Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

May 17, 2023

Administrator
Franklin Restorative Care Center
900 3rd Street South
Franklin, MN 55333

RE: CCN: 245273
Cycle Start Date: May 3, 2023

Dear Administrator:

On May 3, 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:

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, 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 August 3, 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 November 3, 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

Please contact me with any questions regarding this letter.

Sincerely,

Lori Hagen

Lori Hagen, Compliance Analyst
Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Telephone: 651-201-4306
E-Mail: Lori.Hagen@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245273	A. BUILDING _____ B. WING _____	C 05/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANKLIN RESTORATIVE CARE CENTER	900 3RD STREET SOUTH FRANKLIN, MN 55333

(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 5/1/23 through 5/3/23, a survey for compliance with Appendix Z, Emergency Preparedness Requirements for Long Term Care facilities, §483.73(b)(6) was conducted during a standard recertification survey. The facility was NOT in compliance. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulation has been attained.	E 000		
E 039 SS=F	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	E 039		7/30/23

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

Electronically Signed | 05/24/2023

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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E 039	Continued From page 1 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 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	E 039		

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E 039	Continued From page 2 (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: (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	E 039		

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E 039	Continued From page 3 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. (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	E 039		

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E 039	Continued From page 4 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. (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	E 039		

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E 039	Continued From page 5 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 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	E 039		

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E 039	Continued From page 6 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. *[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	E 039		

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E 039	Continued From page 7 (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: (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	E 039		

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E 039	Continued From page 8 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: (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	E 039		

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E 039	Continued From page 9 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 complete a full-scale or tabletop exercise to test their Emergency Preparedness (EP) plan. This had the potential to affect all 35 residents in the facility. Findings include: Review of the facility Emergency preparedness plan identified there was no documentation to support completion of either a full scale and/or tabletop exercise. Interview and EP plan review on 5/3/23, at 5:00 p.m. with the facility administrator identified the facility had participated in a State sponsored tornado drill but he had not completed an analysis or review of the process following the event. He was in the process of revising the EP plan to include clear direction to be in compliance with the requirements for EP.	E 039	The facility administrator spoke with Sherriff Scott Hable from the Renville County Sheriff's department on 5/24/23. Sheriff Hable did say that they can provide a facility based functional exercise within the next 60 day. He will get with his training team to establish training goals and to work on setting a date. During Severe Weather Awareness week, the facility conducted a mock tornado drill on April 20, 2023 by participating in the State wide Tornado drill with tornado watches and warnings. The safety committee met on 5/17/2023 to review the results of the mock drill by completing an after action report to assess how the performance of the mock drill residents. The facility environmental services director will present the results of the mock drill and ask for feedback from residents at the next monthly resident council meeting on May 24, 2023. A summary report will be provided to all	

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E 039	Continued From page 10	E 039	residents and staff. The facility will plan to complete a full-scale or table top exercise to test the Emergency Preparedness (EP) plan or document actual events with a follow-up after action report to remain in compliance. The facility plan to monitors its performance by reviewing at the monthly safety committee meeting and at the Quarterly Quality Assurance meeting to assure EP compliance of testing requirements.+	
F 000	INITIAL COMMENTS On 5/1/23 through 5/3/23, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed with NO deficiencies cited: H52731663C (MN91336), H52731665C (MN92246), H52731666C (MN87220), and H52731707C (MN90529). The following complaints were reviewed: H52731664C (MN92332) with a deficiency cited at F600 and F656. 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	F 000		

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F 000	Continued From page 11 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F 000		
F 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure 2 of 2 residents (R8 and R18) were free of physical abuse by 1 of 1 resident (R1) when staff failed to assess, monitor, and intervene when R1 had increased behaviors. Findings include: Review of the 3/27/23, report to the State agency (SA) identified R1 wanted a regular whole	F 600	R1 was identified to have food related behaviors following multiple aggressive behaviors towards staff and other residents. On 4/22/23 resident diet was changed from puree texture to regular soft diet with a goal to reduce food related behaviors. Care Plan was updated to reflect diet change allowing for more food selection at all times.	5/26/23

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F 600	Continued From page 12 sandwich during snack time, and staff told him he could not eat that due to needing his pureed diet. R1 became angry, grabbed the straws and cups off the East medication cart and chased the staff attempting to hit the staff. The facility identified they had failed to store the snack cart behind a locked door when staff were not in attendance. R8 was seated in his wheelchair in front of the snack cart. When R1 became angry over the sandwich, R1 punched R8 (who was seated next to R1 by the nurses desk) on his right cheek. There was no injury noted. There was no mention staff analyzed R1's behaviors or identified interventions to be placed to minimize and recognize when R1 would begin to show agitation and aggression and prevent future escalation of behaviors from occurring. Review of the 4/29/23 report to the SA identified R18 was seated in the dayroom, and R1 reached for a box of Kleenex on the table, but R18 moved it away. R1 reached over and pinched her on the right upper arm. She screamed, "Oh, it hurt". Nurse removed his hands from R18 and redirected him away from R18. She did complain of pain rated at 5/10, but no red marks, or bruises were noted. The action identified to prevent reoccurrence was to continue to monitor R1's and R18's behavior and interactions with one another. R1's 1/25/23, quarterly Minimum Data Set (MDS) assessment identified he had severe cognitive impairment, required limited assistance of one staff for dressing, toileting, and personal hygiene, but was independent with ambulation and required supervision with meals. R1 had diagnosis of dementia, anxiety, depression, and schizophrenia (serious mental disorder in which people interpret reality abnormally) and received	F 600	On 5/3/2023, R1 pinched another resident after a tissue box was moved out of reach. Staff were instructed to monitor resident when in common areas during mealtimes. Tissues will be made available for R1 and all residents. Social Services and DON conducted interviews with affected residents regarding the incidents with R1. Residents denied injuries or concerns for their safety. A VA report was filed. Follow up review was completed and residents care plan was updated to reflect new interventions to decrease his behavior r/t food. All residents in the facility have the potential to be affected by his behavior. Interventions put into place and have been successful, no further behaviors have been demonstrated. Facility Nursing and Dietary staff educated on the importance of proper storage of snack carts. Will reiterate at staff meeting on 5/26/23. Nursing Facility staff reeducated on Abuse Prevention Policy at the Nursing meeting on 5/26/2023 to ensure all residents in the facility are protected from abuse and neglect from other residents and educated on the interventions to be used for Resident #1. All non-nursing staff to be re-educated at the Quarterly Monthly all-staff meeting in June 2023 on the Abuse Prevention Policy	

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F 600	Continued From page 13 both an anti-depressant and narcotic pain medication daily. R1's current, undated nurse aide care sheet and care plan identified he had behaviors related to food and would grab items off the meal cart and was known to become upset when there was an attempt to take the items away from him. There was no identification of R1's requiring close supervision around mealtime, due to attempts to take food items off other resident's plates, the medication cart, and/or the snack cart. R1 also had a history of verbal and physical aggression directed toward staff and other residents when he was not able to have the items he was attempting to take. R1's Behavior progress notes identified on: 1) 11/27/22 at 9:52 p.m., R1 was digging in the trash for food to eat, when staff attempted to take the spoiled food and provide a fresh snack, he threw the food items at the unidentified staff and raised his fist as if to strike the staff person. 2) 12/9/22 at 2:31 a.m., R1 was observed eating sugar packets while still in the wrapper. Staff attempted to trade opened sugar packets for the ones in his mouth, but he refused to give them to staff and swallowed the packets. 3) 12/19/22 at 10:13 p.m., R 1 was attempting to take cookies off the snack cart, and an unidentified trained medication aide (TMA) asked him to wait so she could check his diet. R1 responded by grabbing her hand and twisted her fingers. R1 was then offered apple sauce which he declined, but when staff crushed the cookies and placed them in the applesauce R1 accepted the snack. 4) 1/15/23 at 5:52 p.m., R1 was upset the supper meal was not being served and was pounding on	F 600	and Reporting guidelines. Administration and or designee will be immediately notified of alleged abusive behaviors followed by an investigation to ensure safety of all residents that have the potential to be affected. Monitoring of incidents will be completed by the IDT at morning stand up with follow up investigation and root cause analysis if necessary. Social Service director to review all incidents at monthly and quarterly Quality Assurance meetings.	

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F 600	Continued From page 14	F 600		

the kitchen door. Unidentified kitchen staff responded to see what R1 wanted. R1 became angry and pointed to the time listed on the sheet posted by the kitchen door which listed supper was to be served at 5:30 p.m. The supper meal was not ready to be served at that time. Staff offered R1 a snack, but he refused. Staff attempted to redirect R1 back to a table. R1 raised his fists as if to strike the staff member. R1 continued to yell at the kitchen staff member and continued to point at the paper. The staff member removed the paper and attempted to redirect R1 by advising R1 he could potentially go back to his room for a few minutes until supper was able to be served or sit at his table. Staff then closed the kitchen door. There was no mention staff had made nursing aware of R1's increasing agitation or if any residents who may have been in the dining room were supervised for safety from R1.

5) 2/1/23 at 5:32 p.m., R1 attempted to take a container of apple sauce, pudding and an Ensure meal supplement drink from the medication cart.

6) 4/30/23 at 1:21 p.m. R1 was in his room and came out of his room to request snacks and other foods frequently. Staff would "continue to monitor".

7) 5/3/23 at 9:58 a.m., R1 was agitated and requesting to "eat" prior to the breakfast meal being served. He walked across the room to R18 seated at a table and pinched her on her upper right arm. Staff intervened and redirected R1 to a different table. R1's breakfast tray was retrieved, and staff sat with him as he ate his meal to encourage him to stay focused on eating his meal and prevent aggression.

There was no mention staff had analyzed R1's behaviors to identify interventions and possibly prevent or minimize his behaviors when they

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F 600	Continued From page 15	F 600		

would occur. There was also no mention of when staff should anticipate R1's aggression to occur or any interventions specific to R18 and R8 to ensure their safety from R1.

R8's 2/22/23, Significant Change MDS, identified his cognition was intact, he had no behaviors, and he required limited assistance of 1 staff for personal hygiene, toileting, dressing, and was independent with other areas. R8 was not able to walk and utilized an electric wheelchair for mobility. R8 had diagnoses of chronic pain syndrome, paraplegia (paralysis in legs or lower half of body), a history of Stage 4 pressure ulcers, adjustment disorder with depressed mood, alcohol abuse, nicotine dependence, adjustment disorder with mixed anxiety and depressed mood.

R8's current care sheets and undated care plan identified he had a safety risk with the potential for abuse due to his medical conditions and was easily manipulated. R8 required the assistance of 1-2 staff for personal cares and mobility if not in his electric wheelchair. R8 had chronic pain related to paraplegia from a gunshot wound and received pain medication daily.

Interview on 5/1/23 at 1:40 p.m., with R8 identified he had been punched by R1 because he had been in the "wrong place". R1 was angry about not being able to take a sandwich off the cart and had been yelling and swinging his arms towards staff, who told him he could not have the sandwich. He was not injured and did not believe R1 had meant to strike him... he had just "been in the way" when R1 was swinging his arms.

Observation on 5/3/23, at 7:51 a.m., of R1 identified he was walking back and forth in the

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F 600	Continued From page 16 hall from his room to the day room where he ate his meals. He was rubbing his stomach and stated he was "so hungry" and had passed staff and other residents. Unidentified staff members responded to R1 that breakfast would be ready shortly and encouraged him to sit down at a table, but he continued to pace back and forth repeating, "so hungry". R18 was seated at a table with her back to the wall not visible from the nursing station as she waited for her meal. She had a box of Kleenex and a wadded tissue on the table in front of her. R1 proceeded to the table where R18 was at. R18 said "owww". R1 was observed beside R18 with his right thumb and first finger holding onto her right forearm, pinching R18. Multiple staff immediately responded and pulled R1's hand away from R18 and redirected him to a table where no other residents were seated. Staff assessed R8 who was found to have a slight reddened area on her right arm below her elbow. R18 reported she was unharmed and agreed with staff to be moved from the day room to the main dining room to eat her breakfast. R18's 1/24/23, Significant change MDS, identified her cognition was intact, and she required extensive assistance from two staff for bed mobility, transfers, dressing, toileting, and personal hygiene. She required limited assistance from 1-2 staff for mobility in her room and hall and ate independently. R18 had diagnoses of unspecified intellectual disabilities, mood affective disorder, obesity, diabetes, and arthritis. She utilized a wheelchair for mobility and was assisted with locomotion using a walker. R18's, current, undated nurse aide care sheet and care plan identified R18 had a safety risk	F 600		

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F 600	Continued From page 17 potential due to intellectual disabilities and major depressive disorder. Staff were to anticipate and meet her needs and remove her from potentially dangerous situations. Neither the Care sheets or care plan identified R18 had been targeted by R1 previously and should be supervised when in the day room/dining room when R1 was present. Observation and interview on 5/03/23 at 7:49 a.m., with licensed practical nurse (LPN)-C as R1 wandered back and forth from his room to the day room. He was known to become more aggressive at mealtimes, and she thought it was possibly due to him being more territorial and aggressive related to his medical history and food issues. R1 was "usually monitored" when he was in the dining room but confirmed at the time of the incident with R18, there was no staff in the room. She reported R1 was to be seated at a table by himself due to his behavior of attempting to take other resident's food. LPN-C reported she had received education on Abuse, vulnerable adults and reporting and would be notifying the director of nursing (DON) of the observation of R1 pinching R18 as soon as she arrived at the facility and would complete a report of the incident. Interview on 5/03/23 at 8:01 a.m., with R18 who was seated in the main dining room with 3 other residents identified she felt safe from R1 when she was with her friends who were at the table with her. R18 denied any pain in her right arm but did have a slightly pink area was noted on the outer aspect of her right arm where R1 had pinched her. R1 had pinched her "before" but she was not able to recall a date when that occurred. Interview on 5/03/23 at 8:14 a.m., with the activity director (AD) reported she was coming down the	F 600		

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F 600	Continued From page 18 hall when she heard the "commotion" in the dining room after pinching R18. Upon arrival staff had retrieved R1's breakfast tray and LPN-C had redirected him to the table to eat. The AD sat at the table with R1 encouraging him to slow down as he was rapidly spooning food into his mouth. She reported staff attempted diversion actives for R1. R1 enjoyed BINGO and table games with staff assistance. R1 was able to understand and responded somewhat, but due to his dementia he was not always clear in what he wanted or needed. The AD was unaware of any other identified interventions non-activity related for R1. Interview on 5/03/23 at 8:22 a.m., with trained medication aide (TMA)-D reported she had not observed R1 display aggressive behavior in the current dining/day room but reported he had been moved to this dining area from another due to his anxiety and agitation when he had to wait for food in the main dining room. The day room was beside the kitchen, and he was able to be served as soon as the meal was ready. TMA-D reported she had observed R1 attempt to interact with R18 previously by offering her his food or drink, but he had not previously attempted to harm her that she was aware of. There was "usually" staff at the nurses station located across from the dining/day room and "usually" was staff in the dining room assisting another resident to eat. There were no specific times to check on R1, but staff often checked on him as they passed by his room or wandering in the hall. R1 would attempt to take food items from the medication or snack cart, and sometimes he would stop and take a bite from the container that was located on the medication cart. As a result, staff were not supposed to leave food items on top of the carts unattended. TMA-D was unaware of interventions if R1 showed	F 600		

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F 600	Continued From page 19 increasing behaviors to ensure the safety of other residents residing at the facility. Interview on 5/3/23 at 9:49 a.m., with the DON reported she had been informed of the incident between R1 and R18 as soon as she had arrived about 8:00 a.m. Appropriate notifications had been made, and an investigation initiated with a report to the SA. Immediate interventions included offering R18 the option to move to the main dining room with other residents. Additional interventions to be implemented included continuous supervision when R1 was wandering. Staff were to offer a diversion of food/drink while waiting for meal trays to be served. R1's diet had been advanced from pureed to regular soft to allow him a larger variety of acceptable food options. The DON reported her expectation was R1 was to be supervised when he was in the dining room during meals and snack times to avoid a repeat of the incident. R1 had approached R18 on 4/29/23, reached for her tissue box, and when R18 moved it out of his reach he had pinched the top of her hand, but there was no injury. She confirmed neither the care sheet or care plan had been updated with revised interventions and there was no assessment or documentation if the interventions were effective. She agreed there had been no documentation of analysis or identified interventions on the care plan or care sheets of R1's specific behaviors towards R8 and R18 to ensure their safety or the safety of other residents. Interview on 5/3/23 at 3:41 p.m. with the medical director identified he had been notified of the incidents which took place on 4/29/23 and again on 5/3/23. R1 was 93 years old and had a history	F 600		

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F 600	Continued From page 20 of dementia and "food-related" behaviors. R1 had demonstrated physical and verbal behaviors toward staff and other residents and was being seen by mental health services. He agreed R1, R8, and R18's care plans and nurse aide care sheets needed to be revised and updated to address the increased agitation and verbal and physical aggression and an analysis of R1's behaviors should have occurred so interventions could be identified. Staff should provide increased supervision to R1 to avoid reoccurrence of behaviors directed toward staff and residents. Review of the 6/9/19, Abuse Prevention Policy identified physicians (MD) and staff were to assist in identification of all risk factors for abuse. Both management and staff were to institute measures to identify resident needs to decrease the possibility of abuse or neglect and make a timely report of any incidents. Both the MD and staff were to address probable causes of behaviors whenever possible. The medical director was to be part of the Quality Assurance process for revision of treatment, interventions, and response to incidents involving abuse and neglect. Training was to be provided to all staff and practioner's on how to appropriately resolve conflicts and deal with resident verbal or physical aggression. Residents with identified behavior problems were to have care plans developed to address their behavior issues. Review of the 6/9/19, Abuse Investigation policy identified a suspected incident of resident abuse or mistreatment was to be reported to the administrator or their designee who would then designate a person to complete the investigation. The individual conducting the investigation was to:	F 600		

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F 600	Continued From page 21 1.) Review the completed documentation forms. 2.) Review the medical record to determine events which led up to the incident. 3.) Interview the person(s) who reported the incident. 4.) Interview any witnesses. 5.) Interview the resident. 6.) Interview the attending MD to determine the resident's current level of cognition and medical condition. 7.) Interview staff members on all shifts that had contact with the resident during the time of the incident. 8.) Interview any roommates, family members, and visitors who may have been in attendance. 9.) Review all events leading up to the alleged incident. The administrator was to provide a written report of the results of all abuse investigations and appropriate action taken to the SA, the local police department, the ombudsman, and others as required by state laws, within five (5) working days of the reported incident.	F 600		
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 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	F 656		5/23/23

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F 656	Continued From page 22 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. §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: R1 Review of the 3/27/23, report to the State agency (SA) identified R1 wanted a regular whole sandwich during snack time, and staff told him he could not eat that due to needing his pureed diet.	F 656	Care Plan(s) of the residents were reviewed an updated as indicated. R1 Care Plan was revised to include new interventions that are being performed,	

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F 656	Continued From page 23 R1 became angry, grabbed the straws and cups off the East medication cart and chased the staff attempting to hit the staff. The facility identified they had failed to store the snack cart behind a locked door when staff were not in attendance. R8 was seated in his wheelchair in front of the snack cart. When R1 became angry over the sandwich, R1 punched R8 (who was seated next to R1 by the nurses desk) on his right cheek. There was no injury noted. There was no mention staff analyzed R1's behaviors or identified interventions to be placed to minimize and recognize when R1 would begin to show agitation and aggression and prevent future escalation of behaviors from occurring. Review of the 4/29/23 report to the SA identified R18 was seated in the dayroom, and R1 reached for a box of Kleenex on the table, but R18 moved it away. R1 reached over and pinched her on the right upper arm. She screamed, "Oh, it hurt". Nurse removed his hands from R18 and redirected him away from R18. She did complain of pain rated at 5/10, but no red marks, or bruises were noted. The action identified to prevent reoccurrence was to continue to monitor R1's and R18's behavior and interactions with one another. R1's 1/25/23, quarterly Minimum Data Set (MDS) assessment identified he had severe cognitive impairment, required limited assistance of one staff for dressing, toileting, and personal hygiene, but was independent with ambulation and required supervision with meals. R1 had diagnosis of dementia, anxiety, depression, and schizophrenia (serious mental disorder in which people interpret reality abnormally) and received both an anti-depressant and narcotic pain medication daily.	F 656	resident has not had any behavioral issues with any other resident in the facility since the survey ended. Residents care plan updated on interventions that need to be utilized to protect other residents from harm. Resident is allowed to sleep as he desires- he is not woke up for breakfast until his room tray is ready, staff observe and monitor him in the dining room, Kleenex boxes are located on tables to prevent any altercation with other residents. Staff have been educated to monitor for any inappropriate behaviors with other residents and to re-direct. Staff also educated on how to interact with resident to decrease his agitation. Staff have also been educated to give resident any snack items when he demonstrates that he is hungry. R28 Care Plan was revised to include current status, recommendations by other departments. Resident Care Plans will be updated to reflect behavioral interventions when behaviors occur for a resident centered approach for individualization to educate staff on how to decrease behaviors in high risk residents. The facility has determined that all residents have the potential to be affected. All interdisciplinary care plan team members responsible for writing care plans will be re-educated on the facilities	

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F 656	Continued From page 24 R1's current, undated nurse aide care sheet and care plan identified he had behaviors related to food and would grab items off the meal cart and was known to become upset when there was an attempt to take the items away from him. There was no identification of R1's requiring close supervision around mealtime, due to attempts to take food items off other resident's plates, the medication cart, and/or the snack cart. R1 also had a history of verbal and physical aggression directed toward staff and other residents when he was not able to have the items he was attempting to take. R1's Behavior progress notes identified on: 1) 11/27/22 at 9:52 p.m., R1 was digging in the trash for food to eat, when staff attempted to take the spoiled food and provide a fresh snack, he threw the food items at the unidentified staff and raised his fist as if to strike the staff person. 2) 12/9/22 at 2:31 a.m., R1 was observed eating sugar packets while still in the wrapper. Staff attempted to trade opened sugar packets for the ones in his mouth, but he refused to give them to staff and swallowed the packets. 3) 12/19/22 at 10:13 p.m., R 1 was attempting to take cookies off the snack cart, and an unidentified trained medication aide (TMA) asked him to wait so she could check his diet. R1 responded by grabbing her hand and twisted her fingers. R1 was then offered apple sauce which he declined, but when staff crushed the cookies and placed them in the applesauce R1 accepted the snack. 4) 1/15/23 at 5:52 p.m., R1 was upset the supper meal was not being served and was pounding on the kitchen door. Unidentified kitchen staff responded to see what R1 wanted. R1 became	F 656	policy and procedure for developing Comprehensive Care Plans. Care Plans will be reviewed weekly in accordance with the care plan review schedule by the Care Plan Coordinator. All Care plans will be updated as indicated. Resident care sheets will be reviewed along with care plans updates to ensure accurate information to ensure cares are performed according to their needs. Currently, 17/35 care plans have had a detailed review. A new Care Plan book has been put into place for all staff to review for information. The Director of Nursing or designee will complete weekly random care plan audits for six (6) consecutive weeks. Random audits will be completed to ensure that comprehensive care plans are developed for residents. Audit results will be reviewed by the QAA committee until such time consistent substantial compliance has been met.	

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F 656	Continued From page 25 angry and pointed to the time listed on the sheet posted by the kitchen door which listed supper was to be served at 5:30 p.m. The supper meal was not ready to be served at that time. Staff offered R1 a snack, but he refused. Staff attempted to redirect R1 back to a table. R1 raised his fists as if to strike the staff member. R1 continued to yell at the kitchen staff member and continued to point at the paper. The staff member removed the paper and attempted to redirect R1 by advising R1 he could potentially go back to his room for a few minutes until supper was able to be served or sit at his table. Staff then closed the kitchen door. There was no mention staff had made nursing aware of R1's increasing agitation or if any residents who may have been in the dining room were supervised for safety from R1. 5) 2/1/23 at 5:32 p.m., R1 attempted to take a container of apple sauce, pudding and an Ensure meal supplement drink from the medication cart. 6) 4/30/23 at 1:21 p.m. R1 was in his room and came out of his room to request snacks and other foods frequently. Staff would "continue to monitor". 7) 5/3/23 at 9:58 a.m., R1 was agitated and requesting to "eat" prior to the breakfast meal being served. He walked across the room to R18 seated at a table and pinched her on her upper right arm. Staff intervened and redirected R1 to a different table. R1's breakfast tray was retrieved, and staff sat with him as he ate his meal to encourage him to stay focused on eating his meal and prevent aggression. There was no mention staff had analyzed R1's behaviors to identify interventions and possibly prevent or minimize his behaviors when they would occur. There was also no mention of when staff should anticipate R1's aggression to occur	F 656		

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F 656	Continued From page 26 or any interventions specific to R18 and R8 to ensure their safety from R1. There was no policy specific to care plans provided by the end of survey. Based on observation, interview and record review, the facility failed to implement the care plan for positioning for on 1 of 1 resident (R28) when up in wheelchair and identify behaviors of verbal or physical aggression for 1 of 4 residents (R1) reviewed for resident to resident abuse. Findings include: R28 Observations of R28 while in his wheelchair identified on: 1. 5/2/23 at 11:28 a.m. of R28 in wheelchair and wedge not placed in wheelchair. 2. 5/2/23 at 11:35 a.m. of R28 in wheelchair and wedge not placed in wheelchair. Wedge noted in R28's closet. 3. 5/3/23 at 7:27 a.m. during R28 morning cares when resident was placed in his wheelchair his wedge was not placed in his chair. R28's 2/28/23, quarterly Minimum Data Set (MDS) identified R28 had an intact cognition and was dependent of staff for transferring and bed mobility and required assistance of 2 staff. R28's current, undated, care plan identified staff were to ensure R28's wedge cushion was in their wheelchair when in use. Staff were to also ensure a neck pillow was utilized while R28 was in bed or sitting up per recommendations made by occupational therapy (OT).	F 656		

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F 656	Continued From page 27 R28's current, undated nurse aide care sheet identified there was no mention staff were to ensure R28 was to have his wedge cushion or neck pillow while up in his wheelchair. Interview and document review on 5/3/23 at 1:06 p.m., with physical therapy assistant (PTA)-A of R28's positioning identified occupational therapy progress notes included staff were to place the neck pillow and wedge cushion on R28's left side while in his wheelchair in order to improve his positioning. PTA-A agreed OT's recommendations should be followed and entered on the nurse aide care sheets to ensure R28's positioning would be maintained to R28's highest practicable physical well-being. Interview on 5/3/23 at 1:21 p.m., with nurse aide (NA)-B agreed the care plan identified staff were to place the neck pillow and wheelchair cushion was to be placed to support his left side when in bed and his wheelchair and was not consistently implemented. Interview on 5/3/23 at p.m., with the DON confirmed if a care was specified on the care plan, it should be on the staff's Care Sheet and those interventions implemented.	F 656		
F 712 SS=F	Physician Visits-Frequency/Timeliness/Alt NPP CFR(s): 483.30(c)(1)-(4) §483.30(c) Frequency of physician visits §483.30(c)(1) The residents must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 thereafter.	F 712		5/24/23

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F 712	Continued From page 28 §483.30(c)(2) A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required. §483.30(c)(3) Except as provided in paragraphs (c)(4) and (f) of this section, all required physician visits must be made by the physician personally. §483.30(c)(4) At the option of the physician, required visits in SNFs, after the initial visit, may alternate between personal visits by the physician and visits by a physician assistant, nurse practitioner or clinical nurse specialist in accordance with paragraph (e) of this section. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to ensure a physician visit was provided every 30 days for the first 90 days for 2 of 2 residents (R27 and R34) and ensure alternating visits every 60 days thereafter were provided by a physician for 11 of 11 residents (R1, R7, R11, R14, R15, R19, R27, R28, R30, R33, and R34). Findings include: R1's medical record identified his date of admission as 10/20/17, with diagnoses of spinal stenosis, bilateral hearing loss, chronic pain syndrome, restlessness/agitation, age related physical disability, Major depressive disorder, and degenerative disease of the nervous system. R1's 9/1/22, 9/15/22, 10/13/22, 10/20/22, 11/17/22 and 4/20/23, progress notes identified certified nurse practioner (CNP)-E saw R1 for review of diagnoses, labs results, care plan and medications. The medical record lacked	F 712	All residents have seen a Physician since the survey and are in compliance. Signed physician notes and progress notes are current. All resident charts were audited for compliance issues and schedule put into place to ensure residents are seen accordingly to the regulations or earlier if needed. Physician visit form completed with documentation of date of visit and when next visit will be due. Visits will alternate between Physician or CNP. Physician/CNP visits will be audited on a weekly basis for 4 weeks, then every 2 weeks for 1 month and then monthly with results to QAA until it is determined that compliance is in place. Policy and Procedure updated to reflect	

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F 712	Continued From page 29 documentation of R1 being seen by a physician for at least every other visit. R7's medical record identified her date of admission as 8/7/18 with diagnoses of Bipolar disorder, Type 2 diabetes, high blood pressure and dementia. R7's 1/19/23, and 4/13/23 progress notes identified certified nurse practioner (CNP)-E saw R7 for review of diagnoses, labs results, care plan and medications. The medical record lacked documentation of any provider visits between January and April and there was no record of R7 being seen by a physician between CNP-E visits. Interview on 5/3/23 at 3:36 p.m., with the director of nursing (DON) reported there were no signed physician documented visits for the residents on record for the past 6 months. She reported CNP-E had been coming to the facility and making provider visits, but there had not been alternating physician visits performed since the fall of 2022. Interview on 5/3/23 at 3:41 p.m. with the medical director reported his expectation for physician visits to be completed on a monthly schedule for the first 90 days after admission, and then according to the required every other month visitation schedule. Also the visits were to be documented in the medical record with the signed recertification for review of the plan of care, medications, and treatments. R19's medical record identified that R19 had been admitted on 10/22/20.	F 712	the correct procedure to be performed to ensure compliance remains in place. Medical Director/CNP were re-educated on the requirements of the deficiency to prevent re-occurrence. Physician Visits and Physician Delegation reviewed with Medical Director and Administration. Resident #1 Seen by CNP on 4.2.23, Physician visit 5.10.23 Resident #7 Seen by CNP on 4.13.23, Physician visit 5.3.23 Resident #9 Seen by CNP on 4.20.23, Physician visit 4.20.23 Resident #19 Seen by CNP on 4.20.23 Physician visit 5.24.23 Resident #27 Seen by CNP for initial visit on 4.6.23, Seen by Hospice CNP on 5.18.23 for recert. Seen by Physician on 5.24.23 for day visit. Resident #28 Seen by Physician for initial visit on 4.13.2023, Seen by CNP on 5.18.23 for 60 day visit. Resident #34 Seen by CNP on 4.27.23, Physician visit on 5.17.23 Resident #33 Seen by CNP on 4.6.23, Physician visit on 5.3.23 and CNP on 5.9.23. Resident discharged from facility on 5.9.23 Resident #14 Seen by CNP on 4.20.23, Physician visit on 5.3.23 Resident #11 Seen by CNP on 4.13.23, Physician visit on 5.3.23 Resident #15 Resident switched provider to in-house on 4.27.23. Initial visit completed on 5.4.23 to establish care with	

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F 712	Continued From page 30 R19's 9/7/22, Physician Round Summary identified that R19 had been seen by his primary physician. The medical record lacked identification that R19 had been seen by a physician following the 9/7/22 visit. R19's 9/22/22, 10/6/22, 11/17/22, 2/8/23, and 3/2/23, progress notes identified certified nurse practitioner (CNP)-E had seen R19 and reviewed diagnoses, labs, care plan, and medications. The progress notes lacked identification that a MD had seen R19 since September of 2022. R27's Admission Record identified R27 had been admitted to the facility on 1/24/23. R27 had diagnoses of chronic obstructive pulmonary disease, opioid dependence, and major depressive disorder. R27's 4/2/23, progress note identified CNP-E had seen R27 and reviewed diagnoses, labs, the care plan, and medication. The progress notes lacked identification that R27 had been seen by a physician every 30 days for the first 90 days. The progress notes further lacked identification that R27 had been seen by a physician at least every other visit thereafter. R28's medical record identified that R28 was admitted on 4/22/22. R28's 11/18/22, Order Summary Report identified that R28 had been seen by a physician. R28's medical record lacked any further provider visits after November 2022. R34's Admission Record identified R34 had been admitted to the facility on 1/20/23. R34 had diagnoses of Dementia with agitation, Alzheimer's	F 712	CNP, Physician visit 5.10.23 Resident #30 Seen by CNP on 4.20.23, Physician visit on 5.24.23 Attachments: Physician Visit Documentation Audit form Physician Visits and Physician Delegation	

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F 712	Continued From page 31 disease, diabetes and a history of falling. R34's 1/26/23, Consultation/Clinic Referral form identified R34 had been seen in the clinic for a follow up physical examination. The form was signed by Certified Nurse Practitioner (CNP)-D. The medical record lacked identification that a physician had seen R34 every 30 days for the first 90 days. The medical record further, lacked documentation that a physician had seen R34 at least every other visit thereafter. R34's 3/21/23, 4/6/23, and 4/27/23, progress notes identified CNP-E had seen R34 and reviewed diagnoses, labs, the care plan, and medications. The progress notes lacked identification that R34 had been seen by a medical provider in the month of March or that a MD visit had occurred. R33's Admission Record identified she had been admitted on 1/16/23, with diagnoses of high blood pressure, stroke, diabetes, degenerative joint disease, spinal stenosis (narrowing of the spine), long term use of anti-coagulants (blood thinners). R33's progress notes identified R33 had been seen by her primary physician on 2/1/23, and had been seen by the nurse practitioner (CNP)-E on 1/19/23, 3/2/23, 4/6/23, and 4/27/23,. R33's medical record lacked any documentation identifying that she had any other physician visits since 2/1/23. R14's Admission Record identified she had been admitted on 3/11/21, with diagnoses of diabetes, celiac disease (disease in which people can't eat gluten because it will damage their small	F 712		

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F 712	Continued From page 32	F 712		

intestine), high blood pressure, rheumatoid arthritis, low thyroid hormone, depression, dementia, anxiety, and epilepsy (seizures).

R14's physician progress notes identified the last physician visit was on 9/7/22, and had been seen by the CNP-E on 10/20/22, 11/3/22, 11/17/22, 1/12/23, 1/19/23, and 3/2/23. R14's medical record lacked any documentation identifying they she had been seen by a physician after the 9/7/22 visit.

R11's 1/28/23, quarterly Minimum Data Set (MDS) assessment identified R11 had diagnosis that included chronic pain, mental and behavioral disorders, heart failure, high blood pressure, diabetes, low sodium levels in the blood, high cholesterol, and Alzheimer's disease.

R11's physician progress notes identified R11 had last been seen by a physician on 6/7/22, and was seen by a CNP-E on 9/15/22, 10/6/22, 11/3/22, 11/22/22, 1/19/23, and 4/13/23. The medical record lacked any indication he had been seen by a physician after the 6/7/22 visit.

R15's progress notes identified he had been admitted on 5/18/21, with diagnoses of traumatic brain injury, tremors, alcohol dependence, high blood pressure, chronic pain, difficulty swallowing, and gastroesophageal reflux disease (GERD).

Review of R15's electronic medical record identified R15 had last been seen via a required visit by a physician on 9/15/22.

R30's Admission Record identified he was admitted to the facility on 1/5/22, with diagnoses of diabetes, high cholesterol, heart murmur, high

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F 712	Continued From page 33 blood pressure, irregular heartbeat, heart disease, enlarged prostate with urinary tract symptoms, dementia, and macular degeneration (eye disease that leads to blindness). Review of R30's electronic medical record identified he had last been seen by his primary physician on 9/7/22, and had been seen by CNP-E on 10/20/22,11/3/22, 11/22/22, 3/2/23. The medical record lacked any documentation identifying R30 had been seen by a physician after 9/7/22. Interview on 5/3/23 at 1:30 p.m., assistant director of nursing (ADON) identified the facility had been aware of the lack of doctor visits at the facility. Management had a meeting with the medical director and completed an audit but had not implemented a plan to ensure all residents were seen by a physician in the required timeframe. Interview on 5/3/23 at 2:00 p.m., director of nursing (DON) and Administrator identified they agreed with the above findings and would expect physician visits to be completed every 30 days for 90 days following a new admission and every 60 days thereafter.	F 712		
F 727 SS=F	RN 8 Hrs/7 days/Wk, Full Time DON CFR(s): 483.35(b)(1)-(3) §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under	F 727		

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F 727	Continued From page 34 paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: The facility's request for a waiver was accepted and and approved by the State Agency following following the survey dated 12/22/22. The tag was re-issued at PAST NON-COMPLIANCE; therefore NO plan of correction is required. This will remain in effect until such time as the registered nurse (RN) coverage can be filled and the facility achieves compliance. F727: CFR 483.35 (b)(1), RN coverage 8 consecutive hours a day, 7 days a week. Findings include: Review of 12/29/22 through 5/3/23 nursing schedule identified no registered nurse (RN) had been scheduled on Saturdays or Sundays. Interview on 5/2/23 at 11:15 a.m., with the administrator identified they had obtained a waiver for RN coverage and the facility was currently working on filling the positions through advertisement on web based hiring platforms and offering a sign on bonus. The facility had hired an additional RN to fill the assistant director of nursing position, however she is currently scheduled on the same days and shifts as the director of nursing. He agreed it may be beneficial to stagger the director of nursing and assistant director of nursing schedules to provide better RN	F 727	Past noncompliance: no plan of correction required. The facility Nursing Administration staff consisting of the Director of Nursing and Assistant Director of Nursing will alternate when possible to provide 8 hours of coverage on weekends. The facility when possible will contract temporary Agency RN Nursing staff to provide weekend 8 hour coverage. The facility will continue operating under the waiver while actively to recruit the hiring of permanent licensed RN's for coverage on weekends. The facility will complete periodic review of advertising efforts to attract RN license applicants through various methods of recruitment strategies. Administration and or designee will provide staffing reports at monthly QA meetings.	

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F 727	Continued From page 35 coverage on the weekends. Review of the current advertisement for available positions identified the facility was actively attempting to hiring full time RN for coverage to meet the requirement.	F 727		
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 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	F 758		5/26/23

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F 758	Continued From page 36 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 record review, the facility failed to ensure as needed (PRN) anti-psychotic medication was not ordered beyond 14 days without a prescribing practitioner face to face evaluation for appropriateness and need for continued use of the PRN medication for 2 of 2 residents (R27 and R34). Findings include: R27's April's 2023, medication administration record (MAR) identified haloperidol lactate (anti-psychotic) oral concentrate 2 milligrams/milliliters (mg/ml), give 0.25 ml by mouth as needed with no end date identified. R27's medical record identified R27 had only 1 face to face provider visit on 4/6/23 by a nurse practitioner.	F 758	The Medication Regimen for R27 was reviewed by the Facility Medical Director and the order was discontinued. Resident is receiving Hospice Services and the medication was part of their comfort orders. The Medication Regimen for R34was reviewed. Resident is currently undergoing more medication changes in order to stabilize his mood /behaviors. Resident was seen on 5/14/2023 and his medication dose was increased d/t frequent PRN use. Resident was seen by Rural Psych on 5/24/23 for their assistance with Medication Management. Resident will start on new medication with plans to completely taper off this medication.	

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F 758	Continued From page 37 R34's April 2023, MAR identified Seroquel (anti-psychotic) 12.5 mg by mouth every 6 hours PRN for unspecified dementia. Review of R34's MAR identified R34 was administered Seroquel during the following months and times administered: 1) February 2023, R34 received Seroquel 19 times. 2) March 2023, R34 received Seroquel 18 times. 3) April 2023, R34 received Seroquel 14 times. R34's review of progress notes revealed R34 had been seen by a nurse practitioner (NP) on the following dates 3/21/23, 4/6/23, and 4/24/23. The NP notes did not identify Seroquel had been reviewed for appropriateness of continuation. R34's medical record had no indication R34 had been evaluated every 14 days by a medical provider. Interview on 5/3/23 at 11:08 a.m. with Pharmacist (RPh)-A, identified if a resident was on a PRN antipsychotic medication, they need to be seen in person every 14 days and have a rational for continuing the medication. Interview on 5/3/23 at 1:39 p.m., with director on nursing (DON), identified R34 and R27 did not get a face-to-face visit by a physician every 14 days and should have had a rational documented to continue the medication. If a resident was on a PRN anti-psychotic medication, the expectation would be the provider would evaluate them face to face every 14 days and document a rational for continued use of the medication. Review of the July 2022, Psychotropic Medication	F 758	Hospice Provider, Medical Director and FNP were all educated on the regulation and the need for a 14 day face to face when orders are initiated and that the rationale for the medication use is in place and the duration of the PRN order will be indicated. The facility has determined that all the residents have the potential to be affected. A review of all PRN Medication orders and indications for use, was completed on 5/14/2023. All Licensed Nursing staff were in-serviced regarding the facility policy for use of Psychoactive Medication. A copy of the regulations regarding un-necessary drugs/un-necessary medication were also provided to the physician as a resource. The Director of Nursing or designee will complete random weekly audits for 4 weeks of any new PRN psychotropic medications to ensure that the indication and length of use is listed and the resident is seen face with their provider to ensure appropriate monitoring of the resident is being completed. Monthly monitoring for 3 months with results reviewed with QAA quarterly until in compliance is made.	

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F 758	Continued From page 38 Use policy identified if a person was on a PRN antipsychotic medication there needed to be an evaluation with a medical provider every 14 days with written rational for continuation of the medication.	F 758		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure 4 of 9 insulin pens used for 4 of 9 residents (R9, R18, R22,	F 761	R34 Insulin was disposed of. R34 no longer had an order for its use.	5/26/23

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F 761	Continued From page 39 and R33) were appropriately labeled according to facility policy and manufacture's guidelines. Findings include: Observation and interview on 5/2/23 at 11:23 a.m. with licensed practical nurse (LPN)-B as he prepared to administer R18's order for Novolog Flex Pen sliding scale insulin identified a R18 had a physician order for 20 units of Novolog insulin in addition of a sliding scale (SS) dose (addition of regularly scheduled insulin determined by blood glucose (sugar) levels) to be administered. R18 was to receive 8 units of sliding scale insulin for a total of 28 units of Novolog insulin. LPN-B cleaned the surface of the pen (#1) with an alcohol wipe, attached the needle and primed the pen. LPN-B reported there was not adequate insulin remaining in the pen for the ordered dose of 28 units, and obtained a new pen (#2) from the refrigerator in the medication room, and repeated the above process for the remainder of the insulin to be administered. LPN-B took both pens and attempted to administer the insulin to R18. The administration was postponed and LPN-B was asked by the surveyor to identify if the insulin in pen #1 was appropriate to administer as there was no date identified on the pen to when the medication would expire after opening. LPN-B was uncertain, but thought it may have been opened approximately 5 days ago. LPN-B confirmed he could not be certain as to when the date the insulin pen had been opened due to no date labeled on the pen. Continued observation and interview with LPN-B identified LPN-B administered R18's insulin with the new pen (#2), but failed to write a date of opening or use-by date on the #2 pen before	F 761	R27 Resident was given a new Insulin Pen with a date opened label on it. The facility determined that all residents who require insulin have the potential to be affected. The Nurses were educated on 5/3/23 of the importance of labeling all Insulins when opened. They were all educated that once a pen is open, it can only be used for 28 days. Policy and Procedures regarding the administration of medications was updated to reflect dating and time for insulin usage. Nurses will also be educated at the Nursing Department meeting on 5/26/2023. The DON and or designee will review all insulin pens to ensure they are dated when opened and removed from use after 28 days. Weekly audits will be conducted x4 weeks, then monthly x3. Weekly audits will be conducted x4 weeks, then monthly x3. Audit findings will be reviewed at the monthly and quarterly QAPI meetings. Attachments: Insulin Pen Audit form Administering Medications Policy and Procedure	

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F 761	Continued From page 40 returning it to the drawer before concluding the medication administration. When asked how long the Novolog Flex Pen could be used before discarding it, he was observed turning the pen to read the manufacture's expiration date. He then reported the pen would be good for 1 year per the manufacturer's expiration date. He was unaware the manufacture required use-by dating which would require the insulin remaining in the pen be discarded after 28 days from opening. LPN-B agreed the pen should be labeled according to manufacturer's instructions to ensure opened insulin was discarded appropriately. Review of the current, undated manufacturer's instructions identified once staff had opened the Novolog Flexpen, the pen was to be discarded after 28 days, even if insulin remained in the pen. Review of the remainder of insulin pens currently in use for the 9 residents currently receiving insulin revealed 3 of the other 9 pens observed (currently in use for R9, R22 and R33) had also not been dated with a use-by date according to manufacturer's instructions. Interview on 5/2/23 at 11:51 a.m. with the director of nursing (DON) reported it was her expectation for all insulin pens and/or vials of insulin to be dated when they were opened according to facility policy and the manufacture's recommendation. She reported the Novolog Flexpen was good for 28 days from the date it was opened and should be discarded even if there was still insulin left in the pen. Review of the September 2014, Insulin Administration policy identified the type of insulin, ordered dose, strength and method of	F 761		

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F 761	Continued From page 41 administration was to be verified before the insulin was administered. Steps in the procedure for administration identified staff were to check the expiration date, and if opening a new pen or vial, the [used by] date was to be recorded on the pen or vial. Staff were to follow the manufacture's recommendations for the date of expiration following opening of the pen or vial.	F 761		
F 868 SS=D	QAA Committee CFR(s): 483.75(g)(1)(i)-(iii)(2)(i); 483.80(c) §483.75(g) Quality assessment and assurance. §483.75(g) Quality assessment and assurance. §483.75(g)(1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and (iv) The infection preventionist. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (i) Meet at least quarterly and as needed to coordinate and evaluate activities under the QAPI program, such as identifying issues with respect to which quality assessment and assurance activities, including performance improvement projects required under the QAPI program, are necessary.	F 868		6/29/23

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F 868	Continued From page 42 §483.80(c) Infection preventionist participation on quality assessment and assurance committee. The individual designated as the IP, or at least one of the individuals if there is more than one IP, must be a member of the facility's quality assessment and assurance committee and report to the committee on the IPCP on a regular basis. This REQUIREMENT is not met as evidenced by: Based on document review and interview, the facility failed to ensure Quality Assurance Performance Improvement (QAPI) meetings were held on a quarterly basis. The facility also failed to ensure the medical director had attended the quarterly QAPI meeting. Findings include: Review of the QAPI meeting minutes and agenda identified a QAPI meeting in October 2022, and the most recent meeting on March 30, 2023. There was no additional documentation of QAPI meetings provided for the 2022 year. The record of members in attendance failed to include the medical director who was required to be in attendance at the quarterly QAPI meetings. Members required to be present at the quarterly QAPI meetings included the director of nursing services; the Medical Director or his/her designee; at least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and the infection preventionist. Interview on 5/1/23 at 2:37 p.m., with the facility administrator identified he did not know if the facility had previously had QAPI meetings prior to	F 868	The facility met on Thursday 3/30/2023 for the Quarterly QAPI meeting. The next Quarterly QAPI meeting is scheduled for Thursday 6/29/2023. The facility has contacted the Medical Director to inform the Medical Director of the meeting. The facility will ensure that members required to be in attendance at minimum on a Quarterly basis will include the Medical Director or his/her designee, the Director of Nursing Services and at least three other members of the facility's staff, at least one of who must be the the administrator, owner or other individual in a leadership role; and the infection preventionist. The facility Administrator and/or designee will schedule QAPI meetings well in advance to ensure members required to be in attendance have confirmed meeting date(s) and time of day. The QAPI meetings are held the last Thursday of the month. Records of attendance will be required to ensure evidence of compliance.	

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F 868	Continued From page 43 his arrival at the facility in March 2023, but he was not able to provide any documentation of meetings having occurred.	F 868	The Medical Director and/or Rounding Physician may attend in person or via zoom meetings. This option is also available to other team members if unable attend in person.	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals 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;	F 880		5/26/23

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F 880	Continued From page 44 (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. 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 a multi-resident use Assure Platinum glucose monitor was appropriately disinfected between use during 1 of	F 880	The TMA was immediately in-serviced on 5/2/23 of the proper procedures for glucometer disinfection.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245273	A. BUILDING _____ B. WING _____	C 05/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANKLIN RESTORATIVE CARE CENTER	900 3RD STREET SOUTH FRANKLIN, MN 55333

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F 880	Continued From page 45 1 observation of blood glucose testing. Findings include: Observation, interview, and label review on 5/2/23 at 11:04 a.m., with trained medication aide (TMA)-A during a blood glucose (blood sugar (BS) check) identified she removed the glucose meter from the medication cart, retrieved and retrieved items for checking BS. She proceeded to R18's room where she obtained a test strip and inserted it into the meter to check R18's BS which was 302. TMA-A disposed of the used supplies and returned to the medication cart. TMA-A reported there were not any disinfectant wipes on the cart at that time, so she retrieved a new canister of Micro-Kill One germicidal alcohol wipes, removed a wipe from the container, and wiped over the surface of meter. She then tossed the used wipe in the trash, recorded BS reading. She then obtained a second wipe, wiped over the surface of the meter and tossed that wipe in the trash. TMA-A replaced the BS meter in the plastic container, closed the lip and placed it back into the drawer of the medication cart. The disinfectant wipe label directed staff to ensure a wet contact time of one minute. TMA-A reported she was unaware of the need for the surface to remain wet for a minute for appropriate disinfection to occur according to the manufacture's directions. She agreed she had not appropriately disinfected the BS meter. Interview on 5/2/23 at 11:52 a.m. with the director of nursing (DON) reported it was her expectation for staff to follow the facility policy and the manufacture's recommendations to ensure appropriate disinfection was completed for BS meters.	F 880	The facility determined that all residents who require glucose monitoring have the potential to be affected. All the Nurses and TMA's have been educated between 5/9/23-5/17/23 on Glucometer Cleaning Disinfection Policy and procedures and received in-person training on how to perform the procedure. Findings were reviewed with each staff individually to ensure compliance. Each resident has a designated machine that is used. Weekly Glucometer cleaning were added to each residents TAR to ensure glucometers are cleaned and disinfected on a weekly basis. The Director of Nursing or designee will complete staff audits to ensure that the proper policy and procedures are being followed x2 weeks, then periodically, and results will be reviewed monthly and quarterly QAPI meetings until deemed to be in compliance. Attachments: Glucometer Cleaning and Disinfection Record of In-Serviced Training Form.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245273	A. BUILDING _____ B. WING _____	C 05/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANKLIN RESTORATIVE CARE CENTER	900 3RD STREET SOUTH FRANKLIN, MN 55333

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F 880	Continued From page 46 Review of the current, undated Infection Prevention and Control Manual Cleaning and Disinfecting Blood Glucose Meters policy identified staff were to follow the manufacturer's directions for cleaning and disinfecting BS meters. The policy identified the use of disinfectants, antiseptics, and germicides were to be used according to the manufacture's instructions to ensure effectiveness. All staff were to be trained in the proper procedure, the use of protective equipment needed and safety precautions. A note at the end of the policy directed staff to review the required contact time. The expectation was for understanding and demonstration of the required contact time to achieve disinfection and to be aware of different products required different lengths of time to achieve the results.	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245273	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**05/02/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANKLIN RESTORATIVE CARE CENTER	**900 3RD STREET SOUTH** **FRANKLIN, MN 55333**

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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 05/02/2023. At the time of this survey, Franklin Restorative Care Center was found in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, the Health Care Facilities Code. Franklin Rehabilitation and Health Care Center was constructed as follows: The original building was constructed 1962, is one-story, has a partial basement, is fully fire sprinkler protected and was determined to be of Type II(111) construction; The 1st Addition was constructed in 1972, is one-story, has a partial basement, is fully fire sprinkler protected and was determined to be of Type II(111) construction; The 2nd Addition was constructed in 1994, is one-story, has no basement, is fully fire sprinkler protected and was determined to be of Type II(111) construction. The facility has a capacity of 40 beds and had a census of 35 at time of the survey. The requirements at 42 CFR, Subpart 483.70(a), are MET.	K 000		

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

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

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
August 8, 2023

Administrator
Franklin Restorative Care Center
900 3rd Street South
Franklin, MN 55333

RE: CCN: 245273
Cycle Start Date: May 3, 2023

Dear Administrator:

On July 11, 2023, we notified you a remedy was imposed. On August 7, 2023 the Minnesota Department of Health 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 30, 2023.

As authorized by CMS the remedy of:

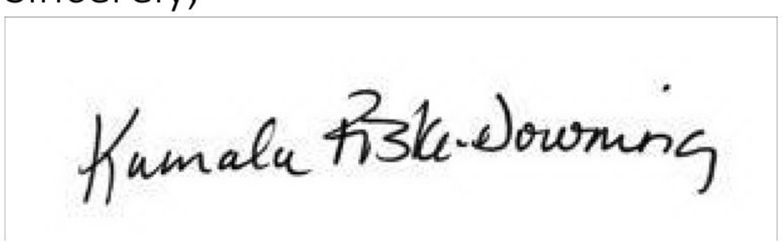
- Mandatory denial of payment for new Medicare and Medicaid admissions effective August 3, 2023 did not go into effect. (42 CFR 488.417 (b))

In our letter of May 17, 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 was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from August 3, 2023 due to denial of payment for new admissions. Since your facility attained substantial compliance on July 30, 2023, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

The CMS 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
Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900

An equal opportunity employer.

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