2023, identified R14's current physician orders and treatments. This lacked evidence R14 was receiving the recommended Voltaren 1% gel as outlined on the Encounter - Nursing Home Visit note (dated 3/1/23). Further, R14's medical record was reviewed and lacked evidence the recommendations, including referral to the orthopedic surgeon and x-ray request, had been acted upon or implemented despite this recommendation being made over a month prior.

On 4/5/23 at 10:50 a.m., licensed practical nurse

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F 697	Continued From page 124 (LPN)-C was interviewed, and they stated R14 "rarely" complained about pain. LPN-C explained the process for order processing included the medical provider (i.e., NP) writing orders and either handing them directly to staff or placing them in a folder to be addressed at the nursing station; however, LPN-C stated such process was "also an issue" as of late with several situations happening where orders were not being acted upon or addressed. LPN-C elaborated and explained several residents had recently reported situations where the NP would tell them certain items or orders would be placed, however, then it never happen or get followed up on. LPN-C reviewed R14's recommendations and stated they were unaware such items had been written or requested on the visit note (dated 3/1/23). LPN-C reviewed R14's medical record and verified R14 did not have any current or past orders for Voltaren 1% gel listed and expressed "the nurses" should have followed up and acted upon the note recommendations, including the orthopedic referral and x-ray recommendation. When interviewed on 4/5/23 at 1:03 p.m., the assistant director of nursing (ADON) verified they had reviewed R14's medical record and the listed recommendations from the visit note had not been acted upon or addressed. ADON added, "It doesn't look like anything was followed up on that." ADON stated the NP will usually have a corresponding "written order" note with the progress notes, however, they were unable to locate one so they needed to follow-up with the NP. ADON explained the NP had recently switched dictation programs and, as a result, the DON and ADON weren't always being updated with the corresponding notes adding, "That fell off." As a result, there was not always someone	F 697		

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F 697	Continued From page 125 checking the progress notes for recommendations and, if included, subsequent orders or treatment plans. ADON stated they were working to address the issue currently, however, acknowledged the recommendations should have been acted upon and clarified to help ensure R14's pain management needs were being met and R14 was "not in outstanding pain." R30's quarterly MDS, dated 2/22/23, indicated R30 had mild cognitive deficits, required supervision of one staff for toileting and was independent with all other ADLs. R30's EMR indicated R30 had diagnoses including a stable burst fracture of the spine (thoracic vertebra T11-T12), muscle weakness, alcoholic cirrhosis of the liver, high blood pressure, major depression, morbid obesity, sciatica (pain in the sciatic nerve from the lower back down one or both legs) and hepatic (liver) failure. R30's CAA dated 11/22/22, indicated R30 triggered for ADL function, falls, and psychotropic drug use. R30's care plan dated 7/15/22, indicated R30 had ADL self-care needs due to limited range of motion. R30 had chronic pain due to a spinal fracture. Interventions indicated anticipating R30's need for pain relief and responding immediately to any complaint of pain. No further interventions including non-pharmacological interventions were indicated. R30's physician order dated 4/3/23, indicated R30 was to receive a Lidocaine External Patch 5%	F 697		

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applied to his back every morning and at bedtime for back pain; however, the order scheduling details indicated the patch was to be "on" between 7:30 a.m. and 8:30 a.m., and "off" between 8:30 p.m. and 9:30 p.m.

R30's medication administration record (MAR) dated April 2023, indicated R30's lidocaine patch was applied as follows:
-4/3/23, AM no data entered.
-4/3/23, HS (bedtime) "off" and "9" indicating a progress note was made; however, no note was documented.
-4/4/23, AM refused. No further information available.
-4/4/23, HS "X" and "9" however no further documentation was noted for clarification.
-4/5/23, AM "on"
-4/5/23, HS "off"

During an interview on 4/5/23 at 8:48 a.m., R30 was sitting on the edge of his bed. R30 stated he had fractured his spine and although the pain was tolerable when he walked or sat in a chair, it hurt "all the time" when he was in his bed. R30 stated he tried laying in different positions, but it did not relieve the pain and he was often unable to sleep. R30 further stated Tylenol only relieved the pain for approximately two hours.

During an observation and interview on 4/5/23 at 3:26 p.m., R30 was ambulating in the dining room using a walker. R30 had a lidocaine patch on his lower back dated "4/5" and staff initials "OO." Although R30 was supposed to get the pain patch applied daily, R30 stated it was the first-time staff had put the patch on. R30 further stated he liked the pain patch because it helped relieve his back pain and that he had not refused it.

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During an interview and observation on 4/6/23 at 8:12 a.m., R30 was sitting on the edge of his bed with no lidocaine patch applied to his lower back. The lidocaine patch that was dated "4/5" with staff initials "OO" was balled up and stuck to itself on the floor. Licensed practical nurse (LPN)-A stated R30 was asleep earlier but would assist R30 "next."

During an interview and observation on 4/6/23 at 1:55 p.m. R30 was sitting in a chair in the dining room. R30 did not have a lidocaine pain patch on his lower back and stated his pain was 7/10. R30 stated he would like to have the pain patch applied. LPN-A was then notified and applied the lidocaine patch to R30's lower back.

During an interview on 4/6/23 at 3:20 p.m. the director of nursing (DON) stated although R30's orders indicated R30 was to have his lidocaine patch applied in the morning and at bedtime, she believed R30's lidocaine patch was to be applied in the morning and removed at bedtime as indicated in the "supplementary documentation"; however, the DON was unable to locate the original order to clarify and stated the order was confusing.

A provided Pain Assessment and Management policy, dated 10/2021, identified pain management was a multi-disciplinary approach which included, "Developing and implementing approaches to pain management." However, the policy lacked specific guidance or direction on how physician orders for pain management, including recommendations, would be addressed, acted upon, and implemented.

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F 698	Continued From page 128	F 698		
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure post-dialysis access site monitoring was consistently completed and documented to provide continuity of care and reduce the risk of complication (i.e., bleeding) for 1 of 1 resident (R38) reviewed for dialysis care and services. Findings include: R38's quarterly Minimum Data Set (MDS), dated 2/20/23, identified R38 had moderate cognitive impairment and demonstrated no rejection of care behavior. Further, R38 required extensive assistance for most activities of daily living (ADLs) and received dialysis while a resident. R38's care plan, dated 8/2022, identified R38 was at high-risk for complications and required on-going dialysis due to renal failure. The care plan listed several interventions for R38 including coordinating services with the dialysis clinic, encouraging R38 to attend their scheduled appointments, checking and removing the dressing at the access site after four (4) hours and documenting such, and, "Shunt Care: Observe shunt for s/sx [signs, symptoms] of infection and/or other complications (such as	F 698	F 698 R 38 had dialysis on 05/04/23 and a post dialysis observation was completed. R 38 will have a dialysis care plan created and interventions added. Existing facility residents who receive dialysis services will have their care plan, orders and post dialysis reviewed and updated as needed. Future resident who receives dialysis services will have post dialysis observation completed per facility policy. Licensed nurses will be in-serviced on the Hemodialysis Care Policy and Procedure with emphasis on documenting post dialysis site location, if dialysis occurred on the nurses shift and condition of dressing (if applicable). Director of Nursing and/or designee will be responsible for compliance. Audits on post dialysis assessment completion, dialysis orders and dialysis care plan will begin weekly x 4 weeks then monthly to ensure compliance. Audit results will be reviewed by the Executive Director and the Executive Director will take audit results to QAPI for review and recommendation. Compliance: 5/12/2023	5/12/23

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F 698	Continued From page 129	F 698		

Continued From page 129
redness, swelling, bleeding, temperature)."

On 4/4/23 at 8:19 a.m., R38 was interviewed. R38 explained they went to dialysis "three times a week" to an offsite clinic in St. Paul, and had received dialysis for "about two years" now. R38 stated they had a fistula access in their left arm and denied issues or concerns with bleeding. In addition, R38 stated the site access' bruit and thrill (a rumbling sound and a rumbling sensation one can feel; indicative of a health AV fistula) was being checked, however, R38 then was dismissive with questions and just answering simple one or two word responses.

R38's medical record was reviewed for recent dialysis treatments, and the following was identified:

A progress note, dated 3/20/23, identified R38 was at dialysis. However, the medical record lacked any further information or post-dialysis assessment demonstrating R38 was assessed following the procedure to ensure medical stability and/or site access characteristics/patency.

A progress note, dated 3/22/23, identified R38 was at dialysis. A corresponding Dialysis (Post) Observation V2, dated 3/22/23, identified various sections to record R38's post-dialysis care and vitals including vital signs, shunt (i.e., fistula) care, and facility communication to and from the dialysis clinic. This listed R38's blood pressure as 178/98 and R38's fistula had bruit and thrill present. There was no complications from the dialysis treatment recorded.

A progress note, dated 3/24/23, identified R38 was at dialysis. However, the medical record

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F 698	Continued From page 130 lacked any further information or post-dialysis assessment demonstrating R38 was assessed following the procedure to ensure medical stability and/or site access characteristics/patency. A progress note, dated 3/27/23, identified R38 left the nursing home for dialysis. However, again, the medical record lacked any further information or post-dialysis assessment demonstrating R38 was assessed following the procedure to ensure medical stability and/or site access characteristics/patency. A progress note, dated 3/29/23, identified R38 was offsite at dialysis. A corresponding Dialysis (Post) Observation V2, dated 3/29/23, identified R38 attended the dialysis treatment and listed R38's blood pressure as 178/98 and R38's fistula had bruit and thrill present. The section provided to record R38's pre and/or post dialysis weight(s) was left blank and not completed. There was no complications from the dialysis treatment recorded. A progress note, dated 3/31/23, identified R38 received dialysis. However, the medical record lacked any further information or post-dialysis assessment demonstrating R38 was assessed following the procedure to ensure medical stability and/or site access characteristics/patency. A progress note, dated 4/3/23, identified R38 was offsite at dialysis. A corresponding Dialysis (Post) Observation V2, dated 4/3/23, identified R38 attended the dialysis treatment and R38's fistula had bruit and thrill present. The section to record R38's post-procedure blood pressure was left blank and not completed. Further, the fields to record if there were any complications or issues	F 698		

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F 698	Continued From page 131 communicated from the dialysis center was also left blank and not completed. There was no other information identified in the medical record to determine if these items (i.e., blood pressure, communication) had been evaluated or completed upon R38's return from the procedure. On 4/6/23 at 8:20 a.m., registered nurse (RN)-B was interviewed and verified they were the nurse assigned to care for R38. RN-B explained R38 went to an offsite dialysis clinic for treatments three times a week and staff, prior to him leaving, obtain vital signs and send "paperwork" with him to communicate with the dialysis clinic. Upon R38's return, RN-B explained a set of vital signs and a weight should be collected, and the nurse should check the bruit and thrill to ensure a secure, functioning access site was present and to determine "if he's [R38] bleeding." RN-B reviewed R38's medical record and explained these post-dialysis assessments should be completed and recorded, however, they were unable to find all of them on R38's completed dialysis treatments. RN-B added, "It is not clear [where it's recorded]." RN-B reviewed R38's current Treatment Administration Record (TAR) and verified it also lacked directive or information on what, if any, items were to be assessed when R38 returned from the dialysis clinic adding, "I wish it was more clear on the treatments." Further, RN-B stated it was important to ensure R38's post-dialysis assessments (i.e., vital signs, bruit and thrill check) were completed and recorded to provide continuity of care and because if the information was not recorded "then it's like it's not done." When interviewed on 4/6/23 at 1:12 p.m., the assistant director of nursing (ADON) verified the	F 698		

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F 698	Continued From page 132 nurses were to be completing a post-dialysis assessment of R38 and recorded it using the "Dialysis (Post) Observation V2" in the medical record. ADON reviewed R38's medical record and verified this had not consistently been completed over the past several weeks and should have been describing it as "hit or miss." ADON stated R38 had not sustained any recent complications from dialysis to their knowledge, however, verified the post-dialysis assessment and corresponding documentation should be completed to ensure R38's fistula was patent adding, "[R38's fistula] is a huge risk of bleeding," and if it was injured it could be "a big problem." A provided Dialysis Care - External Facility policy, dated 11/2021, identified the facility would assure each resident who received hemodialysis would receive care consistent with professional standards of practice. The policy outlined, "The nursing home staff will observe and document the status of the resident's access site upon return from the dialysis treatment to observe for bleeding or other complications."	F 698		
F 732 SS=C	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses.	F 732		5/12/23

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F 732	Continued From page 133 (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to ensure nurse staffing information was posted on the weekend and in a timely manner at the start of the shift. This had potential to affect all 58 residents, staff, and visitors who wanted to review this information. Findings include: During entrance to the nursing home on Monday 4/3/23 at 6:45 a.m., the staff posting was observed hanging on the walk in a picture frame.	F 732	F 732 The nurse staffing post was corrected upon notification from the state surveyor. From survey entry to exit, the nurse staff posting census and staff numbers were updated to reflect current census and staff. Future census and staff posting will be updated each shift by the charge nurse to ensure correct staffing and census. Human Resource Director and Licensed nurses will be in-serviced on the Posting Direct Care Staffing Policy and Procedure	

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F 732	Continued From page 134 The document displayed was dated 3/31/21, 3 days prior. The form contained the actual and total hours of registered nurses, licensed practical nurses, trained medication aides, and certified nursing assistants which was broken down into each respective shift (i.e., day shift, evening shift, night shift). There was no visible nurse staffing information posted or displayed for 4/1/23, 4/2/23 or 4/3/23. During an interview on 4/5/23 at 1:19 p.m., the staff coordinator (SC)-A stated she was responsible for updating the staff posting sign daily. SC-A further stated she had been solely responsible for the daily staff posting for the past year and confirmed nobody had been updating the posting on the weekends. During an interview on 4/6/23 at 1:04 p.m., the administrator stated the expectation was for the daily staff posting to be updated daily. The administrator further confirmed the daily staff posting was not getting updated on the weekends as it should be. A policy on staff posting was requested but not received.	F 732	with emphasis on item #1 that within 2 hours of each shift, the number of licensed and unlicensed nursing staff along with resident census must be posted. Human Resource Director and/or designee will be responsible for compliance. Audits on location of nurse staffing and accuracy will begin weekly x 4 weeks then monthly to ensure compliance. Audit results will be reviewed by the Executive Director and the Executive Director will take audit results to QAPI for review and recommendation. Compliance: 5/12/2023	
F 740 SS=D	Behavioral Health Services CFR(s): 483.40 §483.40 Behavioral health services. Each resident must receive and the facility must provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Behavioral health encompasses a resident's whole emotional and	F 740		5/12/23

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F 740	Continued From page 135 mental well-being, which includes, but is not limited to, the prevention and treatment of mental and substance use disorders. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to offer mental health services to increase and/or support the mental well-being of 2 of 2 residents (R29, R30) diagnosed with mental health disorders. Findings include: R30's quarterly MDS dated 2/22/23, indicated R30 had mild cognitive deficits, required supervision of one staff for toileting and was independent with all other ADLs. R30's EMR indicated R30 had diagnoses including a stable burst fracture of the spine (thoracic vertebra T11-T12), muscle weakness, alcoholic cirrhosis of the liver, high blood pressure, major depression, morbid obesity, sciatica (pain in the sciatic nerve from the lower back down one or both legs) and hepatic (liver) failure. R30's Care Area Assessment (CAA) dated 11/22/22, indicated R30 triggered for ADL function, falls, urinary incontinence, nutrition, pressure ulcers, and psychotropic drug use. R30's care plan dated 7/15/22, indicated R30 was Cuban. Interventions indicated R30 spoke loudly, directly, and may seem aggressive, and viewed a lack of eye contact as disrespectful. R30 may also greet others with a hug/kiss. R30's culture believed the mind, body and spirit were connected and physical illness may be caused by	F 740	F 740 R 29 and R 30 will be referred to Behavioral Health Services for resident review and recommendation. R 30 will have a new PHQ9 and from this assessment, the NP/MD will be notified for medication review. R 30 will also be given the number to the facility. R 29 MD will be notified that the resident refused medications on various dates in February, March, and April. The MD response will be recorded in the resident electronic medical record. R 29 and R 30 behavioral care plans will be initiated, and interventions implemented. All existing residents who request Behavioral Health Services will be referred to the appropriate behavioral health agency. Future residents will be screened upon admission and from this screening will be referred to Behavioral Health Services as needed. Social Service Designee and Licensed Nurses will be in-serviced on the Behavioral Assessment, Intervention and Observation policy with emphasis on notifying the physician of details regarding changes in a resident mood, behavior or cognition and document these changes in behavior regardless of the degree of risk to the resident or others. Social Service Designee will be responsible for compliance.	

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F 740	Continued From page 136 mental stress or supernatural forces. R30 had substance abuse related to alcohol with a family history of alcohol abuse. Interventions included "encouraging self-stabilization techniques daily of drinking in moderation." R30 also had depression and used antidepressant medication. Interventions included arranging for a psychological consult and follow up as needed. R30's provider orders dated 8/17/22, indicated R30 took sertraline (an antidepressant psychotropic). R30's provider notes dated 2/15/23, indicated R30 continued to drink alcohol daily but will not admit to how much; however, nursing staff had reported several episodes. R30's progress note dated 2/22/23, indicated during R30's quarterly assessment, R30 stated he felt "separated from the other residents" and the other residents are "different" from him. R30 also stated he "feels alone" and that caused him stress. R30 also missed his hometown and speaking his native language. R30's Consultant Pharmacist Recommendation to Physician dated 3/22/23, indicated a gradual dose reduction (GDR) of R30's sertraline was not recommended due to reports of ongoing depression. During an interview on 4/5/23 at 8:48 a.m., R30 stated he had depression and became frustrated because his family was too busy to visit, and he didn't always get along with some of the other residents. R30 stated he had weekly virtual appointments with a therapist from the county but didn't think it was "good enough" and would like to	F 740	Audits on behavioral health resident request, appointments made, and behavioral care plans will begin weekly x 4 weeks then monthly to ensure compliance. Audit results will be reviewed by the Executive Director and the Executive Director will take audit results to QAPI for review and recommendation. Compliance: 5/12/2023	

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F 740	Continued From page 137 have more frequent visits. R30 stated the facility social worker changed often and therefore nothing was getting done for him. R30 did not have enough money to pay for phone service but did not know the phone number to the facility phone in his room and therefore could not receive calls. R30 stated he felt "very alone" and didn't want to "think about bad things." During an interview on 4/6/23 at 3:20 p.m., the director of nursing (DON) verified R30's EMR lacked indication a referral to psychological services had been made for R30 and stated she would have expected R30 to be offered mental health services after expressing he felt lonely and depressed. The facility Behavioral Assessment, Intervention and Observing policy dated 10/18/21, indicated residents would receive behavioral health services to attain or maintain the highest practicable mental and psychosocial well-being. Staff were to identify and inform the physician of details regarding changes in a resident's mental status, behavior, and cognition and document changes in behavior regardless of the degree of risk to the resident or others. The interdisciplinary team (IDT) will "thoroughly evaluate" behavior symptoms including depression, loneliness, and anxiety. The resident and/or representative will be involved in the development and implementation of the plan of care and non-pharmacological interventions will be utilized to the extent possible. The facility Behavioral Health Services policy dated 10/18/21, indicated residents with signs of emotional/psychosocial distress were to receive services to support their needs and goals for care. The policy also indicated behavioral health	F 740		

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F 740	Continued From page 138	F 740		

services would be provided to residents as needed.

R29's significant change Minimum Data Set (MDS), dated 2/23/23, indicated R29 had short-term and long-term memory problems with severely impaired cognitive skills for decision making, needed extensive assistance with bed mobility, transfers, toileting use, personal hygiene, and supervision with eating.

R29's Medical Diagnoses report, dated 2/10/23, indicated medical diagnoses to include metabolic encephalopathy (a problem in the brain caused by a chemical imbalance in the blood which can lead to personality changes), binge eating disorder (frequently consuming unusually large amounts of food in one sitting and feeling that eating behavior is out of control), venous insufficiency (a condition in which the veins have problems sending blood from the legs back to the heart), major depressive disorder (a mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life), obstructive sleep apnea (Intermittent airflow blockage during sleep causing decreased oxygen saturation or arousal from sleep), and schizoid personality disorder (a condition in which people avoid social activities and interacting with others).

R29's care plan, dated 3/15/23, indicated R29 had impaired cognition and impaired thought process related to hypoxemia (low levels of oxygen in the blood).

R29's entire medical record, including his care

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plan, lacked interventions for R29's frequent refusals of medication and food including what works or has not worked for R29 in the past.

R29's Social Service Admission assessment, dated 2/17/23, indicated R29 received medications for depression and anxiety, had a history of abuse towards self or others with a history of aggression, behavioral disturbances, suicidal thoughts or attempts, and impulsiveness. The Social Services assessment further indicated R29 had been receiving psychiatrist services in the past as recent as 12/14/22.

R29's Social Service Trauma Informed Care History, dated 2/17/23, indicated R29 had a troubled childhood with lack of support from his family and parents who abused alcohol and drugs.

R29's Progress Notes indicated R29 had refused food and medications on 18 occasions resulting in three hospitalizations since admission to the facility on 2/9/23 and documented as follows;

On 2/10/23 at 11:56 a.m., it was documented R29 refused Topiramate, a medication given for seizures.

On 2/11/23 at 9:44 a.m., it was documented R29 was sent to the emergency department after being found unresponsive.

On 2/24/23 at 10:00 a.m., it was documented R29 refused all medications and meals for the shift.

On 2/24/23 at 3:30 p.m., it was documented resident had eaten no food since morning.

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F 740	Continued From page 140 On 2/24/23 at 6:41 p.m., it was documented R29 was sent to the emergency department for evaluation due to lack of food intake and depression. On 3/8/23 at 3:13 p.m., it was documented R29 was not eating the meals served to him and refused nutritional supplements. On 3/10/23 at 4:02 p.m., it was documented R29 was very weak because he refused to eat breakfast and lunch. On 3/11/23 at 4:15 p.m., it was documented R29 refused breakfast and lunch. On 3/16/23 at 5:55 p.m., it was documented R29 continued to refused meals. On 3/19/23 at 11:08 a.m., it was documented R29 refused house supplement. On 3/19/23 at 10:48 p.m., it was documented R29 continued to refused meals. On 3/20/23 at 8:47 a.m., it was documented R29 refused his house supplement. On 3/20/23 at 9:38 p.m., it was documented R29 refused dinner and a bedtime snack. On 3/26/23 at 4:10 p.m., it was documented R29 refused lunch. On 328/23 at 9:48 a.m., it was documented R29 refused all medications. On 3/29/23 at 11:09 a.m., it was documented R29 refused his house supplement	F 740		

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F 740	Continued From page 141	F 740		

On 3/31/23 at 1:41 p.m., it was documented R29 continues to refuse meals and medications

On 4/2/23 at 10:35 a.m., it was documented R29 refused his medications and claims they are making him sick.

On 4/2/23 at 4:58 p.m., it was documented R29 refused all afternoon medications.

On 4/3/23 at 3:17 p.m., it was documented R29 was sent to the emergency department for profound depression.

On 4/5/23 at 12:09 p.m., it was documented R29 refused all medications.

R29's Dietary note, dated 3/31/23, indicated R29 had significant weight changes in the past 30 days with a 21.6% weight loss due to refusal of meals. The dietary note indicated the registered dietician (RD)-A had been notified by the director of nursing (DON) R29 had a history of mental illness related to food and refusing medication cares. The RD recommended R29 be followed by psychology and/or an eating disorder specialist.

During an interview on 4/5/23 at 2:08 p.m., RD-A stated R29 had childhood trauma surrounding food and when RD-A introduced himself as the dietician, R29, "shut down." RD-A stated, "I was concerned, mentioning that word kind of triggered him." The RD-A further stated R29 had binge eating disorder and "maybe anorexia too" which was why RD-A recommended for R29 to be followed by either psychology or an eating disorder specialist.

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F 740	Continued From page 142 During an interview on 4/5/23 at 2:21 p.m., the DON stated she was aware R29 was, "refusing everything" and had childhood trauma around food. The DON confirmed she had not followed up on RD-A's recommendation for psychology or an eating disorder specialist and stated she would look into an eating disorder consult stating, "it would be a good idea." The DON stated staff were encouraged to educate R29 when refusing food or medication and reapproach him. The DON further confirmed there were no specific interventions on R29's care plan to inform staff of R29's history of refusal and interventions to try with R29. During an interview on 4/6/23 at 8:00 a.m., R29 stated his goal was to discharge and return to his home in St. Paul where he resided alone. R29 stated staff have not been educating him on steps he could make to work towards his discharge goals, and how refusing medications and food may slow down or make discharge more difficult. During an interview on 4/6/23 at 9:32 a.m., the DON confirmed that Associated Clinic of Psychology (ACP) was not following R29 and stated, "I just put in a referral for ACP." The DON confirmed that although R29 was documented as not able to make appropriate decision, his family nor guardianship were involved and stated, "we will start looking into guardianship to help with decision-making." The DON concluded she was hopeful ACP could make medication changes to get R29 to a better place with his mental health.	F 740		
F 745 SS=D	Provision of Medically Related Social Service CFR(s): 483.40(d) §483.40(d) The facility must provide	F 745		5/12/23

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F 745	Continued From page 143 medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to submit a MAARC (Minnesota adult abuse reporting center) report for one of one resident (R60) who discharged against medical advice (AMA). Findings include: R60's discharge Minimum Data Set (MDS) dated 1/23/23, indicated moderately impaired cognition, required limited assist with bed mobility, and was unsteady. R60's Medical Diagnosis form in the electronic medical record (EMR) indicated R60 had the following diagnoses: sepsis (generalized systemic infection) due to escherichia coli (bacteria found in the digestive tract), alcohol dependence, gastritis (inflamation of the stomach), alcohol use unspecified with withdrawal uncomplicated, anxiety, and SARS-associated coronavirus. R60's nursing progress note dated 1/21/23, indicated R60 was admitted to the facility with acute confusion, urinary tract infection, and post COVID-19. R60's nursing progress notes dated 1/23/23, indicated R60 planned to discharge home as soon as possible and was at high risk for falling. R60 left AMA on 1/23/23. The note indicated a MAARC report would be filed. Attempted to call R60 on 4/5/23 at 8:42 a.m.,	F 745	F 745 R 60 is no longer a resident at the facility. From survey exit until present, there has been one MARCC report that was completed timely. For future residents who desire to leave against medical advice, a MARCC report will be filed, and the attending physician will be notified. Licensed Nurses and Social Service Designee will be in-serviced on the Leave Against Medical Advice policy with emphasis on items #4,5,6 that the MD/NP will be contacted, the resident will be presented with the Release of Responsibility form and a MARCC report initiated. Social Service designee will be responsible for compliance. Audits on MARCC reporting, physician notification, release form and ombudsman notification will begin weekly x 4 weeks then monthly to ensure compliance. Audit results will be reviewed by the Executive Director and the Executive Director will take audit results to QAPI for review and recommendation. Compliance: 5/12/2023	

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F 745	Continued From page 144 listed contact number called was unreachable. During interview on 4/5/23 at 8:46 a.m., the director of nursing (DON) stated MAARC reports were completed depending on a resident's cognition and risk to themselves or whether family could help. The report was required if a resident was considered more vulnerable. During interview on 4/5/23 at 9:54 a.m., DON stated the MAARC was supposed to be filed and stated it was important to complete because R60 had moderate cognitive impairment and also had an alcohol problem and did not have a copy of a MAARC report filed for R60. On 4/5/23 at 10:07 a.m., Aspen Complaints/Incident Tracking System (ACTS) was reviewed and there was no record of a MAARC report filed. A policy, Transfer or Discharge, Preparing a Resident for Dated 1/25/23, was provided, but lacked information regarding when a resident leaves AMA.	F 745		
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the	F 756		5/12/23

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F 756	Continued From page 145 facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to ensure consultant pharmacist recommendations were evaluated and addressed by the attending physician for 2 of 2 residents (R4, R32) whose diagnoses were inappropriate for the use of their antipsychotic medications. Findings include: R4's significant change Minimum Data Set (MDS)	F 756	F 756 R 4 risperidone order diagnosis was updated on 5/2/23. R 32 order for quetiapine diagnosis was updated on 4/27/23. The 2/23/2023 and 9/12/2022 pharmacy recommendations will be completed, and NP/MD response recorded. All existing resident pharmacy recommendations for diagnosis clarification will be reviewed and updated	

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F 756	Continued From page 146 dated 12/30/22, lacked a cognitive assessment for R4. The MDS indicated R4 required extensive assistance for all activities of daily living (ADLs). R4's Care Area Assessment (CAA) dated 12/30/22, indicated R4 triggered for psychotropic drug use. R4's quarterly MDS dated 10/28/22, indicated R4 had mild cognitive deficits. R4's electronic medical record (EMR) indicated R4 had diagnoses including Parkinson's disease, a stroke resulting in cognitive dysfunction, dysphagia (difficulty swallowing), dementia without behavioral disturbance, major depressive disorder, and anxiety. R4's EMR lacked indication R4 had a diagnosis of schizophrenia. R4's provider orders dated 2/2/23, indicated R4 took 0.75 milligrams (mg) of risperidone (an antipsychotic) at bedtime for schizophrenia. R4's Consultant Pharmacist Recommendation to Physician dated 9/19/22, indicated to clarify/confirm the appropriate diagnosis for R4's prescribed risperidone. During an interview on 4/6/23 at 4:06 p.m., the director of nursing (DON) verified schizophrenia was not included in R4's diagnoses and did not know why it was listed as a reason for R4's risperidone order. During an interview on 4/10/23 at 11:01 a.m., pharmacy consultant (PH) stated she submitted a recommendation to the facility regarding R4's inaccurate schizophrenia diagnosis on 9/19/22, but did not recall receiving a response from the	F 756	as needed. Future residents will have the appropriate diagnosis entered for each prescribed medication per facility policy. Licensed nurses will be in-serviced on the Medication Order policy with emphasis on item #1 when recording orders, the dose, diagnosis, frequency, route, type, and strength must be recorded. In addition, the licensed nurses will also be in-serviced on the Polaris Pharmacy Consultant Pharmacist Policy item #G that provider accepts or rejects the recommendation and provides an explanation and if there is a potential for serious harm and the attending disagrees, the Medical Director will be contacted. Director of Nursing and/or designee will be responsible for compliance. Audits on consultant report with diagnosis discrepancies will begin weekly x 4 weeks then monthly to ensure compliance. Audit results will be reviewed by the Executive Director and the Executive Director will take audit results to QAPI for review and recommendation. Compliance: 5/12/2023	

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facility and would check her emails.

Review of an email correspondence from the PH dated 4/10/23, indicated the PH had not received an email indicating the facility had responded to her 9/19/22, recommendation regarding R4's schizophrenia diagnosis for risperidone and would resubmit another recommendation for clarification.

R32's quarterly Minimum Data Set (MDS) dated 11/7/22, indicated intact cognition and required extensive assist with transferring, bed mobility, toileting, and hygiene, occasionally had bladder incontinence, and did not reject cares.

R32's Admission Record form in the electronic medical record (EMR) indicated R32 was his own representative.

R32's Medical Diagnosis form in the electronic medical record (EMR) indicated R32 had the following diagnosis: anxiety disorder unspecified and depression unspecified.

R32's physician orders indicated on 2/10/23, quetiapine fumarate (an antipsychotic medication) 12.5 milligrams (mg) by mouth twice daily for 90 days with a stop date of 5/11/23 for agitation.

R32's pharmacy recommendation 2/23/23, signed 2/24/23, indicated R32 received quetiapine for a diagnosis of agitation which was not considered an appropriate indication for antipsychotic use and requested a clarification or confirmation of the appropriate diagnosis. The nurse practitioner (NP) replied to the recommendation 2/24/23, "This is currently being tapered."

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During observation 4/5/23 at 8:10 a.m., R32 was in his room and had a visitor. He was not agitated.

During interview on 4/6/23 at 10:11 a.m., the director of nursing stated she was in charge of the pharmacy recommendations and sends any recommendations that require a provider response to the NP to complete. Once the NP completes the recommendation, she gives them back to the DON and DON updates the information in the computer. DON verified NP-C never provided an appropriate diagnosis for use of the quetiapine and stated it was important to have an appropriate diagnosis in order to see why R32 was using the medication and added the NP should be providing the diagnosis.

During interview on 4/6/23 at 12:39 p.m., the pharmacist consultant (PH) stated she expected a diagnosis for an antipsychotic to be documented in the chart even if the medication was being tapered because there were numerous potential adverse effects and there needed to be a way to alert care providers if the medication was indicated. She added staff could monitor the behaviors and if they saw symptoms improving, could reach out if the resident no longer needed the medication. PH added sometimes the providers need education why the appropriate diagnosis is necessary and it should have been communicated with the doctor because the medication was ordered for an additional three months.

A policy, Antipsychotic Medication Use, dated 7/13/22, indicated diagnosis of a condition for which antipsychotics are necessary will be based

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F 756	Continued From page 149 on a comprehensive assessment of the residents. The policy also indicated antipsychotic medications shall generally be used only for the following conditions/diagnoses as documented in the record, consistent with the definitions in the diagnostic and statistical manual of mental disorders: schizophrenia, schizoaffective disorder, schizophreniform disorder, delusional disorder, mood disorders such as bipolar disorder, depression with psychotic features, and treatment refractory major depression, psychosis in the absence of dementia, Tourette's disorder, Huntington's disease, hiccups, or nausea and vomiting associated with cancer or chemotherapy. A facility policy regarding pharmacy recommendations was not received.	F 756		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs	F 758		5/12/23

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F 758	Continued From page 150 unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure appropriate side-effect monitoring (i.e., orthostatic blood pressures) was completed in accordance with physician orders and standard of care to reduce the risk of complication (i.e., falls) with consumed antipsychotic medication for 1 of 5 residents	F 758	F 758 R 33 had orthostatic blood pressure monitoring attempted on 5/3/23 and will be reattempted on 5/4/23 if resident allows. R 33 orders was updated to include monthly orthostatic blood pressure monitoring. All existing residents who	

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F 758	Continued From page 151 (R33) reviewed for unnecessary medication use. Findings include: A National Library of Medicine (NIH) Management of Commons Adverse Effects of Antipsychotic Medication article, dated 9/2018, identified the elderly were at risk of adverse effects (i.e., falls) of antipsychotic medication. The article outlined, "All antipsychotics carry some risk of orthostatic hypotension ... [which can] lead to dizziness, syncope, falls ... it should be evaluated by both history and measurement ... Risk factors include systemic diseases causing autonomic instability (e.g., diabetes, alcohol dependence, Parkinson's disease), dehydration, drug-drug interactions, and age." R33's annual Minimum Data Set (MDS), dated 2/11/23, identified R33 had severe cognitive impairment, demonstrated no rejection of care behavior(s), and was independent with ambulation and required supervision with transfers. Further, the MDS outlined R33 consumed antipsychotic medication on a daily basis during the review period. R33's signed Order Summary Report, dated 2/27/23, identified R33's current physician ordered medications and treatments at the nursing home. This included orders for hydrocortisone 2.5 milligrams (mg) twice daily and lisinopril 10 mg daily for high blood pressure, and an order for olanzapine (an antipsychotic medication) 2.5 milligrams (mg) by mouth daily for unspecified dementia with behavioral disturbance. Further, the summary listed an order which read, "Monitor monthly orthostatic BP [blood pressure] ... for antipsychotic," with a start	F 758	have antipsychotic medication will have orthostatic blood pressure monitoring orders added as needed. Future residents who take antipsychotics will have initial and ongoing monthly monitoring per facility policy. Licensed nurses and HIM/Medical Record Director will be in-serviced on the Antipsychotic Use Policy and Procedures with emphasis on item # 5 d that medication monitoring will be weekly for the first 6 weeks then quarterly thereafter. Any adverse side effects to any antipsychotic, the MD/NP will be notified. Director of Nursing and/or designee will be responsible for compliance. Audits on orthostatic blood pressures will begin weekly x 4 weeks then monthly to ensure compliance. Audit results will be reviewed by the Executive Director and the Executive Director will take audit results to QAPI for review and recommendation. Compliance: 5/12/2023	

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date listed as 8/15/21.

R33's care plan, dated 12/2022, identified R33 consumed psychotropic medications and listed several goals for care including, " ... will be/remain free of psychotropic drug related complications ... through review date." The care plan listed several interventions to help R33 meet this goal including consulting with pharmacy on a quarterly basis, administering the medication as ordered, and, "Monitor for side effects and effectiveness Q-SHIFT [every shift]."

R33's Blood Pressure Summary, printed 4/6/23, identified R33's collected blood pressures for the past several months. However, the summary lacked evidence R33's orthostatic blood pressures had been collected or assessed in the past several months.

R33's Medication Administration Record (MAR), dated 4/2023, identified the order for olanzapine and recorded R33 received the medication, as ordered, on a daily basis. However, the MAR and Treatment Administration Record (TAR) both lacked evidence of an order for R33's orthostatic blood pressure to demonstrate it had been evaluated, assessed or completed. Further, R33's medical record was reviewed and lacked evidence R33's orthostatic blood pressures were being collected, assessed, or evaluated on a monthly basis as ordered by the physician in 2021.

On 4/5/23 at 9:49 a.m., nursing assistant (NA)-A was interviewed. NA-A explained R33 "barely talks" to others and, at times, could become "very angry" with staff and other residents. NA-A stated R33 was able to self transfer out of their

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F 758	Continued From page 153 wheelchair and often did so even, at times, walking on their own. Further, NA-A stated R33 had not sustained any recent falls to their knowledge, and R33 had not, at least to them, reported ever being light-headed or dizzy when standing but reiterated R33 had little verbal communication with staff. When interviewed on 4/6/23 at 1:08 p.m., the assistant director of nursing (ADON) stated they had reviewed R33's medical record and were unable to locate evidence R33's orthostatic blood pressures had been attempted, completed, or evaluated on a monthly basis. ADON explained the blood pressures should have been completed and recorded in the Blood Pressure Summary but added, "I don't see that." ADON stated if the blood pressures were refused, such information should also have been recorded in the medical record or care planned. Further, ADON expressed it was important to ensure monthly orthostatic blood pressures were done to help evaluate if R33 was able to "safely transfer himself" and to ensure there was no medication side effects. A provided Antipsychotic Medication Use policy, dated 7/2022, identified residents would only receive the medication when needed to treat specific conditions for which indicated and effective. The policy included, "Nursing staff shall monitor for and report any of the following side effects and adverse consequences of antipsychotic medications ... Cardiovascular: orthostatic hypotension, arrhythmias ... ".	F 758		
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1)	F 759		5/12/23

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F 759	Continued From page 154 §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure medications were administered in accordance with physician orders and standards of care for 2 of 6 residents (R43 and R 49) observed to receive medications during the survey. A total of 2 of 39 opportunities were in error resulting in an 5.12 % medication error rate. Findings include: R43's Significant change Minimum Data set (MDS), dated 3/13/23, identified R43's as cognitively intact, required assistance with activities of daily living (ADLs). In addition, R43's MDS stated diagnosis of thyroid disorder (prevents the thyroid from making the right amount of hormones), hypertension (high blood pressure) and Parkinson's disease (disorder that affects movement and causes tremors). During observation on 4/4/23 at 10:03 a.m., licensed practical nurse (LPN)-C prepared medications for R43 in the hallway from a mobile cart. LPN-C had the electronic Medication Administration Record (eMAR) open which displayed several boxes, all with exception of one read "AM". The "AM" medications directed staff to administer medications between 6:30 a.m. to 9:30 a.m. "AM" medications included Lisinopril (blood pressure medication), metoprolol (treats high blood pressure), levothyroxine (treats	F 759	F 759 R 43 and R 49 had a risk management incident created and thoroughly investigated for root cause for the medication errors that occurred during the annual survey. There were no ill effects experienced from this deficient practice. All existing residents who receive carbidopa and pantoprazole orders were reviewed and updated as needed. Future resident medications will be administered per the facility medication administration policy. Licensed nurses will be in-serviced on the Medication Administration Policy which indicates that medications will be administered 1-hour of their prescribed time and scheduled medications that may cause harm or sub-therapeutic effects are administered at the scheduled time or within 30 minutes of the scheduled time. Director of Nursing and/or designee will be responsible for compliance. Audits on medications being administered timely will begin weekly x 4 weeks then monthly to ensure compliance. Audit results will be reviewed by the Executive Director and the Executive Director will take audit results to QAPI for review and recommendation. Compliance: 5/12/2023	

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underactive thyroid gland), Ragasiline (treats Parkinson's disease), niacin (vitamin B) and Modafinil (used for excessive sleepiness). A box indicated an administration time of "8 AM" for carbidopa 25-100 milligrams (mg) take one and a half tablet at 8:00 a.m. R43 received this medication at 10:10 a.m.

During interview on 4/4/23 at 10:15 a.m., LPN-C stated R43 takes carbidopa for Parkinson's disease. LPN-C verified the order on the eMAR which directed staff to administer carbidopa at 8 a.m.,12 p.m., 4 p.m., and 8 p.m.. LPN-C stated, R43 takes carbidopa for his Parkinson's disease and it needs to be administered as ordered to manage body tremors. LPN-C verified carbidopa was administered over two hours later from the scheduled time.

R49's Admission Minimum Data Set (MDS), dated 3/9/23, indicated R49 required extensive assistance with activities of daily living (ADLs) and indicated a diagnosis of gastroesophageal reflux disease (irritation of the esophagus), heart failure (heart doesn't pump enough blood), hypertension (high blood pressure).

A physician order dated 2/24/23, for R49 identified: pantoprazole 40 mg tablet, take one tablet daily by mouth before a meal.

During observation on 4/4/23 at 8:47 a.m., licensed practical nurse (LPN)-D prepared R49's medications in the hallway from a mobile cart. LPN-D used the electronic Medication Administration Record (eMAR). LPN-D prepared the following medications, morphine (narcotic pain medication), lorazepam(anxiety), multivitamin, Eliquis (blood thinner to reduce risk

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for clots), metoprolol (blood pressure medication), tamsulosin (enlarge prostate, difficulty urinating), and pantoprazole (acid reflux). Upon entering R49's room, resident was sitting at the edge of the bed and was eating breakfast. R49 consumed all the medications,including the pantoprazole.

During interview on 4/4/23 at 8:55 a.m., LPN-D indicated pantoprazole was prescribed for R49 to treat his gastroesophageal reflux disease (GERD- occurs when stomach acid repeatedly flows back into the esophagus causing discomfort). LPN-D stated that this medication needs to be administered before a meal to prevent discomfort related to (GERD) gastroesophageal reflux disease symptoms. LPN-D verified, R49's order directed staff to administer pantoprazole 40 mg at 7 a.m. before a meal (breakfast).

During interview on 4/6/23 at 1:34 p.m., the director of nursing (DON) stated expectation was medications should be administered an hour before or after from the scheduled time. Medications with specific orders like before or after meals needed to be administered as indicated (before or after meals). DON indicated, the facility goal was to assess every resident for unnecessary medications and added "I am working on everything about medications".

The facility's Policy titled Administering Medications, indicated Medications are administer in accordance with prescriber order, including any required time frame. It also indicated, medication administration times are determined by resident need and benefit, not staff convenience. Factors that are considered include:

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F 759	Continued From page 157 a. enhancing optimal therapeutic effect of the medication. Furthermore, policy indicated medications are administered within one hour of their prescribed time, unless otherwise specified (for example, before and after meal orders).	F 759		
F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to follow provider orders to ensure resident (R31) was free of significant medication error. Findings include: R31's significant change Minimum Data Set (MDS) dated 3/22/23, identified R31 required extensive assistance with two plus staff for bed mobility, transfers, and extensive assistance with assist of one for personal hygiene and dressing. Diagnosis include morbid obesity, atrial fibrillation, heart failure, and history of venous thrombosis and embolism (blood clots). R31 medication orders dated 4/3/23, identified order for "INR Check" on 4/7/23 with no indication for anticoagulation medication such as Coumadin. R31's care plan revised 1/30/23, stated "resident on anticoagulant therapy Coumadin Oral Tablet r/t Paroxysmal Atrial Fibrillation" (condition associated with increase risk of heart failure,	F 760	F 760 R 31 has since discharged from the facility. All existing residents who receive coumadin will have their orders reviewed and updated as needed. Future residents will have their blood level testing per physician orders. Licensed nurses will be in-serviced on the Anticoagulation Policy with emphasis on result section #4 that INR testing will be recorded in the resident electronic medical record. Director of Nursing and/or designee will be responsible for compliance. Audits on coumadin order, specimen collection and physician notification of results will begin weekly x 4 weeks then monthly to ensure compliance. Audit results will be reviewed by the Executive Director and the Executive Director will take audit results to QAPI for review and recommendation. Compliance: 5/12/2023	5/12/23

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F 760	Continued From page 158	F 760		

dementia, and stroke).

R31's progress note dated 3/31/23 at 16:03 stated "Writer called NP with INR results of 2.95 today. Verbal order to continue 5mg daily of Warfarin through 4/6/23. Recheck INR 4/7". (The INR, or International Normalized Ratio, is a measure of how long it takes your blood to clot.)

Interview with R31 on 4/3/23 at 2:09 p.m., stated she had been receiving anticoagulation daily and had been taking Coumadin "a long time. 7-8 years. I was told that I was going to have to stay on it for the rest of my life."

Interview with licensed practical nurse (LPN)-A on 4/3/23 at 2:14 p.m., stated R31 anticoagulant "gets it every night." LPN-A looked in electronic medical record (EMR) then stated, "I don't see it". LPN-A then looked in the EMR medication administration record (MAR) and stated "I guess she is not taking it" verifying that anticoagulant was not given to R31 since 2/29/2023. LPN-A verified she was the staff member that obtained the provider order on 3/31/23 to continue Coumadin and stated, "I should have put it in the orders but did not".

Interview with Nurse Practitioner (NP-A) on 4/3/23 at 3:44 p.m., stated expectation of INR result goal was 2.0. NP-A stated, "I am not entirely worried" about clotting risk for R31 missing a week of daily Coumadin.

Interview with director of nursing (DON) on 4/3/23 at 2:36 p.m., stated R31, "doesn't have any order right now for Coumadin. No order at the moment. I would expect to see it ordered." DON then looked at R31's orders and noted "INR Check for

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F 760	Continued From page 159 4/7/23". DON looked in R31's progress note dated 3/31/23 and confirmed "Writer called NP with INR results of 2.95 today. Verbal order to continue 5mg daily of Warfarin through 4/6/23. Recheck INR 4/7". DON stated the order for coumadin "fell off" or discontinued on 3/30/23 when the INR was drawn. DON stated a "concern that she hasn't received coumadin for clots." DON obtained stat (immediate) order for point of care INR for R31. DON calibrated point of care monitoring system and obtained INR with result of 1.4.	F 760		
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	F 761		5/12/23

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F 761	Continued From page 160 quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure medications were securely stored, permitting only authorized personnel to have access to medications. This had the potential to affect all residents, visitors and staff with access to the conference room. Findings include: During observation on 4/3/23 at 8:40 a.m., the facility's conference room was made available to surveyors for the annual survey. On entrance to the conference room an opened cardboard box was observed containing 19 cards of medications with 4 to 30 tablets each which was placed on top of medical supplies and equipment against the wall. These medication cards were accessible to all individuals (staff, visitors, and residents) capable of entering the unlocked conference room located near the main entrance to the building. The observed medications belonged to two residents. One card belonged to a current resident, R265. The card contained six capsules of Gabapentin(treats nerve pain) 600 milligrams (mg). The other 18 cards belonged to a discharged resident, R6. R6's medications were as follows: four capsules of Gabapentin 100 mg, eight tablets of Tamsulosin(enlarged prostate), 0.4 mg, 30 tablets of Metoclopramide(treats nausea and vomiting) 5 mg, 17 Triphcaps(vitamin supplement), 29 tablets of Meclizine(medication for motion sickness) 12.5 mg, 30 tablets of Sucralfate(treats ulcers) 1 mg, seven capsules of	F 761	F 761 Resident medications observed during the survey in the conference room were destroyed. All medication carts were audited and discontinued or expired medications were placed in the Med Safe for destruction. Future medications that are discontinued or destroyed, licensed nurses will destroy or return to the pharmacy per facility policy. Licensed nurses will be in-serviced on the Discarding/Destroying Medication with emphasis on item #1 that all medications must remain securely locked area with restricted access until medications are disposed of. Licensed nurses were also educated on the Polaris return procedure and access codes were obtained for facility nurses to destroy medication. Director of Nursing and/or designee will be responsible for compliance. Audits on medication discontinue date and destruction date will begin weekly x 4 weeks then monthly to ensure compliance. Audit results will be reviewed by the Executive Director and the Executive Director will take audit results to QAPI for review and recommendation. Compliance: 5/12/2023	

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Continued From page 161
Carvedilol(lowers blood pressure) 6.25 mg, ten tablets of Folic Acid (vitamin) 1 mg, 12 tablets of Cetirizine (allergy relief) 10 mg, five capsules of Pantoprazole (damaged esophagus) 40 mg, nine tablets of Montelukast (anti-inflammatory) 10 mg, nine tablets of Atorvastatin(cholesterol lowering medication) 80 mg, 12 tablets of Midodrine(high blood pressure/dizziness), 23 tablets of Sertraline (depression) 100 mg and four cards for a total of 100 tablets of GNP gas relief 80 mg.

When interviewed on 4/5/23 at 11 a.m., registered nurse (RN)-C indicated discontinued medications or medications belonging to all discharged residents were to be removed from the medication cart and given to the managers or the director of nursing to dispose of.

When interviewed on 4/5/23 at 9:30 a.m., licensed practical nurse (LPN)-A stated, when residents are discharged or if the resident expired, medications are left in the medication carts and the director of nursing (DON) , or the assistant director of nurses (ADON) disposes of the medications. In addition, (LPN)-A stated, "Medications need to be locked".

When interviewed on 4/5/23 at 10:45 a.m., DON stated any medications removed from the medication carts should be brought to her or to ADON to be safely discarded. The DON indicated the medications needed to be locked up for destruction and it was not acceptable to leave any medications in the conference room.

Facility policy titled Storage of Medications reviewed 12/3/21, indicated "Drugs and biologicals used in the facility are stored in locked compartments under proper temperature, light

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F 761	Continued From page 162 and humidity control. Only authorized to prepare and administer medications have access to locked medications". The policy and procedure titled Discarding and Destroying Medications reviewed 12/13/21, indicated medications will be disposed of in accordance with federal, state and local regulations governing management of non-hazardous pharmaceuticals, hazardous waste and controlled substances.	F 761		
F 791 SS=D	Routine/Emergency Dental Srvcs in NFs CFR(s): 483.55(b)(1)-(5) §483.55 Dental Services The facility must assist residents in obtaining routine and 24-hour emergency dental care. §483.55(b) Nursing Facilities. The facility- §483.55(b)(1) Must provide or obtain from an outside resource, in accordance with §483.70(g) of this part, the following dental services to meet the needs of each resident: (i) Routine dental services (to the extent covered under the State plan); and (ii) Emergency dental services; §483.55(b)(2) Must, if necessary or if requested, assist the resident- (i) In making appointments; and (ii) By arranging for transportation to and from the dental services locations; §483.55(b)(3) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within	F 791		5/12/23

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F 791	Continued From page 163 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay; §483.55(b)(4) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; and §483.55(b)(5) Must assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State plan. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure the need for dental services, and subsequent referral for such services, was acted upon, assessed, and provided for 1 of 1 resident (R33) observed to have several missing teeth and difficulty chewing. Findings include: R33's annual Minimum Data Set (MDS), dated 2/11/23, identified R33 had severe cognitive impairment, demonstrated no rejection of care behaviors during the review period, and required supervision for personal hygiene cares (i.e., brushing teeth). Further, the MDS outlined R33 was not edentulous (lacking teeth) and had no obvious broken teeth or cavities present. In addition, R33's Census listing, printed 4/6/23, identified R33's payer source as, "Minnesota Medicaid," effective June 2022.	F 791	F 791 R 33 will have a dental appointment that is scheduled for 5/22/23, care plan updated and review of the MDS dated 2/11/2023. R 33 will have an oral assessment and the findings will be recorded in the resident electronic medical record. All existing residents with dental caries will have a dental consult scheduled. Their care plans will be reviewed and updated as needed. Future residents will have an oral inspection upon admission, quarterly and as needed, a dental care plan initiated, and dental appointments made as need and/or requested. Licensed nurses and the IDT team will be in-serviced on the Dental Services Policy with emphasis on residents have the right to select their own dentist, dental list will be available from social services and/or	

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R33's care plan, dated 3/23/23, identified R33 had an oral and/or dental health and listed, "Poor oral hygiene." The care plan listed multiple goals for R33 including remaining free of infection, pain, or oral bleeding; along with several interventions including administering medications as ordered, coordinating dental care appointments or transportation, and providing mouth care. The care plan lacked evidence when, or if, R33 had last been evaluated by a dentist or if they declined such services.

On 4/3/23 at 10:54 a.m., a telephone interview was completed with R33's family member (FM)-B. FM-B explained they had not been able to visit R33 at the nursing home for a "few years" now due to travel limitations; however, expressed they had not been told or updated with any current concerns about R33 or his care needs.

On 4/4/23 at 8:11 a.m., R33 was observed seated in their wheelchair in the commons area of the dining room. R33 had nearly constant drooling onto their shirt and, when they opened their mouth to smile at others, had numerous, visible missing teeth on the upper palate.

R33's most recent HDG (Health Dimension Group) SNF - Dental/Oral Data Collection Tool, dated 9/16/21, identified R33 had their own teeth with none broken, loose or decaying. R33 was recorded as having no issues with their gums or bleeding along with dictation reading, " ... complete set up for oral cares and supervision or will not do." Further, the tool provided a section to ask if a dental visit was requested which was answered, "No."

HIM. Routine and emergency dental services are available to meet the resident oral care needs.
Social Service and HIM/Medical Records will be responsible for compliance.
Audits on dental appointments and oral inspection will begin weekly x 4 weeks then monthly to ensure compliance.
Audit results will be reviewed by the Executive Director and the Executive Director will take audit results to QAPI for review and recommendation.
Compliance: 5/12/2023

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However, R33's most recent Quarterly Resident Review, dated 2/10/23, identified a section labeled, "Oral Status," which outlined R33 had their own teeth and no cavities were listed. The review outlined R33 had no oral pain, however, a questioned asked, "Any chewing difficulties[?]," which was answered, "Yes." The review lacked spacing or dictation to outline when, if ever, R33's last dental appointment was or if it was currently needed or desired.

When interviewed on 4/5/23 at 9:49 a.m., nursing assistant (NA)-A verified R33 had numerous missing teeth and nearly constant drooling. NA-A stated R33 "barely talks" and was not always receptive to care or staff attempting to provide cares to him. NA-A explained they were unsure when, if ever, R33 had been offered or seen by a dental provider for the missing teeth and expressed they did not believe R33 would allow such a visit to occur. However, NA-A stated they had noticed R33 did have evident trouble with chewing lately and eating now "takes him awhile" even with a pureed diet being served.

R33's medical record was reviewed and lacked evidence R33 had been offered, refused, and/or seen by a dental provider in the past year despite having visibly missing teeth and being identified as having trouble chewing on the completed evaluation (dated 2/10/23) and direct care staff.

On 4/6/23 at 7:55 a.m., R33 was again observed seated in the dining room at a table. R33 was served their breakfast meal which consisted of pureed pancakes, pureed sausage, and hot cereal in a bowl. R33 continued to have near-constant drooling on themselves as they ate their meal. Further, R33 had a visible gulping

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F 791	Continued From page 166 motion as they chewed the provided meal. R33 did not answer questions when asked; however, at 8:05 a.m. and at the request of the surveyor, NA-A approached and questioned R33 on if they would be willing to see a dentist to help address their teeth. R33 was agreeable. When interviewed on 4/6/23 at 9:46 a.m., the assistant director of nursing (ADON) explained dental care needs, including the needs for dental appointments, should be reviewed on a quarterly basis and recorded in the medical record. ADON explained the facility was going to work on starting a "new IDT [interdisciplinary team] process" to ensure appointments would get scheduled and coordinated going forward. During subsequent interview, on 4/6/23 at 1:06 p.m., ADON verified R33's medical record lacked evidence the need for a dental visit had been assessed, offered or provided within the past year and explained such services should have been coordinated when issues (i.e., difficulty chewing) were identified. ADON stated it was important to ensure dental care visits were offered and completed for residents, including R33, to help prevent tooth infections and potential oral pain. A facility' policy on dental evaluations and appointments was requested, however, none was received.	F 791		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal,	F 812		5/12/23

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F 812	Continued From page 167 state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure opened food in the walk-in cooler were labeled or dated to ensure expired food was not served which had the ability to effect 57 of 58 residents due to R47 being strictly tube fed. Findings include: During observation on the initial kitchen tour and interview on 4/3/23 at 7:01 a.m., multiple open foods were undated in the walk-in cooler These included cheese slices, cottage cheese, liquid eggs, and staff personal food items. The dietary manager confirmed these items were undated and the expectation was all open food be dated and tossed out after 7 days. During interview on 4/6/23 at 9:12 a.m., dietary aide (DA)-B states that the walk-in cooler with the undated food was the "dairy" cooler which fed all of the residents and stated, "this is where all the food comes from." DA-B stated the expectation is	F 812	F 812 All outdated food was removed from the facility dietary department. A new order for replacement items was created and items were delivered. Facility resident documentation was reviewed from survey exit through 04/09/2023, and there was no adverse reaction to this deficient practice. For future food storage, food items will be dated and stored per dietary facility policy. The Dietary department was in-serviced on the Food Storage Policy with emphasis on item #7 that stock must be rotated with each new order received, old stock used first and food must be dated when placed on the shelves. Executive Director and/or designee will be responsible for compliance. Audits on food delivery, food labeling and food storage rotation will begin weekly x 4 weeks then monthly to ensure compliance. Audit results will be reviewed by the	

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F 812	Continued From page 168 for all food to be dated as soon as it is open and disposed of seven day after opening. DA-B further stated food should be disposed of if it is not dated to avoid serving expired food. During observation and interview on 4/6/23 at 4:45 p.m., the unit refrigerator on the first floor had opened, undated food which included meat and cheese sandwiches, cheese slices, grapes, milk, and lemonade. A sign on the refrigerator door indicated all staff should label and date food so expired food could be disposed. Registered nurse (RN)-C confirmed the refrigerator was used to hold food for the residents. A policy titled Food Safety and Sanitation, dated 2017, indicated when a food package is opened, the food item should be dated to determine when the food should be discarded.	F 812	Executive Director and the Executive Director will take audit results to QAPI for review and recommendation. Compliance: 5/12/2023	
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections	F 880		5/12/23

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	245028	A. BUILDING ______ B. WING ______	C 04/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLAND OPERATIONS LLC	2319 WEST SEVENTH STREET SAINT PAUL, MN 55116

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 169 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, 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.	F 880		

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F 880	Continued From page 170 §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 soiled and potentially contaminated laundry was bagged, collected, and transported in a manner to reduce the risk of cross-contamination and subsequent infection spread. These findings had potential to affect all 58 residents residing in the nursing home. Findings include: On 4/3/23 at 7:05 a.m., a laundry tour was completed with laundry aide (LA)-A present. A closed doorway on the main level of the nursing home labeled, "Stairs/Service Area," was opened where LA-A explained soiled laundry was brought to by the nursing assistant (NA) staff the evening prior. Inside this corridor, a yellow-colored, open-top, mobile bin was present which had two closed bags inside mixed with other various, loose resident' personal clothing items including socks, pants, and shirts. LA-A verified the items were soiled inside the mobile bin and they had not yet handled or touched the items thus far that day. LA-A stated the loose items should have been bagged as they were soiled adding clothing was "usually but not always [bagged]."	F 880	F 880 All unbagged linen during survey was washed and the linen cart was cleaned. All existing resident soiled linen was bagged and washed per policy. Future residents who have soiled clothing items will be bagged prior to being placed in the linen bin. Nursing staff was in-serviced on the Soiled Laundry Bedding Policy and procedure with emphasis on item 1a that all linen is consider contaminated and must be bagged at the point of collection before placing it into the linen transport cart. Assistant Director of Nursing/IP and/or designee will be responsible for compliance. Audits on linens handling and bagging of soiled linen will begin 2x week for 2 weeks, weekly x 4 weeks then monthly to ensure compliance. Audit results will be reviewed by the Executive Director and the Executive Director will take audit results to QAPI for review and recommendation. Compliance: 5/12/2023	

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F 880	Continued From page 171	F 880		

On 4/6/23 at 8:50 a.m., a subsequent laundry tour was completed, and inside the same area marked, "Stairs/Service Area," were now three yellow-colored, open-top, mobile bins labeled, "2 West," and, "2 Center," and, "1 East," respectively. These bins were inspected and, again, inside each bin were loose, non-bagged personal resident laundry items including socks, shirts, pants, and visible blue-colored mechanical lift harnesses. LA-A reviewed these bins with the surveyor and verified the items were soiled (i.e., dirty) and had not been handled or touched by them yet. LA-A stated the items, again, should have been bagged at the point of soiling and transported in the mobile bins while bagged and not loose and co-mingled with other resident items. LA-A explained the bins had been brought down last evening by the NA staff and the laundry not being bagged happened "quite often." Further, LA-A stated they had reported this happening to the administrator who voiced they would "talk to them [staff]" about it. LA-A stated laundry should be bagged and not transported loose and with other resident items for "infection control" purposes.

When interviewed on 4/6/23 at 9:52 a.m., the assistant director of nursing (ADON) explained they were the acting infection preventionist (IP), and soiled items should be bagged before being transported outside of the resident rooms and transported to the "yellow laundry bins." ADON stated the nursing home only laundered personal clothing items and verified items should be bagged for "infection control" reasons and to avoid staff potentially carrying soiled items with their hands "down the hallway" to the bins. ADON expressed the items being transported loose and not bagged was laundry "not done correctly," and

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F 880	Continued From page 172 they were unaware such practice was happening. On 4/6/23 at 10:40 a.m., the administrator was interviewed. He explained he was aware staff had been disposing of various linens in the trash or "wrong bin," however, was unaware staff were transporting loose laundry items in the mobile bins. He added, "I didn't realize it was an issue." The administrator stated they had not been doing any audits of such, however, would start now after being told of the issue. Further, the administrator verified soiled laundry items should be bagged at the contamination point and transported accordingly as a resident could have "something contagious" and they "don't want it to spread" to other residents or the laundry staff. He added, "We want to limit the spread of infections as best we can." A provided Laundry and Bedding, Soiled policy, dated 1/2022, identified soiled laundry was to be handled, transported and processed according to best practices for infection prevention and control. The policy outlined, "All used laundry is handled as potentially contaminated until it is properly bagged and labeled for appropriate processing." This included, "Laundry that is contaminated with blood or body substances is placed in leak-proof bags or containers," and, "Contaminated laundry is placed in a bag or container at the location where it is used and not sorted or rinsed at the location of use."	F 880		
F 888 SS=C	COVID-19 Vaccination of Facility Staff CFR(s): 483.80(i)(1)-(3)(i)-(x) §483.80(i) COVID-19 Vaccination of facility staff. The facility must develop and implement policies and	F 888		5/12/23

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLAND OPERATIONS LLC	**2319 WEST SEVENTH STREET** **SAINT PAUL, MN 55116**

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F 888	Continued From page 173 procedures to ensure that all staff are fully vaccinated for COVID-19. For purposes of this section, staff are considered fully vaccinated if it has been 2 weeks or more since they completed a primary vaccination series for COVID-19. The completion of a primary vaccination series for COVID-19 is defined here as the administration of a single-dose vaccine, or the administration of all required doses of a multi-dose vaccine. §483.80(i)(1) Regardless of clinical responsibility or resident contact, the policies and procedures must apply to the following facility staff, who provide any care, treatment, or other services for the facility and/or its residents: (i) Facility employees; (ii) Licensed practitioners; (iii) Students, trainees, and volunteers; and (iv) Individuals who provide care, treatment, or other services for the facility and/or its residents, under contract or by other arrangement. §483.80(i)(2) The policies and procedures of this section do not apply to the following facility staff: (i) Staff who exclusively provide telehealth or telemedicine services outside of the facility setting and who do not have any direct contact with residents and other staff specified in paragraph (i)(1) of this section; and (ii) Staff who provide support services for the facility that are performed exclusively outside of the facility setting and who do not have any direct contact with residents and other staff specified in paragraph (i)(1) of this section. §483.80(i)(3) The policies and procedures must include, at a minimum, the following components: (i) A process for ensuring all staff specified in	F 888		

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F 888	Continued From page 174 paragraph (i)(1) of this section (except for those staff who have pending requests for, or who have been granted, exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations) have received, at a minimum, a single-dose COVID-19 vaccine, or the first dose of the primary vaccination series for a multi-dose COVID-19 vaccine prior to staff providing any care, treatment, or other services for the facility and/or its residents; (iii) A process for ensuring the implementation of additional precautions, intended to mitigate the transmission and spread of COVID-19, for all staff who are not fully vaccinated for COVID-19; (iv) A process for tracking and securely documenting the COVID-19 vaccination status of all staff specified in paragraph (i)(1) of this section; (v) A process for tracking and securely documenting the COVID-19 vaccination status of any staff who have obtained any booster doses as recommended by the CDC; (vi) A process by which staff may request an exemption from the staff COVID-19 vaccination requirements based on an applicable Federal law; (vii) A process for tracking and securely documenting information provided by those staff who have requested, and for whom the facility has granted, an exemption from the staff COVID-19 vaccination requirements; (viii) A process for ensuring that all documentation, which confirms recognized clinical contraindications to COVID-19 vaccines and which supports staff requests for medical exemptions from vaccination, has been signed	F 888		

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F 888	Continued From page 175	F 888		

and dated by a licensed practitioner, who is not the individual requesting the exemption, and who is acting within their respective scope of practice as defined by, and in accordance with, all applicable State and local laws, and for further ensuring that such documentation contains:
(A) All information specifying which of the authorized COVID-19 vaccines are clinically contraindicated for the staff member to receive and the recognized clinical reasons for the contraindications; and
(B) A statement by the authenticating practitioner recommending that the staff member be exempted from the facility's COVID-19 vaccination requirements for staff based on the recognized clinical contraindications;
(ix) A process for ensuring the tracking and secure documentation of the vaccination status of staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations, including, but not limited to, individuals with acute illness secondary to COVID-19, and individuals who received monoclonal antibodies or convalescent plasma for COVID-19 treatment; and
(x) Contingency plans for staff who are not fully vaccinated for COVID-19.

Effective 60 Days After Publication:
§483.80(i)(3)(ii) A process for ensuring that all staff specified in paragraph (i)(1) of this section are fully vaccinated for COVID-19, except for those staff who have been granted exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and

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F 888	Continued From page 176 considerations; This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure 1 of 75 staff members, including both direct and non-direct care staff, were vaccinated with a complete primary series of COVID-19 vaccine and/or had an approved or pending exemption on record. This resulted in a vaccination rate of only 98.6% and had potential to affect all 58 residents in the facility. Findings include: The Centers for Disease Control (CDC) COVID Data Tracker, dated 3/30/23 to 4/5/23, identified Ramsey County as having "Moderate" community transmission of COVID-19. A series of listings each labeled, "Highland Chateau," was provided which contained the names of all 75 facility-employed direct and non-direct care staff members along with their respective positions, COVID-19 vaccination doses, any approved exemptions (i.e., religious) and current status (i.e., active). This listing identified nursing assistant (NA)-C as an active employee, however, the fields to record NA-C's vaccination series and/or exemption(s) were left blank with no data entered. A provided untitled document, dated 2/22/23, identified NA-C was an active employee and had worked several shifts between 3/23/23 and 4/5/23. During the recertification survey, from 4/3/23 to 4/6/23, evidence was requested demonstrating NA-C had either completed a primary series of COVID-19 vaccination or been granted an exemption. However, no evidence	F 888	F 888 NA-C completed an exemption to the COVID vaccine on 4/4/23. There were no ill effects experienced from residents or staff for this deficient practice. Future employees will follow the facility COVID-19 mandate for exemptions to vaccination. Human Resource Director, Director of Nursing, and Infection Preventionist was in-serviced on the COVID-19 Policy with emphasis on paragraph 3 that if employee□s do not meet the vaccination deadlines and without an approved exemption, the employee cannot work. Assistant Director of Nursing/IP and/or designee will be responsible for compliance. Audits on exemption and vaccination status for employees will begin weekly x 4 weeks then monthly to ensure compliance. Audit results will be reviewed by the Executive Director and the Executive Director will take audit results to QAPI for review and recommendation. Compliance: 5/12/2023	

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F 888	Continued From page 177 was received or provided. On 4/4/23 at 12:55 p.m., a telephone call to NA-C was attempted, however was unsuccessful and no message could be left. When interviewed on 4/4/23 at 1:04 p.m., the assistant director of nursing (ADON) explained they were the current infection preventionist (IP) and helping to manage the COVID-19 staff vaccinations. ADON verified they were unable to locate any evidence NA-C had received a primary vaccination series or pending and/or approved exemption. ADON stated NA-C had been given the forms to complete for an exemption, however, never returned them. ADON stated NA-C was not currently being required to do any routine COVID-19 testing for work, despite not having a completed vaccination series or exemption, to their knowledge. Further, ADON stated NA-C should have completed the vaccination series or got an exemption approved to ensure "we [facility] follow CDC and MDH protocols." On 4/4/23 at 1:21 p.m., the human resources coordinator (HR)-A was interviewed. HR-A explained NA-C was hired in November 2022, and the paperwork for an exemption had been provided in the "orientation packet," however, had not been returned to date. HR-A stated they had followed-up with NA-C about getting the paperwork done and completed "a few months ago," however, it had still not been done. HR-A verified NA-C was an active employee and scheduled to work a designated FTE on the schedule. Further, HR-A expressed they were "recently" charged with responsibility to ensure all staff were vaccinated or had an approved exemption; and verified NA-C did not have a	F 888		

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F 888	Continued From page 178 completed vaccine series on file adding, "Not that I remember." A provided CMS Omnibus COVID-19 Health Care Staff Vaccine Interim Final Rule policy, dated 2/8/22, identified the expectation of the nursing home to be in compliance with all applicable CMS COVID-19 rules and regulations. This outlined a primary vaccination series or approved exemption was to be completed. In addition, a corresponding Employee Infection and Vaccination Status policy, dated 1/2022, identified employees were to be current with mandated vaccinations prior to performing direct resident care.	F 888		

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 04/06/2023. At the time of this survey, Highland Operations 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		05/03/2023

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

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K 000	Continued From page 1	K 000		

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.

Highland Operations Health Care Center is a two-story building with a partial basement. The building was constructed at two different times. The original building was constructed in 1963 and was determined to be of Type II(222) construction. In 1970, an addition was constructed to the south side of the building that was determined to be of Type II(222) construction. Because the original building and the additions meet the construction type allowed for existing buildings, the facility was surveyed as

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K 000	Continued From page 2 one building. The building is protected by a full fire sprinkler system. The facility has a fire alarm system with full corridor smoke detection and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 64 beds and had a census of 60 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 345 SS=B	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to maintain the fire alarm system per NFPA 101 (2012 edition), Life Safety Code, section 9.6.1.3 and NFPA 72 (2010 editon), National Fire Alarm and Signaling Code, section 14.2.1.2.2. This deficient finding could have a isolated impact on the residents within the facility. Findings include:	K 345	The trouble alarm was remote power supply. LVC company visited the facility prior to the survey on 03/30/2023. Parts for the trouble alarm was ordered on 04/11/2023 and service will be scheduled to have parts installed. The tentative date for installation will be determined when parts are delivered. The trouble panel will be placed on the inspection report via TELSs for quarterly and as needed facility monitoring.	5/13/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245028	A. BUILDING **01 - MAIN BUILDING 01** B. WING ______	**04/06/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLAND OPERATIONS LLC	**2319 WEST SEVENTH STREET** **SAINT PAUL, MN 55116**

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K 345	Continued From page 3 On 04/06/2023 at 0930 AM, it was revealed by a review of available documentation and observation that the fire alarm system showed a trouble alarm on the main panel for a horn/strobe on the 2nd floor. An interview with the Executive Director verified this deficient finding at the time of discovery.	K 345	Audits will be performed quarterly to ensure sustained compliance. Maintenance and/or designee is responsible for compliance. Compliance 05/13/2023	
K 712 SS=C	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility needed to conduct Fire drills per NFPA 101 (2012 edition), Life Safety Code section 19.7.1.6. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 04/06/2023 at 09:30 AM, it was revealed by a review of available documentation that the facility failed to conduct two fire drills for the 3rd shift, 1st and 2nd quarters.	K 712	A fire drill is scheduled for night shift on 05/05/2023. All previous fire drills from January 1, 2023, until present will be loaded into the electronic maintenance portal TELS. Future fire drills will be performed per facility policy The TELs system will be updated to reflect next fire drill date to ensure sustained compliance. Maintenance Director and/or designee is responsible for compliance. Fire drill frequency will be audited quarterly and as need to ensure	5/13/23

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K 712	Continued From page 4 An interview with Executive Director verified this deficient findings at the time of discovery.	K 712	compliance. Compliance: 05/13/2023	
K 753 SS=D	Combustible Decorations CFR(s): NFPA 101 Combustible Decorations Combustible decorations shall be prohibited unless one of the following is met: o Flame retardant or treated with approved fire-retardant coating that is listed and labeled for product. o Decorations meet NFPA 701. o Decorations exhibit heat release less than 100 kilowatts in accordance with NFPA 289. o Decorations, such as photographs, paintings and other art are attached to the walls, ceilings and non-fire-rated doors in accordance with 18.7.5.6(4) or 19.7.5.6(4). o The decorations in existing occupancies are in such limited quantities that a hazard of fire development or spread is not present. 19.7.5.6 This REQUIREMENT is not met as evidenced by: Based on observation or a review of available documentation and staff interview, the facility failed to prohibit combustible decorations per NFPA 101 (2012 edition), Life Safety Code, sections 19.7.5.6 and 19.7.5.6 (4). These deficient findings could have an isolated on the residents within the facility. Findings include: 1. On April 6, 2023, at 11:00 AM, it was revealed by observation that room 217 has the walls in the residence room and bathroom covered with photos from floor to ceiling on all walls.	K 753	Room 217 was cleared of all photos from ceiling to floor on 05/05/2023. Room 227 was cleared of all inflatable plastic devices on 05/05/2023. All other resident rooms will be audited to ensure there are no combustible items located in resident rooms. Existing residents will be educated at the next resident council that combustible items will not be allowed into the resident room. Room audits will occur weekly for 3 weeks then monthly to ensure sustained compliance.	5/13/23

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K 753	Continued From page 5 2. On April 6, 2023, at 11:10 AM, it was revealed by observation that room 227 had several inflatable plastic devices throughout the room. An interview with Executive Director verified these deficient findings at the time of discovery.	K 753	Maintenance Director and/or designee is responsible for compliance. Compliance: 05/13/2023	

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
April 26, 2023

Administrator
Highland Operations, LLC
2319 West Seventh Street
Saint Paul, MN 55116

Re: State Nursing Home Licensing Orders
Event ID: XXHJ11

Dear Administrator:

The above facility was surveyed on April 3, 2023 through April 6, 2023 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

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

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

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

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

Pete Cole, RN Unit Supervisor
Metro Team C District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: peter.cole@state.mn.us
Office/Mobile: (651) 249-1724

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

Please feel free to call me with any questions.

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Phone: 651-201-4384
Email: holly.zahler@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00494	A. BUILDING: ______ B. WING ______	C 04/06/2023

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2 000	Initial Comments	2 000		

*****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 4/3/23 to 4/6/23, a licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was not in compliance with the MN State Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you have reviewed these orders and

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

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2 000	Continued From page 2 IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 265	MN Rule 4658.0085 Notification of Chg in Resident Health Status A nursing home must develop and implement policies to guide staff decisions to consult physicians, physician assistants, and nurse practitioners, and if known, notify the resident's legal representative or an interested family member of a resident's acute illness, serious accident, or death. At a minimum, the director of nursing services, and the medical director or an attending physician must be involved in the development of these policies. The policies must have criteria which address at least the appropriate notification times for: A. an accident involving the resident which results in injury and has the potential for requiring physician intervention; B. a significant change in the resident's physical, mental, or psychosocial status, for example, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications; C. a need to alter treatment significantly, for example, a need to discontinue an existing form of treatment due to adverse consequences, or to begin a new form of treatment; D. a decision to transfer or discharge the resident from the nursing home; or E. expected and unexpected resident deaths.	2 265		5/12/23

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2 265	Continued From page 3 This MN Requirement is not met as evidenced by: Based on interview and record review the facility failed to immediately consult with the provider following a fall with injury for 1 of 1 resident (R32). Findings include: R32's quarterly Minimum Data Set (MDS) dated 11/7/22, indicated intact cognition and required extensive assist with transferring, bed mobility, toileting, and hygiene, occasionally had bladder incontinence, and did not reject cares. R32's Medical Diagnosis form in the electronic medical record (EMR) indicated R32 had the following diagnoses: Crohn's disease (an inflammatory disease that affects the digestive tract), muscle weakness, and difficulty walking. R32's medication administration record (MAR) dated November 2022 indicated an order for acetaminophen 1000 milligrams (mg) by mouth three times a day for pain with a start date of 5/3/22, pregabalin (a medication for nerve pain) 25 mg twice daily for pain management with a start date of 5/2/22, and oxycodone (a narcotic for pain management) 5 mg every four hours as needed for pain management with a start date of 5/4/22. The oxycodone was documented on the MAR as given one time in November on 11/26/22 at 12:09 p.m. R32's nursing progress note dated 11/26/22, indicated R32 was found on the floor about 5:45 a.m. lying on left side and was trying to walk to the bathroom and fell. The progress note indicated R32 rated pain a seven out of 10 and	2 265	Corrected	

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2 265	Continued From page 4	2 265		

was unable to raise his left arm and, "NP and administrator notified." The progress note lacked information on the outcome of the consultation with the nurse practitioner (NP).

R32's Incident Audit Report form dated 11/26/22, indicated R32 was found on the floor and under the heading immediate action taken, rated pain a seven out of 10, was unable to raise left arm and was lifted up with two assist to the toilet and put back to bed.

A progress note dated 11/26/22 at 4:43 p.m., indicated R32 was seen and assessed by medical doctor (MD) and a new order was written for left upper arm and shoulder x-ray due to pain and not using after fall.

R32's physician progress note from medical doctor (MD)-K indicated R32 was seen on 11/26/22 and had severe pain with passive range of motion of the left upper extremity and shoulder and an apparent left upper extremity injury and an x-ray was ordered for the left upper arm and shoulder.

R32's nursing progress note dated 11/27/22 at 10:45 p.m., indicated R32 had a fall the previous day and an x-ray had been ordered and further assessment indicated R32 was in "dire" pain guarding his arm screaming his arm was broken, 911 was called at 8:00 a.m. and was sent to the hospital.

R32's hospital discharge summary indicated R32 was hospitalized 11/27/22 through 12/3/22 for a humerus fracture (upper arm bone) and acute hypoxic respiratory failure.

During interview on 4/5/23 at 9:36 a.m., licensed

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2 265	Continued From page 5	2 265		

practical nurse (LPN)-F stated when a resident falls, the nurse determines what happened, and stated you have to get ahold of the doctor and document what their response was under the progress notes. LPN-F stated R32 was not able to lift his arms which could indicate that something happened and stated she left a message for NP after the fall, but could not recall if NP called back and stated R32 was having pain. LPN-F verified if a resident was having pain and difficulty moving their arm the provider should be notified right away. LPN-F added she recalled updating MD-K when he came to the facililty on the afternoon shift 11/26/22.

During interview on 4/5/23 at 9:03 a.m. LPN-G stated if a resident falls the nurse must determine what happened and if there is an injury, the nurse must talk to a provider and added you can't leave a voicemail.

During interview on 4/6/23 at 1:56 p.m. NP-C stated if a resident fell and had pain staff should call and talk to her right away and document whether or not there were any recommendations.

During interview on 4/5/23 at 3:01 p.m. the assistant director of nursing stated if a resident fell and complained of pain or was injured, the provider must be called and expected staff to keep calling the provider until they received a response and document the provider's response.

During interview on 4/6/23 at 10:11 a.m. director of nursing (DON) stated she expected staff to contact her and speak with a provider when a resident falls and is injured.

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2 265	Continued From page 6 SUGGESTED METHOD OF CORRECTION: The administrator or designee could develop/revise and implement policies and procedures related to the physician notification. The quality assessment and assurance committee could perform random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) days	2 265		
2 302	MN State Statute 144.6503 Alzheimer's disease or related disorder train ALZHEIMER'S DISEASE OR RELATED DISORDER TRAINING: MN St. Statute 144.6503 (a) If a nursing facility serves persons with Alzheimer's disease or related disorders, whether in a segregated or general unit, the facility's direct care staff and their supervisors must be trained in dementia care. (b) Areas of required training include: (1) an explanation of Alzheimer's disease and related disorders; (2) assistance with activities of daily living; (3) problem solving with challenging behaviors; and (4) communication skills. (c) The facility shall provide to consumers in written or electronic form a description of the training program, the categories of employees trained, the frequency of training, and the basic topics covered. (d) The facility shall document compliance with this section.	2 302		5/12/23

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2 302	Continued From page 7 This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to ensure dementia training was completed for 3 of 8 staff (nursing assistant (NA)-G, NA-K, licensed practical nurse (LPN)-B) reviewed for dementia training. Findings include: During interview on 4/4/23 at 1:23 p.m., a list was provided to the director of nursing (DON) of the following staff for review of dementia training: LPN-B hired 6/30/10 NA-I NA-J NA-G hired 4/29/20 NA-K hired 7/22/21 DON Assistant director of nursing Social services director (SSD-A) On 4/4/23 at 2:24 p.m. staff coordinator (SC)-A provided the quizzes and staff roster requested for review of dementia training. There was no record of completion of a competency exam for NA-G, NA-K, and LPN-B. During interview on 4/6/23 at 9:51 a.m. the staff coordinator (SC)-A stated she was in charge of general orientation and had contacted Med Com, a company the facility utilized for dementia training and was informed they did not have record of dementia training for NA-G, NA-K, and LPN-B. SC-A stated she may be able to provide additional information on training for NA-G, NA-K, and LPN-B, but the information was not provided.	2 302	Corrected	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 302	Continued From page 8 SUGGESTED METHOD OF CORRECTION: The DON or designee could ensure the training for Alzheimer's was completed for all staff. The Director of Nursing or designee could educate all appropriate staff on the policies and procedures. The Director of Nursing or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 302		
2 540	MN Rule 4658.0400 Subp. 1 & 2 Comprehensive Resident Assessment Subpart 1. Assessment. A nursing home must conduct a comprehensive assessment of each resident's needs, which describes the resident's capability to perform daily life functions and significant impairments in functional capacity. A nursing assessment conducted according to Minnesota Statutes, section 148.171, subdivision 15, may be used as part of the comprehensive resident assessment. The results of the comprehensive resident assessment must be used to develop, review, and revise the resident's comprehensive plan of care as defined in part 4658.0405. Subp. 2. Information gathered. The comprehensive resident assessment must include at least the following information: A. medically defined conditions and prior medical history; B. medical status measurement; C. physical and mental functional status; D. sensory and physical impairments; E. nutritional status and requirements;	2 540		5/12/23

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	00494	A. BUILDING: ______ B. WING ______	C 04/06/2023

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2 540	Continued From page 9 F. special treatments or procedures; G. mental and psychosocial status; H. discharge potential; I. dental condition; J. activities potential; K. rehabilitation potential; L. cognitive status; M. drug therapy; and N. resident preferences. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to complete multiple significant change in status (SCSA) Minimum Data Set (MDS) in a thorough and accurate manner to ensure cognitive and mood needs were comprehensively evaluated for 2 of 4 residents (R31, R26) reviewed for MDS accuracy. Findings include: The Centers for Medicare & Medicaid Services (CMS) Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual, dated 10/2018, outlined, "The SCSA is a comprehensive assessment for a resident that must be completed when the IDT [interdisciplinary team] has determined that a resident meets the significant change guidelines for either major improvement of decline." A section labeled, "SECTION C: COGNITIVE PATTERNS," identified the items reviewed in the section were, " ... intended to determine the resident's attention, orientation and ability to register and recall new information. These items are crucial factors in many care-planning decisions." A subsequent section labeled, "SECTION D: MOOD," identified the items reviewed in the section, " ... address mood	2 540	Corrected	

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2 540	Continued From page 10 distress ... It is particularly important to identify signs and symptoms of mood distress among nursing home residents because these signs can be treatable." R31's SCSA MDS, dated 3/11/23, identified R31 admitted to the nursing home in September 2022 from an acute care hospital. The MDS' section labeled, "Section C: Cognitive Patterns," however, had no data at all entered, with most fields not even having a "-" symbol demonstrating the item had been dashed. In addition, the section labeled, "Section D: Mood," had all the items to be assessed or addressed completed with a " - " mark and no other data entered. R31's medical record, and the completed MDS, lacked evidence these items had been assessed within the assessment reference date (ARD) as directed by the RAI manual to ensure a full evaluation of the resident. R26's SCSA MDS, dated 1/20/23, identified R26 admitted to the nursing home in August 2022 from an acute care hospital. The MDS' section labeled, "Section C: Cognitive Patterns," however, had no data at all entered, with most fields not even having a "-" symbol demonstrating the item had been dashed. In addition, the section labeled, "Section D: Mood," had all the items to be assessed or addressed completed with a " - " mark and no other data entered. R26's medical record, and the completed MDS, lacked evidence these items had been assessed within the ARD as directed by the RAI manual to ensure a full evaluation of the resident. On 4/5/23 at 1:32 p.m., the assistant director of nursing (ADON) was interviewed. ADON	2 540		

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2 540	Continued From page 11 explained the facility currently did not have an MDS coordinator in-house so, as a result, the MDS' were being outsourced to a "third party" located out of State. ADON stated getting all the MDS(s), and their corresponding assessments, had been "a little bit of a struggle" as a result and explained there had been instances when themselves and the director of nursing (DON), whom were responsible to complete those corresponding assessments (i.e., BIMS), were not told of ARD(s) so it resulted in the assessments not getting completed timely for the MDS. On 4/6/23 at 2:05 p.m., registered nurse (RN)-A was interviewed, and they verified they were currently completing the MDS' for the nursing home while out of State. RN-A explained the items left blank on the MDS or which were 'dashed' were "not assessed" so they couldn't be coded on the MDS. RN-A stated the corresponding assessments (i.e., BIMS, PHQ-9) should have been completed so the MDS(s) could be accurately completed, adding with them there was "no data to pull [to the MDS]." A facility' policy on MDS completion was requested, however, none was received. SUGGESTED METHOD OF CORRECTION: The director of nursing, or designee, could review applicable policies on MDS and the corresponding assessments to be completed; then inservice appropriate staff and audit to ensure ongoing compliance. TIME FRAME FOR CORRECTION: Twenty-one (21) Days	2 540		

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2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to complete multiple significant change in status (SCSA) Minimum Data Set (MDS) in a thorough and accurate manner to ensure cognitive and mood needs were comprehensively evaluated for 2 of 4 residents (R31, R26) reviewed for MDS accuracy. Findings include: The Centers for Medicare & Medicaid Services (CMS) Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual, dated 10/2018, outlined, "The SCSA is a comprehensive assessment for a resident that must be completed when the IDT [interdisciplinary team] has determined that a resident meets the significant change guidelines for either major improvement of decline." A section labeled, "SECTION C: COGNITIVE PATTERNS," identified the items reviewed in the section were, " ... intended to determine the resident's attention, orientation and ability to register and recall new information. These items are crucial factors in many care-planning decisions." A subsequent section labeled, "SECTION D: MOOD," identified the items reviewed in the section, " ... address mood	2 565	Corrected	5/12/23

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2 565	Continued From page 13 distress ... It is particularly important to identify signs and symptoms of mood distress among nursing home residents because these signs can be treatable." R31's SCSA MDS, dated 3/11/23, identified R31 admitted to the nursing home in September 2022 from an acute care hospital. The MDS' section labeled, "Section C: Cognitive Patterns," however, had no data at all entered, with most fields not even having a "-" symbol demonstrating the item had been dashed. In addition, the section labeled, "Section D: Mood," had all the items to be assessed or addressed completed with a " - " mark and no other data entered. R31's medical record, and the completed MDS, lacked evidence these items had been assessed within the assessment reference date (ARD) as directed by the RAI manual to ensure a full evaluation of the resident. R26's SCSA MDS, dated 1/20/23, identified R26 admitted to the nursing home in August 2022 from an acute care hospital. The MDS' section labeled, "Section C: Cognitive Patterns," however, had no data at all entered, with most fields not even having a "-" symbol demonstrating the item had been dashed. In addition, the section labeled, "Section D: Mood," had all the items to be assessed or addressed completed with a " - " mark and no other data entered. R26's medical record, and the completed MDS, lacked evidence these items had been assessed within the ARD as directed by the RAI manual to ensure a full evaluation of the resident. On 4/5/23 at 1:32 p.m., the assistant director of nursing (ADON) was interviewed. ADON	2 565		

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2 565	Continued From page 14 explained the facility currently did not have an MDS coordinator in-house so, as a result, the MDS' were being outsourced to a "third party" located out of State. ADON stated getting all the MDS(s), and their corresponding assessments, had been "a little bit of a struggle" as a result and explained there had been instances when themselves and the director of nursing (DON), whom were responsible to complete those corresponding assessments (i.e., BIMS), were not told of ARD(s) so it resulted in the assessments not getting completed timely for the MDS. On 4/6/23 at 2:05 p.m., registered nurse (RN)-A was interviewed, and they verified they were currently completing the MDS' for the nursing home while out of State. RN-A explained the items left blank on the MDS or which were 'dashed' were "not assessed" so they couldn't be coded on the MDS. RN-A stated the corresponding assessments (i.e., BIMS, PHQ-9) should have been completed so the MDS(s) could be accurately completed, adding with them there was "no data to pull [to the MDS]." A facility' policy on MDS completion was requested, however, none was received. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee should review and revise policies and procedures related to creating and implementing and/or revising a comprehensive care plan as needed to ensure cares meet the specific needs of each individual resident. The director of nursing or designee should develop a system to educate staff and develop a monitoring system such as measurable audits to ensure individual care plans are created,	2 565		

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2 565	Continued From page 15 and/or revised and implemented. The results of those audits should be taken to the QAPI committee to determine compliance or the need for further monitoring. The administrator should be responsible to ensure this occurs. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 565		
2 570	MN Rule 4658.0405 Subp. 4 Comprehensive Plan of Care; Revision Subp. 4. Revision. A comprehensive plan of care must be reviewed and revised by an interdisciplinary team that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, with the participation of the resident, the resident's legal guardian or chosen representative at least quarterly and within seven days of the revision of the comprehensive resident assessment required by part 4658.0400, subpart 3, item B. This MN Requirement is not met as evidenced by: Based on interview, and document review, the facility failed to ensure resident and/or resident representatives participated in the resident care planning process and subsequent development of interventions for 4 of 4 residents (R31, R49, R29, R162) reviewed for participation in care planning. Findings include: R31's significant change Minimum Data Set (MDS) dated, 3/22/23, identified R31 required	2 570	Corrected	5/12/23

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2 570	Continued From page 16 extensive assistance with two plus staff for bed mobility, transfers, and extensive assistance with assist of one for personal hygiene and dressing. Diagnoses includes morbid obesity, atrial fibrillation, heart failure, and history of venous thrombosis and embolism (blood clots). R31's hospital after visit summary printed 9/28/22 stated, "General info for SNF for Length of Stay Estimate: Short Term Care: Estimated # of Days <30". R31 progress note dated 12/16/22, by facility social worker (SW)-B stated "Met with [R31], Here in TCU on short term recovery from fall and broken elbow and shoulder. Scheduled Care Conference for Tuesday at 1:00pm". R31 progress note titled "Care Conference" dated 2/22/23 at 9:29 a.m., by SW-A stated "Note Text: Contacted [R31's] [family member] to arrange a Care Conference, [family member][FM-(A)] stated that he will give me a call back." During interview with R31 on 4/3/23 at 10:38 a.m., R31 stated facility "has not had a care conference since my admission", which was on 9/28/22. During interview with administrator on 4/3/23 at 11:26 a.m., administrator stated expectation that care conference notes from the social worker can be viewed in the resident's electronic medical record (EMR) under progress notes and/or assessments tab. "I don't see it in there". Administrator stated expectation was SW-A was told and "she should be doing this". During interview with SW-A on 4/3/23 at 1:39 p.m., SW-A stated "We have not had a care	2 570		

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2 570	Continued From page 17	2 570		

Continued From page 17

conference yet since admission" for R31. SW-A stated care conferences are expected to be done within 48 hours of admission and quarterly. SW-A stated care conference notes are expected to be found in the progress note of EMR.

During interview with director of nursing (DON) on 4/5/23 at 1:01 p.m., DON stated expectation of care conferences to be done and documented by facility at resident admission, quarterly and as needed. DON verified R31 care conference was not done since admission on 9/28/23. "I don't see one documented. There should be."

During interview with R31's emergency contact, (FM-A) on 4/5/23 at 1:58p.m., FM-A stated no care conferences have been scheduled for R31 since admission to facility. FM-A stated he has "not been notified about anything" since his mother was admitted to facility. FM-A stated he had called the facility twice to discuss discharge planning for R31, but facility has not responded to him. FM-A stated "if they are saying they are calling me they are not telling the truth. I expect to be included in the care conferences". FM-A stated R31 "lives with my [family member]" and "no has talked to me or anyone in our family including my mother about discharge planning".

Facility policy titled Resident Care Conference/Care Plan Review updated 03/30/2021 stated "The overall care conference goal process will aid in better resident care outcomes for our long-term and safe discharge to the community for our short-term residents".

R49's face sheet dated 4/6/23, indicated R49 admitted to the facility on 2/24/23.

R49's significant change Minimum Data Set

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2 570	Continued From page 18 (MDS) dated 3/21/23, indicated R49 had severe cognitive deficits. R49's electronic medical record (EMR) indicated R49's diagnoses included a stroke resulting in one-sided paralysis, encephalopathy (disorder or disease affecting the brain), coronary artery disease (CAD, increased plaque in the arteries of the heart), cardiomyopathies (diseases affecting the heart muscle), history of clostridium difficile (C-Diff a bacterial infection of the intestine that can lead to death), heart failure, malnutrition, obstructive sleep apnea (the cessation of breathing during sleep), atrial fibrillation (irregular heart rhythm increasing the incidents of blood clots), high blood pressure, shortness of breath, dysphagia (difficulty swallowing), and second-degree burn to left lower limb. R49's Care Area Assessment (CAA) dated 3/21/23, indicated R49 triggered for cognitive loss/dementia, communication, activities of daily living (ADL) function, urinary incontinence, falls, pressure ulcers, and pain. R49's care plan dated 2/27/23, indicated R49 had a goal for his preferences to be honored while at the facility. R49 was also on hospice with the goal to remain comfortable related to his hospice care. Interventions included coordinating R49's care with the hospice services and other end of life cares. Review of R49's progress notes lacked indication of a care conference or documentation of efforts to coordinate a care conference since R49's admission on 2/24/23. R49's responsible party was unavailable for interview.	2 570		

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2 570	Continued From page 19 During an interview on 4/3/23 at 11:35 a.m., the social services director (SSD)-A stated residents were to have a care conference within 48 hours of admission and then every quarter. SSD-A verified R49 has not had a care conference since his admission on 2/24/23, and she had not contacted R49's responsible party to schedule one. R29's significant change Minimum Data Set (MDS), dated 2/23/23, indicated R29 had short-term and long-term memory problems with severely impaired cognitive skills for decision making, needed extensive assistance with bed mobility, transfers, toileting use, personal hygiene, and supervision with eating. The MDS further indicated medical diagnoses to include metabolic encephalopathy (a problem in the brain caused by a chemical imbalance in the blood which can lead to personality changes), binge eating disorder (frequently consuming unusually large amounts of food in one sitting and feeling that eating behavior is out of control), venous insufficiency (a condition in which the veins have problems sending blood from the legs back to the heart), major depressive disorder (a mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life), obstructive sleep apnea (Intermittent airflow blockage during sleep causing decreased oxygen saturation or arousal from sleep), and schizoid personality disorder (a condition in which people avoid social activities and interacting with others). During interview on 4/4/23 at 8:28 a.m., R29 stated he had never been invited to or attended a care conference since being admitted to the facility on 2/9/23.	2 570		

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2 570	Continued From page 20 Review of R29's electronic medical record (EMR) lacked evidence of any interdisciplinary team meetings or a care conference being held since admission to the facility on 2/9/23. During interview on 4/6/23 at 9:53 a.m., the director of nursing (DON) confirmed there was no evidence of a care conference in R29's medical record. The DON stated the expectation would be for care conferences to be help within the first 72 hours of admission and quarterly. The DON further stated every care conference should be documented in progress notes. The five day, in progress, Minimum Set Data (MDS) dated 3/30/23, indicated R162 was severely cognitive impaired, easily distracted, incoherent, needed extensive assistance with bed mobility, transfers toileting, ambulation, dressing, eating and hygiene. The MDS further indicated medical diagnoses to include aphasia (loss of ability to understand or express speech), cerebral infarction (area of damaged tissue on the brain), epilepsy (brain disorder that causes recurring, unprovoked involuntary movement), pain in right leg, pulmonary hypertension (a type of blood pressure that affects arteries in the lungs and in the heart), schizophrenia (mental disorder that affects how a person thinks, acts and expresses emotions) and diabetes mellitus, During interview on 4/3/23 at 8:01 a.m., R162 was sitting at the edge of the bed and was calling for help to use the bathroom. R162 was able to answer simple concrete yes and no questions but R162 was unable to answer questions related to his stay at the facility and goals of care. During interview on 4/3/23 at 3:45 p.m., R162's	2 570		

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2 570	Continued From page 21	2 570		

family member stated she had not participated on a care conference to revise R162's care plan or therapy program. Regarding R162's discharge planning, family member (FM)-A stated that R162 would return home with her.

During interview on 4/5/23 at 10 a.m., social worker (SW)-A stated admission care conferences were scheduled within 48 hours of admission. Thereafter, care conferences are scheduled every three months, annually and with significant changes. SW-A stated documentation of care conferences should be noted on R162's progress notes or under assessments. SW-A stated a care conference was not done for R162.

During interview with director of nursing (DON) on 4/5/23 at 1:02 p.m., DON stated expectation of care conferences to be done and documented by facility at resident admission, quarterly and as needed. DON verified R162's care conference was not done since admission.

SUGGESTED METHOD OF CORRECTION:
The director of nursing (DON) or designee could review and revise policies and procedures related to revision of the care plan as needed to meet the needs of each individual resident. The director of nursing or designee could develop a system to educate staff and develop a monitoring system to ensure individual care plans are revised as necessary.

TIME PERIOD FOR CORRECTION: Twenty-one (21) days.

2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General	2 830		5/12/23

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2 830	Continued From page 22 Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review the facility failed to implement individualized interventions to mitigate risk for falls following a fall with a fracture for 1 of 1 resident (R32). Findings include: R32's quarterly Minimum Data Set (MDS) dated 11/7/22 indicated intact cognition and requirement of extensive assist with transferring, bed mobility, toileting, and hygiene, occasionally had bladder incontinence, and did not reject cares. R32's significant change MDS dated 1/13/23, indicated intact cognition, did not reject cares, required extensive assist with bed mobility, transfers, dressing, toileting, personal hygiene, and had a balance problem when moving from seated to standing, walking, and during transfer between bed , chair, and wheelchair. The MDS indicated R32 was occasionally incontinent.	2 830	Corrected	

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2 830	Continued From page 23	2 830		

R32's Medical Diagnosis form in the electronic medical record (EMR) indicated R32 had the following diagnoses: Crohn's disease (an inflammatory disease that affects the digestive tract), muscle weakness, and difficulty walking.

R32's falls care plan dated 7/15/22 indicated the following interventions created on 7/15/22: be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed, the resident needs prompt response to all requests for assistance, and physical therapy to evaluate and treat as ordered or as needed. The care plan was revised on 4/4/23, to update the goal that R32 would be free of falls through the review target date of 4/21/23.

R32's Resident Fall Risk form dated 11/1/22 indicated intermittent confusion, was ambulatory but incontinent, had a balance problem while walking and decreased muscular coordination and gait problems. The form also indicated R32 took one or two medications that included antipsychotics, antianxiety agents, antidepressants, hypnotics, cardiovascular medications, diuretics, narcotic analgesics, neuroleptics, or other medications that caused lethargy or confusion, and had predisposing diseases. The form had a score of 16 indicating a high risk for falls.

R32's Resident Fall Risk form dated 12/6/22, indicated intermittent confusion, a history of one or two falls in the past three months, was ambulatory but incontinent, had a balance problem while standing, walking and required an assistive device. The form also indicated R32 took one or two medications that included antipsychotics, antianxiety agents,

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2 830	Continued From page 24 antidepressants, hypnotics, cardiovascular medications, diuretics, narcotic analgesics, neuroleptics, or other medications that caused lethargy or confusion, and had predisposing diseases. The form had a score of 19 indicating a high risk for falls. R32's Resident Fall Risk form dated 12/14/22, indicated disoriented at all times, had one to two falls in the past three months, was chair bound and required assist with elimination, had a balance problem with standing and walking. The form also indicated R32 took one or two medications that included antipsychotics, antianxiety agents, antidepressants, hypnotics, cardiovascular medications, diuretics, narcotic analgesics, neuroleptics, or other medications that caused lethargy or confusion, and had predisposing diseases. The form had a score of 13 indicating a high risk for falls. R32's Resident Fall Risk form dated 1/5/23 indicated R32 was alert, had one to two falls in the past three months, was ambulatory but incontinent, had gait problems. The form also indicated R32 took one or two medications that included antipsychotics, antianxiety agents, antidepressants, hypnotics, cardiovascular medications, diuretics, narcotic analgesics, neuroleptics, or other medications that caused lethargy or confusion, and had predisposing diseases. The form had a score of 12 indicating a high risk for falls. R32's Resident Fall Risk form dated 1/13/23 indicated R32 was alert, had a history of one to two falls in the past three months, was ambulatory and continent, and required an assistive device. The form also indicated R32 took one or two medications that included	2 830		

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2 830	Continued From page 25 antipsychotics, antianxiety agents, antidepressants, hypnotics, cardiovascular medications, diuretics, narcotic analgesics, neuroleptics, or other medications that caused lethargy or confusion, and had predisposing diseases. The form had a score of eight, indicating a moderate risk for falls. R32's nursing progress note dated 11/26/22, indicated R32 was found on the floor about 5:45 a.m. lying on left side and was trying to walk to the bathroom and fell. R32's Incident Audit Report form dated 11/26/22, indicated R32 was found on the floor in his room on his left side. He tried to walk to the bathroom and fell. Under the heading immediate action taken, R32 was assessed, rated pain a seven out of ten, was unable to raise his left arm, and was lifted up with two assist to the toilet and back to bed. The form indicated the type of injury was R32's left shoulder, predisposing factors included weakness, and under other information "diarrhea" was documented. R32's nursing progress note dated 11/27/22 at 10:45 p.m., indicated R32 had a fall the previous day and an x-ray had been ordered and further assessment indicated R32 was in "dire" pain guarding his arm screaming his arm was broken, 911 was called at 8:00 a.m. and R32 was sent to the hospital. R32's hospital discharge summary indicated R32 was hospitalized 11/27/22 through 12/3/22 for a humerus fracture (upper arm bone) and acute hypoxic respiratory failure. R32's Care Area Assessment Worksheet form dated 1/21/23, indicated an actual problem for	2 830		

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2 830	Continued From page 26	2 830		

Continued From page 26

falls and indicated R32 took antipsychotics, antidepressants, and hypnotics, had diagnoses related to his heart, and neuromuscular, and psychiatric or cognitive and the form indicated falls would be addressed in the care plan to slow or minimize decline.

R32's Toilet Use task form from 3/7/23 through 4/5/23 indicated R32 was mostly independent with toilet use, but required supervision on one occasion, limited assistance on six occasions, and extensive assistance on four occasions. The task indicated R32 did not refuse this task.

R32's Bladder Elimination task form from 3/7/23 through 4/5/23, indicated R32 was mostly continent, but had four episodes of incontinence. The task indicated R32 did not refuse this task.

During interview and observation on 4/5/23 at 8:10 a.m., R32 stated he still felt pain to his shoulder and stated staff don't remind him to use his call light, he sometimes pushes the call button and waits for hours.

During interview on 4/5/23 at 8:31 a.m., nursing assistant (NA)-A stated R32 does not allow you to take care of him adding he goes to the bathroom and is able to wipe and dress himself. NA-A stated R32 was only incontinent when he is ill.

During interview on 4/5/23 at 2:26 p.m., licensed practical nurse (LPN)-F stated when a resident falls they try to determine the cause and document in a risk management report.

During interview on 4/5/23 at 3:01 p.m., the assistant director of nursing (ADON) stated R32's fall risk assessment was completed in January and was categorized as a moderate risk for falls.

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2 830	Continued From page 27 ADON stated the interventions on R32's care plan were not specific to his prior fall and added that every fall has to have an intervention and be specific to the fall and R32 did not have specific interventions following his fall. ADON stated Associated Clinic of Psychology (ACP) spoke with resident 3/30/23 and mentioned R32 would benefit from more assist with his activities of daily living and expected interventions to be in place on the care plan to prevent falls. During interview on 4/6/23 at 10:11 a.m., the director of nursing (DON) stated R32 was at at risk for falls and stated fall prevention interventions for R32 would include to encourage the use of the walker, answer the call light, assist to toilet after meals, assure call light is in reach, and the walker should be within reach. DON added the interventions should be assumed, but could be on the care plan. A policy, Fall Risk Assessment dated 10/4/21 indicated the nursing staff, in conjunction with the attending physician, consultant pharmacist, therapy staff, and others, would seek to identify and document resident risk factors for falls and establish a resident-centered falls prevention plan based on relevant assessment information. A policy, Care Plans, Comprehensive Person-Centered dated 11/30/21, indicated the interdisciplinary team must review and update the care plan when the desired outcome is not met. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could review/revise policies and procedures related to falls, accidents and resident supervision to assure proper assessment and interventioins are being	2 830		

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2 830	Continued From page 28 implemented. They could re-educate staff on the policies and procedures. A system for evaluating and monitoring consistent implementation of these policies could be developed, with the results of these audits being brought to the facility's Quality Assurance Committee for review. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		
2 920	MN Rule 4658.0525 Subp. 6 B Rehab - ADLs Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that: B. a resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure routine personal hygiene (i.e., nail care) was completed and provided for 2 of 4 residents (R43, R50) reviewed for activities of daily living (ADLs) and who were dependent on staff for their care. Findings include: R43's significant change in status Minimum Data Set (MDS), dated 3/13/23, identified R43 had intact cognition, demonstrated no rejection of care behavior, and required extensive assistance from staff to complete personal hygiene. Further, the MDS identified R43 was not diabetic.	2 920	Corrected	5/12/23

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2 920	Continued From page 29	2 920		

R43's care plan, dated 3/20/23, identified R43 had ADL self care needs due to musculoskeletal impairment. The care plan listed several interventions for this including, "PERSONAL HYGIENE/ORAL CARE: The resident requires extensive assistance of 1." The care plan lacked any indication how often nail care would be attempted or provided, or if R43 had any preferences for their nails (i.e., longer or short).

On 4/3/23 at 11:38 a.m., R43 was observed seated in a wheelchair in his room. R43 had visibly long, some of them being several millimeters in length, fingernails present on both hands with black debris present under various ones. R43 was interviewed and expressed "clipping the nails hasn't happened in quite awhile," which R43 voiced had been "several weeks" at least. R43 stated they did not always agree to take their scheduled showers as their room was cold, however, reiterated they wanted their nails clipped adding, "Yes, I would." R43 stated they would have attempted to clip them on their own, however, they didn't have a clippers.

R43's completed Weekly Bath Audit 020919 - V2, dated 2/8/23, identified R43 received a shower. However, the audit lacked any information or indication if nail care had been offered, completed or attempted. R43's next completed Weekly Bath Audit 020919 - V2, dated 3/30/23, identified R43 received a bed bath. However, the audit lacked any information or indication if nail care had been offered, completed or attempted. There was no other completed weekly audits identified in the medical record between 2/8/23 and 3/30/23.

R43's progress note, dated 3/9/23, identified R43 refused their shower despite multiple attempts. However, the note lacked information on if nail

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2 920	Continued From page 30	2 920		

care was offered, attempted, or provided.

R43's progress note, dated 3/16/23, identified R43 had refused their bed bath as it was "too cold." R43 had no skin issues though, however, again, the note lacked information on if nail care was offered, attempted, or provided.

R43's progress note, dated 3/23/23 (nearly two weeks prior), identified, "Nails clipped and feet OK."

R43's medical record was reviewed and lacked evidence R43 had nail care attempted, offered, or provided since 3/23/23, despite having visibly long nails present and desiring them to be clipped.

On 4/5/23 at 8:29 a.m., nursing assistant (NA)-B was interviewed. NA-B explained R43's level of care seemed to "depends on his mood" as sometime they were able to care for themselves and other times not. NA-B stated R43 was typically accepting of care offered, and expressed R43 had a scheduled bath for every Thursday according to the posted bath schedule. NA-B stated nail care could be completed on the scheduled bath day or "if you see it [needs to be]" but added such was "just my opinion." NA-B then observed R43's nails at the surveyors request and verified they were long and soiled adding, "We can get them clipped down a little bit." Further, NA-B stated any attempts to complete nail care, including a refusal, should be recorded in the medical record.

When interviewed on 4/5/23 at 10:42 a.m., licensed practical nurse (LPN)-C stated nail care should be completed on a weekly basis during the assigned "shower day." LPN-C observed

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2 920	Continued From page 31	2 920		

R43's nails and verified their length adding they "should be trimmed." LPN-C stated R43 was not diabetic and, as a result, the NA(s) could clip them and document such action in the "POC charting." LPN-C verified any attempt, including a refusal, should be documented.

R50's annual MDS, dated 2/17/23, identified R50 and unclear speech and required extensive assistance with ADL(s). However, the section to record R50's cognition (i.e., BIMS) was left blank and not completed.

R50's care plan, dated 3/20/23, identified R50 had an ADL self-care deficit and listed several interventions including, "PERSONAL HYGIENE/ORAL CARE: dependent ax1 [assist of one]." The care plan lacked any indication how often nail care would be attempted or provided, or if R43 had any preferences for their nails (i.e., longer or short).

R50's progress note, dated 3/23/23, identified, "Nail and toes trimmed. Skin is good."

On 4/3/23 at 10:45 a.m., R50 was observed laying in bed while in his room. R50 did not verbally respond to the surveyor' questions, however, would smile at times. R50 had visibly long fingernails present on both hands with several nails having a black debris present under the nail bed. Later, on 4/3/23 at 1:21 p.m., R50 continued to have long fingernails with the black-colored debris present underneath several of them.

R50's most recent Weekly Bath Audit 020919 - V2, dated 4/3/23, identified R50 had a bed bath completed and R50 was not resistive. However,

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2 920	Continued From page 32 the audit lacked any information or indication if nail care had been offered, completed or attempted despite R50 having visibly long fingernails observed on the same day (4/3/23). On 4/5/23 (two days later) at 8:23 a.m., R50 was again observed laying in bed while in his room. R50 continued to have visibly long fingernails present on both hands with the same black-colored debris present under several of the nail beds. R50 remained non-verbal and unable to answer questions when asked. R50's medical record was reviewed and lacked evidence R50 had nail care attempted, offered, or provided since 3/23/23, despite having visibly long nails present and evidence of bathing being completed on 4/3/23. On 4/5/23 at 9:53 a.m., nursing assistant (NA)-A was interviewed. NA-A explained R50 was totally dependent on staff for care and cares for them, including bathing, were "not that hard." NA-A stated they had noticed R50's fingernails were long "a month ago or so" so they clipped them, however, was not sure when it was last done since. NA-A observed R50's nails and verified their length and condition. NA-A stated R50's nails should be cleaned and clipped when staff "see they're longer," adding when they had clipped them last time (about a month prior) the nails then were even "way longer than this." NA-A expressed they had noticed some cares, including nail care, not be completed recently and reiterated R50's nails should have been clipped as R50 will scratch at himself at times. Further, NA-A stated any nail care completed, or attempted, should have been recorded in the medical record.	2 920		

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2 920	Continued From page 33 On 4/5/23 at 1:20 p.m., the assistant director of nursing (ADON) was interviewed and explained nail care should be completed on a weekly basis with the scheduled bathing. ADON stated they had noticed a few weeks ago the nails "are a problem" for several residents and, as a result, they used an extra nurse to clip them which explained the progress notes on 3/23/23 for R43 and R50. ADON stated "going forward" the nail care would be closer reviewed on the completed bath audits to ensure it was done and documented. A provided Fingernails/Toenails, Care of policy, dated 2/2022, identified nail care included daily cleaning and regular trimming. The policy outlined, "Proper nail care can aid in the prevention of skin problems around the nail bed," and, "Trimmed and smooth nails prevent the resident from accidentally scratching and injuring his or her skin." A procedure of how to complete nail care was provided, and the policy directed the provided nail care should be recorded in the medical record, including if it was refused despite being offered/attempted. SUGGESTED METHOD OF CORRECTION: The director of nursing, or designee, could review applicable policies on personal hygiene care (i.e., nail care) to ensure completed on a ongoing, routine basis; then inservice appropriate staff and audit to ensure ongoing compliance. TIME FRAME FOR CORRECTION: Twenty-one (21) Days	2 920		
21095	MN Rule 4658.0650 Subp. 4 Food Supplies; Storage of Nonperishable food	21095		5/12/23

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21095	Continued From page 34 Subp. 4. Storage of nonperishable food. Containers of nonperishable food must be stored a minimum of six inches above the floor in a manner that protects the food from splash and other contamination, and that permits easy cleaning of the storage area. Containers may be stored on equipment such as dollies, racks, or pallets, provided the equipment is easily movable and constructed to allow for easy cleaning. Nonperishable food and containers of nonperishable food must not be stored under exposed or unprotected sewer lines or similar sources of potential contamination. The storage of nonperishable food in toilet rooms or vestibules is prohibited. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure opened food in the walk-in cooler were labeled or dated to ensure expired food was not served which had the ability to effect 57 of 58 residents due to R47 being strictly tube fed. Findings include: During observation on the initial kitchen tour and interview on 4/3/23 at 7:01 a.m., multiple open foods were undated in the walk-in cooler These included cheese slices, cottage cheese, liquid eggs, and staff personal food items. The dietary manager confirmed these items were undated and the expectation was all open food be dated and tossed out after 7 days. During interview on 4/6/23 at 9:12 a.m., dietary aide (DA)-B states that the walk-in cooler with the	21095	Corrected	

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21095	Continued From page 35 undated food was the "dairy" cooler which fed all of the residents and stated, "this is where all the food comes from." DA-B stated the expectation is for all food to be dated as soon as it is open and disposed of seven day after opening. DA-B further stated food should be disposed of if it is not dated to avoid serving expired food. During observation and interview on 4/6/23 at 4:45 p.m., the unit refrigerator on the first floor had opened, undated food which included meat and cheese sandwiches, cheese slices, grapes, milk, and lemonade. A sign on the refrigerator door indicated all staff should label and date food so expired food could be disposed. Registered nurse (RN)-C confirmed the refrigerator was used to hold food for the residents. A policy titled Food Safety and Sanitation, dated 2017, indicated when a food package is opened, the food item should be dated to determine when the food should be discarded. SUGGESTED METHOD OF CORRECTION: The dietary director could review and revise food storage policies and procedures. They could provide education to appropriate staff and develop a monitoring system to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21095		
21330	MN Rule 4658.0725 Subp. 2 A&B Providing Routine & Emergency Oral Health Ser Subp. 2. Annual dental visit. A. Within 90 days after admission, a resident	21330		5/12/23

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21330	Continued From page 36 must be referred for an initial dental examination unless the resident has received a dental examination within the six months before admission. B. After the initial dental examination, a nursing home must ask the resident if the resident wants to see a dentist and then provide any necessary help to make the appointment, on at least an annual basis. This opportunity for an annual dental checkup must be provided within one year from the date of the initial dental examination or within one year from the date of the examination done within the six months before admission. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure the need for dental services, and subsequent referral for such services, was acted upon, assessed, and provided for 1 of 1 resident (R33) observed to have several missing teeth and difficulty chewing. Findings include: R33's annual Minimum Data Set (MDS), dated 2/11/23, identified R33 had severe cognitive impairment, demonstrated no rejection of care behaviors during the review period, and required supervision for personal hygiene cares (i.e., brushing teeth). Further, the MDS outlined R33 was not edentulous (lacking teeth) and had no obvious broken teeth or cavities present. In addition, R33's Census listing, printed 4/6/23, identified R33's payer source as, "Minnesota Medicaid," effective June 2022.	21330	Corrected	

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21330	Continued From page 37 R33's care plan, dated 3/23/23, identified R33 had an oral and/or dental health and listed, "Poor oral hygiene." The care plan listed multiple goals for R33 including remaining free of infection, pain, or oral bleeding; along with several interventions including administering medications as ordered, coordinating dental care appointments or transportation, and providing mouth care. The care plan lacked evidence when, or if, R33 had last been evaluated by a dentist or if they declined such services. On 4/3/23 at 10:54 a.m., a telephone interview was completed with R33's family member (FM)-B. FM-B explained they had not been able to visit R33 at the nursing home for a "few years" now due to travel limitations; however, expressed they had not been told or updated with any current concerns about R33 or his care needs. On 4/4/23 at 8:11 a.m., R33 was observed seated in their wheelchair in the commons area of the dining room. R33 had nearly constant drooling onto their shirt and, when they opened their mouth to smile at others, had numerous, visible missing teeth on the upper palate. R33's most recent HDG (Health Dimension Group) SNF - Dental/Oral Data Collection Tool, dated 9/16/21, identified R33 had their own teeth with none broken, loose or decaying. R33 was recorded as having no issues with their gums or bleeding along with dictation reading, " ... complete set up for oral cares and supervision or will not do." Further, the tool provided a section to ask if a dental visit was requested which was answered, "No." However, R33's most recent Quarterly Resident Review, dated 2/10/23, identified a section	21330		

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21330	Continued From page 38 labeled, "Oral Status," which outlined R33 had their own teeth and no cavities were listed. The review outlined R33 had no oral pain, however, a questioned asked, "Any chewing difficulties[?]," which was answered, "Yes." The review lacked spacing or dictation to outline when, if ever, R33's last dental appointment was or if it was currently needed or desired. When interviewed on 4/5/23 at 9:49 a.m., nursing assistant (NA)-A verified R33 had numerous missing teeth and nearly constant drooling. NA-A stated R33 "barely talks" and was not always receptive to care or staff attempting to provide cares to him. NA-A explained they were unsure when, if ever, R33 had been offered or seen by a dental provider for the missing teeth and expressed they did not believe R33 would allow such a visit to occur. However, NA-A stated they had noticed R33 did have evident trouble with chewing lately and eating now "takes him awhile" even with a pureed diet being served. R33's medical record was reviewed and lacked evidence R33 had been offered, refused, and/or seen by a dental provider in the past year despite having visibly missing teeth and being identified as having trouble chewing on the completed evaluation (dated 2/10/23) and direct care staff. On 4/6/23 at 7:55 a.m., R33 was again observed seated in the dining room at a table. R33 was served their breakfast meal which consisted of pureed pancakes, pureed sausage, and hot cereal in a bowl. R33 continued to have near-constant drooling on themselves as they ate their meal. Further, R33 had a visible gulping motion as they chewed the provided meal. R33 did not answer questions when asked; however, at 8:05 a.m. and at the request of the surveyor,	21330		

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NA-A approached and questioned R33 on if they would be willing to see a dentist to help address their teeth. R33 was agreeable.

When interviewed on 4/6/23 at 9:46 a.m., the assistant director of nursing (ADON) explained dental care needs, including the needs for dental appointments, should be reviewed on a quarterly basis and recorded in the medical record. ADON explained the facility was going to work on starting a "new IDT [interdisciplinary team] process" to ensure appointments would get scheduled and coordinated going forward. During subsequent interview, on 4/6/23 at 1:06 p.m., ADON verified R33's medical record lacked evidence the need for a dental visit had been assessed, offered or provided within the past year and explained such services should have been coordinated when issues (i.e., difficulty chewing) were identified. ADON stated it was important to ensure dental care visits were offered and completed for residents, including R33, to help prevent tooth infections and potential oral pain.

A facility' policy on dental evaluations and appointments was requested, however, none was received.

SUGGESTED METHOD OF CORRECTION: The director of nursing, or designee, could review applicable policies on dental assessment and, if needed, appointment coordination to ensure timely and thorough completion; then inservice appropriate staff and audit to ensure ongoing compliance.

TIME FRAME FOR CORRECTION: Twenty-one (21) Days

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21475	Continued From page 40	21475		
21475	MN Rule 4658.1005 Subp. 1 Social Services: General Requirements Subpart 1. General requirements. A nursing home must have an organized social services department or program to provide medically related social services to each resident. A nursing home must make referrals to or collaborate with outside resources for a resident who is in need of additional mental health, substance abuse, or financial services. This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to submit a MAARC (Minnesota adult abuse reporting center) report for one of one resident (R60) who discharged against medical advice (AMA). Findings include: R60's discharge Minimum Data Set (MDS) dated 1/23/23, indicated moderately impaired cognition, required limited assist with bed mobility, and was unsteady. R60's Medical Diagnosis form in the electronic medical record (EMR) indicated R60 had the following diagnoses: sepsis (generalized systemic infection) due to escherichia coli (bacteria found in the digestive tract), alcohol dependence, gastritis (inflamation of the stomach), alcohol use unspecified with withdrawal uncomplicated, anxiety, and SARS-associated coronavirus. R60's nursing progress note dated 1/21/23, indicated R60 was admitted to the facility with	21475	Corrected	5/12/23

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21475	Continued From page 41 acute confusion, urinary tract infection, and post COVID-19. R60's nursing progress notes dated 1/23/23, indicated R60 planned to discharge home as soon as possible and was at high risk for falling. R60 left AMA on 1/23/23. The note indicated a MAARC report would be filed. Attempted to call R60 on 4/5/23 at 8:42 a.m., listed contact number called was unreachable. During interview on 4/5/23 at 8:46 a.m., the director of nursing (DON) stated MAARC reports were completed depending on a resident's cognition and risk to themselves or whether family could help. The report was required if a resident was considered more vulnerable. During interview on 4/5/23 at 9:54 a.m., DON stated the MAARC was supposed to be filed and stated it was important to complete because R60 had moderate cognitive impairment and also had an alcohol problem and did not have a copy of a MAARC report filed for R60. On 4/5/23 at 10:07 a.m., Aspen Complaints/Incident Tracking System (ACTS) was reviewed and there was no record of a MAARC report filed. A policy, Transfer or Discharge, Preparing a Resident for Dated 1/25/23, was provided, but lacked information regarding when a resident leaves AMA. SUGGESTED METHOD OF CORRECTION: The administrator, or designee, could review applicable policies and procedures to ensure	21475		

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21475	Continued From page 42 timely review and coordination of outside consultation services for vulnerable adults; then educate staff and audit to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21475		
21530	MN Rule 4658.1310 A.B.C Drug Regimen Review A. The drug regimen of each resident must be reviewed at least monthly by a pharmacist currently licensed by the Board of Pharmacy. This review must be done in accordance with Appendix N of the State Operations Manual, Surveyor Procedures for Pharmaceutical Service Requirements in Long-Term Care, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system. It is not subject to frequent change. B. The pharmacist must report any irregularities to the director of nursing services and the attending physician, and these reports must be acted upon by the time of the next physician visit, or sooner, if indicated by the pharmacist. For purposes of this part, "acted upon" means the acceptance or rejection of the report and the signing or initialing by the director of nursing services and the attending physician. C. If the attending physician does not concur with the pharmacist's recommendation, or does not provide adequate justification, and the pharmacist believes the resident's quality of life is being adversely affected, the pharmacist must refer the matter to the medical director for review if the medical director is not the attending physician. If the medical director determines that	21530		5/12/23

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21530	Continued From page 43 the attending physician does not have adequate justification for the order and if the attending physician does not change the order, the matter must be referred for review to the quality assessment and assurance committee required by part 4658.0070. If the attending physician is the medical director, the consulting pharmacist must refer the matter directly to the quality assessment and assurance committee. This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to ensure consultant pharmacist recommendations were evaluated and addressed by the attending physician for 2 of 2 residents (R4, R32) whose diagnoses were inappropriate for the use of their antipsychotic medications. Findings include: R4's significant change Minimum Data Set (MDS) dated 12/30/22, lacked a cognitive assessment for R4. The MDS indicated R4 required extensive assistance for all activities of daily living (ADLs). R4's Care Area Assessment (CAA) dated 12/30/22, indicated R4 triggered for psychotropic drug use. R4's quarterly MDS dated 10/28/22, indicated R4 had mild cognitive deficits. R4's electronic medical record (EMR) indicated R4 had diagnoses including Parkinson's disease, a stroke resulting in cognitive dysfunction, dysphagia (difficulty swallowing), dementia without behavioral disturbance, major depressive disorder, and anxiety. R4's EMR lacked indication	21530	Corrected	

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R4 had a diagnosis of schizophrenia.

R4's provider orders dated 2/2/23, indicated R4 took 0.75 milligrams (mg) of risperidone (an antipsychotic) at bedtime for schizophrenia.

R4's Consultant Pharmacist Recommendation to Physician dated 9/19/22, indicated to clarify/confirm the appropriate diagnosis for R4's prescribed risperidone.

During an interview on 4/6/23 at 4:06 p.m., the director of nursing (DON) verified schizophrenia was not included in R4's diagnoses and did not know why it was listed as a reason for R4's risperidone order.

During an interview on 4/10/23 at 11:01 a.m., pharmacy consultant (PH) stated she submitted a recommendation to the facility regarding R4's inaccurate schizophrenia diagnosis on 9/19/22, but did not recall receiving a response from the facility and would check her emails.

Review of an email correspondence from the PH dated 4/10/23, indicated the PH had not received an email indicating the facility had responded to her 9/19/22, recommendation regarding R4's schizophrenia diagnosis for risperidone and would resubmit another recommendation for clarification.

R32's quarterly Minimum Data Set (MDS) dated 11/7/22, indicated intact cognition and required extensive assist with transferring, bed mobility, toileting, and hygiene, occasionally had bladder incontinence, and did not reject cares.

R32's Admission Record form in the electronic medical record (EMR) indicated R32 was his own

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21530	Continued From page 45 representative. R32's Medical Diagnosis form in the electronic medical record (EMR) indicated R32 had the following diagnosis: anxiety disorder unspecified and depression unspecified. R32's physician orders indicated on 2/10/23, quetiapine fumarate (an antipsychotic medication) 12.5 milligrams (mg) by mouth twice daily for 90 days with a stop date of 5/11/23 for agitation. R32's pharmacy recommendation 2/23/23, signed 2/24/23, indicated R32 received quetiapine for a diagnosis of agitation which was not considered an appropriate indication for antipsychotic use and requested a clarification or confirmation of the appropriate diagnosis. The nurse practitioner (NP) replied to the recommendation 2/24/23, "This is currently being tapered." During observation 4/5/23 at 8:10 a.m., R32 was in his room and had a visitor. He was not agitated. During interview on 4/6/23 at 10:11 a.m., the director of nursing stated she was in charge of the pharmacy recommendations and sends any recommendations that require a provider response to the NP to complete. Once the NP completes the recommendation, she gives them back to the DON and DON updates the information in the computer. DON verified NP-C never provided an appropriate diagnosis for use of the quetiapine and stated it was important to have an appropriate diagnosis in order to see why R32 was using the medication and added the NP should be providing the diagnosis. During interview on 4/6/23 at 12:39 p.m., the	21530		

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pharmacist consultant (PH) stated she expected a diagnosis for an antipsychotic to be documented in the chart even if the medication was being tapered because there were numerous potential adverse effects and there needed to be a way to alert care providers if the medication was indicated. She added staff could monitor the behaviors and if they saw symptoms improving, could reach out if the resident no longer needed the medication. PH added sometimes the providers need education why the appropriate diagnosis is necessary and it should have been communicated with the doctor because the medication was ordered for an additional three months.

A policy, Antipsychotic Medication Use, dated 7/13/22, indicated diagnosis of a condition for which antipsychotics are necessary will be based on a comprehensive assessment of the residents. The policy also
indicated antipsychotic medications shall generally be used only for the following conditions/diagnoses as documented in the record, consistent with the definitions in the diagnostic and statistical manual of mental disorders: schizophrenia, schizoaffective disorder, schizophreniform disorder, delusional disorder, mood disorders such as bipolar disorder, depression with psychotic features, and treatment refractory major depression, psychosis in the absence of dementia, Tourette's disorder, Huntington's disease, hiccups, or nausea and vomiting associated with cancer or chemotherapy.

A facility policy regarding pharmacy recommendations was not received.

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21530	Continued From page 47 SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee and the consulting pharmacist should develop and/or revise policies to monitor medications to ensure recommendations are acted upon. The director of nursing (DON) or designee and the consulting pharmacist should educate physicians and staff on the importance of ensuring recommendations are acted upon. Audits should be developed to monitor timeliness of action from physician, using appropriate timeframes for a specific and measurable amount of time. The DON and/or designee should take those findings/education to the Quality Assurance Performance Improvement (QAPI) committee to determine compliance or the need for further monitoring. TIME PERIOD FOR CORRECTION: Twenty-one 21 days.	21530		
21535	MN Rule4658.1315 Subp.1 ABCD Unnecessary Drug Usage; General Subpart 1. General. A resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used: A. in excessive dose, including duplicate drug therapy; B. for excessive duration; C. without adequate indications for its use; or D. in the presence of adverse consequences which indicate the dose should be reduced or discontinued. In addition to the drug regimen review required in part 4658.1310, the nursing home must comply with provisions in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (1) found in Appendix P of the State Operations Manual, Guidance to Surveyors for	21535		5/12/23

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21535	Continued From page 48 Long-Term Care Facilities, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system and the State Law Library. It is not subject to frequent change. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure appropriate side-effect monitoring (i.e., orthostatic blood pressures) was completed in accordance with physician orders and standard of care to reduce the risk of complication (i.e., falls) with consumed antipsychotic medication for 1 of 5 residents (R33) reviewed for unnecessary medication use. Findings include: A National Library of Medicine (NIH) Management of Commons Adverse Effects of Antipsychotic Medication article, dated 9/2018, identified the elderly were at risk of adverse effects (i.e., falls) of antipsychotic medication. The article outlined, "All antipsychotics carry some risk of orthostatic hypotension ... [which can] lead to dizziness, syncope, falls ... it should be evaluated by both history and measurement ... Risk factors include systemic diseases causing autonomic instability (e.g., diabetes, alcohol dependence, Parkinson's disease), dehydration, drug-drug interactions, and age." R33's annual Minimum Data Set (MDS), dated 2/11/23, identified R33 had severe cognitive impairment, demonstrated no rejection of care behavior(s), and was independent with	21535	Corrected	

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21535	Continued From page 49 ambulation and required supervision with transfers. Further, the MDS outlined R33 consumed antipsychotic medication on a daily basis during the review period. R33's signed Order Summary Report, dated 2/27/23, identified R33's current physician ordered medications and treatments at the nursing home. This included orders for hydrocortisone 2.5 milligrams (mg) twice daily and lisinopril 10 mg daily for high blood pressure, and an order for olanzapine (an antipsychotic medication) 2.5 milligrams (mg) by mouth daily for unspecified dementia with behavioral disturbance. Further, the summary listed an order which read, "Monitor monthly orthostatic BP [blood pressure] ... for antipsychotic," with a start date listed as 8/15/21. R33's care plan, dated 12/2022, identified R33 consumed psychotropic medications and listed several goals for care including, " ... will be/remain free of psychotropic drug related complications ... through review date." The care plan listed several interventions to help R33 meet this goal including consulting with pharmacy on a quarterly basis, administering the medication as ordered, and, "Monitor for side effects and effectiveness Q-SHIFT [every shift]." R33's Blood Pressure Summary, printed 4/6/23, identified R33's collected blood pressures for the past several months. However, the summary lacked evidence R33's orthostatic blood pressures had been collected or assessed in the past several months. R33's Medication Administration Record (MAR), dated 4/2023, identified the order for olanzapine and recorded R33 received the medication, as	21535		

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ordered, on a daily basis. However, the MAR and Treatment Administration Record (TAR) both lacked evidence of an order for R33's orthostatic blood pressure to demonstrate it had been evaluated, assessed or completed. Further, R33's medical record was reviewed and lacked evidence R33's orthostatic blood pressures were being collected, assessed, or evaluated on a monthly basis as ordered by the physician in 2021.

On 4/5/23 at 9:49 a.m., nursing assistant (NA)-A was interviewed. NA-A explained R33 "barely talks" to others and, at times, could become "very angry" with staff and other residents. NA-A stated R33 was able to self transfer out of their wheelchair and often did so even, at times, walking on their own. Further, NA-A stated R33 had not sustained any recent falls to their knowledge, and R33 had not, at least to them, reported ever being light-headed or dizzy when standing but reiterated R33 had little verbal communication with staff.

When interviewed on 4/6/23 at 1:08 p.m., the assistant director of nursing (ADON) stated they had reviewed R33's medical record and were unable to locate evidence R33's orthostatic blood pressures had been attempted, completed, or evaluated on a monthly basis. ADON explained the blood pressures should have been completed and recorded in the Blood Pressure Summary but added, "I don't see that." ADON stated if the blood pressures were refused, such information should also have been recorded in the medical record or care planned. Further, ADON expressed it was important to ensure monthly orthostatic blood pressures were done to help evaluate if R33 was able to "safely transfer himself" and to ensure there was no medication

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21535	Continued From page 51 side effects. A provided Antipsychotic Medication Use policy, dated 7/2022, identified residents would only receive the medication when needed to treat specific conditions for which indicated and effective. The policy included, "Nursing staff shall monitor for and report any of the following side effects and adverse consequences of antipsychotic medications ... Cardiovascular: orthostatic hypotension, arrhythmias ... ". SUGGESTED METHOD OF CORRECTION: The director of nursing, or designee, could review applicable policies on medication management and side effect montioring; then then inservice appropriate staff and audit to ensure ongoing compliance. TIME FRAME FOR CORRECTION: Twenty-one (21) Days	21535		
21610	MN Rule 4658.1340 Subp. 1 Medicine Cabinet and Preparation Area;Storage Subpart 1. Storage of drugs. A nursing home must store all drugs in locked compartments under proper temperature controls, and permit only authorized nursing personnel to have access to the keys. This MN Requirement is not met as evidenced by: Based on observation and interview, the facility failed to ensure medications were securely stored, permitting only authorized personnel to have access to medications. This had the potential to affect all residents, visitors and staff	21610	Corrected	5/12/23

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with access to the conference room.

Findings include:

During observation on 4/3/23 at 8:40 a.m., the facility's conference room was made available to surveyors for the annual survey. On entrance to the conference room an opened cardboard box was observed containing 19 cards of medications with 4 to 30 tablets each which was placed on top of medical supplies and equipment against the wall. These medication cards were accessible to all individuals (staff, visitors, and residents) capable of entering the unlocked conference room located near the main entrance to the building.

The observed medications belonged to two residents. One card belonged to a current resident, R265. The card contained six capsules of Gabapentin(treats nerve pain) 600 milligrams (mg). The other 18 cards belonged to a discharged resident, R6. R6's medications were as follows: four capsules of Gabapentin 100 mg, eight tablets of Tamsulosin(enlarged prostate), 0.4 mg, 30 tablets of Metoclopramide(treats nausea and vomiting) 5 mg, 17 Triphcaps(vitamin supplement), 29 tablets of Meclizine(medication for motion sickness) 12.5 mg, 30 tablets of Sucralfate(treats ulcers) 1 mg, seven capsules of Carvedilol(lowers blood pressure) 6.25 mg, ten tablets of Folic Acid (vitamin) 1 mg, 12 tablets of Cetirizine (allergy relief) 10 mg, five capsules of Pantoprazole (damaged esophagus) 40 mg, nine tablets of Montelukast (anti-inflammatory) 10 mg, nine tablets of Atorvastatin(cholesterol lowering medication) 80 mg, 12 tablets of Midodrine(high blood pressure/dizziness), 23 tablets of Sertraline (depression) 100 mg and four cards for a total of 100 tablets of GNP gas relief 80 mg.

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When interviewed on 4/5/23 at 11 a.m., registered nurse (RN)-C indicated discontinued medications or medications belonging to all discharged residents were to be removed from the medication cart and given to the managers or the director of nursing to dispose of.

When interviewed on 4/5/23 at 9:30 a.m., licensed practical nurse (LPN)-A stated, when residents are discharged or if the resident expired, medications are left in the medication carts and the director of nursing (DON) , or the assistant director of nurses (ADON) disposes of the medications. In addition, (LPN)-A stated, "Medications need to be locked".

When interviewed on 4/5/23 at 10:45 a.m., DON stated any medications removed from the medication carts should be brought to her or to ADON to be safely discarded. The DON indicated the medications needed to be locked up for destruction and it was not acceptable to leave any medications in the conference room.

Facility policy titled Storage of Medications reviewed 12/3/21, indicated "Drugs and biologicals used in the facility are stored in locked compartments under proper temperature, light and humidity control. Only authorized to prepare and administer medications have access to locked medications".

The policy and procedure titled Discarding and Destroying Medications reviewed 12/13/21, indicated medications will be disposed of in accordance with federal, state and local regulations governing management of non-hazardous pharmaceuticals, hazardous waste and controlled substances.

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21610	Continued From page 54 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 to the importance of properly securing medications. The DON or designee, along with the pharmacist, could conduct audits on a regular basis to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21610		
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: Based on observation, interview, and document review, the facility failed to ensure soiled and potentially contaminated laundry was bagged, collected, and transported in a manner to reduce the risk of cross-contamination and subsequent infection spread. These findings had potential to affect all 58 residents residing in the nursing home.	21675	Corrected	5/12/23

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Findings include:

On 4/3/23 at 7:05 a.m., a laundry tour was completed with laundry aide (LA)-A present. A closed doorway on the main level of the nursing home labeled, "Stairs/Service Area," was opened where LA-A explained soiled laundry was brought to by the nursing assistant (NA) staff the evening prior. Inside this corridor, a yellow-colored, open-top, mobile bin was present which had two closed bags inside mixed with other various, loose resident' personal clothing items including socks, pants, and shirts. LA-A verified the items were soiled inside the mobile bin and they had not yet handled or touched the items thus far that day. LA-A stated the loose items should have been bagged as they were soiled adding clothing was "usually but not always [bagged]."

On 4/6/23 at 8:50 a.m., a subsequent laundry tour was completed, and inside the same area marked, "Stairs/Service Area," were now three yellow-colored, open-top, mobile bins labeled, "2 West," and, "2 Center," and, "1 East," respectively. These bins were inspected and, again, inside each bin were loose, non-bagged personal resident laundry items including socks, shirts, pants, and visible blue-colored mechanical lift harnesses. LA-A reviewed these bins with the surveyor and verified the items were soiled (i.e., dirty) and had not been handled or touched by them yet. LA-A stated the items, again, should have been bagged at the point of soiling and transported in the mobile bins while bagged and not loose and co-mingled with other resident items. LA-A explained the bins had been brought down last evening by the NA staff and the laundry not being bagged happened "quite often." Further, LA-A stated they had reported this

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happening to the administrator who voiced they would "talk to them [staff]" about it. LA-A stated laundry should be bagged and not transported loose and with other resident items for "infection control" purposes.

When interviewed on 4/6/23 at 9:52 a.m., the assistant director of nursing (ADON) explained they were the acting infection preventionist (IP), and soiled items should be bagged before being transported outside of the resident rooms and transported to the "yellow laundry bins." ADON stated the nursing home only laundered personal clothing items and verified items should be bagged for "infection control" reasons and to avoid staff potentially carrying soiled items with their hands "down the hallway" to the bins. ADON expressed the items being transported loose and not bagged was laundry "not done correctly," and they were unaware such practice was happening.

On 4/6/23 at 10:40 a.m., the administrator was interviewed. He explained he was aware staff had been disposing of various linens in the trash or "wrong bin," however, was unaware staff were transporting loose laundry items in the mobile bins. He added, "I didn't realize it was an issue." The administrator stated they had not been doing any audits of such, however, would start now after being told of the issue. Further, the administrator verified soiled laundry items should be bagged at the contamination point and transported accordingly as a resident could have "something contagious" and they "don't want it to spread" to other residents or the laundry staff. He added, "We want to limit the spread of infections as best we can."

A provided Laundry and Bedding, Soiled policy, dated 1/2022, identified soiled laundry was to be

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21675	Continued From page 57 handled, transported and processed according to best practices for infection prevention and control. The policy outlined, "All used laundry is handled as potentially contaminated until it is properly bagged and labeled for appropriate processing." This included, "Laundry that is contaminated with blood or body substances is placed in leak-proof bags or containers," and, "Contaminated laundry is placed in a bag or container at the location where it is used and not sorted or rinsed at the location of use." SUGGESTED METHOD OF CORRECTION: The administrator, or designee, could review applicable policies on linen handling and transportation to ensure accuracy; then then inservice appropriate staff and audit to ensure ongoing compliance. TIME FRAME FOR CORRECTION: Twenty-one (21) Days	21675		
21695	MN Rule 4658.1415 Subp. 4 Plant Housekeeping, Operation, & Maintenance Subp. 4. Housekeeping. A nursing home must provide housekeeping and maintenance services necessary to maintain a clean, orderly, and comfortable interior, including walls, floors, ceilings, registers, fixtures, equipment, lighting, and furnishings. This MN Requirement is not met as evidenced by: Based on interview, observation, and document review, the facility failed to ensure a home-like environment was provided for rooms that were	21695	Corrected	5/12/23

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21695	Continued From page 58 free of odors for 1 of 1 resident (R39) and room vents were maintained in a clean manner and sound levels were at a comfortable level due to call light system for 1 of 1 resident (R50). Findings include: R39's clinical resident profile in the electronic medical record (EMR) indicated R39 was their own representative. R39's progress note dated 2/10/23, indicated a BIMS score of 15 (cognitively intact). During interview and observation on 4/5/23 at 12:15 p.m., R39 stated staff and residents constantly smoke outside his bedroom window and yelled at them not to smoke. R39 added he could not stand the smell from the cigarettes that came in to his room from the window. The ground outside R39's window was covered with cigarette butts. R39 stated the admission brochure indicated people were supposed to smoke in designated areas and the second hand smoke should not bother other residents and added someone was smoking outside his window last night. During interview on 4/5/23 at 12:32 p.m., the director of nursing (DON) stated staff and residents were supposed to smoke in the front of the building in the gazebo. DON verified there were cigarette butts all over the ground and the smell could go in R39's window and added her expectation was staff should redirect people to the front of the building. R50's annual Minimum Data Set (MDS) dated 2/17/23, indicated a diagnosis of hemiplegia (paralysis on one side of the body) and	21695		

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hemiparesis (weakness on one side of the body) following cerebral infarction (stroke) affecting the right side, and had adequate hearing.

R50's nursing progress notes dated 3/20/23, indicated R50 was able to shake his head yes or no during interview.

R50's care plan dated 8/21/22, indicated R50 had expressive aphasia (a condition where a person can comprehend speech, but has difficulty speaking) and interventions included: ask yes or no questions if appropriate, and allow adequate time to respond.

During interview and observation on 4/3/23 at 10:45 a.m., R50 was laying in bed in his room and the call light display outside had audible beeps. R50 nodded yes when asked if the sound bothered him. The white colored ventilation duct above the doorway contained a visible black debris.

During interview and observation on 4/5/23 at 11:45 a.m. R50 was in bed smiling and nodded head yes when asked if the call light system noise bothered him. The ventilation duct contained black debris.

During interview and observation on 4/5/23 at 12:07 p.m., licensed practical nurse (LPN)-C stated the call light system noise could be annoying if it kept going off and observed the black debris on the ventilation duct adding she thought it was dust and looked like it had been there a while. LPN-C asked R50 if the call light system bothered him and R50 nodded head indicating yes. LPN-C asked R50 if he could still hear the noise if the door was closed and R50 again nodded head indicating yes. LPN-C stated

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21695	Continued From page 60 maybe the call light system could be moved and added it would be easier to see if it was closer to the nursing station. During interview on 4/5/23 at 1:08 p.m., the maintenance director (MD)-I indicated the ventilation on the ceilings were cleaned every three to four months. MD-I produced documentation R50's ventilation duct was cleaned 7/28/22, and stated the ducts were also cleaned in December, but did not have documentation to verify ventilation ducts were cleaned. During interview on 4/6/23 at 10:57 a.m., the administrator stated he expected documentation when ventilation ducts were cleaned, verified he would have to look at the call light system, and expected staff and residents to smoke under the pavilion. A policy, Homelike Environment dated 12/8/21, indicated residents were provided a safe, clean, comfortable and homelike environment and encouraged to use their personal belongings to the extent possible. The facility staff and management maximized, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. These characteristics include: comfortable sound levels, pleasant neutral scents, and a clean, sanitary and orderly environment. A policy, Resident Smoking Policy dated 7/1/22, indicated the goal of the policy was to allow residents to safely smoke while ensuring non-smoking residents were able to be free from second-hand smoke. The designated smoking area is the gazebo in the front of the building, located outside the main entrance.	21695		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00494	A. BUILDING: ______ B. WING ______	C 04/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLAND OPERATIONS LLC	**2319 WEST SEVENTH STREET SAINT PAUL, MN 55116**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21695	Continued From page 61 SUGGESTED METHOD OF CORRECTION: The administrator could ensure the facility has an adequate system for ensuring smoking is conducted in designated locations, so odors from cigarettes doesn't affect other residents. Facility audits could be conducted to ensure compliance, and the results could be reviewed by the quality committee. The maintenance director could maintain records of cleaning ventilation systems. Facility audits could be conducted to ensure clean ventilation. The director of nursing or designee could assess residents near call system to meet the needs of residents who are bothered by the noise of the call light system. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21695		
21830	MN St. Statute 144.651 Subd. 10 Patients & Residents of HC Fac.Bill of Rights Subd. 10. Participation in planning treatment; notification of family members. (a) Residents shall have the right to participate in the planning of their health care. This right includes the opportunity to discuss treatment and alternatives with individual caregivers, the opportunity to request and participate in formal care conferences, and the right to include a family member or other chosen representative or both. In the event that the resident cannot be present, a family member or other representative chosen by the resident may be included in such conferences. (b) If a resident who enters a facility is unconscious or comatose or is unable to	21830		5/12/23

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21830	Continued From page 62 communicate, the facility shall make reasonable efforts as required under paragraph (c) to notify either a family member or a person designated in writing by the resident as the person to contact in an emergency that the resident has been admitted to the facility. The facility shall allow the family member to participate in treatment planning, unless the facility knows or has reason to believe the resident has an effective advance directive to the contrary or knows the resident has specified in writing that they do not want a family member included in treatment planning. After notifying a family member but prior to allowing a family member to participate in treatment planning, the facility must make reasonable efforts, consistent with reasonable medical practice, to determine if the resident has executed an advance directive relative to the esident's health care decisions. For purposes of this paragraph, "reasonable efforts" include: (1) examining the personal effects of the resident; (2) examining the medical records of the resident in the possession of the facility; (3) inquiring of any emergency contact or family member contacted under this section whether the resident has executed an advance directive and whether the resident has a physician to whom the resident normally goes for care; and (4) inquiring of the physician to whom the resident normally goes for care, if known, whether the resident has executed an advance directive. If a facility notifies a family member or designated emergency contact or allows a family member to participate in treatment planning in accordance with this paragraph, the facility is not liable to resident for damages on the grounds that the notification of the family member or	21830		

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21830	Continued From page 63 emergency contact or the participation of the family member was improper or violated the patient's privacy rights. (c) In making reasonable efforts to notify a family member or designated emergency contact, the facility shall attempt to identify family members or a designated emergency contact by examining the personal effects of the resident and the medical records of the resident in the possession of the facility. If the facility is unable to notify a family member or designated emergency contact within 24 hours after the admission, the facility shall notify the county social service agency or local law enforcement agency that the resident has been admitted and the facility has been unable to notify a family member or designated emergency contact. The county social service agency and local law enforcement agency shall assist the facility in identifying and notifying a family member or designated emergency contact. A county social service agency or local law enforcement agency that assists a facility in implementing this subdivision is not liable to the resident for damages on the grounds that the notification of the family member or emergency contact or the participation of the family member was improper or violated the patient's privacy rights. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure a Physician's Orders for Life Sustaining Treatment (POLST) was acted upon and completed in a thorough manner to reflect resident' wishes for emergency, and potential prolonged care needs, for 1 of 1 resident (R43) reviewed who had an incomplete POLST in	21830	Corrected	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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21830	Continued From page 64	21830		

the medical record.

Findings include:

R43's significant change in status Minimum Data Set (MDS), dated 3/13/23, identified R43 had intact cognition, demonstrated no rejection of care behaviors, and required extensive assistance to complete most late-loss activities of daily living (ADLs). Further, the MDS outlined R43 had several medical conditions including progressive neurological conditions, high blood pressure, and Parkinson's Disease.

R43's medical record was reviewed. A POLST, undated, was located in the scanned electronic medical record (EMR) which had several sections to be completed and labeled "A" through "E", respectively. The scanned POLST had R43's name, date of birth (DOB), and one single 'checkmark' placed next to directions under section "A" which read, "Attempt Resuscitation / CPR (Note: selecting this requires selecting "Full Treatment" in Section B)." The remainder of the POLST contained these sections and corresponding medical intervention wishes for both emergency and/or prolonged care needs:

Section "B" was labeled, "Medical Treatments," and outlined the medical interventions, assumed the patient had a pulse or was breathing. It provided three options to be selected to reflect the patient wishes for care including, "Full Treatment," and, "Selective Treatment," and, "Comfort-Focused Treatment (Allow Natural Death)." However, there were no visible markings or checkmarks placed to either of these options and the section was left blank.

Section "C" was labeled, "Documentation of

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21830	Continued From page 65 Discussion," and outlined directions to select who was involved in the discussion of the POLST (i.e., resident, family, surrogate). There was also provided spacing for the patient or surrogate to sign. However, again, there were no visible markings, checkmarks, or signatures on the POLST to demonstrate this information had been reviewed with R43 or their responsible parties, if applicable. The entire section was left blank. Section "D" was labeled, "Signature of Physician / APRN / PA," and provided spacing for the medical provider to sign the document and instill it as a current physician order for care. These individual spaces (i.e., name, license type) each had bolded print which outlined, "Required." However, there were no signatures or markings present and the entire section was left blank and not completed. Section "E" was labeled, "Additional Patient Preferences (Optional)," which provided options to place a marking or checkmark next to desire treatment options including artificial nutrition, antibiotic use, and any other treatments as desired. However, again, the entire section was left blank and not completed. Further, the spacing provided for the health care provider who prepared the document (i.e., facility staff) to sign was also left blank and not completed. R43's medical record was reviewed and lacked evidence these items had been discussed with R43 to facilitate person-center care planning for medical treatments in the event R43 sustained an emergency medical event (i.e., cardiac arrest) which could require emergency intervention or prolonged medical treatment (i.e., dialysis, tube feedings).	21830		

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21830	Continued From page 66 On 4/5/23 at 10:31 a.m., R43 was interviewed. R43 recalled the staff asking them if they wanted CPR or not, however, didn't recall the other information on the POLST (i.e., antibiotics, tube feeding) having been discussed with them, at least not "in that much detail [i.e., what they'd like done]." R43 explained, "I don't want to be a vegetable." R43 decided they would like the staff to attempt CPR and, if not successful, ensure their tissues get donated to the University of Maryland which had been pre-arranged. R43 stated such was "important" to them. Further, R43 expressed they would be open to IV medications or tube feedings but only if there was "some hope" of a full recovery and reiterated, "I don't want to be a vegetable." When interviewed on 4/5/23 at 10:36 a.m., licensed practical nurse (LPN)-C explained the social worker usually completed the POLST with a resident upon admission; however, at times, they would "have us [nurses] do it." LPN-C reviewed R43's EMR and verified the 'banner' for the EMR directed CPR should be initiated. LPN-C reviewed R43's scanned POLST and verified it was not completed adding most of the information was "not in there," and LPN-C verified R43 did not have a "hard chart" which could contain more information as everything should be scanned into the EMR. LPN-C explained R43 was "[their] own person" and, if a situation happened emergently and R43 was unable to speak for themselves, they would call the nurse manager or director of nursing (DON) for direction on how to proceed. LPN-C added the current POLST "doesn't tell me much," and needed to be completed. On 4/5/23 at 1:25 p.m., the assistant director of nursing (ADON) was interviewed. ADON	21830		

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21830	Continued From page 67 explained the nursing home used hospital discharge orders for a resident' code status (i.e., CPR / DNR) until the nursing home had a change to "complete the POLST." ADON reviewed R43's POLST and verified it had not been completed. ADON explained R43 had admitted to the nursing home when it was owned by a previous management group, however, expressed staff should be checking the POLST on a quarterly basis to see if the document "needs to be redone" or not. ADON verified the medical record lacked evidence the staff had identified and acted upon to resolve the incomplete POLST and stated such action should have happened so there wasn't discrepancy in R43's wishes should he suffer an acute medical event. A provided Advance Directive policy, dated 10/2022, identified residents' had the right to formulate advanced directives and they would be honored in accordance with state law and facility policy. The policy outlined the interdisciplinary team (IDT) would assess decision-making capacity and if an advanced directive was not previously on file, then staff would offer to make and establish one. Further, the policy outlined the information on the advanced directive would be reviewed on an annual basis with the resident. SUGGESTED METHOD OF CORRECTION: The director of nursing, or designee, could review applicable policies on healthcare directives to ensure timely and thorough completion; then inservice appropriate staff and audit to ensure ongoing compliance. TIME FRAME FOR CORRECTION: Twenty-one (21) Days	21830		

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21925	Continued From page 68	21925		
21925	MN St. Statute 144.651 Subd. 29 Patients & Residents of HC Fac.Bill of Rights Subd. 29. Transfers and discharges. Residents shall not be arbitrarily transferred or discharged. Residents must be notified, in writing, of the proposed discharge or transfer and its justification no later than 30 days before discharge from the facility and seven days before transfer to another room within the facility. This notice shall include the resident's right to contest the proposed action, with the address and telephone number of the area nursing home ombudsman pursuant to the Older Americans Act, section 307(a)(12). The resident, informed of this right, may choose to relocate before the notice period ends. The notice period may be shortened in situations outside the facility's control, such as a determination by utilization review, the accommodation of newly-admitted residents, a change in the resident's medical or treatment program, the resident's own or another resident's welfare, or nonpayment for stay unless prohibited by the public program or programs paying for the resident's care, as documented in the medical record. Facilities shall make a reasonable effort to accommodate new residents without disrupting room assignments. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure a Physician's Orders for Life Sustaining Treatment (POLST) was acted upon and completed in a thorough manner to reflect resident' wishes for emergency, and potential prolonged care needs, for 1 of 1 resident (R43) reviewed who had an incomplete POLST in the medical record.	21925	Corrected	5/12/23

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21925	Continued From page 69 Findings include: R43's significant change in status Minimum Data Set (MDS), dated 3/13/23, identified R43 had intact cognition, demonstrated no rejection of care behaviors, and required extensive assistance to complete most late-loss activities of daily living (ADLs). Further, the MDS outlined R43 had several medical conditions including progressive neurological conditions, high blood pressure, and Parkinson's Disease. R43's medical record was reviewed. A POLST, undated, was located in the scanned electronic medical record (EMR) which had several sections to be completed and labeled "A" through "E", respectively. The scanned POLST had R43's name, date of birth (DOB), and one single 'checkmark' placed next to directions under section "A" which read, "Attempt Resuscitation / CPR (Note: selecting this requires selecting "Full Treatment" in Section B)." The remainder of the POLST contained these sections and corresponding medical intervention wishes for both emergency and/or prolonged care needs: Section "B" was labeled, "Medical Treatments," and outlined the medical interventions, assumed the patient had a pulse or was breathing. It provided three options to be selected to reflect the patient wishes for care including, "Full Treatment," and, "Selective Treatment," and, "Comfort-Focused Treatment (Allow Natural Death)." However, there were no visible markings or checkmarks placed to either of these options and the section was left blank. Section "C" was labeled, "Documentation of Discussion," and outlined directions to select who	21925		

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21925	Continued From page 70 was involved in the discussion of the POLST (i.e., resident, family, surrogate). There was also provided spacing for the patient or surrogate to sign. However, again, there were no visible markings, checkmarks, or signatures on the POLST to demonstrate this information had been reviewed with R43 or their responsible parties, if applicable. The entire section was left blank. Section "D" was labeled, "Signature of Physician / APRN / PA," and provided spacing for the medical provider to sign the document and instill it as a current physician order for care. These individual spaces (i.e., name, license type) each had bolded print which outlined, "Required." However, there were no signatures or markings present and the entire section was left blank and not completed. Section "E" was labeled, "Additional Patient Preferences (Optional)," which provided options to place a marking or checkmark next to desire treatment options including artificial nutrition, antibiotic use, and any other treatments as desired. However, again, the entire section was left blank and not completed. Further, the spacing provided for the health care provider who prepared the document (i.e., facility staff) to sign was also left blank and not completed. R43's medical record was reviewed and lacked evidence these items had been discussed with R43 to facilitate person-center care planning for medical treatments in the event R43 sustained an emergency medical event (i.e., cardiac arrest) which could require emergency intervention or prolonged medical treatment (i.e., dialysis, tube feedings). On 4/5/23 at 10:31 a.m., R43 was interviewed.	21925		

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21925	Continued From page 71 R43 recalled the staff asking them if they wanted CPR or not, however, didn't recall the other information on the POLST (i.e., antibiotics, tube feeding) having been discussed with them, at least not "in that much detail [i.e., what they'd like done]." R43 explained, "I don't want to be a vegetable." R43 decided they would like the staff to attempt CPR and, if not successful, ensure their tissues get donated to the University of Maryland which had been pre-arranged. R43 stated such was "important" to them. Further, R43 expressed they would be open to IV medications or tube feedings but only if there was "some hope" of a full recovery and reiterated, "I don't want to be a vegetable." When interviewed on 4/5/23 at 10:36 a.m., licensed practical nurse (LPN)-C explained the social worker usually completed the POLST with a resident upon admission; however, at times, they would "have us [nurses] do it." LPN-C reviewed R43's EMR and verified the 'banner' for the EMR directed CPR should be initiated. LPN-C reviewed R43's scanned POLST and verified it was not completed adding most of the information was "not in there," and LPN-C verified R43 did not have a "hard chart" which could contain more information as everything should be scanned into the EMR. LPN-C explained R43 was "[their] own person" and, if a situation happened emergently and R43 was unable to speak for themselves, they would call the nurse manager or director of nursing (DON) for direction on how to proceed. LPN-C added the current POLST "doesn't tell me much," and needed to be completed. On 4/5/23 at 1:25 p.m., the assistant director of nursing (ADON) was interviewed. ADON explained the nursing home used hospital	21925		

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21925	Continued From page 72 discharge orders for a resident' code status (i.e., CPR / DNR) until the nursing home had a change to "complete the POLST." ADON reviewed R43's POLST and verified it had not been completed. ADON explained R43 had admitted to the nursing home when it was owned by a previous management group, however, expressed staff should be checking the POLST on a quarterly basis to see if the document "needs to be redone" or not. ADON verified the medical record lacked evidence the staff had identified and acted upon to resolve the incomplete POLST and stated such action should have happened so there wasn't discrepancy in R43's wishes should he suffer an acute medical event. A provided Advance Directive policy, dated 10/2022, identified residents' had the right to formulate advanced directives and they would be honored in accordance with state law and facility policy. The policy outlined the interdisciplinary team (IDT) would assess decision-making capacity and if an advanced directive was not previously on file, then staff would offer to make and establish one. Further, the policy outlined the information on the advanced directive would be reviewed on an annual basis with the resident. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON), or designee could review and/or develop policy and procedures to ensure timely written notification was provided to the resident and their representative as soon as practicable before discharge. The facility could educate staff on these policies and audit periodically. The results of these audits will be reviewed by the quality assessment committee to ensure compliance.	21925		

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21925	Continued From page 73 TIME PERIOD FOR CORRECTION: Twenty One (21) days.	21925		

Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF ASSESSMENT FOR NONCOMPLIANCE WITH CORRECTION ORDERS
FOR NURSING HOMES

Electronically delivered

July 13, 2023

Administrator
Highland Operations LLC
2319 West Seventh Street
Saint Paul, MN 55116

Re: CCN: 245028
Cycle Start Date: April 6, 2023

Dear Administrator:

On July 6, 2023, survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on April 6, 2023 with orders received by you electronically on .

State licensing orders issued pursuant to the last survey/revisit completed on May 24, 2023, found not corrected at the time of this July 6, 2023 revisit and subject to penalty assessment are as follows:

1095-MN Rule 4658.0650 Subp. 4 --Food Supplies; Storage Of Nonperishable Food $350.00

The details of the violations noted at the time of this revisit completed on July 6, 2023 (listed above) are on the attached Minnesota Department of Health Statement of Deficiencies-Licensing Orders Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags. It is not necessary to develop a plan of correction, electronically acknowledge and date this form and submit to the Minnesota Department of Health if there are no new orders issued.

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

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

Pete Cole, RN Unit Supervisor
Metro Team C District Office
Licensing and Certification Program
Health Regulation Division

Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: peter.cole@state.mn.us
Office/Mobile: (651) 249-1724

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

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

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

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

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

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

Sincerely,

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

Enclosure

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

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

July 13, 2023

Administrator
Highland Chateau Health And Rehabilitation Center
2319 West Seventh Street
Saint Paul, MN 55116

RE: CCN: 245028
Cycle Start Date: April 6, 2023

Dear Administrator:

On April 26, 2023, we informed you that we may impose enforcement remedies.

On July 6, 2023, the Minnesota Department(s) of Health completed a revisit 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 Region V Office for imposition. The CMS Region V Office concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- 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 July 6, 2023

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective July 6, 2023. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective July 6, 2023.

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

This Department is also recommending that CMS impose a civil money penalty. You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

- Civil money penalty. (42 CFR 488.430 through 488.444)

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 July 6, 2023, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Highland Chateau Health And Rehabilitation Center will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from July 6, 2023. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

ELECTRONIC PLAN OF CORRECTION (ePOC)

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

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

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

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

DEPARTMENT CONTACT

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

Pete Cole, RN Unit Supervisor
Metro Team C District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: peter.cole@state.mn.us
Office/Mobile: (651) 249-1724

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by October 6, 2023 (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://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

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

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

Feel free to contact me if you have questions.

Sincerely,

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

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
July 21, 2023

Administrator
Highland Chateau Health And Rehabilitation Center
2319 West Seventh Street
Saint Paul, MN 55116

RE: CCN: 245028
Cycle Start Date: April 6, 2023

Dear Administrator:

On June 8, 2023, we notified you a remedy was imposed. On July 19, 2023 the Minnesota Department(s) 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 July 10, 2023.

As authorized by CMS the remedy of:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective July 6, 2023 be discontinued as of July 10, 2023. (42 CFR 488.417 (b))

In our letter of June 8, 2023, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from July 6, 2023. This does not apply to or affect any previously imposed NATCEP loss.

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

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

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

NOTICE OF TOTAL AMOUNT OF ASSESSMENT
FOR NURSING HOMES

July 21, 2023

Administrator
Highland Chateau Health And Rehabilitation Center
2319 West Seventh Street
Saint Paul, MN 55116

RE: Project Number

Dear Administrator:

On July 13, 2023, a Notice of Assessment for Noncompliance with Correction Orders with an imposed a daily fine in the amount of $350.00 was electronically issued to the above facility. An acknowledgement was electronically received by the Department stating that the violation(s) had been corrected. A reinspection was held on July 19, 2023 and it was determined that compliance with the licensing rules was attained.

Therefore, the total amount of the assessment is $350.00. In accordance with Minnesota Statutes, § 144A.10, subdivision 7, the costs of the reinspection, totaling $133.40, are to be added to the total amount of the assessment. You are required to submit a check, made payable to the Commissioner of Finance, Treasury Division, in the amount of $483.40 within 15 days of the receipt of this notice. That check should be forwarded to:

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

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health

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

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

P r o t e c t i n g , M a i n t a i n i n g a n d I m p r o v i n g t h e H e a l t h o f A l l M i n n e s o t a n s

Electronically Delivered

NOTICE OF TOTAL AMOUNT OF ASSESSMENT
FOR NURSING HOMES

July 21, 2023

Administrator
Highland Chateau Health And Rehabilitation Center
2319 West Seventh Street
Saint Paul, MN 55116

Re: Reinspection Results
Event ID: XXHJ13

Dear Administrator:

On July 5, 2023, a Notice of Assessment for Noncompliance with Correction Orders with an imposed a daily fine in the amount of $550.00 was electronically issued to the above facility. An acknowledgement was electronically received by the Department stating that the violation(s) had been corrected. A reinspection was held on July 6, 2023 and it was determined that compliance with the licensing rules was attained.

Therefore, the total amount of the assessment is $550.00. In accordance with Minnesota Statutes, § 144A.10, subdivision 7, the costs of the reinspection, totaling $342.20, are to be added to the total amount of the assessment. You are required to submit a check, made payable to the Commissioner of Finance, Treasury Division, in the amount of $892.20 within 15 days of the receipt of this notice. That check should be forwarded to:

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

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112

Email: Kamala.Fiske-Downing@state.mn.us

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