DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

October 19, 2022

Administrator
Victory Health & Rehabilitation Center
512 49th Avenue North
Minneapolis, MN 55430

Re: Reinspection Results
Event ID: YW9C12

Dear Administrator:

On September 8, 2022 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on July 18, 2022. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
January 26, 2023

****PLEASE NOTE THAT HEALTH AND LIFE SAFETY CODE SURVEYS ARE BEING PROCESSED IN SEPERATE ENFORCEMENT CYCLES.****

Administrator
Victory Health & Rehabilitation Center
512 49th Avenue North
Minneapolis, MN 55430

RE: CCN: 245544
Cycle Start Date: July 12, 2022

Dear Administrator:

Please note that this facility has been chosen as a Special Focus Facility (SFF). CMS' policy of progressive enforcement means that any SFF nursing home that reveals a pattern of persistent poor quality is subject to increasingly stringent enforcement action, including stronger civil monetary penalties, denial of payment for new admissions and/or termination of the Medicare provider agreement.

On July 12, 2022, a standard survey was completed at your facility by the Minnesota Department of 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 constitute no actual harm with potential for no more than minimal harm (Level C), 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 plan of correction (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 a 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:

- Discretionary denial of payment for new Medicare and Medicaid admissions (42 CFR 88.417 (a));

- Per day civil money penalty (42 CFR 488.430 through 488.444).

Failure to submit an acceptable ePoC could also result in the termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

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 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.

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 plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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

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

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
August 11, 2022

Administrator
Victory Health & Rehabilitation Center
512 49th Avenue North
Minneapolis, MN 55430

RE: CCN: 245544
Cycle Start Date: May 6, 2022

Dear Administrator:

Please note that this facility has been chosen as a Special Focus Facility (SFF). CMS' policy of progressive enforcement means that any SFF nursing home that reveals a pattern of persistent poor quality is subject to increasingly stringent enforcement action, including stronger civil monetary penalties, denial of payment for new admissions and/or termination of the Medicare provider agreement.

On May 24, 2022, we informed you of imposed enforcement remedies.

On July 18, 2022, the Minnesota Department(s) of Health and Public Safety completed a survey and it has been determined that your facility continues to not to be in substantial compliance. The most serious deficiencies in your facility were found to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

As a result of the survey findings:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective June 8, 2022, will remain in effect.

- Directed plan of correction, Federal regulations at 42 CFR § 488.424 Please see electronically attached documents for the DPOC.

This Department continues to recommend that CMS impose a civil money penalty. (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective June 8, 2022. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective June 8, 2022.

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

As we notified you in our letter of May 24, 2022, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from June 8, 2022.

ELECTRONIC PLAN OF CORRECTION (ePOC)

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

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

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

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:

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

- Per day civil money penalty (42 CFR 488.430 through 488.444).

DEPARTMENT CONTACT

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

Sarah Grebenc, Unit Supervisor
Metro A District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: sarah.grebenc@state.mn.us
Office: (651) 201-3792 Mobile (651)238-8786

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by November 6, 2022 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at 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.

APPEAL RIGHTS

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

Tamika.Brown@cms.hhs.gov

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

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

INFORMAL DISPUTE RESOLUTION/ 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 plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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

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

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	C 07/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VICTORY HEALTH & REHABILITATION CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

(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 7/11/22 - 7/18/22, 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 009 SS=C	Local, State, Tribal Collaboration Process CFR(s): 483.73(a)(4) §403.748(a)(4), §416.54(a)(4), §418.113(a)(4), §441.184(a)(4), §460.84(a)(4), §482.15(a)(4), §483.73(a)(4), §483.475(a)(4), §484.102(a)(4), §485.68(a)(4), §485.625(a)(4), §485.727(a)(5), §485.920(a)(4), §486.360(a)(4), §491.12(a)(4), §494.62(a)(4) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years [annually for LTC facilities]. The plan must do the following:] (4) Include a process for cooperation and collaboration with local, tribal, regional, State, and Federal emergency preparedness officials' efforts	E 009		8/30/22

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

Electronically Signed | 08/25/2022

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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E 009	Continued From page 1 to maintain an integrated response during a disaster or emergency situation. * * [For ESRD facilities only at §494.62(a)(4)]: (4) Include a process for cooperation and collaboration with local, tribal, regional, State, and Federal emergency preparedness officials' efforts to maintain an integrated response during a disaster or emergency situation. The dialysis facility must contact the local emergency preparedness agency at least annually to confirm that the agency is aware of the dialysis facility's needs in the event of an emergency. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the agency failed to include a process for cooperation and collaboration with local, tribal, regional, state, and federal emergency preparedness officials' efforts to maintain an integrated response during a disaster or emergency, including documentation of the agency's efforts to contact such officials and, when applicable, of its participation in collaborative and cooperative planning efforts in their emergency plan. This had the potential to affect all 54 residents residing at the facility. Findings include: Review of the Emergency Preparedness (EP) Plan, revised 9//21, included contact information for assistance sources (federal, state, and local agencies) but did not include a process for cooperation and collaboration with those agencies. During review of the facility EP documents with the administrator on 7/14/22, at 9:42 a.m. administrator was unable to locate a policy	E 009	E 009 The emergency preparedness plan was updated to include the process how collaboration with state, local and federal agencies will occur. Copies of the Emergency Management Plan was delivered to the local fire department per facility policy. The IDT team was in-serviced on the Coordination with Emergency Management Agencies with emphasis on item #5 which list how coordination can occur. The Administrator and/or Designee is responsible for compliance. Audits on efforts to contact agencies will begin 1x a month then quarterly to ensure sustained compliance. Audit results will be reviewed by the Administrator and the Administrator will take the audit results to QAPI for review and recommendation. Compliance: _____8/30/2022_____	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	C 07/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VICTORY HEALTH & REHABILITATION CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

(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 009	Continued From page 2 pertaining to collaboration with community EP officials but stated she would continue to look for it. On 9/18/22, at 9:33 a.m. administrator stated she did not believe the facility had a policy for collaboration with community EP officials and was not aware of any attempts to contact such officials.	E 009		
E 036 SS=C	EP Training and Testing CFR(s): 483.73(d) §403.748(d), §416.54(d), §418.113(d), §441.184(d), §460.84(d), §482.15(d), §483.73(d), §483.475(d), §484.102(d), §485.68(d), §485.625(d), §485.727(d), §485.920(d), §486.360(d), §491.12(d), §494.62(d). *[For RNCHIs at §403.748, ASCs at §416.54, Hospice at §418.113, PRTFs at §441.184, PACE at §460.84, Hospitals at §482.15, HHAs at §484.102, CORFs at §485.68, CAHs at §486.625, "Organizations" under 485.727, CMHCs at §485.920, OPOs at §486.360, and RHC/FHQs at §491.12:] (d) Training and testing. The [facility] must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. *[For LTC facilities at §483.73(d):] (d) Training and testing. The LTC facility must develop and maintain an emergency preparedness training	E 036		8/30/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VICTORY HEALTH & REHABILITATION CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

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E 036	Continued From page 3 and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually. *[For ICF/IIDs at §483.475(d):] Training and testing. The ICF/IID must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. The ICF/IID must meet the requirements for evacuation drills and training at §483.470(i). *[For ESRD Facilities at §494.62(d):] Training, testing, and orientation. The dialysis facility must develop and maintain an emergency preparedness training, testing and patient orientation program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training, testing and orientation program must be evaluated and updated at every 2 years. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to develop and maintain annual	E 036	E 036 Facility staff will be in-serviced on the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	C 07/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VICTORY HEALTH & REHABILITATION CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

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E 036	Continued From page 4 emergency preparedness (EP) training and testing based on the emergency plan, risk assessment, policies and procedures, and the communication plan for 1 of 1 Emergency Preparedness program. This had the potential to affect all 54 residents, their families/representatives and the staff of the facility. Findings include: Review of the facility EP plan dated 9/21, revealed the plan lacked a policy on EP training and testing. During review of the facility EP documents with the administrator on 7/14/22, at 9:42 a.m. administrator confirmed the program lacked a policy pertaining to EP initial and ongoing training and testing. The administrator stated she planned to review the EP program in its entirely but had not had time to do so yet.	E 036	emergency preparedness plan tentatively scheduled for 8/25/2022. Upon hire, newly hired employees will have emergency preparedness education during orientation then annually per policy. The facility risk assessment and emergency policies and procedures will be reviewed and updated as needed. Annually, the emergency preparedness plan, risk assessment and all emergency policies and procedures will be reviewed and updated as needed. The IDT team will be in-served on the Emergency Management Plan with emphasis on item #19 that the plan will be reviewed and updated at a minimum annually to ensure its accuracy. Administrator and/or designee is responsible for compliance. Audits on emergency plan review will begin 1x month then quarterly to ensure sustained compliance. Audit results will be reviewed by the Administrator and the Administrator will take the audit results to QAPI for review and recommendation. Compliance: __8/30/2022_____	
E 037 SS=C	EP Training Program CFR(s): 483.73(d)(1) §403.748(d)(1), §416.54(d)(1), §418.113(d)(1), §441.184(d)(1), §460.84(d)(1), §482.15(d)(1), §483.73(d)(1), §483.475(d)(1), §484.102(d)(1), §485.68(d)(1), §485.625(d)(1), §485.727(d)(1), §485.920(d)(1), §486.360(d)(1), §491.12(d)(1). *[For RNCHIs at §403.748, ASCs at §416.54, Hospitals at §482.15, ICF/IIDs at §483.475, HHAs	E 037		8/30/22

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	245544	A. BUILDING _____ B. WING _____	C 07/18/2022

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VICTORY HEALTH & REHABILITATION CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

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E 037	Continued From page 5 at §484.102, "Organizations" under §485.727, OPOs at §486.360, RHC/FQHCs at §491.12:] (1) Training program. The [facility] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the [facility] must conduct training on the updated policies and procedures. *[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles. (ii) Demonstrate staff knowledge of emergency procedures. (iii) Provide emergency preparedness training at least every 2 years. (iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others. (v) Maintain documentation of all emergency	E 037		

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E 037	Continued From page 6 preparedness training. (vi) If the emergency preparedness policies and procedures are significantly updated, the hospice must conduct training on the updated policies and procedures. *[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) After initial training, provide emergency preparedness training every 2 years. (iii) Demonstrate staff knowledge of emergency procedures. (iv) Maintain documentation of all emergency preparedness training. (v) If the emergency preparedness policies and procedures are significantly updated, the PRTF must conduct training on the updated policies and procedures. *[For PACE at §460.84(d):] (1) The PACE organization must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, contractors, participants, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Demonstrate staff knowledge of emergency procedures, including informing participants of what to do, where to go, and whom to contact in case of an emergency. (iv) Maintain documentation of all training.	E 037		

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E 037	Continued From page 7 (v) If the emergency preparedness policies and procedures are significantly updated, the PACE must conduct training on the updated policies and procedures. *[For LTC Facilities at §483.73(d):] (1) Training Program. The LTC facility must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. *[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following: (i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment.	E 037		

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E 037	Continued From page 8 (v) If the emergency preparedness policies and procedures are significantly updated, the CORF must conduct training on the updated policies and procedures. *[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following: (i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the CAH must conduct training on the updated policies and procedures. *[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least every 2 years.	E 037		

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E 037	Continued From page 9 This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide initial training in emergency preparedness (EP) policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role. This had the potential to affect all 54 residents who resided in the facility. Findings include: On 7/14/22, at 9:42 a.m. the EP program documents were reviewed with the administrator. The administrator confirmed the EP program lacked evidence of initial EP training for staff, and stated staff received EP education upon hire. Evidence of training for five staff was requested at that time. On 7/15/22, at 11:15 a.m. evidence of training for five staff was requested again from the administrator. On 7/18/22, at 9:33 a.m. evidence of training for five staff was requested and not provided.	E 037	E 037 The facility failed to provide staff emergency preparedness training at least annually which was based on the facility emergency preparedness plan (EPP). Upon hire, newly hired employees will have emergency preparedness education during orientation then annually per policy. The IDT team will be in-serviced on the Disaster Training Plan with emphasis on item #4 that training exercise drills will be conducted at least annually to test the emergency preparedness plan. Administrator and/or designee is responsible for compliance. Audits on employee training on emergency preparedness education and training will begin 1x week for 4 weeks the monthly to ensure sustained compliance. Audit results will be reviewed by the Administrator and the Administrator will take the audit results to QAPI for review and recommendation. Compliance: __8/30/2022_____	
E 039 SS=C	EP Testing Requirements CFR(s): 483.73(d)(2) §416.54(d)(2), §418.113(d)(2), §441.184(d)(2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2), §483.475(d)(2), §484.102(d)(2), §485.68(d)(2), §485.625(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, OPO, "Organizations" under §485.727, CMHCs at	E 039		8/30/22

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E 039	Continued From page 10 §485.920, RHCs/FQHCs at §491.12, and ESRD Facilities at §494.62]: (2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following: (i) Participate in a full-scale exercise that is community-based every 2 years; or (A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or (B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event. (ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is 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.	E 039		

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E 039	Continued From page 11 *[For Hospices at 418.113(d):] (2) Testing for hospices that provide care in the patient's home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the following: (i) Participate in a full-scale exercise that is community based every 2 years; or (A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full scale community-based exercise or individual facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (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:	E 039		

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E 039	Continued From page 12 (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual facility-based functional exercise; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospice is exempt from engaging in its next required full-scale community based or facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop led by a facilitator that includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (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	E 039		

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E 039	Continued From page 13 accessible, conduct an annual individual, facility-based functional exercise; or (B) If the [PRTF, Hospital, CAH] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (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	E 039		

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E 039	Continued From page 14 (B) If the PACE experiences an actual natural or man-made emergency that requires activation of the emergency plan, the PACE is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the PACE's response to and 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.	E 039		

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E 039	Continued From page 15 (B) If the [LTC facility] facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required a full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [LTC facility] facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [LTC facility] facility's emergency plan, as needed. *[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	E 039		

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E 039	Continued From page 16 functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the ICF/IID's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID's emergency plan, as needed. *[For HHAs at §484.102] (d)(2) Testing. The HHA must conduct exercises to test the emergency plan at least annually. The HHA must do the following: (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	E 039		

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E 039	Continued From page 17 exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the HHA's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the HHA's emergency plan, as needed. *[For OPOs at §486.360] (d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following: (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	E 039		

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	245544	A. BUILDING _____ B. WING _____	C 07/18/2022

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E 039	Continued From page 18 OPO's] emergency plan, as needed. *[RNCHIs at §403.748]: (d)(2) Testing. The RNHCI must conduct exercises to test the emergency plan. The RNHCI must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the RNHCI's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the RNHCI's emergency plan, as needed. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to conduct an exercise to test their Emergency Preparedness Program (EPP) at least annually; to include participation in a full-scale exercise, an individual facility-based functional exercise, a mock disaster drill, a tabletop exercise, or activation of their emergency plan. This had the potential to affect all 54 residents who resided in the facility and the staff. Findings include: A review of the facility's EPP on 7/14/22, lacked documentation of the above exercises to test their EPP in the past year, or activation of their plan with a subsequent after action analysis and revision. During an interview on 7/18/22, at 9:33 a.m. the administrator confirmed the EP plan lacked	E 039	E 039 The facility will conduct a mock disaster training drill tentatively schedule for Active Shooter on 7/21/2022. For future training, the facility will conduct mock drills annually per facility policy. The IDT team will be in-serviced on the Disaster Training policy with emphasis on #4 that training exercise drills will be conducted at least annually to test the emergency preparedness plan and identify opportunities for improvement. Administrator and/or designee is responsible for compliance. Audits on mock disaster training will begin 1x week for 4 weeks the monthly to ensure sustained compliance. Audit results will be reviewed by the Administrator and the Administrator will take the audit results to QAPI for review	

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E 039	Continued From page 19 documentation of participation in any community-based full-scale exercise to test their EPP in the last year, but stated it was a good idea. In addition, the administrator stated she did not think the facility activated their plan in the last year with a follow-up after action analysis and plan revision.	E 039	and recommendation. Compliance: ___8/30/2022_____	
F 000	INITIAL COMMENTS Victory Health & Rehabilitation Center is a Special Focus Facility (SFF). On 7/11/22 - 7/18/22, a standard recertification survey was conducted by surveyors from the Minnesota Department of Health (MDH). Complaint investigations were also completed. Victory Health & Rehabilitation Center was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were found to be SUBSTANTIATED: H55443119C (MN84313); with a deficiency cited at F921. H55443120C (MN84474); with a deficiency cited at F921. The following complaints were found to be UNSUBSTANTIATED: H5544312C (MN82602) H55443121C (MN84759) H5544311C (MN82247) H5544313C (MN83035) The facility's plan of correction (POC) will serve as your allegation of compliance upon the	F 000		

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F 000	Continued From page 20 Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F 000		
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to assess safety of self-administration of medications for 1 of 1 residents (R9) who was self-administering medications after staff set-up and had inhalers at bedside. Findings include: R9's quarterly Minimum Data Set (MDS) dated 7/9/22, indicated R9 was mildly cognitively impaired, was independent with bed mobility and transfers. R9's Admission Record dated 7/15/22, indicated R9 had diagnoses that included chronic obstructive pulmonary disease (COPD - lung disease). R9's care plan date 4/14/22, included R9 had	F 554	F 554 A self-administration assessment was completed and a self-administration of medication care plan was created for R 9. All other residents who self-administer medications were reviewed and their care plans were updated as needed. Future residents who request self-administration of medication will have an assessment completed and a care plan initiated. The IDT team and licensed nursing staff were in-serviced on the self-administration policy with emphasis on item #2 that the IDT team will assess the resident for self-administration and licensed nurses focus on item #12 that self-administration doses will be recorded in the electronic medical record. Director of Nursing and/or designee is responsible for compliance.	8/30/22

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F 554	Continued From page 21 asthma related to COPD, and interventions of give medications as ordered, monitor/document side effects and effectiveness, give nebulizer treatments and oxygen as ordered. The care plan also included R9 had COPD related to smoking, and an intervention of give aerosol or bronchodilators as ordered and monitor for side effects and effectiveness. R9's Self Administration of Medications Assessment dated 4/1/21, indicated R9 did not wish to self-administer medications. R9's Order Summary Report dated 7/15/22, included the following: " Albuterol Sulfate Nebulization Solution 2.5 milligrams (mg)/0.5 milliliters (mL), 3 mL, inhale orally every four hours as needed for wheezing/shortness of breath (SOB) " Incruse Ellipta Aerosol Powder Breath Activated 62.5 micrograms (mcg)/inhale (Umeclidinum Bromide), One inhalation, inhale orally one time a day for COPD " Salmeterol Xinafoate Aerosol Powder Breath Activated 50 mcg/dose (Serevent), One puff, inhale orally two times per day for Chronic Obstructive Lung Disease " Ipratropium Albuterol Solution 0.5-2.5 (3) mg/3 mL. 3 ml inhale orally every four hours as needed for chronic lung disease. The Order Summary Report lacked an order for medication self-administration. During interview on 7/14/22, at 7:47 a.m. R9	F 554	Audits on resident self-administration of medication assessments, care plan and resident compliance will begin weekly x 2 weeks then monthly to ensure sustained compliance. Audit results will be reviewed by the Administrator and the Administrator will take audit results to QAPI for review and recommendation. Compliance: _____8/30/2022_____	

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F 554	Continued From page 22 opened the top drawer of his nightstand where two prescription inhalers were visible inside the drawer in a denture cup. R9 confirmed he stored his own inhalers in the drawer. On 7/15/22, at 9:38 a.m. R9 was observed in his room self-administering a nebulizer treatment. R9 stated he was having a hard time breathing and asked the nurse for it, as he generally did when he needed it. He confirmed he also kept his inhalers in his top drawer and used them both twice per day, once in the morning and once at night, and they helped his breathing. He stated he 'handled' those himself. R9 opened his top drawer where one Incuse inhaler with 13 remaining doses and one Serevent inhaler with 28 remaining doses were observed. R9 stated he was still trying to get another inhaler because one was nearly empty. R9 reached into a plastic grocery bag which hung on the back of his wheelchair and removed an Albuterol inhaler with ten doses remaining. He stated he used the Albuterol inhaler if needed when he left the building. During interview on 7/15/22, at 9:56 a.m. trained medication aide (TMA)-A stated she brought R9's nebulizer treatment to his room that morning where R9 used it independently. She stated a licensed practical nurse (LPN) or registered nurse (RN) completed self-administration assessments and teaching, and R9 was allowed to administer his own treatments and keep inhalers in his room because he needed to use them frequently. She stated staff asked residents who self-administered how many doses they took and documented it. During interview on 7/15/22, at 10:11 a.m. LPN-E	F 554		

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F 554	Continued From page 23 stated residents needed a provider order to keep inhalers at bedside and stated she would have no idea how many times a resident used them. During interview on 7/15/22, at 10:17 a.m. RN-C stated most resident inhalers were stored in the medication carts unless they had orders allowing a resident to keep them at bedside. She stated the facility did not have any residents who self-administered inhalers, but if a resident asked to self-administer staff completed an assessment. RN-C was unsure if any residents could self-administer nebulizer treatments. During interview on 7/15/22, at 10:22 a.m. director of nursing (DON) stated inhalers were normally kept in the medication cart. DON stated he had not seen any residents self-administer any inhalers, but if there was an order it was ok, although he would discourage it because there was no way to monitor it. He stated they did have a self-administration assessment when a resident requested to keep inhalers at bedside to make sure they were safe. He stated standard practice was the nurse stayed and watched residents during nebulizer treatments, and staff did not leave the resident unless they had a medication self-administration order. He stated it was important to complete an assessment to ensure the resident could safely take the medications and would not take too many or too few doses. DON reviewed R9's medical record and confirmed he did not have a medication self-administration assessment or provider order to self-administer medications. The facility policy Administering Medications dated 4/2019, indicated residents may self-administer their own medications only if the	F 554		

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F 554	Continued From page 24 attending physician, in conjunction with the interdisciplinary care planning team, has determined that they have the decision-making capacity to do so safely.	F 554		
F 577 SS=C	Right to Survey Results/Advocate Agency Info CFR(s): 483.10(g)(10)(11) §483.10(g)(10) The resident has the right to- (i) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility; and (ii) Receive information from agencies acting as client advocates, and be afforded the opportunity to contact these agencies. §483.10(g)(11) The facility must-- (i) Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility. (ii) Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request; and (iii) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public. (iv) The facility shall not make available identifying information about complainants or residents. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure survey results were placed in a prominent place and contained or directed where to obtain the last three years of survey results.	F 577	F 577 The survey binder was updated to include the past 3 years of survey results and is now located in the front lobby in reach so	8/30/22

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F 577	Continued From page 25 This had the potential to affect all 54 residents residing in the facility, along with family, visitors, and staff. Findings include: An observation on 7/13/22, at 12:25 p.m. the entry way and through out the facility, lacked evidence of the facility's past survey results or direction on how to obtain the facility's survey results. During a resident meeting on 7/13/22, at 2:00 p.m. R45 stated they were unaware of a way to review the facility's survey results. R8 further stated there used to be some books located by the front entrance but was not aware of any books recently. On 7/15/22, at 12:27 p.m. the Human Resources Manager (HRM) stated the facility results for resident/family were normally kept on the cabinet located at the entrance of the facility. HRM looked at the cabinet and verified the survey results were not there. HRM then asked the Infection Preventionist (IP) where the survey results book was located. IP verified the book was normally located on the cabinet by the entrance and verified it was not there. HRM and IP then went to the Administrator who verified the facility's survey result book was located on the cabinet near the entrance. The Administrator verified the book was not there and was not sure where it was. On 7/15/22, at 12:38 p.m. the Chief Operating Officer (COO) stated, "I brought the survey book back home with me to New York". COO further stated the survey results book was needed to	F 577	that residents and visitors may view. Social Service Director met with R 45 and R8 and informed both where the facility survey binder is located. Upon admission, future residents will be informed where the survey results are located. A resident council meeting will be held on 8/23/2022 to inform residents where the binder is located. Staff were in-serviced on Resident Rights Policy with emphasis on item #w emphasizing that residents have the right to view facility past survey results the survey binder and location. Social Service Director and/or designee is responsible for compliance. Audits will be completed on residents knowing where to locate the survey binder to prevent reoccurrence of this deficiency monthly x 3. Audits results will be reviewed by the administrator then taken to QAPI committee for further review and recommendations. Compliance: 8/30/2022	

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F 577	Continued From page 26 help with upcoming preparation for court proceedings. During an interview on 7/18/22, at 9:50 a.m. the Administrator stated she expected the survey results book to be available for residents and family to review. The Administrator further acknowledged the survey results were not accessible as it was taken home by the COO. A facility policy titled Resident Rights, revised 12/2016, directed residents have the rights to examine the facility's survey results.	F 577		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;	F 584		8/30/22

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F 584	Continued From page 27 §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide a personalized and homelike environment for 1 of 1 residents (28) who was denied use of a personal refrigerator. Findings include: R28's admission Minimum Data Set (MDS) dated 6/9/22, indicated R28 was cognitively intact and had diagnoses that included moderate protein malnutrition. R28's care plan dated 6/9/22, indicated R28 was independent with eating and had a regular diet with thin liquids. Furthermore, staff should encourage resident to accept facility meals and offer alternatives as needed. R28's resident admission agreement dated	F 584	F 584 R 28 met with social service director and R 28 was notified of the facility policy pertaining to residents personal refrigerator. R28 was informed that any items that require refrigeration can be stored in the designated refrigerator located in the front room of the medication room. Food that are stored will be labeled and dated. Current residents will be informed of facility policy by social services and at resident council meeting. The policy prohibiting personal refrigerator will be included in the facility admission agreement for acknowledgement. Future residents will be allowed to bring personal food items which will be stored in the Nourishment refrigerator. The IDT team was in-serviced on the personal refrigerator policy.	

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F 584	Continued From page 28 5/26/22, lacked evidence of an agreement to not use personal refrigerators or a personal refrigerator policy. R28's medical record lacked evidence of an assessment or education of food storage had been completed. R28's assessment or education of food storage was requested however was not received. During an observation on 7/11/22, at 8:29 a.m. R28's room had a larger unopened boxed item in his room, pushed up against the wall. An interview on 7/11/22, at 8:30 a.m. R28 stated the facility food was not very good and he had stomach problems related to the food. R28 further stated there were not enough food choices and he preferred other healthier options and preferred to purchase food items from outside the facility. R28 stated their food items would go missing and staff was possibly eating the food, so R28 ordered a personal fridge to keep in his room. R28 stated the director of nursing (DON) initially told R28 he could have a personal fridge for his items, but then was later informed it was against facility rules by the Administrator. R28 further stated the refrigerator was right here in the box, but was unable to open it for use: "I just want to be able to have my own food and not worry about items missing". R28 was told by the Administrator if the refrigerator was in use, staff had to monitor temperatures and inspect the items food for safety. "Well come in and inspect it- I just want to have my own food". An interview on 7/12/22, nursing assistant (NA)-B stated R28 eats some meals at the facility but	F 584	Social Services and/or designee is responsible for compliance. Audits will be completed on resident request for home-like environment item request will begin weekly x 2 weeks then monthly x 3 months. Audits results will be reviewed by the administrator then taken to QAPI committee for further review and recommendations. Compliance: 8/30/2022	

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F 584	Continued From page 29	F 584		

preferred to bring in his own food items. NA-B stated food that was brought in was placed in the community fridge after being dated and labeled. NA-B stated R28 purchased items that were frozen and juices or fruit. If opened, food items need to be thrown out in three days, if not open can be in longer. NA-B was sure why R28 was not using the fridge in his room. NA-B was not aware of any food missing for R28.

An interview on 7/12/22, at 5:49 p.m. DON stated R28 had wanted a fridge, but residents cannot use personal fridges in the facility. DON further stated a resident could have one with a provider order, but there was not an indication for R28 to have one. DON acknowledged he was unaware of criteria needed to have a personal fridge in the facility. DON denied giving R28 permission to have one. DON stated the only other resident who had a personal fridge was R18 and was unaware of the criteria that allowed R18 to have one.

An interview on 7/12/22, at 6:06 p.m. the Administrator stated R28 purchased the fridge online without telling anyone. R28 doesn't like the food in the facility and often goes to purchase or order his own. The Administrator further stated she told R28 there was a resident fridge to store his items and "if I let [R28] have one (personal refrigerator), everyone else would want one." R18 was the only resident with a personal fridge and that was grandfathered in. The administrator stated this was her rule that was placed due to it creating another thing for staff to monitor and an increased risk of error. Administrator stated any opened items were thrown away within 3 days and if R28 stored items in a personal fridge he would eat it "...if I was at home I would eat it, but

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F 584	Continued From page 30 the rules are different here." The Administrator stated she was unsure there was a policy and again stated it was her decision due to resident risk. The Administrator was unsure if the rule was discussed with facility residents. A follow up interview on 7/14/22, at 10:17 a.m. the Administrator verified it was unknown if there was an electrical reason R28 could not use the fridge in the room. The administrator reviewed the personal food storage policy provided and verified it was a condensed version from the original. The original policy was provided, and any mention of personal fridge was crossed out. The administrator could not verify any communication was given to residents about the policy/rule for no personal fridges was discussed or provided to the residents. On 7/14/22, at 11:12 a.m. the Chief Operations Officer (COO) stated the no personal fridge policy started in 2019 and R18 was grandfathered in. The COO further stated the facility was allowed to make facility policies, for example, how some facilities are no smoking facilities. COO verified there was no documents about the policy, and nothing was given to residents upon admission, but could place in the admission agreement if required. A facility policy titled Personal food Storage, dated 2010, directed food or beverages brought in from outside sources for storage in the facilities pantries, refrigeration units, or personal room refrigerators will be monitored by designated facility staff for food safety. Furthermore, the policy directed individuals will be educated on safe food handing and storage techniques by designated facility staff as needed.	F 584		

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F 584	Continued From page 31 A facility policy titled Resident Rights dated 2001, directed residents have the right to retain and use personal possessions to the maximum extent that space and safety permit.	F 584		
F 623 SS=B	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of	F 623		8/30/22

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this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and
(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and

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F 623	Continued From page 33 email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure a written notice of transfer was provided to the resident and/or resident representative following a facility-initiated transfer for 3 of 3 residents (R60, R15, R9) reviewed for hospitalization. Additionally, the facility failed to notify the Office of the Ombudsman of facility-initiated transfers for 3 of 3 residents (R60, R12, R18) reviewed for Ombudsman notification. Findings include: Written notice of transfer:	F 623	F 623 R 60 and R 15 have discharged from the facility. R 9 will be presented for the hospital transfer that occurred and this form will be uploaded into the resident electronic medical record. All other residents who were transferred to the hospital from survey exit until present will have a transfer/discharge notice completed and uploaded into the electronic medical record and the ombudsman notification will be updated and sent. Future residents will have the transfer/discharge	

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F 623	Continued From page 34 R60's discharge Minimum Data Set (MDS) dated 4/17/22, indicated R60 cognition was not assessed and an unplanned discharged to a hospital occurred on 4/17/22. R60's progress note dated 4/15/22, indicated R60 was transferred to the hospital for evaluation and treatment. Facility census showed R60 did not return to the facility and remained on hospital leave until he was discharged on 5/6/22. Review of R60's medical record lacked indication R60 was provided a written transfer notice when transferred to the hospital on 4/17/22. During an interview on 7/14/22, at 9:00 a.m. the administrator stated R60 was not provided a written notice of transfer when he went to the hospital on 4/15/22. R15's significant change MDS, dated 5/12/22, identified R15 had intact cognition. When interviewed on 7/11/22 at 1:31 p.m., R15 stated he was just recently hospitalized for his blood sugar being too high. R15 recalled he was conscious and not gravely-ill when taken to the hospital, and he stated he did not recall being provided a written notice of transfer when he left for the hospital. R15 added, "This is the first I have heard about it." R15's progress note, dated 7/8/22, identified R15 was agitated, having emesis, and had a blood glucose of 456. Insulin was administered and the emesis subsided. The physician was notified and R15 was sent to the hospital. A subsequent note, dated 7/10/22, identified R15 re-admitted to the	F 623	notice presented before leaving the facility. Licensed nursing staff and social services will be in-serviced on the transfer discharge policy with emphasis on item #1 residents will be given a transfer notice prior to leaving the facility. Social Service director will be in-serviced on the Bed Hold Policy with emphasis on item #6 that the area Ombudsman will be notified of all transfers and discharges monthly. Social Services and/or designee is responsible for compliance. Audits on transfer notice issuance and Ombudsman notification will be weekly x 2 weeks then monthly to ensure compliance. Audits will be reviewed by the administrator and the administrator will take audit results to QAPI for review and recommendation. Compliance: 8/30/2022	

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F 623	Continued From page 35 nursing home. However, R15's medical record was reviewed and lacked any evidence a written notice of transfer had been completed or provided to R15 when he was hospitalized or since his return on 7/10/22. On 7/15/22 at 9:42 a.m., the director of nursing (DON) was interviewed and reviewed R15's medical record. The DON verified a written notice of transfer was not provided to R15 and should have been completed so, as a result, the DON asked R15 to sign the notice that day (7/15/22). The DON explained the nurse working when R15 was hospitalized was from an outside agency and it had been "a huge complication" to get needed and necessary forms completed at times with those nurse. The DON added it was important to ensure these written notices were provided so resident's were aware they "have the right to come back" and ensure their resident right's were maintained. R9's quarterly Minimum Data Set (MDS) dated 7/9/22, indicated R9 was mildly cognitively impaired and had unplanned discharges to the hospital on 4/30/22, and 6/20/22. The MDS lacked indication of an unplanned discharge on 7/14/22. A progress note dated 5/4/22, indicated R9 was readmitted to the facility after being hospitalized for COVID-19 from 4/30/22, through 5/4/22. A progress note dated 6/21/22, indicated R9 was admitted to the hospital with cardiac concerns. A progress note dated 7/4/22, indicated R9 was	F 623		

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F 623	Continued From page 36 admitted to the hospital with respiratory difficulties. During interview on 7/14/22, at 9:44 a.m. R9 stated he did not receive a written transfer notice for any of the three hospital admissions. Review of R9's medical record lacked evidence R9 was provided a written transfer notice when transferred to the hospital on 4/30/22, 6/21/22, and 7/14/22. R9's medical record also lacked evidence the ombudsman was notified of the hospital transfer. Notification the Office of the Ombudsman: R12's MDS dated 4/2/22 indicated intact cognition and an unplanned discharge to a hospital occurred on 4/2/22. R12's progress note dated 4/2/22, indicated R12 was transfer to the hospital. R12's progress note dated 4/5/22, indicated R12 was readmitted to the facility. Review of R12's medical record lacked indication the office of the ombudsman was notified of the transfer to the hospital. R18's MDS dated 5/3/22, indicated independence with decision making and an unplanned discharge to the hospital on 5/3/22. R18's progress note dated 5/3/22, indicated R18 was transferred to the hospital. R18's progress note dated 5/6/22, indicated R18 readmitted to the facility.	F 623		

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F 623	Continued From page 37 Review of R18's medical record lacked indication the office of the ombudsman was notified of the transfer to the hospital. R60's discharge Minimum Data Set (MDS) dated 4/17/22, indicated R60 cognition was not assessed and an unplanned discharged to a hospital occurred on 4/17/22. R60's progress note dated 4/15/22, indicated R60 was transferred to the hospital for evaluation and treatment. Facility census showed R60 did not return to the facility and remained on hospital leave until he was discharged on 5/6/22. R60's medical record also lacked indication the ombudsman was notified of the hospital transfer. An email dated 7/12/22, from Ombudsman-A informed she had not received notification from the facility of any hospital transfers since March 2022. During an interview on 7/14/22, at 10:43 a.m. Chief Operating Officer (COO) stated the social worker was expected to notify Ombudsman-A of all hospitalizations via a monthly email. During an interview on 7/14/22, at 10:44 a.m. social worker (SW)-A stated she had not notified Ombudsman-A of any hospitalizations. The facility policy, "Transfer or Discharge Documentation, dated 2016, included, "When a resident is transferred or discharged from the facility, the following information will be	F 623		

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F 623	Continued From page 38 documented in the medical record: a. The basis for the transfer or discharge; 1) If the resident is being transferred or discharged because his or her needs cannot be met at the facility documentation will include: (a) the specific resident needs that cannot be met; (b) this facility's attempt to meet those needs; and (c) the receiving facility's service(s) that are available to meet those needs. b. That an appropriate notice was provided to the resident and or legal representative."	F 623		
F 676 SS=D	Activities Daily Living (ADLs)/Mntn Abilities CFR(s): 483.24(a)(1)(b)(1)-(5)(i)-(iii) §483.24(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that: §483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section ... §483.24(b) Activities of daily living. The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living: §483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care,	F 676		8/30/22

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F 676	Continued From page 39 §483.24(b)(2) Mobility-transfer and ambulation, including walking, §483.24(b)(3) Elimination-toileting, §483.24(b)(4) Dining-eating, including meals and snacks, §483.24(b)(5) Communication, including (i) Speech, (ii) Language, (iii) Other functional communication systems. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide assistance with routine personal grooming (i.e., fingernail care) for 1 of 8 residents (R39) reviewed for activities of daily living (ADLs). Findings include: R39's admission Minimum Data Set (MDS), dated 6/9/22, identified R39 had intact cognition and was independent with personal hygiene. R39's care plan, dated 6/24/22, identified R39 had an ADL self-care deficit, had a weekly bath scheduled for Saturday evening, and listed an interventions which outlined, "PERSONAL HYGIENE: The resident is independent." On 7/11/22, at 2:52 p.m., R39 was observed in his room lying in bed. R39 had visibly long fingernails on both hands with several nails having a black-colored debris present underneath of them. R39 stated he typically kept his fingernails clipped shorter and had "been trying to get my fingernails cut for awhile," however, when	F 676	F 676 R 39s nails were trimmed per resident preference. R 39's ADL grooming care plan intervention were reviewed and updated as needed. Current residents needing assistance with grooming ADL their care plan intervention will be reviewed and updated as needed. The nursing department was in-serviced on the ADL policy and procedure item #2 that resident who are unable to carry out ADLs will be assisted by staff. Director of Nursing and/or designee is responsible for compliance Audits on resident grooming will begin 2x week for 2 weeks, weekly x 4 weeks then monthly to ensure compliance. Audits will be reviewed by the administrator and the administrator will take audit results to QAPI for review and recommendation. Compliance	

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F 676	Continued From page 40 he'd ask staff for help or a clippers, they would say they'd return but then never come back. R39's completed Weekly Skin Check, dated 7/12/22, identified a section labeled, "Nail Care," which provided several questions for staff to select a response. This included, "Finger Nails are trimmed, or filed," which was answered, "No," along with a comment which read, "Need finger nails trimmed." However, during subsequent observation on 7/14/22, at 11:21 a.m. (two days later), R39 continued to have the same visibly long fingernails with black-colored debris present underneath of them. R39 reiterated he wanted his fingernails clipped adding, "Oh, hell yea [I do]." R39's medical record was reviewed and lacked evidence R39 had been offered, refused and/or provided nail care the previous Saturday (7/9/22) when his bath was schedule per his care plan, nor despite the completed skin check identifying the need for such care on 7/12/22. When interviewed on 7/14/22, at 11:25 a.m., nursing assistant (NA)-A stated R39 needed minimal assistance to complete most ADLs and typically did not refuse cares when offered. NA-A stated "the nurses" were responsible to help R39 with grooming, including nail care, as he was a male and the NA(s) only are responsible to complete grooming for the women. NA-A reiterated, "We're [NA] responsible for grooming on women." NA-A observed R39's nails at this time and verified they had dark debris present underneath of the them, and NA stated they were "long, long" and needed to be clipped. Further, NA-A stated she noticed R39 often scratched his	F 676		

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F 676	Continued From page 41 arms and any refusals of offered nail care should be recorded in the nurses' notes. When interviewed on 7/14/22 at 11:36 a.m., licensed practical nurse (LPN)-A stated nail care should be provided on shower days by the NA staff unless the resident was diabetic, then it was the nurses' responsibility. LPN-A stated R39 was not diabetic and the NA staff were able to help him complete any personal hygiene or grooming cares needed or requested. LPN-A then left to observe R39's nails at the surveyor's request. LPN-A returned moments later and stated they were long and needed to be clipped, so she just clipped them. LPN-A stated R39 expressed they had not been clipped since he admitted to the nursing home several weeks prior. On 7/14/22 at 2:11 p.m., the director of nursing (DON) was interviewed and explained nail care should be completed with the weekly bathing. The DON verified all staff were able to complete a resident's ADL needs and he would "have an education" on this with the direct care staff. Further, the DON stated it was important to ensure routine grooming and nail care was provided as long, soiled nails could be an infection control issue. A provided Fingernails/Toenails (Care Of) policy, dated 2018, identified nail care included daily cleaning and regular trimming adding, "Proper nail care can aid in prevention of skin problems around the nail bed," and, "Trimmed and smooth nails prevent the resident from accidentally scratching and injuring his or her skin." Further, the policy outlined the provided nail care should be recorded in the medical record.	F 676		

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	245544	A. BUILDING _____ B. WING _____	C 07/18/2022

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VICTORY HEALTH & REHABILITATION CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 42	F 689		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, interview and document review the facility failed to comprehensively assess safe smoking practices for 1 of 1 residents (R47) reviewed for smoking. Findings include: R47's significant change Minimum Data Set (MDS) dated 6/17/22, indicated R47 was admitted to the facility on 5/23/22, had mild cognitive impairment and diagnoses of cerebral infarction (stroke) with left sided hemiparesis (weakness). R47s hospital discharge records dated 5/19/22, indicated R47 had an active diagnoses of tobacco disorder. Furthermore, the records indicated R47 was a current daily smoker who smoked .5 (1/2) packs per day. R47's resident smoking observation assessment dated 5/26/22, indicated R47 never smoked and was not a current smoker. R47's nursing progress note dated 5/26/22, indicated R47 smoking observation was complete	F 689	F 689 R 47 had a new smoking assessment completed and the resident care plan was reviewed and updated. Current residents who smoke, their smoking assessments and care plans were reviewed and updated as needed. Future residents will be assessed upon admission for smoking and a smoking assessment and care plan will be initiated. IDT will be in-serviced on the Smoking Policy with emphasis on item #6 that residents will be assessed upon admission for smoking and the smoking policy will be reviewed with the resident upon admission. Social Service designee and/or designee is responsible for compliance. Audits on resident smoking assessment, care plan and if the resident is smoking in the designated smoking area will begin 2x week for 2 weeks, weekly x 4 weeks then monthly to ensure compliance. Audits will be reviewed by the administrator and the administrator will take audit results to QAPI for review and	8/30/22

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F 689	Continued From page 43 and "based on this observation the resident was (blank, nothing was identified on the form of the observation of the resident)". A facility document titled List of Current Smoker, updated 7/11/22, had not included R47. During an interview on 7/11/22, at 11:54 a.m. R47 stated the provider ordered not to smoke and that was (explicit language) as R47 had been smoking since age 12. "If I had cigarettes I would be out smoking". R47 further stated the facility was aware of her smoking and had not required any supervision while smoking. R47 was unaware of any smoking assessment completed. An observation on 7/12/22, at 8:02 p.m. R47 was sitting in the wheelchair outside the front of the facility. R47 was behind a pillar to the left side by the small patio area. R47 had a cigarette in her hand and was smoking. In her lap were two packs of cigarettes. R47 stated her brother finally came and she was happy. R47 then flicked the cigarette on the ground as Maintenance-A walked out of the front door to help R47 back in due to it starting to rain. An observation on 7/13/22, at 11:17 a.m. R47 shouted "I paid 25 bucks last night and I want my cigarettes back ...doesn't have an assessment on me, never needed one before." at activities aide (AA)-A During an interview on 7/13/22, at 12:01 p.m. licensed practical nurse (LPN)-D stated R47 talked about smoking sometimes but was not aware of R47's smoking status. Furthermore, LPN-D stated if R47 smoked, supervision was needed.	F 689	recommendation. Compliance: 8/30/2022	

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F 689	Continued From page 44 During an interview on 7/13/22, at 1:13 p.m. AA-A stated R47 had not mentioned smoking until recently. When AA-A arrived to work today, R47 had cigarettes in the lock box, but a nurse had not completed an assessment so it was unknown what support was needed for R47 to be safe when smoking. AA-A recognized R47 was very upset throughout the day and wanted to smoke. AA-A further stated the director of nursing (DON) was notified this morning about needing an assessment, but one had not been completed. An observation on 7/13/22, at 1:40 p.m. R47 was observed in the hallway near the nurses station yelling "I don't care about any assessment ...never had to do it before. I want my cigarettes". During an interview on 7/13/22, at 3:02 p.m. DON stated an assessment was required for any resident who smoked. The assessment was important and determined a resident's ability to smoke safely. DON stated R47 was not a regular smoker previously and suddenly wanted to smoke. DON verified R47 had made comments about wanting to smoke off and on since admission, but R47 was not consistent with the request to smoke. DON stated he was aware of R47's need of an assessment this morning but wanted to complete the assessment himself as the state agency (SA) was onsite. DON was not aware R47 was upset about waiting for the assessment to be completed and stated if the SA was not in the building, he expected the assessment to be completed right away. DON further stated he expected all residents to have an assessment completed before smoking to ensure resident safety.	F 689		

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F 689	Continued From page 45 A facility policy titled Smoking Policy, updated 1/18/22, directed residents who smoke will be assessed by nursing for safety at the time of admission, quarterly, and with change of condition.	F 689		
F 697 SS=D	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to comprehensively reassess and develop interventions to ensure implemented pain-relief interventions were effective and pain was adequately managed for 1 of 2 residents (R39) reviewed for pain management. Findings include: R39's admission Minimum Data Set (MDS), dated 6/9/22, identified R39 had intact cognition, was independent with nearly all of his activities of daily living (ADLs), and have several medical conditions including heart failure, spinal stenosis, and low-back pain. Further, the MDS outlined R39 received schedule and as-needed (PRN) pain medication, and had pain "frequently" over the review period which he rated a three (3) out of 10 (10 being the worst). R39's Pain Interview (MDS) with Pain	F 697	F 697 R 39 had a new pain assessment completed, pain medication adjustment and R 39's pain care plan reviewed and updated. Existing residents who receive pain medication were reviewed for pain medication effectiveness and their pain care plan was reviewed and interventions updated as needed. Future residents will have a pain care plan initiated and interventions implemented. Nursing staff was in-serviced on the policy Administering Pain Medications with emphasis on item # 9 under steps in the procedure section that the nurse assess the resident after the onset of pain and reassessed until relief is obtained. Director of Nursing and/or designee is responsible for compliance. Audits on pain medication administration and effectiveness will begin 2x week for 2 weeks, weekly x 4 weeks then monthly to	8/30/22

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F 697	Continued From page 46 Management Review, dated 6/7/22, identified R39 was interviewed about his pain and stated he had pain or hurting during the last five-day period which he described as, "Frequently." R39 denied the pain woke him up or affected his day-to-day activities, and R39 rated the pain at a "3" on a 0 - 10 scale (10 being the worst). The assessment continued and listed a section labeled, "Pain Management," which outlined several areas and questions to be completed by the nurse. These included determining if R39 was on scheduled or as-needed pain medications, if the treatments had side effects and were effective, any administration patterns, and any non-pharmacological interventions used for pain. However, all of these sections were left blank and not completed. The assessment concluded with dictation reading, "Resident received tylenol and hydrocodone [a narcotic]. this is effective for his pain symptoms." R39's care plan, dated 6/20/22, identified R39 was on pain medication therapy and listed a goal for R39 which read, "The resident will be free of any discomfort or adverse side effects from pain medication ..." The care plan listed several interventions to help R39 meet this goal including administering analgesic medication as ordered, monitor for increased risk for falls and/or injury, and, "Review (SPECIFY FREQ[uency]) for pain medication efficacy. assess [sic] whether pain intensity acceptable to resident, no treatment regimen or change in regimen required ... " On 7/11/22, at 2:36 p.m., R39 was observed in his room lying in bed with an ice pack under his shoulder. R39 was interviewed at this time and stated he had pain 'everywhere" which included his neck, shoulders, hips and extended down his	F 697	ensure compliance. Audit results will be reviewed by the Administrator and the Administrator will bring audit results to QAPI for review and recommendation. Compliance: 08/30/2022	

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F 697	Continued From page 47 thigh which he described as "like giant cramps that won't go away." R39 explained he had been admitted to the hospital prior to coming to the nursing home where he had been told his lumbar vertebrae (L4 and L5) were "shot" and causing him severe nerve pain. R39 stated he took "a ton" of medications, including pain medications, but was unsure of what exactly as the nursing home staff just give them to him. R39 stated he felt his pain was well managed when he first admitted to the nursing home; however, since then a "pain physician" had taken over his medication regimen and decreased his medications which caused him to not have adequate pain relief. R39 expressed this pain physician had only seen him once since admission to the nursing home and questioned why he was allowed to change prescriptions and medication orders with no follow up since then. Further, R39 reiterated he was not satisfied with his current pain management regimen and, again, expressed the hospital had his pain under control when he left and now at the nursing home it was "all [expletive] up." R39's Medication Administration Record (MAR), dated June 2022, identified R39 admitted to the nursing home on 6/2/22, and since used several scheduled medications for pain including a lidocaine patch applied daily, Lyrica 75 milligrams (mg) once a day, and Tylenol 1000 mg twice a day. Further, R39's consumed as-needed (PRN) medications identified an order for hydromorphone 2 mg every four hours as needed for pain. This recorded R39 consumed a total of 16 doses of PRN hydromorphone (2 mg) between 6/3/22 and 6/15/22, with corresponding pain ratings between "3" and "8," with R39 rating his pain below a "5" only three times with five times of pain rated "6' or higher being recorded. On	F 697		

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F 697	Continued From page 48 6/16/22, the original hydromorphone order was discontinued, and a new order was entered which directed to give 1 tablet (2 mg) twice a day PRN with directions, "Educate resident that he now receives 1 tablet two times a day as needed." This recorded R39 consumed a total of 12 doses of PRN hydromorphone (2 mg) between 6/16/16 and 6/29/22, with R39 rating his pain below a "5" now only two times with nine times of pain rated "6" or higher being recorded. On 6/29/22, the hydromorphone order was again discontinued, and a new order was entered which directed, "Norco 5-325 mg ... 1 tablet by mouth as needed for pain ... three times a day." This recorded only a single dose being given on 6/29/22, with a pain rating of "7" listed. This was effective. Further, in addition to the provided PRN narcotic medication, the MAR identified R39 received a total of three doses of tizanidine HCL (4 mg) (a muscle relaxant) between 6/11/22 and 6/23/22, however, there was no recorded pain rating with these administrations. R39's handwritten Physician Orders, dated 6/29/22, identified the pain physician changed R39's pain medication regimen and wrote the following orders: 1) Discontinue Dilaudid (hydromorphone), 2) Norco 5/325 mg one tablet three times daily as needed, and, 3) Belbuca 150 mcg (micrograms; medication used to treat pain and/or addiction to narcotic pain medications) 1 film bucally twice daily. R39's MAR, dated July 2022, identified R39 continued to use several scheduled medications for pain including a lidocaine patch applied daily, Lyrica 75 milligrams (mg) once a day, and Tylenol 1000 mg twice a day. The Belbuca 150 mcg film was listed as being administered for all doses	F 697		

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F 697	Continued From page 49 during the month along with a corresponding pain rating scale which outlined R39 reported his pain ratings were between "0" and "9," with four of the six times pain was recorded being at "7" or above. The Tylenol 1000 mg dose was listed as being administered consistently with only six times the medication was not given due to R39 being absent from the nursing and/or refused. The corresponding pain rating scale for this medication was listed which outlined R39 reported his pain rating were between "0" and "9," with four of the 10 times pain was recorded being at "7" or above. R39's as-needed (PRN) medications were listed which identified Norco 5/325 mg was administered three times with corresponding pain ratings being listed as, "6,", "5", and, "4," respectively. Further, R39's PRN tizanidine HCL (4 mg) was recorded as being administered seven times during the month, so far, with doses being both effective and ineffective in pain relief. R39's progress notes, dated 6/29/22 to 7/12/22, were reviewed. On 7/11/22, a note recorded, "Resident's back, shoulder, neck, and legs hurt to [sic] much to sit in Dialysis chair ... therefore he is unable to go to dialysis today ... said he will resume dialysis on Wednesday, 7/13/22." However, R39's medical record was reviewed and lacked evidence R39 had been comprehensively reassessed by the nursing staff to ensure the implemented interventions and adjusted pain medication regimen completed on 6/29/22 was effective and adequately managing his pain despite numerous continued pain ratings being recorded above five (5), and R39 now being recorded as missing scheduled dialysis treatments due to pain.	F 697		

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F 697	Continued From page 50 During subsequent observation, on 7/12/22 at 5:21 p.m., R39 was seated on a four-wheeled walker in the hallway outside his room. R39 stated his pain seemed better but he was still "sore as hell." R39 stated he had not used any ice packs so far that day as staff accidentally threw them out. When interviewed on 7/14/22 at 11:25 a.m., nursing assistant (NA)-A stated R39 needed minimal help to complete his activities of daily living (ADLs) and staff usually just provided him with towels or washcloths in the morning. NA-A stated she had never heard R39 complain of pain before when questioned. When interviewed on 7/14/22 at 1:05 p.m., licensed practical nurse (LPN)-A stated R39 was followed and "the pain doctor" who oversees his medication regimen, with R39's medications being last adjusted on 6/29/22, when the Dilaudid was discontinued and the Norco was started. LPN-A explained she had worked with R39 only twice in the past few weeks but she recalled he had complained of back pain. LPN-A stated the floor nurses were responsible to complete initial and ongoing pain assessments, and LPN-A reviewed R39's initial pain assessment in the record (Pain Interview (MDS) with Pain Management Review, dated 6/7/22). LPN-A stated the assessment was not adequately completed and added, "I guess we're going to have to do this assessment over." Further, LPN-A stated she was unaware when, or if, pain re-evaluations were completed after medication orders were changed but verified the record lacked evidence a comprehensive reassessment of R39's pain was completed after the 6/29/22	F 697		

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F 697	Continued From page 51 medication adjustments. On 7/15/22 at 9:52 a.m., the director of nursing (DON) was interviewed, and he explained a formal pain evaluation should be completed on admission, quarterly thereafter and "PRN as needed." The DON explained the nurses were asking residents, including R39, their pain using a pain scale on a daily basis which "based on that" response would trigger interventions. The DON reviewed R39's completed, initial pain evaluation and stated it "should be updated" and completed. The DON expressed R39 was seen by a pain physician who typically rounded on a weekly basis, however, had not returned to re-evaluate R39 since 6/29/22, when the orders for his pain medication were adjusted. The DON acknowledged R39 had several pain ratings above a five (5) recorded on his rating and had missed his dialysis appointment as a result of pain and, as a result, he expected R39 to be reevaluated by the physician for his pain which had not happened. Further, the DON reviewed R39's medical record and verified it lacked evidence R39 had been comprehensively reassessed for his pain after 6/29/22, despite having pain medications adjusted and missing medical appointments due to complaints of pain and discomfort. The DON stated one should have been completed to ensure adequate pain relief was provided and added, "I am going to include it on my education." A provided Pain - Clinical Protocol policy, dated 2018, identified the physician and staff would identify persons who have pain or who are at risk for pain. The policy directed, "The nursing staff will assess each individual for pain upon admission ... whenever there is a significant	F 697		

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F 697	Continued From page 52 change in condition, and when there is onset of new pain or worsening of existing pain," including identifying the characteristics of the pain, intensity of the pain, frequency of the pain, and any patterns. Further, the policy outlined, "The staff will reassess the individual's pain and related consequence at regular intervals; at least each shift for acute pain or significant changes in levels of chronic pain and at least weekly in stable chronic pain."	F 697		
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to provide an ongoing assessment of the resident's condition and monitoring for complications pre and post dialysis treatments for 1 of 1 residents (R53) reviewed for dialysis. Furthermore, the facility failed to ensure ongoing communication and collaboration with the dialysis facility. This deficient practice resulted in a missed medication order for R53 and has the potential to impact all three residents residing in the facility who receive dialysis treatment. Findings include: R53's significant change Minimum Data Set, dated 6/21/22, indicated R53 was admitted to the facility on 5/30/22, was cognitively intact, received	F 698	F689 R53 has been discharged from the facility. Current residents receiving dialysis services will be reviewed for post dialysis assessment completion F 698 R 53 has since discharged and post dialysis communication received from dialysis facility. Future residents receiving dialysis services will have Nursing staff will be in-serviced on the Dialysis Care policy with emphasis on items #3 and #4 to complete the dialysis assessment after each resident treatment and to review dialysis documentation when resident returns. DON and/or designee will be responsible for compliance. Audits on dialysis post treatment	8/30/22

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F 698	Continued From page 53 dialysis and had diagnoses of diabetes, and chronic kidney disease. R53's order summary report, printed 7/15/22, indicated bumex (medication to remove excess fluids) 1 milligram (mg) by mouth twice a day for high blood pressure was ordered on 7/13/22. R53's dialysis appointments were scheduled on Tuesdays, Thursdays, and Saturdays at 8:00 a.m. at DaVita Dialysis Center in Arden Hills. The order summary lacked orders directing staff to monitor or assess R53 pre or post dialysis treatments. R53's care plan dated 6/22/22, indicated R53 required dialysis related to renal failure. Interventions included to check and change dressing daily at access site and document, encourage to go to dialysis appointments, and do not draw labs or take blood pressure from left arm with fistula site. R53's care plan lacked further post dialysis treatment monitoring. A review of R53's electronic medical record (EMR) revealed R53's post dialysis assessment was completed 4 times (6/11/22, 6/25/22, 6/30/22, 7/12/22) out of the 19 scheduled dialysis treatments since admission. The remaining 15 assessments were requested by the facility however were not provided. A review of R53's dialysis binder on 7/12/22, revealed the dialysis center's post dialysis treatment report was received for R53's dialysis treatment on 7/5/22, a lab report was received dated 3/31/222, and a weekly rounding sheet was received from 6/23/22. The binder lacked any other post treatment reports from the dialysis facility.	F 698	assessment and received communication review will began daily x 5 days, weekly x 4 weeks then monthly to ensure compliance. All audits will be reviewed by the Administrator and brought to QAPI for review and recommendation. Compliance: 8/30/2022	

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F 698	Continued From page 54 A review of R53's paper medical record lacked evidence of any further post dialysis reports or weekly rounding sheets. R53's weekly rounding sheet dated 6/23/22, indicated written orders for bumex 1 mg by mouth twice daily. A dialysis agreement between DaVita Dialysis and the facility was requested but was not provided. An email communication dated 7/14/22, indicated the Administrator had requested a nursing home transfer agreement from DaVita Dialysis. During an interview on 7/13/22, at 9:17 a.m. R53 verified dialysis treatments are Tuesday, Thursday, and Saturday. R53 further stated when she returned from a dialysis treatment, staff check her blood pressure and blood sugar and stated, "I need my medications, so I don't let them forget that". R53 was not sure about any other assessments completed after dialysis and stated paperwork was not always sent from the dialysis center. During an interview on 7/13/22, at 9:46 a.m. licensed practical nurse (LPN)-D stated R53 had not always return with paperwork after dialysis and stated sometimes a call was placed to send the information. LPN-D verified no paperwork was sent with the resident on 7/12/22, so the dialysis center was called. LPN-D was not aware if any information was faxed from the dialysis center. If there were orders from the dialysis provider, the nurse at the desk would transcribe them. LPN-D stated the post dialysis	F 698		

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F 698	Continued From page 55	F 698		

assessment had to be completed after each dialysis treatment. LPN-D verified there was not much information in R53's dialysis binder.

During an interview on 7/14/22, at 7:55 a.m. LPN-A stated there used to be a form to complete and send with residents before going to dialysis but was not sure if that was still the process. LPN-A stated after a dialysis treatment paperwork may be delivered. Sometimes residents take paperwork to their rooms and sometimes staff get it. LPN-A further stated if staff have it, it was filed in the resident's dialysis binder. When asked about post dialysis assessments, LPN-A verified vital signs had to be completed.

During an interview on 7/14/22, at 9:22 a.m. dialysis registered nurse (RN)-P stated residents usually arrived to the dialysis center with paperwork with them. The paperwork included the resident face sheet, weight, and vital signs. RN-P verified there was no envelope or paperwork sent with R53's dialysis treatment on 7/14/22. If there was an envelope sent with the resident, a post dialysis report was sent back in the envelope. RN-P further stated the facility can always call and request information, but a verbal or phone report was not given unless there was an issue with the resident's dialysis treatment. RN-P further stated she was not certain how new orders were sent back to the facility, but likely they would be written on the post-dialysis report given to the facility.

During an interview on 7/14/22, at 9:48 a.m. dialysis physician assistant (PA)-A verified R53 had bumex was ordered by the dialysis team on 6/23/22. This medication was restarted to help maintain fluid levels for R53. R53 does not

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F 698	Continued From page 56 respond well when too much fluid was taken off in a dialysis run and this medication aided in fluid management. PA-A expected this medication to be started when ordered or other communication to be had if there was a contraindication. PA-A further stated the dialysis nurse would send the orders to the facility through communication or a phone call. It was then up to the facility to place the order. In review of R53's labs and weights, PA-A stated there was no adverse impact on R53's status from the delayed start of bumex medication. During an interview on 7/14/22, at 11:30 a.m. the director of nursing (DON) stated the nursing staff were expected to complete a post dialysis assessment each time a resident returned from a dialysis treatment. DON further verified this was important to complete and ensure resident safety and minimize any risks. Furthermore, the DON expected staff to send an envelope with a communication sheet, that has the resident weights, vital signs and any concerns that may be going on with the resident, to dialysis. When the resident returned, the envelope should be given to the nursing staff and contain the post dialysis report and any new orders from the dialysis providers. DON reviewed R53's dialysis binder and verified there were many post dialysis reports were missing but thought the health unit coordinator (HUC)-A may have more that were not filed. During an interview on 7/14/22, at 11:47 a.m. HUC-A stated she had not given any dialysis residents envelopes when going to dialysis. HUC-A further stated since dialysis was a routine appointment that happened so frequently, an envelope was not required. HUC-A stated	F 698		

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F 698	Continued From page 57 sometimes information was sent back, but not often. HUC-A further indicated no knowledge of a dialysis binder for residents or what information was placed in them. During a follow up interview on 7/14/22, at 11:55 a.m. DON verified there was process used to coordinate with dialysis, but the process was not implemented due to a lack of education of HUC-A who had not received the correct training. Furthermore, DON acknowledged this lack of coordination led to the transcribing error with R53's bumex. DON stated if the correct form was sent with R53, there was a section for new orders that would have been easier to acknowledge. DON stated coordination and communication were important to ensure orders and plan of care moves forward and minimizes the risk for error. During an interview on 7/15/22, at 3:24 p.m. the Dialysis Administrator was not able to locate a dialysis contract with the facility. A facility policy titled Dialysis no date, directed the facility must ensure residents who require dialysis are provided with services consistent with professional standards of practice.	F 698		
F 732 SS=C	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and	F 732		8/30/22

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F 732	Continued From page 58 unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure required and complete nurse staffing information was posted in a readily available, visible location with the nursing home. This had potential to affect all 54 residents and visitors who wanted to review this information. Findings include:	F 732	F 732 The daily nurse staff information was revised and moved to a location accessible for all residents and visitors in the facility can view. The daily staffing sheets from July 2022 were re-created and the current staffing postings have been posted and any adjustments to staffing were revised per facility policy.	

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F 732	Continued From page 59 On 7/11/22 at 9:28 a.m., a tour was completed of the nursing home including the main desk, nursing station, and public hallways of the building. However, there was no posted nurse staffing information located. Further, on 7/11/22, the past three weeks of posted nurse staffing information was requested; however, none was ever provided or received. When interviewed on 7/11/22 at 10:21 a.m., the human resources coordinator (HRC)-A stated the nurse staffing information was supposed to be presented on a bulletin board outside the administrator's office by the main entrance. HRC-A verified there was no posted information and expressed while she was the person responsible to ensure this was completed, she had previously had an assistant who was helping her with these tasks, however, the person had "stopped doing it" before she resigned. HRC-A stated she was unable to provide the past several weeks of nurse staffing posting(s) as they had not been done or displayed. HRC-A stated the last copy of a nurse staffing posting they could locate and provide was dated 5/13/22 (nearly two months prior). HRC-A stated the information, including census and total nursing hours worked, should have been posted so residents and visitors could review it, if desired. On 7/13/22 at 3:10 p.m., the interim administrator was interviewed, and she verified the required nurse staffing data and information had not been posted for past several weeks. The administrator stated the information should have been posted and added "moving forward" she would ensure it happened which was important "so that we know our staff ratio."	F 732	On weekends, the charge shift nurses are responsible for positing and making adjusting to the weekend staff posting. The staffing coordinator will be in-serviced on the staffing policy and procedure with emphasis on the policy statement that the facility will post on a daily basis the number of nursing personnel responsible for providing direct resident care. Staffing coordinator and/or designee is responsible for compliance. Audits for staffing posting requirements begin weekly x 2 weeks then monthly to ensure compliance. Audits will be reviewed by the Administrator and brought to QAPI for review and recommendation. Compliance: 8/30/2022	

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F 732	Continued From page 60 A provided Posting Direct Care Daily Staffing Numbers policy, dated 2016, identified the facility would post, on a daily basis for each shift, the number of nursing personnel responsible for providing direct care to residents. This posted information would include the facility name, date, census, type of staff, and the total and actual hours worked for those staff members. Further, the policy directed the records of these postings would be kept for a minimum of 18 months or as required by State law.	F 732		
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	F 758		8/30/22

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F 758	Continued From page 61 contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure as-needed (PRN) antipsychotic medications were limited to 14 days of use or re-evaluated by the medical provider to ensure necessity and reduce the risk of complication for 1 of 5 residents (R27) reviewed for unnecessary medication use. Findings include: R27's quarterly Minimum Data Set (MDS), dated 5/30/22, identified R27 had severe cognitive impairment and demonstrated no physical, verbal, or other behavioral symptoms during the	F 758	F 758 * DPOC R 27 was discharged from the facility on 8/23. All other residents with PRN psychotropic medications, their orders will be reviewed and a stop date will be added to the current order. For future residents receiving PRN psychotropic medications, a automatic stop date will be added to the order unless the physician rational is documented. Licensed nurses will be in-serviced on the Antipsychotic Medication Policy item #14 that unless identified, an automatic 14-day stop date will be included into the	

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F 758	Continued From page 62 review period. Further, the MDS outlined R27 consumed antidepressant and antipsychotic medication on a daily basis during the review period. R27's care plan, dated 6/8/22, identified R27 was at risk for adverse reaction due to psychotropic medication use and listed a goal for R27 which read, " ... will be/remain free of psychotropic drug related complications ... through review date." The care plan listed several goals to help R27 meet this goal including administering medications as ordered, consulting with the pharmacy or physician to consider dose-reductions when appropriate, and monitoring for adverse effects of medications. R27's Twin Cities Physicians order, dated 6/6/22, directed to discontinue R27's current Seroquel (an antipsychotic medication) orders and begin the following: 1) Seroquel 12.5 milligrams (mg) by mouth daily, and, 2) Seroquel 12.5 mg by mouth daily PRN. The completed order did not list a stop date for the PRN dosing of antipsychotic. R27's Medication Administration Records (MAR), dated 6/1/22 to 7/14/22, identified R27 continued to have an active, current order for the PRN Seroquel which listed a start date of 6/10/22; however, R27 had received no doses of the as-needed antipsychotic. R27's progress note, dated 6/22/22, identified R27's medical regimen had been reviewed by the consulting pharmacist (CP) and no recommendations were made. However, R27's medical record was reviewed and lacked evidence the PRN antipsychotic medication had an established stop date, or the medication had	F 758	physician order. A Directed Plan of Correction will also be conducted by the IDT team and a root cause will be identified and from the identified root cause a plan for correction will be implemented. The Director of Nursing and/or designee is responsible for compliance. Audits on PRN psychotropic medication stop date will begin 2x week for x 2 weeks, weekly x 4 weeks then monthly to ensure compliance. Audits will be reviewed by the Administrator and brought by the Administrator to QAPI for review and recommendation. Compliance: 8/30/2022	

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F 758	Continued From page 63 been reviewed by the physician for continued need and/or efficacy since being ordered on 6/10/22 (over a month prior). When interviewed on 7/14/22 at 1:23 p.m., nursing assistant (NA)-A stated R27 was able to ambulate on her own and required cues or supervision to complete most activities of daily living (ADLs). NA-A stated, at times, R27 would pack up her belongings and then tell staff she needed to find her car or "go to the bank," but aside from those infrequent episodes, R27 really demonstrated no behavioral issues or complications. On 7/14/22 at 1:49 p.m., the CP was interviewed. CP stated the medication had been entered into an "other" category when the nursing staff listed it in the physician orders and, as a result, the PRN Seroquel and lack of a stop date was missed on his review. CP stated had it been identified on his review on 6/22/22, it would have been written as a recommendation to be addressed by the nurses as as-needed antipsychotic orders must be re-evaluated or discontinued after 14 days regardless of patient use. When interviewed on 7/15/22 at 10:10 a.m., the director of nursing (DON) stated he had reviewed R27's medical record, and he verified R27's as-needed antipsychotic medication extended beyond 14 days without re-evaluation. As a result, the DON had just reached out to the physician and got the order discontinued. Further, the DON stated addressing as-needed psychotropic medications, including their stop dates and re-evaluations, was a "collaborative effort" between the nurses and pharmacist and they would work to ensure such incident didn't happen	F 758		

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F 758	Continued From page 64 again adding this was important to do so residents don't receive medication "if not necessary." A provided Antipsychotic Medication Use policy, dated 2016, identified antipsychotic medications would be prescribed at the lowest possible dosage for the shortest period of time. The policy outlined the need to continue PRN orders for psychotropic medications beyond 14 days required the physician or provider to document the rationale for the order and indicate the duration of the order. Further, "PRN orders for antipsychotic medications will not be renewed beyond 14 days unless the healthcare practitioner has evaluated the resident for the appropriateness of that medication."	F 758		
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure medications were administered in accordance with physician orders and standards of care for 2 of 4 residents (R25, R53) observed to receive medication during the survey. A total of 4 of 26 opportunities were in error resulting in a 15.38% medication error rate. Findings include: On 7/12/22 at 5:32 p.m., licensed practical nurse	F 759	F 759 R 25 MD will be notified that R 25 medications were administered late on 7/12/2022. The MD response will be recorded in the resident electronic medical record. R 53 has since discharged from the facility. Current resident medication times were reviewed to ensure correct medication pass times and frequency. With meals and every 8 hour (6 am, 2pm and 10pm) pick list for	8/30/22

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F 759	Continued From page 65 (LPN)-B prepared medications for R25 in the hallway from a mobile cart. LPN-B had the electronic Medication Administration Record (MAR) open which displayed a single red-colored rectangle with a bolded "1600 [4 p.m.]" and the name of a medication to be given. LPN-B stated the red coloring meant it was "time now to give it," and presented the medication card to the surveyor for review which directed Baclofen (a muscle relaxant used to treat muscle spasms) 20 milligrams (mg) three times a day as needed for muscle spasm. However, LPN-B stated the medication was actually scheduled for every eight hours and was due to be given at 4:00 p.m., but the trained medication aide (TMA) did not show up for their shift so it was late. LPN-B stated medications with specific times ordered (i.e., every eight hours) have a one-hour window on either side of the time to be given. LPN-B then removed and placed a single tablet of the medication into a cup and entered R25's room. R25 was seated on the bed and stated his back was sore when asked. R25 was asked to rate his current pain level and responded, "10 [out of 10]." LPN-B then administered the medication to R25. Immediately following, R25's current physician orders were reviewed. R25's Twin Cities Physicians order, dated 6/24/22, identified a physician order which read, "Patient is requesting Baclofen scheduled instead of PRN - Please contact Dr. [name] regarding this." The same order then had black-colored handwritten directions by the director of nursing (DON) which read, "T.O. [telephone order] every 8 hrs [hours] scheduled." The telephone order was dated 6/24/22. R25's admission Minimum Data Set (MDS), dated	F 759	the medication pass time was added to the facility EMR. Licensed Nurses and TMAs will be in-serviced on the Administering Medication Policy and procedure with emphasis on item #7 that medications are administered 1 hour before their prescribed time unless otherwise specified. Director of Nursing and/or designee is responsible for compliance. Audits on medication delivery timely, medication availability and medication label check will begin 2x week for x 2 weeks, weekly x 4 weeks then monthly to ensure compliance. Audits will be reviewed by the Administrator and brought by the Administrator to QAPI for review and recommendation. Compliance: 8/30/2022	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	C 07/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 759	Continued From page 66 5/27/22, identified R25 had intact cognition. When interviewed on 7/12/22 at 5:47 p.m., R25 stated he was not consistently getting his Baclofen every eight hours as was ordered adding "a lot of times" he had to physically ask the staff for them to bring it to him. R25 stated the nurses seemed to pass medications by wing rather than by times ordered, as sometimes, he would not get his scheduled 4:00 p.m. Baclofen dose until after the supper meal. Further, R25 stated the Baclofen did seem to help reduce his back pain when it was given consistently and on-time as ordered. When interviewed on 7/12/22, 5:52 p.m., LPN-B verified the medication was administered late; however, stated he was unsure if a late administration would be considered a medication error or not. LPN-B reiterated the one-hour window before and after the scheduled time for time-specific medications to be given and stated he felt it was best to contact the physician and let them know it was given late. When interviewed on 7/13/22, at 1:24 p.m., the director of nursing (DON) stated medications with specific times listed needed to be given within "an hour before or an hour after" the listed time. The DON stated if staff go "way, way beyond" the time, then the physician should be notified and a late administration, such as happened with R25's Baclofen, could possible constitute a medication error. The DON added, "I will give him an education." When interviewed on 7/14/22, at 10:25 a.m., the consulting pharmacist (CP) stated specific medications required "more timely" administration and "an hour before and an hour after is reasonable" for those to be given. CP stated he	F 759		

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F 759	Continued From page 67 typically discouraged specific schedules of medications (i.e., every eight hours), and expressed he would have to consider the nursing home's policy before determining if an error had happened or not with R25's Baclofen. CP stated this scenario and event would be a "good point" to bring to the next Quality Assurance (QA) meeting but added, "We don't want a person waiting in pain." On 7/12/22, at 7:04 p.m., LPN-C prepared medications for R53 in the hallway from a mobile cart. LPN-C opened R53's MAR and read aloud each medication due to be administered which included Phoslo (used to prevent elevated phosphate levels in dialysis patients), Atorvastatin (used to treat high cholesterol levels), and Pyridoxine (Vitamin B6; used to prevent B6 deficiency). LPN-B then presented a single medication card to the surveyor for review which directed Phoslo (calcium acetate) 2,001 mg " ... by mouth three times a day with meals." However, LPN-B stated there was no supply of Atorvastatin or Pyridoxine to administer R53 adding, "We don't have that." LPN-B stated he was unsure why there was no supply of the medication but explained he would order it and hopefully get some the same evening. LPN-B then administered the remaining available medications to R53 in her room. Immediately following, R53's current physician orders were reviewed. R53's Transfer Orders, dated 5/30/22, identified R53's physician-ordered hospital discharge medications. This included: - Phoslo 667 mg, "take 3 Capsules (2,001 mg) by mouth three times a day with meals;"	F 759		

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F 759	Continued From page 68 - Atorvastatin 40 mg, "Take 1 tablet (40 mg) by mouth daily at bedtime; and, - Pyridoxine 25 mg, "Take 1 tablet by mouth every evening." R53's significant change MDS, dated 6/21/22, identified R53 had intact cognition. On 7/12/22, at 7:24 p.m. R53 was interviewed and stated she went to dialysis several times a week at an offsite clinic. R53 stated she ate her supper meal "between 6:15 [p.m.] and 6:30 [p.m.]" which was approximately an hour prior. R53 stated she recalled the Phoslo was supposed to be given with meals but added she "never gets it like that" with the staff often giving the medication before or after the meal. R53 stated she was unsure of her last phosphate level or if it was elevated. On 7/12/22, at 7:44 p.m. LPN-C and the DON were interviewed. LPN-C stated he provided the Phoslo to R53 after 7:00 p.m. as it was scheduled for 8:00 p.m. in the MAR. LPN-C and the DON both acknowledged the label and physician orders which directed to give the medication with meals, and the DON added he would "look into this" to determine what happened. During subsequent interview on 7/13/22 at 10:37 a.m., the DON stated they were unable to get R53's Atorvastatin and Pyridoxine from the pharmacy last evening so the medications were not given as ordered. The DON stated R53's Phoslo should have been given with meals, as directed, and he had just adjusted the MAR to better reflect the specific administration times ordered. This was important to do as Phoslo "helps the absorption" of phosphate consumed in R53's dietary intake. However, the DON stated he was not sure if	F 759		

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F 759	Continued From page 69 these omitted medications and incorrectly timed medications would be considered errors or not. On 7/14/22, at 9:34 a.m. dialysis registered nurse (RN)-P and dialysis physician assistant (PA)-A were interviewed via telephone. PA-A stated Phoslo should be given with "the first bite" of food at meals to be effective, and if given an hour after R53 had finished eating the medication would be "completely ineffective" and could likely contribute to elevated phosphate levels. When interviewed on 7/14/22, at 10:25 a.m., the consulting pharmacist (CP) stated he had not encountered issues with missed medications or untimely re-ordering in the past medication cart audits, nor had the pharmacy contacted him voicing such issues. CP stated medications should be reordered when there is about a three-day supply left to allow adequate time for processing, filling and delivering the medication. CP stated missed Atorvastatin and Pyridoxine doses due to a lack of supply would constitute medication errors; however, CP added it was not likely to be a significant risk to the patient. Further, CP reviewed Phoslo and verified it was best given with meals and could "theoretically" lead to elevated phosphate levels in the blood as the medication binds with food and reduces the reabsorption of phosphate. A provided Administering Medications policy, dated 2019, identified medications would be administered in " ... a safe and timely manner, as prescribed." The policy outlined, "Medications are administered in accordance with prescriber orders, including any required time frame," and were to be given " ... within one (1) hour of their prescribed time, unless otherwise specified."	F 759		

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F 759	Continued From page 70 Further, a provided Adverse Consequence and Medication Errors policy, dated 2014, identified a medication error was defined as " ... the preparation or administration of drugs or biological which is not in accordance with physician's orders, manufacturer specifications, or accepted professional standards and principles of the professional(s) providing services." The policy listed several examples of medication errors which included, "Omission - a drug is ordered but not administered," and, "Wrong time."	F 759		
F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure medications were administered in accordance with physician orders and standards of care to promote comfort and reduce the risk of adverse disease-associated complications for 2 of 4 residents (R25, R53) observed to receive medication during the survey. These findings constituted significant medication errors for R25 and R53. Findings include: On 7/12/22 at 5:32 p.m., licensed practical nurse (LPN)-B prepared medications for R25 in the hallway from a mobile cart. LPN-B had the electronic Medication Administration Record (MAR) open which displayed a single red-colored rectangle with a bolded "1600 [4 p.m.]" and the	F 760	F 760 R 25 MD will be notified that R 25 medications were administered late on 7/12/2022. The MD response will be recorded in the resident electronic medical record. R 53 has since discharged from the facility. Cart audits were performed and medications that were missing were reordered. Future residents will have their medications administered per MD order and times. Licensed Nurses and TMAs will be in-serviced on the Medication Error Policy and Procedure with emphasis on paragraph 2 that all errors or unanticipated events associated with the medication system or a step in the medication process shall be reported using the resident electronic medical	8/30/22

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F 760	Continued From page 71 name of a medication to be given. LPN-B stated the red coloring meant it was "time now to give it," and presented the medication card to the surveyor for review which directed Baclofen (a muscle relaxant used to treat muscle spasms) 20 milligrams (mg) three times a day as needed for muscle spasm. However, LPN-B stated the medication was actually scheduled for every eight hours and was due to be given at 4:00 p.m., but the trained medication aide (TMA) did not show up for their shift so it was late. LPN-B stated medications with specific times ordered (i.e., every eight hours) have a one-hour window on either side of the time to be given. LPN-B then removed and placed a single tablet of the medication into a cup and entered R25's room. R25 was seated on the bed and stated his back was sore when asked. R25 was asked to rate his current pain level and responded, "10 [out of 10]." LPN-B then administered the medication to R25. Immediately following, R25's current physician orders were reviewed. R25's Twin Cities Physicians order, dated 6/24/22, identified a physician order which read, "Patient is requesting Baclofen scheduled instead of PRN - Please contact Dr. [name] regarding this." The same order then had black-colored handwritten directions by the director of nursing (DON) which read, "T.O. [telephone order] every 8 hrs [hours] scheduled." The telephone order was dated 6/24/22. R25's admission Minimum Data Set (MDS), dated 5/27/22, identified R25 had intact cognition. When interviewed on 7/12/22 at 5:47 p.m., R25 stated he was not consistently getting his Baclofen every eight hours as was ordered adding "a lot of times" he had to physically ask the staff for them to bring	F 760	record incident module and indicate whether or not the error reached the resident. Director of Nursing and/or designee is responsible for compliance. Audits on medication errors and root cause for medication error identified will begin 2x week for x 2 weeks, weekly x 4 weeks then monthly to ensure compliance. Audits will be reviewed by the Administrator and brought by the Administrator to QAPI for review and recommendation. Compliance:8/30/2022	

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F 760	Continued From page 72 it to him. R25 stated the nurses seemed to pass medications by wing rather than by times ordered, as sometimes, he would not get his scheduled 4:00 p.m. Baclofen dose until after the supper meal. Further, R25 stated the Baclofen did seem to help reduce his back pain when it was given consistently and on-time as ordered. When interviewed on 7/12/22, 5:52 p.m., LPN-B verified the medication was administered late; however, stated he was unsure if a late administration would be considered a medication error or not. LPN-B reiterated the one-hour window before and after the scheduled time for time-specific medications to be given and stated he felt it was best to contact the physician and let them know it was given late. When interviewed on 7/13/22, at 1:24 p.m., the director of nursing (DON) stated medications with specific times listed needed to be given within "an hour before or an hour after" the listed time. The DON stated if staff go "way, way beyond" the time, then the physician should be notified and a late administration, such as happened with R25's Baclofen, could possibly constitute a medication error. The DON added, "I will give him an education." When interviewed on 7/14/22, at 10:25 a.m., the consulting pharmacist (CP) stated specific medications required "more timely" administration and "an hour before and an hour after is reasonable" for those to be given. CP stated he typically discouraged specific schedules of medications (i.e., every eight hours), and expressed he would have to consider the nursing home's policy before determining if an error had happened or not with R25's Baclofen. CP stated	F 760		

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F 760	Continued From page 73	F 760		

this scenario and event would be a "good point" to bring to the next Quality Assurance (QA) meeting but added, "We don't want a person waiting in pain."

On 7/12/22, at 7:04 p.m., LPN-C prepared medications for R53 in the hallway from a mobile cart. LPN-C opened R53's MAR and read aloud each medication due to be administered which included Phoslo (used to prevent elevated phosphate levels in dialysis patients). LPN-B presented the medication card to the surveyor for review which directed Phoslo (calcium acetate) 2,001 mg " ... by mouth three times a day with meals." LPN-B removed the dosage from the card, placed it inside a cup and then administered the medication to R53 in her room.

Immediately following, R53's current physician orders were reviewed. R53's Transfer Orders, dated 5/30/22, identified R53's physician-ordered hospital discharge medications. This included Phoslo 667 mg with directions reading, " ... take 3 Capsules (2,001 mg) by mouth three times a day with meals;"

R53's significant change MDS, dated 6/21/22, identified R53 had intact cognition and renal insufficiency and/or failure. Further, R53 received dialysis while a resident at the nursing home. On 7/12/22, at 7:24 p.m. R53 was interviewed and stated she went to dialysis several times a week at an offsite clinic. R53 stated she ate her supper meal "between 6:15 [p.m.] and 6:30 [p.m.]" which was approximately an hour prior. R53 stated she recalled Phoslo was supposed to be given with meals but added she "never gets it like that" with the staff often giving the medication before or after the meal. R53 stated she was unsure of her

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F 760	Continued From page 74 last phosphate level or if it was elevated. On 7/12/22, at 7:44 p.m. LPN-C and the DON were interviewed. LPN-C stated he provided the Phoslo to R53 after 7:00 p.m. as it was scheduled for 8:00 p.m. in the MAR. LPN-C and the DON both acknowledged the label and physician orders which directed to give the medication with meals, and the DON added he would "look into this" to determine what happened. During subsequent interview on 7/13/22 at 10:37 a.m., the DON stated R53's Phoslo should have been given with meals, as directed, and he had just adjusted the MAR to better reflect the specific administration times ordered. This was important to do as Phoslo "helps the absorption" of phosphate consumed in R53's dietary intake. However, the DON stated he was not sure if incorrectly timed medications would be considered an error or not. R53's MAR, dated 6/1/22 to 6/30/22, identified an order for Phoslo 667 mg with directions, "Give 3 capsule by mouth three times a day for Renal Insuff. Take 3 capsules TID [three times daily] with meals," along with outlined hours the medication was to be administered. These hours included 8:00 a.m., 2:00 p.m. and 8:00 p.m. from 6/1/22 to 6/17/22, when the hours were changed to 8:00 a.m., 12:00 p.m., and 8:00 p.m. This order had a recorded start date of 5/31/22, and all doses were recorded as administered at these times unless R53 was on LOA and/or hospitalized. Further, R53's MAR, dated 7/1/22 to 7/14/22, identified the same order and administration times as the June 2022 MAR, with all doses recorded as administered at these times unless R53 was on LOA and/or hospitalized.	F 760		

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F 760	Continued From page 75 On 7/14/22, at 9:34 a.m. dialysis registered nurse (RN)-P and dialysis physician assistant (PA)-A were interviewed via telephone. RN-P verified R53 received dialysis at their site and PA-A stated Phoslo should be given with "the first bite" of food at meals to be effective. RN-P stated R53's most recent phosphate level was drawn on 6/30/22, and was elevated at 7.0 mg/dl (milligrams per deciliter; normal adult range 2.5 to 4.5 mg/dl). PA-A stated R53's Phoslo being given outside of meal times would cause the medication to be "completely ineffective," and that could likely be contributing to R53's elevated phosphate levels given the period of time the staff were giving it outside of those times. When interviewed on 7/14/22, at 10:25 a.m., the consulting pharmacist (CP) stated he reviewed Phoslo and verified the medication was best to be given with meals, and he explained incorrect administration could "theoretically" lead to elevated phosphate levels in the blood as the medication binds with food and reduces a reabsorption of phosphate. A provided Administering Medications policy, dated 2019, identified medications would be administered in " ... a safe and timely manner, as prescribed." The policy outlined, "Medications are administered in accordance with prescriber orders, including any required time frame," and were to be given " ... within one (1) hour of their prescribed time, unless otherwise specified." Further, a provided Adverse Consequence and Medication Errors policy, dated 2014, identified a medication error was defined as " ... the preparation or administration of drugs or biological which is not in accordance with physician's orders, manufacturer specifications,	F 760		

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F 760	Continued From page 76 or accepted professional standards and principles of the professional(s) providing services." The policy listed several examples of medication errors which included, "Omission - a drug is ordered but not administered," and, "Wrong time."	F 760		
F 761 SS=D	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 prescribed medications were appropriately and accurately	F 761	Compliance:8/ F 761*DPOC R 25 and R 38 medication cards with the wrong labels were removed from the	8/30/22

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	245544	A. BUILDING _____ B. WING _____	C 07/18/2022

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F 761	Continued From page 77 labeled with current physician-ordered administration instructions to reduce the risk of administration error for 2 of 4 residents (R25, R38) observed to receive medication during the survey. Findings include: R25's Twin Cities Physicians order, dated 6/24/22, identified a physician order which read, "Patient is requesting Baclofen scheduled instead of PRN [as-needed] - Please contact Dr. [name] regarding this." The same order then had black-colored handwritten directions by the director of nursing (DON) which read, "T.O. [telephone order] every 8 hrs [hours] scheduled." The telephone order was dated 6/24/22. On 7/12/22 at 5:32 p.m., licensed practical nurse (LPN)-B prepared medications for R25 in the hallway from a mobile cart. LPN-B presented the Baclofen 20 milligram (mg) medication card to the surveyor for review; however, the directions on the label of the medication card directed, "1 TAB BY MOUTH THREE TIMES DAILY AS NEEDED FOR MUSCLE SPASMS." There was no other directions or guidance displayed on the label despite the physician order from 6/24/22, directing the medication to be given on a scheduled basis and not just as-needed. Further, the label listed a fill-date of 6/27/22. LPN-B reviewed the label and stated the label was incorrect and should have an "order change" sticker placed on it. This was important to do so others "don't get confused by the label" when giving the medication. LPN-B then reviewed the other Baclofen medication cards present in the mobile cart for R25 and stated there were multiple cards with the same incorrect	F 761	medication cart. All current resident medication cards were reviewed with the current medication order and any discrepancies, the medication will be removed and the pharmacy contacted for new medication cards. Future resident medication order changes, the old medication card will be removed from the medication cart and returned to the pharmacy Licensed nurses and TMA will be in-serviced on the Label Medication Container Policy with emphasis on item #2 that any label that is improperly labeled will be returned to the pharmacy. A Directed Plan of Correction will also be conducted by the IDT team and a root cause will be identified and from the identified root cause a plan for correction will be implemented. Director of Nursing and/or designee is responsible for compliance. Audits on medication label accuracy and expired meds will begin 2x week for x 2 weeks, weekly x 4 weeks then monthly to ensure compliance. Audits will be reviewed by the Administrator and brought by the Administrator to QAPI for review and recommendation. 30/2022	

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F 761	Continued From page 78 administration directions on them. LPN-B reiterated the labels should have a sticker affixed to them to alert the nurse the orders had changed, which is done to help prevent a medication error. R38's Twin Cities Physicians order, dated 6/20/22, identified a physician order to discontinue R38's current citalopram (an antidepressant medication) orders, and begin, "Citalopram 20 mg PO QD [by mouth daily]." On 7/14/22 at 7:50 a.m. trained medication aide (TMA)-B prepared R38's medications at a mobile cart outside his room. TMA-B presented R38's citalopram 10 mg medication card to the surveyor which directed, "GIVE 1 TABLET BY MOUTH ONE TIME A DAY FOR DEPRESSION." There was no other directions or guidance displayed on the label despite the physician order from 6/20/22, directing the medication be increased (to 20 mg daily) and the current dose being 10 mg in strength. Further, the label listed a fill-date of 7/3/22. TMA-B reviewed R38's MAR and the label and stated she would administer the medication according to the MAR and the label was inaccurate. TMA-B stated a sticker should have been placed on the label when the order changed to alert staff to double check the orders adding the physician orders and labels "should match." When interviewed on 7/14/22 at 10:08 a.m., the director of nursing (DON) stated labels should have a 'directions changed' sticker placed on them when physician orders get modified. This was important to do as it helps the staff ensure the correct medication and dose were being given to help "avoid [an] error." Further, the DON stated medication cart audits were routinely completed	F 761		

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F 761	Continued From page 79 and there had been no concerns with inaccurate labeling present to him prior to the survey. On 7/14/22 at 10:25 a.m. the consulting pharmacist (CP) was interviewed. CP explained labels should have a sticker placed on them when physician orders change to alert the staff adding "the ideal situation" is for the physician orders and medication labels to match. This was important to do so staff are able to verify the correct medication and dose were being given to the patient. A provided Labeling of Medication Containers policy, dated 2019, identified all medications maintained in the nursing home were to be properly labeled in accordance with current state and federal guidelines. The policy outlined only the dispensing pharmacy could label or alter the label on a medication container and nursing staff were to inform the pharmacy of any changes in physician orders for a medication. However, the policy lacked any process or guidance on how staff were to respond to current medication supply labels when orders were changed in-between routine cycle fills by the dispensing pharmacy.	F 761		
F 776 SS=D	Radiology/Other Diagnostic Services CFR(s): 483.50(b)(1)(i)(ii) §483.50(b) Radiology and other diagnostic services. §483.50(b)(1) The facility must provide or obtain radiology and other diagnostic services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. (i) If the facility provides its own diagnostic	F 776		8/30/22

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F 776	Continued From page 80 services, the services must meet the applicable conditions of participation for hospitals contained in §482.26 of this subchapter. (ii) If the facility does not provide its own diagnostic services, it must have an agreement to obtain these services from a provider or supplier that is approved to provide these services under Medicare. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure timely follow-up on physician ordered diagnostic services for 1 of 1 (R18) residents reviewed for radiological services. Findings include: R18's significant change Minimum Data Set (MDS) dated 5/20/22, indicted R18 had moderately impaired cognition, no behaviors, and needed extensive assist with activities of daily living (ADLs). R18's diagnoses included dementia without behavioral disturbance, major depressive disorder, and cutaneous abscess of buttock. R18's progress note dated 6/14/22, at 12:08 p.m. included, "Resident['s] surgical wound of the left ischium nearly resolved with only a pin sized opening and no s/sx [signs or symptoms] of infection. Palpation of wound discovers hardened mass beneath wound bed. [Medical Doctor (MD)-A] updated to assessment findings." R18's nurse practitioner's progress note dated 6/22/22 included, "Golf ball size swelling in the right gluteal region - firm, slightly moveable. Today no evidence of sinus draining tracts. No drainage is observed, and areas [sic] is not warm	F 776	F 776 R 18 had radiology appointment on 7/21/2022 and results relayed to the MD the same day. Current resident appointments from survey exit until present have been completed and results relayed to the physician. Future resident diagnostic/lab orders will be processed per facility policy by the assigned nurse and/or health unit coordinator. Licensed nurses will be in-serviced on the Lab/Diagnostic Test Result policy and procedure with emphasis on item #1 that the staff is responsible for processing these orders timely. In addition, during physician rounds, the nurse will review physician orders and/or progress notes and process diagnostic testing per order. Director of Nursing and/or designee is responsible for compliance. Audits on lab/diagnostic test orders and physician notification will begin 2x week for x 2 weeks, weekly x 4 weeks then monthly to ensure compliance. Audits will be reviewed by the Administrator and brought by the Administrator to QAPI for review and recommendation.	

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F 776	Continued From page 81 to touch. No signs of pain when palpating mass." Additionally, the progress note instructed, "Continue to monitor and provide supportive cares. Will f/u [follow-up] next week." On 6/28/22, R18's physician wrote an order for, "ASAP [as soon as possible] CT [computed tomography] of the sacral/pelvis to eval [evaluate] for abscess - hx [history] of right gluteal decub [decubitus] ulcer." R18's nurse practitioner's progress dated 7/11/22, included, "Right gluteal abscess" "Per CN [case notes], wound appears healed externally, but still concern for hardened mass underneath wound. Still painful to the touch." "Cutaneous abscess of buttock - orders sent to ensure CT gets completed, waiting on results" During an interview on 7/12/22, at 4:32 p.m. the health unit coordinator (HUC)-A stated she attempts to follow-up on providers' orders within 2 days. HUC-A stated she was aware R18 had an order for a CT scan to be scheduled, but did not know when the order had been written. HUC-A stated she had attempted to schedule the CT, which had been ordered on 6/23/22, today, 7/12/22, but learned she needed to get the order clarified prior to scheduling. A message was left for R18's doctor requesting the necessary clarification. The procedure remained unscheduled. HUC-A added that not addressing a physician order for 14 days was, "unreasonable." During an interview on 7/12/22, at 4:38 p.m. R18 stated, "If a sit in a [wheel]chair my bottom hurts. I stay [up] as long as I can until the pain starts. I want to get up [out of bed], but when I get up the pain gets me and it is just disguising so I get back	F 776	Compliance:8/30/2022	

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F 776	Continued From page 82 in bed." R18 added, "I would stay up but the pain puts me back to bed." During an interview on 7/14/22, at 8:50 a.m. HUC-A stated R18's CT still remain unscheduled, but she planned to schedule it later "today." At 12:51 p.m. HUC-A stated R18's CT procedure had been scheduled for 7/21/22. During an interview on 7/14/22, 8:52 a.m. the director of nursing (DON) stated appointments should be scheduled immediately after being ordered by the doctor. "If we get an order today the appointment should be scheduled that same day." DON stated HUC-A is responsible for ensuring all appointments ordered by the physician are scheduled timely. The DON added, prompt follow-up on diagnostic procedures ordered by the physician is very important as it helps the provider understand the underlying health condition of the resident. Facility policy, "Diagnostic Services" (undated) included, "It is the policy of this facility to ensure that laboratory, radiology, and other diagnostic services meet the needs of residents, that results are reported promptly to the ordering provider to address potential concerns and for disease prevention, provide for resident assessment, diagnosis, and treatment, and that the facility has established policies and procedures, and is responsible for the quality and timeliness of services whether services are provided by the facility or an outside resource."	F 776		
F 790 SS=D	Routine/Emergency Dental Srvcs in SNFs CFR(s): 483.55(a)(1)-(5) §483.55 Dental services.	F 790		8/30/22

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F 790	Continued From page 83 The facility must assist residents in obtaining routine and 24-hour emergency dental care. §483.55(a) Skilled Nursing Facilities A facility- §483.55(a)(1) Must provide or obtain from an outside resource, in accordance with with §483.70(g) of this part, routine and emergency dental services to meet the needs of each resident; §483.55(a)(2) May charge a Medicare resident an additional amount for routine and emergency dental services; §483.55(a)(3) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; §483.55(a)(4) Must if necessary or if requested, assist the resident; (i) In making appointments; and (ii) By arranging for transportation to and from the dental services location; and §483.55(a)(5) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay. This REQUIREMENT is not met as evidenced by:	F 790		

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F 790	Continued From page 84 Based on interview and document review, the facility failed to ensure a voiced request to see a dental provider and obtain new dentures was acted upon and addressed for 1 of 2 residents (R20) reviewed for dental hygiene and services. Findings include: R20's admission Minimum Data Set (MDS), dated 5/23/22, identified R20 had moderate cognitive impairment, had no natural teeth, and required extensive assistance with personal hygiene (i.e., brushing teeth). Further, R20's Census listing, printed 7/15/22, identified R20's payer source as, "Medicare A." When interviewed on 7/11/22 at 9:57 a.m., R20 stated he needed to get new dentures. R20 explained he told the staff he needed to get to a dentist as he "ain't got no teeth [edentulous]" but the staff never followed up with him. R20 denies concerns with chewing but reiterated he wanted to see a dentist for new dentures. R20's Nurse Admission/Readmission evaluation, dated 5/16/22, included a section labeled, "Oral Status," which identified R20 as being edentulous and having no dentures. In addition, R20's care plan, dated 6/8/22, identified R20 had oral and/or dental health problems due to poor oral hygiene. The care plan outlined, "Resident has no teeth and no dentures." Further, the care plan listed several interventions for R20's oral health which included, "Coordinate appointments for dental care, transportation as needed/as ordered." However, R20's Dietary / Nutrition Assessment, dated 5/24/22, identified a section labeled, "Eathing [sic] / Chewing," which outlined R20 did	F 790	F 790 *DPOC R 20 has a dental appointment scheduled for 9/26/2022. R 20□s care plan will be reviewed and updated. Current residents who are edentulous and have dentures will be assessed and residents with ill-fitting dentures a dental appointment will be made per resident acceptance and their care plan and oral assessment will be reviewed and updated as needed. Future residents with dental request, the facility HUC and Unit Manager will be responsible for dental appointment coordination and a care plan will be initiated and reviewed quarterly and as needed. The IDT team will review the entire Dental Services Policy with emphasis on item #6 that social services director is responsible for coordinating dental appointment, transportation and payment. A Directed Plan of Correction will also be conducted by the IDT team and a root cause will be identified. From the identified root cause a plan for correction will be implemented. Social Services and/or designee is responsible for compliance. Audits on resident dental, hearing and vision request and appointment creation will begin 2x week for x 2 weeks, weekly x 4 weeks then monthly to ensure compliance. Audits will be reviewed by the Administrator and brought by the Administrator to QAPI for review and recommendation. Compliance:8/30/2022	

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F 790	Continued From page 85 not have his own teeth, and used dentures. The section included dictation which read, "Resident had upper & lower dentures but does not wear them due to poor fit. He would like to see a dentist to pursue new dentures if possible. [Health unit coordinator (HUC)-A] notified." R20's medical record was reviewed and lacked evidence this voiced request to see a dental provider had been acted upon, scheduled, or completed despite R20 admitting to the nursing home nearly two months prior. When interviewed on 7/13/22 at 10:02 a.m., nursing assistant (NA)-C stated had worked with R20 several times before, and explained R20 required set-up assistance to complete oral cares. However, NA-C stated she was unsure if R20 used dentures or not, nor if R20 had ever been seen by a dentist for care. NA-C stated an "appointment lady" was responsible to facilitate outside appointments. On 7/13/22 at 10:12 a.m., HUC-A was interviewed and verified she was responsible to arrange and schedule outside appointments with dental clinics and providers. HUC-A stated she tracked all scheduled appointments in a calendar-style binder, however, was unable to locate any scheduled or completed dental appointments for R20 adding, "[R20] might have end up falling through the cracks." HUC-A recalled the registered dietician (RD)-A talking to her about R20 needing dentures; however, explained she felt this was "just recently" expressed to her within the past week or so. HUC-A verified no dental appointment had been arranged for R20 and stated, "It must have got overlooked."	F 790		

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F 790	Continued From page 86 When interviewed on 7/13/22 at 10:20 a.m. RD-A verified she recalled completing R20's nutritional assessment and stated she would have "immediately" notified HUC-A of R20's request to see a dentist when she completed the assessment adding, "It wasn't last week." However, RD-A stated she did not follow-up with HUC-A since requesting the appointment to ensure it was schedule or completed as she had "kind of assumed" HUC-A handled it. On 7/13/22 at 10:42 a.m., the director of nursing (DON) was interviewed. He explained he had investigated the situation and verified the appointment had been missed, so they would immediately schedule a dental appointment for R20. The DON added the appointment had been "oversighted," and should have been scheduled when R20 made the request. A provided Dental Services policy, dated 2016, identified routine and emergency dental services were available to meet a resident's oral health needs in accordance with their assessment and plan of care. The policy directed, "Social services representatives will assist residents with appointments, transportation arrangements, and for reimbursement of dental services ... "	F 790		
F 825 SS=D	Provide/Obtain Specialized Rehab Services CFR(s): 483.65(a)(1)(2) §483.65 Specialized rehabilitative services. §483.65(a) Provision of services. If specialized rehabilitative services such as but not limited to physical therapy, speech-language pathology, occupational therapy, respiratory therapy, and rehabilitative services for mental	F 825		8/30/22

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F 825	Continued From page 87 illness and intellectual disability or services of a lesser intensity as set forth at §483.120(c), are required in the resident's comprehensive plan of care, the facility must- §483.65(a)(1) Provide the required services; or §483.65(a)(2) In accordance with §483.70(g), obtain the required services from an outside resource that is a provider of specialized rehabilitative services and is not excluded from participating in any federal or state health care programs pursuant to section 1128 and 1156 of the Act. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide physical therapy (PT) as ordered for 1 of 1 residents (R26) reviewed for therapy services. Findings include: R26's significant change Minimum Data Set (MDS) dated 6/1/22, indicated R26 was cognitively intact, required supervision with bed mobility, transfers, and toileting, and was unsteady when moving from seated to standing, walking, turning around when walking, moving on and off the toilet, and transferring between surfaces. The MDS indicated R26 used a wheelchair for mobility and lacked documentation of functional rehabilitation potential. R26's Admission Record dated 7/14/22, indicated R26 had diagnoses of history of hip fracture, lung disease, and diabetes. R26's care plan dated 6/8/2022, included	F 825	F 825 R 26 was screened by Physical Therapy on 8/17/2022. R 26 ortho physician was made aware of the delay in therapy services. The ortho MD response will be recorded into the resident electronic medical record. Future residents with therapy orders, the therapy department will be notified via email and/or during morning meeting. Licensed Nurses, IDT team will be in-serviced on the Scheduling Therapy Service Policy with emphasis on item #2 that therapy is scheduled in accordance with nursing services and those services are documented in the resident electronic medical record. Director of Nursing and/or designee is responsible for compliance. Audits on therapy orders and therapy request will begin 2x week for x 2 weeks, weekly x 4 weeks then monthly to ensure compliance.	

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F 825	Continued From page 88 interventions of PT/OT (occupational therapy) to continue to provide services to resident, and identified R26 was at high risk for falls with intervention of PT eval and treat as ordered or PRN (as needed). R26's After Visit Summary dated 5/31/22, indicated R26 was seen by an orthopedic physician for a post-operative follow-up appointment relating to surgical repair of right femur fracture, and included a recommendation for PT. R26's medical record included an order for PT evaluate and treat dated 5/31/22, with a "specific service" of Balance/Falls. R26's Victory Health and Rehabilitation Physician Visit Review/Orders dated 5/31/22, indicated R26 had a post-operative provider appointment and returned with an order for PT for lower extremities, gait training, and strengthening. During interview on 7/11/22, at 2:59 p.m. R26 stated she had two broken hips and she could not pivot but was learning to walk on both feet. She stated she kept asking for a walker, but staff didn't think she was ready. She stated she needed therapy on her legs and was not sure why she was not getting it. During interview on 7/13/22, at 9:27 a.m. occupational therapy assistant (OTA)-A reviewed R26's documentation and confirmed she was not evaluated and had not received PT as ordered on 5/31/22. During interview on 7/14/22, at 11:40 a.m. registered nurse RN-C stated when a resident	F 825	Audits will be reviewed by the Administrator and brought by the Administrator to QAPI for review and recommendation. Compliance:8/30/2022	

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F 825	Continued From page 89 returned from a doctor appointment with documents, including orders, they were given to the health unit coordinator (HUC) who scanned the documents into the electronic record and then gave them to the nursing staff who entered any orders into the computer. If therapies were ordered she copied the paper order and gave the copy to the appropriate therapy department. She stated she did not recall seeing an order for PT for R26. During interview on 7/14/22, at 11:55 a.m. licensed practical nurse (LPN)-A stated when a resident returned from an appointment any paperwork was given to the nurse who reviewed it for orders. If there was an order for PT the nurse photocopied the order and gave it to PT who followed up. LPN-A stated the paper version in the hard chart would be marked when addressed. LPN-A reviewed R26's hard chart and verified the order was present and lacked indication it had been addressed. During interview on 7/14/22, at 11:50 a.m. (HUC)-A stated when a resident returned from an appointment with provider orders she scanned them into the electronic health record and gave the papers to the nurse, although sometimes they were given to the nurse first and then came back to her. She stated normally the nurses took care of the orders, including any referrals to PT, but if the nurse brought her a paper order HUC-A gave a copy of it to the therapy department herself. During interview on 7/14/22. at 12:15 p.m. physical therapy assistant (PTA)-A stated if a resident did not get ordered therapies it could result in increased time in the facility, a decline in health status, and increased burden on facility	F 825		

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F 825	Continued From page 90 staff. He stated PT assisted residents to get to their best level of activity to optimize health and quality of life, and if they were not able to maintain that level they could deteriorate mentally and physically. During interview on 7/14/22, at 1:18 p.m. director of nursing (DON) stated if a resident had an order for PT staff took a copy of the order and delivered it to the PT department. He stated he thought R26's order was somehow lost in between departments, and stated the process fell through. He stated the goal was to make her physically stronger and more independent, and without PT her goals may not be met. A facility rehabilitation and/or therapy policy was requested but not provided.	F 825		
F 865 SS=F	QAPI Prgm/Plan, Disclosure/Good Faith Attmpt CFR(s): 483.75(a)(2)(h)(i) §483.75(a) Quality assurance and performance improvement (QAPI) program. §483.75(a)(2) Present its QAPI plan to the State Survey Agency no later than 1 year after the promulgation of this regulation; §483.75(h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. §483.75(i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as	F 865		8/30/22

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F 865	Continued From page 91 a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the Quality Assurance (QA) committee developed and revised a quality improvement program to correct identified resident care issues including dental care, sanitary environment, and infection control, along with ongoing concerns related to medication management. This practice had the potential to affect all 54 residents residing in the facility. Findings include: Although the facility administrator was aware of identified deficient practices regarding resident care, medication management, and infection control the facility failed to ensure plans of correction developed in response to citated deficient practices were appropriate or maintained to prevent ongoing deficient practice as evidenced by repeated deficiency citation. Examples of repeated cited deficiencies included: - F758 Unnecessary Psychotropic Medication which was cited as a deficient practice in the facility's past 2 recertification surveys - F761 Labeling/Storage of Medication which was cited as a deficient practice in the facility's past 4 recertification surveys - F791 Dental Services in Skilled Nursing Facilities which was cited as a deficient practice in the facility's past 3 recertification surveys - F880 Infection Control Practices which was cited as a deficient practice in a complaint investigation which occurred since the facility's most recent recertification survey in February 2022 - F888 COVID-19 Vaccinations which was citied	F 865	F 865 The IDT team held an emergency ad-hoc QAPI meeting on 7/16/2022 and included the current status of the following deficiencies and audit results for: F 758, F 761, F 790, F 880, F 886, F 888, F 921. Future deficiencies, audits and Performance Improvement Plans will be thoroughly discussed in the QAPI meeting and action plans will be followed up on monthly to ensure sustained compliance. The IDT team will review the QAPI Program Policy and procedure with emphasis on the Objectives of the QAPI program and the Implementation section item #2 on the process for identifying and correcting quality deficiencies. The Administrator and/or designee is responsible for compliance. The monthly QAPI report will be reviewed by the governing board and/or owner/operator to ensure deficient practice is being corrected Compliance: 8/30/2022	

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F 865	Continued From page 92 in the facility's past 2 recertification surveys - F921 Safe and Sanitary Environment which was cited in the facility's past 2 recertification surveys During an interview on 7/18/22, at 9:34 a.m. the administrator stated the QA committee used the required plan of correction the facility developed in response to cited deficient practices to determine area of focus for quality improvement and trying to get back into compliance with state and federal program requirements. The QA team monitors success when deficiencies are no longer issued on a specific focus area and "when we know everyone has the competencies and knowledge to perform their job duties. The administrator described it at a "continual thing." The administrator stated the QA committee is not currently completed any audits to ensure ongoing improvement or compliance in the areas of concern outlined above. The administrator stated she was aware repeated deficiencies have been issued in certain care areas and described the facility as good at cleaning up the deficiency, but not good at maintaining the correction and moving forward with progress. During an interview on 7/18/22, at 11:15 a.m. physician/medical director (MD)-B stated she does attend the facility's QA meetings. MD-B stated, "A lot of issues need to be worked on." MD-B added, "There is a lot of turn-over with leadership and a lot of survey tags" which impacts the facility's ability to focus and maintain quality improvement. There have been patterns and issues, which is why we are where we are now. Accountability had gone by the wayside in the past, however, MD-B stated, the new administrator and director of nursing (DON) have been trying to keep more consistency and hold	F 865		

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F 865	Continued From page 93 staff accountable for quality care. The facility policy, "QAPI" dated 6/5/20, included, "This facility shall maintain a Quality Assurance and Performance Improvement (QAPI) Committee for continuous quality improvement of overall performance." The policy further informed, "The QAPI Committee monitors and sustains operational performance in clinical and nonclinical systems through self-identification and improvement in areas where opportunities for improvement have been identified."	F 865		
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;	F 880		8/30/22

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F 880	Continued From page 94 §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review.	F 880		

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F 880	Continued From page 95 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 hand hygiene was performed during incontinent cares for 1 of 1 residents (R47) reviewed for activities of daily living (ADLs). In addition, the facility failed to ensure wound cares were performed to prevent cross contamination of bacteria for 1 of 1 residents (R53) reviewed for pressure ulcers. Findings include: RESIDENT CARES: R47 R47's significant change Minimum Data Set (MDS) dated 6/17/22, indicated R47 was admitted to the facility on 5/23/22, had mild cognitive impairment and diagnoses of cerebral infarction (stroke) with left sided hemiparesis (weakness). The MDS further indicated R47 was frequently incontinent of bladder and required one assist for toileting. On 7/12/22, at 4:54 p.m. nursing assistant (NA)-B entered R47's room to assist with incontinent cares. NA-B provided privacy and transferred R47 from her wheelchair to her bed. NA-B donned gloves and proceeded to pull down R47's jeans. R47's brief was wet with urine but was not leaking through onto clothing. NA removed soiled brief and placed it in the garbage. NA-B then cleaned R47's peri area and bottom and applied a barrier cream with dirty gloves. NA-B fastened the clean brief and pulled R47's jeans back up.	F 880	F 880 *DPOC R 47 was assessed and there was no ill effect from this deficient practice. R 53 has since discharged from the facility. Current residents receiving peri-care and wound care documentation was reviewed and there were no ill effects experienced from this deficient practice. Future residents will receive peri-care and wound care utilizing proper hand hygiene per facility policy. Facility staff was in-serviced on Handwashing/Hand Hygiene Policy with emphasis on item #7 that hand hygiene is required in all listed situations. Licensed Nurses will be in-serviced on the Wound Care Policy and procedure with emphasis on the section labeled Steps in the Procedure. A Directed Plan of Correction will also be conducted by the IDT team and a root cause will be identified and from the identified root cause a plan for correction will be implemented. Audits on hand hygiene during personal care and wound care dressing change procedure will begin daily x 2 weeks, weekly x 4 weeks then monthly to ensure compliance. Audits will be reviewed by the Administrator and brought by the Administrator to QAPI for review and recommendation. Compliance: 8/30/2022	

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F 880	Continued From page 96 NA-B took the cream and package of wipes used during cares, opened R47's dresser drawer and replaced the items. NA-B grabbed R47's wheelchair by the arm rests to adjust it closer to the bed to prepare to assist R47 back into the chair. NA-B used the R47's bed controls to adjust the bed height, placed the transfer belt on R47 and transferred R47 to her wheelchair. NA-B situated R47 in her chair, unlocked the breaks, turned R47's chair towards the door and opened the door so R47 could exit the room. NA-B then removed the soiled gloves placed in the garbage bag with the wet brief, tied the bag, and utilized hand sanitizer upon exiting R47's room. NA-B had not performed hand hygiene or changed gloves after completing peri care and handling R47's soiled brief. During an interview on 7/12/22, at 5:03 p.m. NA-B stated R47 was normally incontinent and required assistance with incontinent cares. NA-B verified staff were supposed to change gloves after handling a soiled brief and acknowledged that was not done when providing incontinent cares for R47. Furthermore, NA-B stated if the brief was not soiled with bowl movement or an excess of urine, hand hygiene was not required. WOUND CARE R53 R53's significant change Minimum Data Set, dated 6/21/22, indicated R53 was admitted to the facility on 5/30/22, was cognitively intact, received dialysis and had diagnoses of diabetes, and chronic kidney disease. R53's order summary report printed 7/15/22,	F 880		

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F 880	Continued From page 97 indicated R53 had an order to clean R53's right shin wound daily, apply calcium alginate, and apply foam dressing. On 7/13/22, at 11:33 a.m. licensed practical nurse (LPN)-D set up to change R53's shin dressing. R53's wound was located on the inside of the right shin. After obtaining supplies, LPN-D performed hand hygiene and donned gloves on both hands LPN-D removed R53's foam dressing from R53's shin wound and removed gloves and performed hand hygiene. LPN-D donned clean gloves to both hands and sprayed normal saline (NS) on the wound and surrounding area. LPN-D proceeded to pick up clean pad and wiped the NS off the skin surrounding R53's wound before using the same gauze to pat the wound bed. LPN-D removed gloves and performed hand hygiene and donned clean gloves. LPN-D placed calcium alginate on R53's wound bed and covered with a new foam dressing. LPN-D removed gloves and performed hand hygiene at the completion of wound cares. During an interview on 7/13/22, at LPN-D verified gauze was used to dry the skin around the wound first before using the same gauze to pat R53's wound. LPN-D further stated it was a mistake and could bring infection from the skin to the wound. During an interview on 7/14/22, at 11:30 a.m. the director of nursing (DON) stated he expected all staff to remove gloves and perform hand hygiene after handling a soiled brief and before touching other items or continuing cares. DON verified this was important to minimize the risk of spreading bacteria and infection. Furthermore, DON stated wound cares were to be completed	F 880		

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F 880	Continued From page 98 according to the orders. DON stated nurses performing wound care were expected to start from the wound and move out to the surrounding skin. DON indicated moving from the surrounding area of the wound into the wound had the potential to bring bacteria or infection from the skin to the wound. A facility policy titled Infection Prevention and Control and Surveillance program, no date, directed the facility to establish and maintain an infection prevention and control program which prevents, identifies, reports, investigates, and controls the spread of infections and communicable disease in the facility. Furthermore, the policy directed the facility to conduct surveillance for early detection of infections/clusters or outbreaks and to track and trend surveillance data. A facility policy titled hand washing/hand hygiene revised 8/2021, directed staff to use an alcohol-based hand rub or soap and water before moving from a contaminated body site to a clean body site during resident care and after contact with blood or bodily fluids.	F 880		
F 886 SS=F	COVID-19 Testing-Residents & Staff CFR(s): 483.80 (h)(1)-(6) §483.80 (h) COVID-19 Testing. The LTC facility must test residents and facility staff, including individuals providing services under arrangement and volunteers, for COVID-19. At a minimum, for all residents and facility staff, including individuals providing services under arrangement and volunteers, the LTC facility must: §483.80 (h)((1) Conduct testing based on	F 886		8/30/22

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F 886	Continued From page 99 parameters set forth by the Secretary, including but not limited to: (i) Testing frequency; (ii) The identification of any individual specified in this paragraph diagnosed with COVID-19 in the facility; (iii) The identification of any individual specified in this paragraph with symptoms consistent with COVID-19 or with known or suspected exposure to COVID-19; (iv) The criteria for conducting testing of asymptomatic individuals specified in this paragraph, such as the positivity rate of COVID-19 in a county; (v) The response time for test results; and (vi) Other factors specified by the Secretary that help identify and prevent the transmission of COVID-19. §483.80 (h)((2) Conduct testing in a manner that is consistent with current standards of practice for conducting COVID-19 tests; §483.80 (h)((3) For each instance of testing: (i) Document that testing was completed and the results of each staff test; and (ii) Document in the resident records that testing was offered, completed (as appropriate to the resident's testing status), and the results of each test. §483.80 (h)((4) Upon the identification of an individual specified in this paragraph with symptoms consistent with COVID-19, or who tests positive for COVID-19, take actions to prevent the transmission of COVID-19.	F 886		

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F 886	Continued From page 100 §483.80 (h)((5) Have procedures for addressing residents and staff, including individuals providing services under arrangement and volunteers, who refuse testing or are unable to be tested. §483.80 (h)((6) When necessary, such as in emergencies due to testing supply shortages, contact state and local health departments to assist in testing efforts, such as obtaining testing supplies or processing test results. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to routinely test staff that included: licensed practical nurse (LPN)-D, LPN-E, dietary aide (DA)-A, dietary director (DD)-A, activities aide (AA)-A, AA-B, and cook (C)-A for COVID-19 according to Centers for Medicare and Medicaid (CMS) guidance for routine COVID-19 testing requirements. This deficient practice had the potential to affect all 54 vaccinated and unvaccinated residents residing in the facility. Findings include: The CMS QSO-20-38-NH memo revised 3/10/22, directed, routine testing of staff, who are up to date, should be based on the extent of the virus in the community. "Up-to-Date" means a person has received all recommended COVID-19 vaccines, including any booster dose(s) when eligible. Furthermore, the memo directed when COVID-19 community transmission level was high, minimum testing frequency was twice a week for staff who are not up to date. The facility was located in Henepin County	F 886	F 886 *DPOC LPN D was tested on- 8/15 Last day worked LPN E was tested- on 8/18 DA □ A was tested on-No longer employed DD □ A was tested on-8/18 AA □ A was tested on-8/15 on vacation AA □ B was tested on-8/18 Cook □ A was tested on There was no ill effects experienced from this deficient practice. All other staff who are not up to date have been tested per policy frequency. Future staff (Full and Part Time) who are not up to date will be tested prior to the start of their shift and at the frequency per policy. Facility staff were in-serviced on the COVID Outbreak and Routine Testing policy with emphasis on the testing table and that routine testing of staff, who are not up-to-date, should be based on the extent of the virus in the community. A Directed Plan of Correction will also be conducted by the IDT team and a root	

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F 886	Continued From page 101 Minnesota and the COVID-19 community transmission level was high, indicating facility staff who are not "up to date" required a minimum testing of twice weekly. An untitled and undated facility document reviewed on 7/14/22, indicated the status of all direct hires and their COVID -19 vaccination status. The form identified the staff name, position, vaccine type, date of first dose, date of second dose, date of booster, and exemption status. The form identified LPN-D, LPN-E, AA-A, AA-B, DA-A, AA-B, and DD- A had not received a COVID-19 booster, and C-A had an approved exemption. A review of staff COVID-19 testing results and staff time sheets between 6/12/22 through 7/14/22, showed the following: -LPN-D was actively working in the facility during the above time and tested last on 6/30/22. LPN-D tested twice for during the 4-week time. Due to the county transmission level being high, LPN-D should have tested 8 times. -LPN-E was actively working in the facility during the above time and tested last on 7/12/22. LPN-E tested 4 times during the 4-week time. Due to the county transmission level being high, LPN-E should have tested 8 times. -AA-A was actively working in the facility during the above time and tested last on 7/5/22. AA-A tested 5 times during the 4-week time. Due to the county transmission level being high, AA-A should have tested 8 times. -AA-B was actively working in the facility during	F 886	cause will be identified and from the identified root cause a plan for correction will be implemented. Director of Nursing and Infection Preventionist is responsible for compliance. Audits on staff COVID testing will begin 2x week for 2 weeks, weekly x 4 weeks, then monthly to ensure sustained compliance. Audit results will be reviewed by the Administrator and the Administrator will take audit results to QAPI for review and recommendation. Compliance: 8/30/2022	

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F 886	Continued From page 102 the above time and tested last on 6/14/22. AA-B tested once during the 4-week time. Due to the county transmission level being high, AA-B should have tested 8 times. -DD-A was actively working in the facility during the above time and tested last on 7/11/22. DD-A was tested 5 times during the 4-week time. Due to the county transmission level being high, DD-A should have tested 8 times. -C-A was actively working in the facility during the above time and tested last on 6/30/22. C-A was tested twice during the 4-week time. Due to the county transmission level being high, C-A should have tested 8 times. During an interview on 7/14/22, at 10:49 a.m. the Infection Preventionist (IP) verified the community transmission rate was high and staff who were not up to date with the COVID-19 vaccination were expected to test twice weekly. IP further stated testing was completed in the conference room and while there is an effort to have consistent days to test, staff can test on any day they work during the week. IP stated they had ongoing conversations with staff daily to ensure testing completed. During an interview on 7/18/22, at 8:46 a.m. the Administrator stated staff were expected to be tested for COVID-19 twice weekly if not up to date with their COVID-19 vaccination. Administrator reviewed the identified staff listed above, was surprised and thought some of them were up to date. The Administrator further stated routinely testing for COVID-19 was important to detect any COVID-19 positive results quickly and helped to eliminate risk of infection to residents	F 886		

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F 886	Continued From page 103 and staff. A facility policy titled COVID-19 Outbreak and Routine Testing Procedure revised 6/2022, directed routine staff testing who are not up to date should be based on the extent of COVID-19 in the community. Staff who are up to date do not need to be routinely tested. Furthermore, the policy directed for a community transmission rate of "high" twice a week testing was required.	F 886		
F 888 SS=D	COVID-19 Vaccination of Facility Staff CFR(s): 483.80(i)(1)-(3)(i)-(x) §483.80(i) COVID-19 Vaccination of facility staff. The facility must develop and implement policies and procedures to ensure that all staff are fully vaccinated for COVID-19. For purposes of this section, staff are considered fully vaccinated if it has been 2 weeks or more since they completed a primary vaccination series for COVID-19. The completion of a primary vaccination series for COVID-19 is defined here as the administration of a single-dose vaccine, or the administration of all required doses of a multi-dose vaccine. §483.80(i)(1) Regardless of clinical responsibility or resident contact, the policies and procedures must apply to the following facility staff, who provide any care, treatment, or other services for the facility and/or its residents: (i) Facility employees; (ii) Licensed practitioners; (iii) Students, trainees, and volunteers; and (iv) Individuals who provide care, treatment, or other services for the facility and/or its residents, under contract or by other arrangement.	F 888		8/30/22

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F 888	Continued From page 104 §483.80(i)(2) The policies and procedures of this section do not apply to the following facility staff: (i) Staff who exclusively provide telehealth or telemedicine services outside of the facility setting and who do not have any direct contact with residents and other staff specified in paragraph (i)(1) of this section; and (ii) Staff who provide support services for the facility that are performed exclusively outside of the facility setting and who do not have any direct contact with residents and other staff specified in paragraph (i)(1) of this section. §483.80(i)(3) The policies and procedures must include, at a minimum, the following components: (i) A process for ensuring all staff specified in paragraph (i)(1) of this section (except for those staff who have pending requests for, or who have been granted, exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations) have received, at a minimum, a single-dose COVID-19 vaccine, or the first dose of the primary vaccination series for a multi-dose COVID-19 vaccine prior to staff providing any care, treatment, or other services for the facility and/or its residents; (iii) A process for ensuring the implementation of additional precautions, intended to mitigate the transmission and spread of COVID-19, for all staff who are not fully vaccinated for COVID-19; (iv) A process for tracking and securely documenting the COVID-19 vaccination status of all staff specified in paragraph (i)(1) of this section; (v) A process for tracking and securely	F 888		

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F 888	Continued From page 105 documenting the COVID-19 vaccination status of any staff who have obtained any booster doses as recommended by the CDC; (vi) A process by which staff may request an exemption from the staff COVID-19 vaccination requirements based on an applicable Federal law; (vii) A process for tracking and securely documenting information provided by those staff who have requested, and for whom the facility has granted, an exemption from the staff COVID-19 vaccination requirements; (viii) A process for ensuring that all documentation, which confirms recognized clinical contraindications to COVID-19 vaccines and which supports staff requests for medical exemptions from vaccination, has been signed and dated by a licensed practitioner, who is not the individual requesting the exemption, and who is acting within their respective scope of practice as defined by, and in accordance with, all applicable State and local laws, and for further ensuring that such documentation contains: (A) All information specifying which of the authorized COVID-19 vaccines are clinically contraindicated for the staff member to receive and the recognized clinical reasons for the contraindications; and (B) A statement by the authenticating practitioner recommending that the staff member be exempted from the facility's COVID-19 vaccination requirements for staff based on the recognized clinical contraindications; (ix) A process for ensuring the tracking and secure documentation of the vaccination status of staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations, including, but not limited to,	F 888		

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F 888	Continued From page 106 individuals with acute illness secondary to COVID-19, and individuals who received monoclonal antibodies or convalescent plasma for COVID-19 treatment; and (x) Contingency plans for staff who are not fully vaccinated for COVID-19. Effective 60 Days After Publication: §483.80(i)(3)(ii) A process for ensuring that all staff specified in paragraph (i)(1) of this section are fully vaccinated for COVID-19, except for those staff who have been granted exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations; This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure all staff received the COVID-19 vaccination or were granted a religious and/or medical exemption for one facility staff, nursing assistant (NA)-D and two contacted staff, social worker (SW)-A and oxygen delivery driver (OD)- A reviewed for COVID-vaccination. This resulted in a 96.4% staff vaccination rate. Findings include: The Centers for Medicaid and Medicare Services (CMS) QSO-22-07-ALL attachment A revised 4/2022, directed, the facility must develop and implement policies and procedures to ensure that all staff are fully vaccinated for COVID-19. Staff refers to individuals who provide any care, treatment, or other services for the facility and/or its residents, including employees; licensed practitioners; adult students, trainees, and	F 888	F 888 *DPOC NA □ D-Positive COVID 5/6/2022. Second dose administered 7/26/2022 Contract Staff □ Exterminator received Maderna on 03/31/2021 Contract Staff □ Hospice employee received Moderna on 01/21/21 and 02/18/21 Social Worker □ Copy of exemption has been requested from employer Oxygen Delivery □ Copy of vaccination record has been requested from employer The DON, Administrator and Infection Preventionist will review the facility mandatory COVID Vaccination Policy and Procedure with emphasis on requests for exemptions, vaccine administration and procedure for contracted staff/service technicians. A Directed Plan of Correction will also be conducted by the IDT team	

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F 888	Continued From page 107 volunteers; and individuals who provide care, treatment, or other services for the facility and/or its residents, under contract or by other arrangements. This also includes individuals under contract or by arrangement with the facility, including hospice and dialysis staff, physical therapists, occupational therapists, mental health professionals, licensed practitioners, or adult students, trainees, or volunteers". An untitled and undated facility document reviewed on 7/14/22, revealed the status of all direct hires and their COVID -19 vaccination status. The form identified the staff name, position, vaccine type, date of first dose, date of second dose, date of booster, and exemption status. The form identified NA-D was partially vaccinated and had received the first COVID-19 vaccination dose on 1/3/2021. An untitled and undated facility document reviewed on 7/15/22, revealed a list of contracted vendors for the facility. This list included Northwest Respiratory Compant and St. Croix Hospice. NA-D's COVID-19 immunization/exemption was requested however was not provided. NA-D's timecard record printed dated 6/12/22-7/15/22, indicated NA-D was actively working in the facility with the most recent shift being 7/13/22. SW-A's COVID-19 immunization/exemption was requested however was not provided. Review of hospice residential communication form dated 7/7/22, indicated SW-A had a visit	F 888	and a root cause will be identified and from the identified root cause a plan for correction will be implemented. Director of Nursing and Infection Preventionist is responsible for compliance. Audits on COVID vaccine, attestation and exemption request will begin 2x week for x 2 weeks, weekly x 4 weeks then monthly to ensure compliance. Audits will be reviewed by the Administrator and brought by the Administrator to QAPI for review and recommendation. Compliance:8/30/2022	

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F 888	Continued From page 108 with R36. OD-A's COVID-19 immunization/exemption was requested however was not provided. An interview on 7/18/22, at 11:49 a.m. OD-B confirmed OD-A delivered oxygen to the facility on 6/30/22. An interview on 7/15/22, at 11:12 the infection preventionist (IP) stated she was not in charge of the staff vaccinations, only in charge of resident vaccinations. IP deferred to Human Resources Manager (HRM). During an interview on 7/15/22, at 11:56 a.m. HRM stated she was responsible to update the staff immunization matrix. HRM looked at copy provided to the state agency (SA) and made corrections. HRM crossed off some staff who no longer worked in the facility and filled in some dates under the second dose section for staff who just obtained their 2nd dose of the vaccination series. HRM further stated a constant reminder was provided for staff who do not have their second dose of the vaccination. When dates of the second dose or booster doses were provided, the spreadsheet was updated. During a follow up interview on 7/15/22, at 1:25 p.m. HRM stated she was unable to locate NA-D's vaccination card. HRM believed her first dose was given at the facility and would provide if found. During an interview on 7/18/22, at 8:46 a.m. the Administrator stated HRM was responsible for updating the staff vaccination matrix. There was also a binder of attestations and copies of	F 888		

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F 888	Continued From page 109 vaccinations that were collected as they were received from contracted agencies. The Administrator further stated there was no formal process to ensure accurate information or that all staff are meeting requirements, but the Infection Preventionist (IP) was working on a plan. The Administrator further stated staff were expected to be vaccinated if they did not have an exemption and there was a book of vendors/contractors with attestations that was also maintained. When asked if all employees/contracted workers were required to be fully vaccinated before working or providing services to the residents, the Administrator stated she was not sure and would need to refer to the IP on that as the IP was up to date on that information. An undated facility policy titled Mandatory Vaccination Policy, applied to all employees of the facility, except those who do not report to a workplace where coworkers or customers are present or who work exclusively outside. Furthermore, the policy directed all employees were required to be fully vaccinated as a term and condition of employment.	F 888		
F 921 SS=D	Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i) §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed maintain a sanitary environment for 2 of 2 (R18 and R3) residents reviewed for	F 921	2022 F 921 *DPOC R 3□s room was deep cleaned on 8/10/2022. The mattress on the facility	8/30/22

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F 921	Continued From page 110 environmental cleanliness. Finding include: Outdoor environment R18's significant change Minimum Data Set (MDS) dated 5/20/22, indicated R18 had moderately impaired cognition and needed extensive assist with activities of daily living (ADLs). R18's diagnoses included dementia without behavior disturbance, major depressive disorder, and paranoid schizophrenia. R18's care plan dated 9/23/21, included, "[R18] [has] impaired cognitive function/dementia or impaired thought processes r/t [related to] Dementia, Disease Process, short term memory loss." The care plan instructed, "Provide the resident, with a homelike environment." On 7/11/22, at 8:00 a.m. survey team arrived at the facility to begin the recertification survey. Surveyor observed a queen-sized mattress laying in the grass between the parking area and road. The mattress was observed to be visibly soiled and had fraying along 2 edges and full light-brown discoloration from what appeared to be caused by rain and exposure to other outdoor elements. During an interview on 7/11/22, at 8:14 a.m. family member (FM)-A stated she had seen the mattress near the parking area for about 2 weeks. FM-A added, "I called the city to have it removed. I was told it was the nursing home's responsibility. If that was in their front lawn at home, it would not still be there. This is their [resident's] home. It shouldn't be left here either." During an interview on 7/13/22, at 10:03 a.m. the	F 921	grounds was removed on 7/15/2022. Current resident rooms are cleaned daily and deep cleaned per schedule. Environmental rounds were completed and any identified area inside or outside of the facility will be listed and prioritized for repair and/or replacement. Environmental Services Director and Environmental Services Staff will be in-serviced on the Homelike Environment Policy and procedure with emphasis on item #2 list that facility staff and management maximizes the characteristics of the facility to reflect a personalized, homelike setting. A Directed Plan of Correction will also be conducted by the IDT team and a root cause will be identified and from the identified root cause a plan for correction will be implemented. Director of Environmental Services and/or designee is responsible for compliance. Audits on room cleanliness and deep cleaning post room cleaning audits will begin 2x week for x 2 weeks, weekly x 4 weeks then monthly to ensure compliance. Audits will be reviewed by the Administrator and brought by the Administrator to QAPI for review and recommendation. Compliance: 8/30/2022	

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F 921	Continued From page 111 administrator stated she was aware of the mattress one the property near road. The administrator stated, "I noticed last week. I guess we could pull it over to our dumpster." Indoor environment R3's quarterly MDS dated 7/12/22, indicated intact cognition and independence with activities of daily living. R3's diagnoses included Wernicke's encephalopathy and alcohol dependence. On 7/12/22, at 12:49 p.m. writer observed the bottom third of R3's window blinds were soiled with a dried brown matter. R3 stated the blinds had been soiled and unchanged since she admitted about 4 months ago. R3 added, "It looks unclean. It bothers me." R3 also pointed out multiple spots of dried brown matter covering the lower half of 1 of the 2 privacy curtains in the room. The spots were too numerous to count and ranged from the size of a fingertip to the size of a fist. The other privacy curtain was soiled with approximately 7 - 3/4" brown smudges around the middle of the curtain and 1 - 2/3" dark reddish-brown spot. R3 stated, "I think that's dried blood." R3 added, the blinds or the privacy curtains had not been cleaned or replaced since she admitted to the facility approximately 4 months ago." During an interview on 7/14/22, at 8:13 a.m. housekeeper (HK)-A stated she cleaned R3's room daily. HK-A observed the blinds in R3's room and stated, "It looks like something has been spilled or sprayed on them." HK-A added, "It needs to be cleaned." HK-A observed the privacy curtains in R3's room and stated, "There are spots of something on there. It is dirty." HK-A	F 921		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 921	Continued From page 112 stated housekeepers are expected to ensure the blinds and privacy curtains are clean and in good repair while doing the daily cleaning in each resident's room. HK-A was not aware of any established schedule for cleaning or replacing privacy curtains. During an interview on 7/14/22, at 8:27 a.m. the administrator stated housekeeping staff is expected to wipe down all surfaces in the residents' rooms daily and if there is anything visibly unclean it needs to be addressed immediately. This would include the window blinds and privacy curtains. The administrator stated she was unsure if there was an established schedule for cleaning or replacing racy curtains and stated, "That would be up to the housekeeping department." The facility policy, "Homelike Environment," dated 2021, included, "The facility staff and management maximizes, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. These characteristics include: a. clean, sanitary and orderly environment.	F 921		

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER #	MULTIPLE CONSTRUCTION	DATE SURVEY COMPLETE:
	245544	A. BUILDING: _____ B. WING _____	7/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 641	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the Minimum Data Set (MDS) was coded to reflect correct and accurate anticoagulant medication consumption for 2 of 4 residents (R20 and R34) reviewed for MDS accuracy. Findings include: The Centers for Medicare and Medicaid (CMS) Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, dated 10/2019, outlined an overview which included, "The purpose of this manual is to offer clear guidance about how to use the [RAI] correctly and effectively to help provide appropriate care ... The RAI helps nursing home staff in gathering definitive information on a resident's strengths and needs, which must be addressed in an individualized care plan." The manual then outlined each MDS section with corresponding instructions and directions. This included Section N0410, "Medications Received," which had a section labeled, "Coding Instructions," directing, "N0410E, Anticoagulant ... Record the number of days an anticoagulant medication was received by the resident ... Do not code antiplatelet medications such as aspirin/extended release, dipyridamole, or clopidogrel here." R20 R20's significant change MDS dated 7/9/22, indicated R20 was admitted to the facility on 5/16/22, and had diagnoses of heart disease and chronic obstructive pulmonary disease (COPD). R20's Order Summary report, printed 6/18/22, indicated R20 had an order for Apixaban (medication to thin the blood) 5 milligrams (mg) by mouth twice a day for blood thinner, with a start date of 5/16/22. However, R20's completed significant change MDS, dated 7/9/22, identified no recorded doses of anticoagulant being provided despite R20's order for Apixaban. R34 R34's quarterly MDS dated 6/6/22, indicated R20 was admitted on 8/4/21 and had diagnoses of a cerebral infarction (stroke) and right-side hemiparesis (weakness). R34's Order Summary Report printed 7/18/22, indicated R34 had an order for Ticagrelor (antiplatelet medication) 90 mg by mouth daily for carotid artery, with a start date of 10/1/21. Furthermore, R34's order summary lacked evidence R34 was on an anticoagulant medication.

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 245544	MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	DATE SURVEY COMPLETE: 7/18/2022

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ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 641	Continued From Page 1

However, R34's completed quarterly MDS dated 6/6/22, identified R34 had seven doses of an anticoagulant administered during the look back period.

An interview on 7/15/22, at 9:39 a.m. registered nurse (RN)-B stated when completing a resident MDS, diagnoses, medication orders and medication administration were reviewed. RN-B reviewed R20's orders and significant change MDS and verified the error. RN-B acknowledged she had not included R20's Apixaban medication as an anticoagulation in R20's MDS. RN-B further stated R20 was challenging as R20 was on a lot of medications and was in and out of the facility frequently. When reviewing R34's orders, RN-B stated she was not familiar with the medication Ticagrelor but thought it was an anticoagulant. Medications that were unfamiliar would be researched on Google or with the consulting pharmacist. RN-B stated some of the medications and rules for RAI were confusing. RN-B reviewed the RAI instructions and verified antiplatelet medications should not be included as anticoagulants.

An interview on 7/18/22, at 9:29 a.m. the Administrator stated her expectation was for MDS assessments to be thorough and accurate. Inaccurate assessments can impact our resources to provide residents cares.

A facility policy titled MDS Completion and Submission Timeframe's revised July 2017, directed the facility to conduct and submit resident assessments in accordance with current federal and state guidelines.

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
August 11, 2022

Administrator
Victory Health & Rehabilitation Center
512 49th Avenue North
Minneapolis, MN 55430

Re: State Nursing Home Licensing Orders
Event ID: YW9C11

Dear Administrator:

The above facility was surveyed on July 11, 2022 through July 18, 2022 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the

"Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

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

Sarah Grebenc, Unit Supervisor
Metro A District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: sarah.grebenc@state.mn.us
Office: (651) 201-3792 Mobile (651)238-8786

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

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00166	A. BUILDING: _____ B. WING _____	C 07/18/2022

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 7/11/22 - 7/18/22, a standard licensing survey was conducted completed at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found NOT in compliance with the MN State Licensure. The following complaint was found to be	2 000		

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2 000	Continued From page 1 SUBSTANTIATED: H55443119C (MN84313), with a licensing order issued at 1695. H55443120C (MN84474), with a licensing order issued at 1695. The following complaints were found to be UNSUBSTANTIATED: H5544312C (MN82602), H55443121C (MN84759), H5544311C (MN82247), and H5544313C (MN83035), . Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor ' s findings are the Suggested Method of Correction and Time Period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm. The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the	2 000		

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2 000	Continued From page 2 heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		
2 302	MN State Statute 144.6503 Alzheimer's disease or related disorder train ALZHEIMER'S DISEASE OR RELATED DISORDER TRAINING: MN St. Statute 144.6503 (a) If a nursing facility serves persons with Alzheimer's disease or related disorders, whether in a segregated or general unit, the facility's direct care staff and their supervisors must be trained in dementia care. (b) Areas of required training include: (1) an explanation of Alzheimer's disease and related disorders; (2) assistance with activities of daily living; (3) problem solving with challenging behaviors; and (4) communication skills. (c) The facility shall provide to consumers in written or electronic form a description of the training program, the categories of employees trained, the frequency of training, and the basic	2 302		8/30/22

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2 302	Continued From page 3 topics covered. (d) The facility shall document compliance with this section. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure that the facility's direct care staff and their supervisors received the required Alzheimer's disease or related disorder training. This had the potential to affect 11 residents diagnosed with dementia residing in the facility. Findings include: Review of the facility information provided from the CMS 672 federal form indicated the facility had 11 residents diagnosed with dementia residing in the facility at the time of survey. Documentation of Alzheimer's disease training completed within the last year was requested from the facility and not provided for the following direct care staff: Licensed practical nurse (LPN)-A, nursing assistant (NA)-B, NA-D, and NA-E. During an interview on 7/15/22, at 11:11 a.m. Administrator stated all employees were expected to completed Alzheimer's training annually. The Administrator reviewed education records for LPN-A, NA-B, NA-D, and NA-E and noted all four employees had not completed the required Alzheimer's education in the past year. The Administrator added, it was important for all employees to complete Alzheimer's training annually to ensure they know the approaches and	2 302	Corrected	

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2 302	Continued From page 4 communication techniques to work with people with dementia. The facility policy, "Required In-service Training for Nurse Aids," (undated), included, "Training topics will include but are not limited to: a. Abuse, neglect, and exploitation training to include in addition to the freedom from abuse, neglect and exploitation requirements, activities that constitute abuse, neglect, exploitation, and misappropriation of resident property and procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property; b. Dementia management & abuse prevention training, c. care of the cognitively impaired; and d. Training of feeding assistance." SUGGESTED METHOD OF CORRECTION: The administrator and director of nursing could review and revise current policies and procedures on dementia training for employees to ensure timely training is accomplished. The administrator, director of nursing or designee could perform audits on annual dementia training to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 302		
2 550	MN Rule 4658.0400 Subp. 4 Comprehensive Resident Assessment; Review Subp. 4. Review of assessments. A nursing home must examine each resident at least quarterly and must revise the resident's comprehensive assessment to ensure the continued accuracy of the assessment.	2 550		8/30/22

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2 550	Continued From page 5 This MN Requirement is not met as evidenced by: Based on observation and interview, the facility failed to ensure survey results were placed in a prominent place and contained or directed where to obtain the last three years of survey results. This had the potential to affect all 54 residents residing in the facility, along with family, visitors, and staff. Findings include: An observation on 7/13/22, at 12:25 p.m. the entry way and through out the facility, lacked evidence of the facility's past survey results or direction on how to obtain the facility's survey results. During a resident meeting on 7/13/22, at 2:00 p.m. R45 stated they were unaware of a way to review the facility's survey results. R8 further stated there used to be some books located by the front entrance but was not aware of any books recently. On 7/15/22, at 12:27 p.m. the Human Resources Manager (HRM) stated the facility results for resident/family were normally kept on the cabinet located at the entrance of the facility. HRM looked at the cabinet and verified the survey results were not there. HRM then asked the Infection Preventionist (IP) where the survey results book was located. IP verified the book was normally located on the cabinet by the entrance and verified it was not there. HRM and IP then went to the Administrator who verified the facility's survey result book was located on the cabinet near the entrance. The Administrator verified the book was not there and was not sure where it was.	2 550	Corrected	

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2 550	Continued From page 6 On 7/15/22, at 12:38 p.m. the Chief Operating Officer (COO) stated, "I brought the survey book back home with me to New York". COO further stated the survey results book was needed to help with upcoming preparation for court proceedings. During an interview on 7/18/22, at 9:50 a.m. the Administrator stated she expected the survey results book to be available for residents and family to review. The Administrator further acknowledged the survey results were not accessible as it was taken home by the COO. A facility policy titled Resident Rights, revised 12/2016, directed residents have the rights to examine the facility's survey results. SUGGESTED METHOD OF CORRECTION: The administrator or designee, could ensure the survey results book is kept in the facility in a location that is easily accessible to residents. They could then audit to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	2 550		
2 915	MN Rule 4658.0525 Subp. 6 A Rehab - ADLs Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that: A. a resident is given the appropriate treatments and services to maintain or improve abilities in activities of daily living unless deterioration is a normal or characteristic part of the resident's condition. For purposes of this	2 915		8/30/22

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2 915	Continued From page 7 part, activities of daily living includes the resident's ability to: (1) bathe, dress, and groom; (2) transfer and ambulate; (3) use the toilet; (4) eat; and (5) use speech, language, or other functional communication systems; and This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide assistance with routine personal grooming (i.e., fingernail care) for 1 of 8 residents (R39) reviewed for activities of daily living (ADLs). Findings include: R39's admission Minimum Data Set (MDS), dated 6/9/22, identified R39 had intact cognition and was independent with personal hygiene. R39's care plan, dated 6/24/22, identified R39 had an ADL self-care deficit, had a weekly bath scheduled for Saturday evening, and listed an interventions which outlined, "PERSONAL HYGIENE: The resident is independent." On 7/11/22, at 2:52 p.m., R39 was observed in his room lying in bed. R39 had visibly long fingernails on both hands with several nails having a black-colored debris present underneath of them. R39 stated he typically kept his fingernails clipped shorter and had "been trying to get my fingernails cut for awhile," however, when	2 915	Corrected	

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2 915	Continued From page 8 he'd ask staff for help or a clippers, they would say they'd return but then never come back. R39's completed Weekly Skin Check, dated 7/12/22, identified a section labeled, "Nail Care," which provided several questions for staff to select a response. This included, "Finger Nails are trimmed, or filed," which was answered, "No," along with a comment which read, "Need finger nails trimmed." However, during subsequent observation on 7/14/22, at 11:21 a.m. (two days later), R39 continued to have the same visibly long fingernails with black-colored debris present underneath of them. R39 reiterated he wanted his fingernails clipped adding, "Oh, hell yea [I do]." R39's medical record was reviewed and lacked evidence R39 had been offered, refused and/or provided nail care the previous Saturday (7/9/22) when his bath was schedule per his care plan, nor despite the completed skin check identifying the need for such care on 7/12/22. When interviewed on 7/14/22, at 11:25 a.m., nursing assistant (NA)-A stated R39 needed minimal assistance to complete most ADLs and typically did not refuse cares when offered. NA-A stated "the nurses" were responsible to help R39 with grooming, including nail care, as he was a male and the NA(s) only are responsible to complete grooming for the women. NA-A reiterated, "We're [NA] responsible for grooming on women." NA-A observed R39's nails at this time and verified they had dark debris present underneath of the them, and NA stated they were "long, long" and needed to be clipped. Further, NA-A stated she noticed R39 often scratched his arms and any refusals of offered nail care should	2 915		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 915	Continued From page 9 be recorded in the nurses' notes. When interviewed on 7/14/22 at 11:36 a.m., licensed practical nurse (LPN)-A stated nail care should be provided on shower days by the NA staff unless the resident was diabetic, then it was the nurses' responsibility. LPN-A stated R39 was not diabetic and the NA staff were able to help him complete any personal hygiene or grooming cares needed or requested. LPN-A then left to observe R39's nails at the surveyor's request. LPN-A returned moments later and stated they were long and needed to be clipped, so she just clipped them. LPN-A stated R39 expressed they had not been clipped since he admitted to the nursing home several weeks prior. On 7/14/22 at 2:11 p.m., the director of nursing (DON) was interviewed and explained nail care should be completed with the weekly bathing. The DON verified all staff were able to complete a resident's ADL needs and he would "have an education" on this with the direct care staff. Further, the DON stated it was important to ensure routine grooming and nail care was provided as long, soiled nails could be an infection control issue. A provided Fingernails/Toenails (Care Of) policy, dated 2018, identified nail care included daily cleaning and regular trimming adding, "Proper nail care can aid in prevention of skin problems around the nail bed," and, "Trimmed and smooth nails prevent the resident from accidentally scratching and injuring his or her skin." Further, the policy outlined the provided nail care should be recorded in the medical record. SUGGESTED METHOD OF CORRECTION: The director of nursing and/or designee could	2 915		

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2 915	Continued From page 10 educate responsible staff to provide care to residents' dependant on facility staff, based on residents' comprehensively assessed needs. The DON or designee could conduct audits of dependent resident cares to ensure their personal hygiene needs are met consistently. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 915		
21325	MN Rule 4658.0725 Subp. 1 Providing Routine & Emergency Oral Health Ser Subpart 1. Routine dental services. A nursing home must provide, or obtain from an outside resource, routine dental services to meet the needs of each resident. Routine dental services include dental examinations and cleanings, fillings and crowns, root canals, periodontal care, oral surgery, bridges and removable dentures, orthodontic procedures, and adjunctive services that are provided for similar dental patients in the community at large, as limited by third party reimbursement policies. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure a voiced request to see a dental provider and obtain new dentures was acted upon and addressed for 1 of 2 residents (R20) reviewed for dental hygiene and services. Findings include: R20's admission Minimum Data Set (MDS), dated 5/23/22, identified R20 had moderate cognitive impairment, had no natural teeth, and required extensive assistance with personal hygiene (i.e.,	21325	Corrected	8/30/22

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21325	Continued From page 11 brushing teeth). Further, R20's Census listing, printed 7/15/22, identified R20's payer source as, "Medicare A." When interviewed on 7/11/22 at 9:57 a.m., R20 stated he needed to get new dentures. R20 explained he told the staff he needed to get to a dentist as he "ain't got no teeth [edentulous]" but the staff never followed up with him. R20 denies concerns with chewing but reiterated he wanted to see a dentist for new dentures. R20's Nurse Admission/Readmission evaluation, dated 5/16/22, included a section labeled, "Oral Status," which identified R20 as being edentulous and having no dentures. In addition, R20's care plan, dated 6/8/22, identified R20 had oral and/or dental health problems due to poor oral hygiene. The care plan outlined, "Resident has no teeth and no dentures." Further, the care plan listed several interventions for R20's oral health which included, "Coordinate appointments for dental care, transportation as needed/as ordered." However, R20's Dietary / Nutrition Assessment, dated 5/24/22, identified a section labeled, "Eathing [sic] / Chewing," which outlined R20 did not have his own teeth, and used dentures. The section included dictation which read, "Resident had upper & lower dentures but does not wear them due to poor fit. He would like to see a dentist to pursue new dentures if possible. [Health unit coordinator (HUC)-A] notified." R20's medical record was reviewed and lacked evidence this voiced request to see a dental provider had been acted upon, scheduled, or completed despite R20 admitting to the nursing home nearly two months prior.	21325		

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21325	Continued From page 12 When interviewed on 7/13/22 at 10:02 a.m., nursing assistant (NA)-C stated had worked with R20 several times before, and explained R20 required set-up assistance to complete oral cares. However, NA-C stated she was unsure if R20 used dentures or not, nor if R20 had ever been seen by a dentist for care. NA-C stated an "appointment lady" was responsible to facilitate outside appointments. On 7/13/22 at 10:12 a.m., HUC-A was interviewed and verified she was responsible to arrange and schedule outside appointments with dental clinics and providers. HUC-A stated she tracked all scheduled appointments in a calendar-style binder, however, was unable to locate any scheduled or completed dental appointments for R20 adding, "[R20] might have end up falling through the cracks." HUC-A recalled the registered dietician (RD)-A talking to her about R20 needing dentures; however, explained she felt this was "just recently" expressed to her within the past week or so. HUC-A verified no dental appointment had been arranged for R20 and stated, "It must have got overlooked." When interviewed on 7/13/22 at 10:20 a.m. RD-A verified she recalled completing R20's nutritional assessment and stated she would have "immediately" notified HUC-A of R20's request to see a dentist when she completed the assessment adding, "It wasn't last week." However, RD-A stated she did not follow-up with HUC-A since requesting the appointment to ensure it was schedule or completed as she had "kind of assumed" HUC-A handled it. On 7/13/22 at 10:42 a.m., the director of nursing (DON) was interviewed. He explained he had	21325		

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21325	Continued From page 13 investigated the situation and verified the appointment had been missed, so they would immediately schedule a dental appointment for R20. The DON added the appointment had been "oversighted," and should have been scheduled when R20 made the request. A provided Dental Services policy, dated 2016, identified routine and emergency dental services were available to meet a resident's oral health needs in accordance with their assessment and plan of care. The policy directed, "Social services representatives will assist residents with appointments, transportation arrangements, and for reimbursement of dental services ... " SUGGESTED METHOD OF CORRECTION: The administrator or designee could develop/revise and implement policies and procedures related to dental agreements and educate staff on these requirements. The quality assessment and assurance committee could perform random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) days	21325		
21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment. This MN Requirement is not met as evidenced by: Based on observation, interview, and document	21375	corrected	8/30/22

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21375	Continued From page 14	21375		

review, the facility failed to ensure an ongoing, complete process and outcome surveillance was collected and a comprehensive analysis of the data was completed to reduce the spread of infection within the facility. In addition the facility failed to ensure hand hygiene was performed during incontinent cares for 1 of 1 residents (R47) reviewed for activities of daily living (ADLs). The facility also failed to ensure wound cares were performed to prevent cross contamination of bacteria for 1 of 1 residents (R53) reviewed for pressure ulcers. This deficient practice had the potential to affect all 54 residents residing in the facility.

Findings include:

ONGOING SURVEILLANCE

A review of the facility infection control program was conducted on 7/18/22. The facility provided the various monthly forms below:

April 2022:

-Minnesota Department of Health (MDH) Line listing, dated 4/2022, included resident name and information, infection type, onset and resolution date of symptoms, diagnostic testing, antibiotic dose frequency used, and if the infection resolved.

-Infection Control form, dated 4/2022, utilized the information from the 4/22 line listing to identify the total number of antibiotics used in the facility and identified urinary tract infection (UTI) as the most common diagnosis. The report indicated there was no pattern of UTI noted in the building and daily temps, symptoms, and antibiotic use side effects were monitored. The pharmacist utilized

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21375	Continued From page 15 this information to complete a antibiotic report dated 4/22 which included various information such as the number of antibiotic courses used, number of residents on antibiotics, most common diagnosis, route of antibiotics, and prophylactic use. The pharmacist report determined antibiotic use was reasonable and necessary. May 2022: -MDH Line listing, dated 5/2022, included resident name and information, infection type, onset and resolution date of symptoms, diagnostic testing, antibiotic dose frequency used, and if the infection resolved. -Infection Control form, dated 5/2022, utilized the information from the 5/22 line listing to identify the total number of antibiotics used in the facility and identified urinary tract infection (UTI) as the most common diagnosis. The report indicated there was no pattern of UTI was noted in the building and daily temps, symptoms, and antibiotic use side effects were monitored. The pharmacist antibiotic report dated 5/2022, identified various information which included the number of antibiotic courses used, number of residents on antibiotics, most common diagnosis, route of antibiotics, and prophylactic use. The pharmacist report determined antibiotic use was reasonable and necessary. June 2022: -MDH Line listing, dated 6/2022, included resident name and information, infection type, onset and resolution date of symptoms, diagnostic testing, antibiotic dose, and frequency used, and if the infection resolved. Data was collected 6/1/22-6/8/22. A 2nd facility document titled	21375		

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21375	Continued From page 16 June-July 2022, no date, was a handwritten document with data collected from 6/9/22-7/12/22. The data included resident name, type of infection and antibiotic that was started. No further information for further surveillance data was provided. During an interview on 7/14/22, at 11:27 a.m. the Infection Preventionist (IP) stated she currently was working on entering data for June and July into the MDH line listing document. IP stated she had been out of the country since 6/22/22 and had returned on 7/13/22. The IP further stated the director of nursing (DON) was responsible for the infection control program during her absence. During an interview on 7/14/22, at 12:46 p.m. the DON provided the handwritten facility document titled June-July 2022, as referenced above. The DON further stated the document was how he was keeping track of data to provide to the IP upon her return. The DON verified he did not have access to the MDH line listing and only the IP had access. DON stated infection data was collected for IP to enter into the spreadsheet and review upon her return. During a follow up interview on 7/15/22, at 10:49 a.m. the DON stated there was not an analysis of the data collected during the IP's absence. DON stated he did not believe any of the infections were "explosive" and there were no COVID-19 outbreaks, but there was not time to complete any analysis collected during that time before the State Agency (SA) entered the building. During a follow up interview on 7/15/22. At 2:25 p.m. IP stated the normal process was for an analysis of infections to be completed at the end	21375		

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21375	Continued From page 17 of each month. Any new antibiotic use was determined by staff notification, running a report in the electronic medical record, or in morning meetings. The IP further stated the pharmacist did a monthly analysis of the antibiotics while she completed a monthly investigation and analysis of the infection data. The IP stated together this information was a complete analysis and investigation and was provided to the Quality Assurance Committee monthly. The IP stated the last analysis was completed in March 2022, and stated with so much going on and being gone, she was behind. During an interview on 7/18/22, at 8:46 a.m. the Administrator stated she expected any infection in the building should be identified timely so the appropriate care was started and to ensure the spread of infection was minimized in the building. The Administrator stated she expected the IP to then collect and analyze the facility data for any infections occurring with residents or staff in the building and this should occur monthly and as needed. In the absence of the IP, the DON or other nurses would be available to step in as it was important to ensure there was no infection risks to residents and staff. RESIDENT CARES: R47 R47's significant change Minimum Data Set (MDS) dated 6/17/22, indicated R47 was admitted to the facility on 5/23/22, had mild cognitive impairment and diagnoses of cerebral infarction (stroke) with left sided hemiparesis (weakness). The MDS further indicated R47 was frequently incontinent of bladder and required one assist for toileting.	21375		

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21375	Continued From page 18 On 7/12/22, at 4:54 p.m. nursing assistant (NA)-B entered R47's room to assist with incontinent cares. NA-B provided privacy and transferred R47 from her wheelchair to her bed. NA-B donned gloves and proceeded to pull down R47's jeans. R47's brief was wet with urine but was not leaking through onto clothing. NA removed soiled brief and placed it in the garbage. NA-B then cleaned R47's peri area and bottom and applied a barrier cream with dirty gloves. NA-B fastened the clean brief and pulled R47's jeans back up. NA-B took the cream and package of wipes used during cares, opened R47's dresser drawer and replaced the items. NA-B grabbed R47's wheelchair by the arm rests to adjust it closer to the bed to prepare to assist R47 back into the chair. NA-B used the R47's bed controls to adjust the bed height, placed the transfer belt on R47 and transferred R47 to her wheelchair. NA-B situated R47 in her chair, unlocked the breaks, turned R47's chair towards the door and opened the door so R47 could exit the room. NA-B then removed the soiled gloves placed in the garbage bag with the wet brief, tied the bag, and utilized hand sanitizer upon exiting R47's room. NA-B had not performed hand hygiene or changed gloves after completing peri care and handling R47's soiled brief. During an interview on 7/12/22, at 5:03 p.m. NA-B stated R47 was normally incontinent and required assistance with incontinent cares. NA-B verified staff were supposed to change gloves after handling a soiled brief and acknowledged that was not done when providing incontinent cares for R47. Furthermore, NA-B stated if the brief was not soiled with bowl movement or an excess of urine, hand hygiene was not required.	21375		

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21375	Continued From page 19 WOUND CARE R53 R53's significant change Minimum Data Set, dated 6/21/22, indicated R53 was admitted to the facility on 5/30/22, was cognitively intact, received dialysis and had diagnoses of diabetes, and chronic kidney disease. R53's order summary report printed 7/15/22, indicated R53 had an order to clean R53's right shin wound daily, apply calcium alginate, and apply foam dressing. On 7/13/22, at 11:33 a.m. licensed practical nurse (LPN)-D set up to change R53's shin dressing. R53's wound was located on the inside of the right shin. After obtaining supplies, LPN-D performed hand hygiene and donned gloves on both hands LPN-D removed R53's foam dressing from R53's shin wound and removed gloves and performed hand hygiene. LPN-D donned clean gloves to both hands and sprayed normal saline (NS) on the wound and surrounding area. LPN-D proceeded to pick up clean pad and wiped the NS off the skin surrounding R53's wound before using the same gauze to pat the wound bed. LPN-D removed gloves and performed hand hygiene and donned clean gloves. LPN-D placed calcium alginate on R53's wound bed and covered with a new foam dressing. LPN-D removed gloves and performed hand hygiene at the completion of wound cares. During an interview on 7/13/22, at LPN-D verified gauze was used to dry the skin around the wound first before using the same gauze to pat R53's wound. LPN-D further stated it was a mistake and could bring infection from the skin to the	21375		

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21375	Continued From page 20 wound. During an interview on 7/14/22, at 11:30 a.m. the director of nursing (DON) stated he expected all staff to remove gloves and perform hand hygiene after handling a soiled brief and before touching other items or continuing cares. DON verified this was important to minimize the risk of spreading bacteria and infection. Furthermore, DON stated wound cares were to be completed according to the orders. DON stated nurses performing wound care were expected to start from the wound and move out to the surrounding skin. DON indicated moving from the surrounding area of the wound into the wound had the potential to bring bacteria or infection from the skin to the wound. A facility policy titled Infection Prevention and Control and Surveillance program, no date, directed the facility to establish and maintain an infection prevention and control program which prevents, identifies, reports, investigates, and controls the spread of infections and communicable disease in the facility. Furthermore, the policy directed the facility to conduct surveillance for early detection of infections/clusters or outbreaks and to track and trend surveillance data. A facility policy titled hand washing/hand hygiene revised 8/2021, directed staff to use an alcohol-based hand rub or soap and water before moving from a contaminated body site to a clean body site during resident care and after contact with blood or bodily fluids. SUGGESTED METHOD OF CORRECTION: The Infection Preventionist (IP) or designee, could review policy and procedures to ensure	21375		

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21375	Continued From page 21 survalience of infectins are identified, investigatied and analyzied in a timely manner. The director of nursing (DON), or designee, could review/revise facility policies regarding wound care and hand hygiene. The DON, or designee, could then educate staff and perform audits to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21375		
21426	MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home. This MN Requirement is not met as evidenced by:	21426		8/30/22

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21426	Continued From page 22 Based on interview and document review, the facility failed to ensure screening for tuberculosis (TB) history, risk factors and symptoms was completed according to the Centers for Disease Control & Prevention (CDC) guidelines for 6 of 6 residents (R3, R25, R28, R39, R47, R53) reviewed for TB prevention and management. Further, the facility failed to ensure both steps of two-step tuberculosis (TB) skin testing (TST) were completed for 2 of 6 residents (R28, R47), and failed to obtain a chest x-ray or TB blood test for 2 of 6 residents (R25, R39) who refused TST. In addition, the facility lacked documentation of a written TB risk assessment and failed to provide evidence of ongoing TB-related training and education for all health care workers. This had the potential to affect all 54 residents who resided at the facility. Findings include: R3's Admission Record dated 7/18/22, indicated R3 was admitted to the facility on 4/4/22. R3's medical record lacked documentation of baseline TB screening including history, symptoms, and risk factors. R25's Admission Record dated 7/18/22, indicated R25 was admitted to the facility on 5/20/22. R25's medical record lacked documentation of baseline TB screening including history, symptoms, and risk factors. The medical record also indicated R25 refused a TST, however lacked documentation of a chest x-ray or TB blood test to rule out TB. R28's Admission Record dated 7/18/22, indicated R28 was admitted to the facility on 5/26/22. R28's medical record lacked documentation of baseline TB screening including history, symptoms, and	21426	Corrected	

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21426	Continued From page 23 risk factors indicated. R28 had a first step of a two-step TST on 5/27/22, however lacked documentation of a second step. R39's Admission Record dated 7/18/22, indicated R39 was admitted to the facility on 6/2/22. R39's medical record records lacked documentation of baseline TB screening including history, symptoms, and risk factors. The medical record also indicated R39 refused a TST, however the medical record lacked documentation of a chest x-ray or TB blood test to rule out TB. R47's Admission Record dated 7/18/22, indicated R47 was admitted to the facility on 5/23/22. R47's medical records lacked documentation of baseline TB screening including history, symptoms, and risk factors. The medical record also indicated R47 had a first step of a two-step TST on 5/23/22, however lacked documentation of a second step. R53's Admission Record dated 7/18/22, indicated R47 was admitted to the facility on 5/30/22. R53's medical record lacked documentation of baseline TB screening including history, symptoms, and risk factors. During interview on 7/15/22, at 12:58 p.m. registered nurse (RN)-C stated newly admitted residents received a two-step TST, with the first step on the day of admission or the following day, and the second 14 days later. She stated if a resident refused, they ordered a chest x-ray. She stated there was a paper form to complete but was unsure where that paper was kept once completed. During interview on 7/15/22, at 1:43 p.m. director of nursing (DON) stated when a resident was	21426		

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21426	Continued From page 24 admitted the nurse completed an initial TB screening assessment including any symptoms and entered an order for a two-step TST in the computer to identify when each dose should be given and results read. He stated the first step was administered within 24 hours, and another about 7 days later, and each test was read 72 hours after administration and documented under the immunizations tab in the computer. During interview on 7/18/22, at 9:06 a.m., infection preventionist (IP) stated there was a form for TB symptom screening, but she did not know much about the form or where it went after it was completed. She stated when a resident was admitted staff gave a two-step TST, but if they were unable due to previous exposure or resident refusal staff ordered a chest x-ray or TB blood test. She stated documentation of the TST administration and results were entered into the medication administration record or the immunization tab, but the immunization tab was the best place to enter it. She stated it was important to complete TB screening because anyone could come into the facility with TB, and it can spread quickly. She stated they did not want any communicable diseases in the building and needed to protect everyone and make sure they were safe. On 7/18/22, at approximately 10:30 a.m. staff presented incomplete, undated Baseline TB Screening Tool forms for R3, R25, R28, R39, R47, and R53. The facility policy Tuberculosis, Screening Residents Form dated 8/2019, indicated the admitting nurse will screen referrals for admission and readmission for information regarding exposure to or symptoms of TB. The policy	21426		

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21426	Continued From page 25 indicated if a potential resident has been exposed to active TB or is at risk of TB infection, he or she will be screened for latent tuberculosis infection (LTBI) using tuberculin skin tests (TST) or interferon gamma release assay (IGRA). If the IGRA or TST is positive, the nursing staff will contact the physician to obtain orders for a chest x-ray and the physician will assess the resident prior to admission for possible active TB. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could complete a facility TB risk assessment, regularly disseminate TB education to all health care staff, review and/or revise the facility's process to ensure TB testing for residents is completed and documented as required, re-educate nursing staff on the process and TB policy, and review current monitoring or audit system to ensure compliance of TB screening and documentation. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21426		
21510	MN Rule 4658.1200 Subp. 2 A.B. SpecializedRehabilitative Services; Provision Subp. 2. Provision of services. If specialized rehabilitative services are required in the resident's comprehensive plan of care, the nursing home must: A. provide the required services; or obtain the required services from an outside source according to part 4658.0075. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide physical	21510	Corrected	8/30/22

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21510	Continued From page 26 therapy (PT) as ordered for 1 of 1 residents (R26) reviewed for therapy services. Findings include: R26's significant change Minimum Data Set (MDS) dated 6/1/22, indicated R26 was cognitively intact, required supervision with bed mobility, transfers, and toileting, and was unsteady when moving from seated to standing, walking, turning around when walking, moving on and off the toilet, and transferring between surfaces. The MDS indicated R26 used a wheelchair for mobility and lacked documentation of functional rehabilitation potential. R26's Admission Record dated 7/14/22, indicated R26 had diagnoses of history of hip fracture, lung disease, and diabetes. R26's care plan dated 6/8/2022, included interventions of PT/OT (occupational therapy) to continue to provide services to resident, and identified R26 was at high risk for falls with intervention of PT eval and treat as ordered or PRN (as needed). R26's After Visit Summary dated 5/31/22, indicated R26 was seen by an orthopedic physician for a post-operative follow-up appointment relating to surgical repair of right femur fracture, and included a recommendation for PT. R26's medical record included an order for PT evaluate and treat dated 5/31/22, with a "specific service" of Balance/Falls. R26's Victory Health and Rehabilitation Physician Visit Review/Orders dated 5/31/22, indicated R26	21510		

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21510	Continued From page 27 had a post-operative provider appointment and returned with an order for PT for lower extremities, gait training, and strengthening. During interview on 7/11/22, at 2:59 p.m. R26 stated she had two broken hips and she could not pivot but was learning to walk on both feet. She stated she kept asking for a walker, but staff didn't think she was ready. She stated she needed therapy on her legs and was not sure why she was not getting it. During interview on 7/13/22, at 9:27 a.m. occupational therapy assistant (OTA)-A reviewed R26's documentation and confirmed she was not evaluated and had not received PT as ordered on 5/31/22. During interview on 7/14/22, at 11:40 a.m. registered nurse RN-C stated when a resident returned from a doctor appointment with documents, including orders, they were given to the health unit coordinator (HUC) who scanned the documents into the electronic record and then gave them to the nursing staff who entered any orders into the computer. If therapies were ordered she copied the paper order and gave the copy to the appropriate therapy department. She stated she did not recall seeing an order for PT for R26. During interview on 7/14/22, at 11:55 a.m. licensed practical nurse (LPN)-A stated when a resident returned from an appointment any paperwork was given to the nurse who reviewed it for orders. If there was an order for PT the nurse photocopied the order and gave it to PT who followed up. LPN-A stated the paper version in the hard chart would be marked when addressed. LPN-A reviewed R26's hard chart and verified the	21510		

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21510	Continued From page 28 order was present and lacked indication it had been addressed. During interview on 7/14/22, at 11:50 a.m. (HUC)-A stated when a resident returned from an appointment with provider orders she scanned them into the electronic health record and gave the papers to the nurse, although sometimes they were given to the nurse first and then came back to her. She stated normally the nurses took care of the orders, including any referrals to PT, but if the nurse brought her a paper order HUC-A gave a copy of it to the therapy department herself. During interview on 7/14/22. at 12:15 p.m. physical therapy assistant (PTA)-A stated if a resident did not get ordered therapies it could result in increased time in the facility, a decline in health status, and increased burden on facility staff. He stated PT assisted residents to get to their best level of activity to optimize health and quality of life, and if they were not able to maintain that level they could deteriorate mentally and physically. During interview on 7/14/22, at 1:18 p.m. director of nursing (DON) stated if a resident had an order for PT staff took a copy of the order and delivered it to the PT department. He stated he thought R26's order was somehow lost in between departments, and stated the process fell through. He stated the goal was to make her physically stronger and more independent, and without PT her goals may not be met. A facility rehabilitation and/or therapy policy was requested but not provided. SUGGESTED METHOD OF CORRECTION: The administrator or designee could update policies	21510		

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21510	Continued From page 29 related to the provision of physical therapy services, improve processes to ensure services are provided as ordered by the physician, and monitor that the services are provided as ordered. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	21510		
21545	MN Rule 4658.1320 A.B.C Medication Errors A nursing home must ensure that: A. Its medication error rate is less than five percent as described in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (m), found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, which is incorporated by reference in part 4658.1315. For purposes of this part, a medication error means: (1) a discrepancy between what was prescribed and what medications are actually administered to residents in the nursing home; or (2) the administration of expired medications. B. It is free of any significant medication error. A significant medication error is: (1) an error which causes the resident discomfort or jeopardizes the resident's health or safety; or (2) medication from a category that usually requires the medication in the resident's blood to be titrated to a specific blood level and a single medication error could alter that level and precipitate a reoccurrence of symptoms or toxicity. All medications are administered as prescribed. An incident report or medication error report must be filed for any medication error that occurs. Any significant medication errors or resident reactions must be reported to the	21545		8/30/22

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21545	Continued From page 30 physician or the physician's designee and the resident or the resident's legal guardian or designated representative and an explanation must be made in the resident's clinical record. C. All medications are administered as prescribed. An incident report or medication error report must be filed for any medication error that occurs. Any significant medication errors or resident reactions must be reported to the physician or the physician's designee and the resident or the resident's legal guardian or designated representative and an explanation must be made in the resident's clinical record. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure medications were administered in accordance with physician orders and standards of care to promote comfort and reduce the risk of adverse disease-associated complications for 2 of 4 residents (R25, R53) observed to receive medication during the survey. These findings constituted significant medication errors for R25 and R53. In addition, a total of 4 of 26 opportunities were in error resulting in a 15.38% medication error rate. Findings include: On 7/12/22 at 5:32 p.m., licensed practical nurse (LPN)-B prepared medications for R25 in the hallway from a mobile cart. LPN-B had the electronic Medication Administration Record (MAR) open which displayed a single red-colored rectangle with a bolded "1600 [4 p.m.]" and the name of a medication to be given. LPN-B stated	21545	Corrected	

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21545	Continued From page 31 the red coloring meant it was "time now to give it," and presented the medication card to the surveyor for review which directed Baclofen (a muscle relaxant used to treat muscle spasms) 20 milligrams (mg) three times a day as needed for muscle spasm. However, LPN-B stated the medication was actually scheduled for every eight hours and was due to be given at 4:00 p.m., but the trained medication aide (TMA) did not show up for their shift so it was late. LPN-B stated medications with specific times ordered (i.e., every eight hours) have a one-hour window on either side of the time to be given. LPN-B then removed and placed a single tablet of the medication into a cup and entered R25's room. R25 was seated on the bed and stated his back was sore when asked. R25 was asked to rate his current pain level and responded, "10 [out of 10]." LPN-B then administered the medication to R25. Immediately following, R25's current physician orders were reviewed. R25's Twin Cities Physicians order, dated 6/24/22, identified a physician order which read, "Patient is requesting Baclofen scheduled instead of PRN - Please contact Dr. [name] regarding this." The same order then had black-colored handwritten directions by the director of nursing (DON) which read, "T.O. [telephone order] every 8 hrs [hours] scheduled." The telephone order was dated 6/24/22. R25's admission Minimum Data Set (MDS), dated 5/27/22, identified R25 had intact cognition. When interviewed on 7/12/22 at 5:47 p.m., R25 stated he was not consistently getting his Baclofen every eight hours as was ordered adding "a lot of times" he had to physically ask the staff for them to bring it to him. R25 stated the nurses seemed to pass medications by wing rather than by times ordered,	21545		

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21545	Continued From page 32 as sometimes, he would not get his scheduled 4:00 p.m. Baclofen dose until after the supper meal. Further, R25 stated the Baclofen did seem to help reduce his back pain when it was given consistently and on-time as ordered. When interviewed on 7/12/22, at 5:52 p.m., LPN-B verified the medication was administered late; however, stated he was unsure if a late administration would be considered a medication error or not. LPN-B reiterated the one-hour window before and after the scheduled time for time-specific medications to be given and stated he felt it was best to contact the physician and let them know it was given late. When interviewed on 7/13/22, at 1:24 p.m., the director of nursing (DON) stated medications with specific times listed needed to be given within "an hour before or an hour after" the listed time. The DON stated if staff go "way, way beyond" the time, then the physician should be notified and a late administration, such as happened with R25's Baclofen, could possible constitute a medication error. The DON added, "I will give him an education." When interviewed on 7/14/22, at 10:25 a.m., the consulting pharmacist (CP) stated specific medications required "more timely" administration and "an hour before and an hour after is reasonable" for those to be given. CP stated he typically discouraged specific schedules of medications (i.e., every eight hours), and expressed he would have to consider the nursing home's policy before determining if an error had happened or not with R25's Baclofen. CP stated this scenario and event would be a "good point" to bring to the next Quality Assurance (QA) meeting but added, "We don't want a person	21545		

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21545	Continued From page 33 waiting in pain." On 7/12/22, at 7:04 p.m., LPN-C prepared medications for R53 in the hallway from a mobile cart. LPN-C opened R53's MAR and read aloud each medication due to be administered which included Phoslo (used to prevent elevated phosphate levels in dialysis patients), Atorvastatin (used to treat high cholesterol levels), and Pyridoxine (Vitamin B6; used to prevent B6 deficiency). LPN-B then presented a single medication card to the surveyor for review which directed Phoslo (calcium acetate) 2,001 mg " ... by mouth three times a day with meals." However, LPN-B stated there was no supply of Atorvastatin or Pyridoxine to administer R53 adding, "We don't have that." LPN-B stated he was unsure why there was no supply of the medication but explained he would order it and hopefully get some the same evening. LPN-B then administered the remaining available medications to R53 in her room. Immediately following, R53's current physician orders were reviewed. R53's Transfer Orders, dated 5/30/22, identified R53's physician-ordered hospital discharge medications. This included: - Phoslo 667 mg, "take 3 Capsules (2,001 mg) by mouth three times a day with meals;" - Atorvastatin 40 mg, "Take 1 tablet (40 mg) by mouth daily at bedtime; and, - Pyridoxine 25 mg, "Take 1 tablet by mouth every evening." R53's significant change MDS, dated 6/21/22, identified R53 had intact cognition and renal insufficiency and/or failure. Further, R53 received	21545		

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21545	Continued From page 34	21545		

dialysis while a resident at the nursing home. On 7/12/22, at 7:24 p.m. R53 was interviewed and stated she went to dialysis several times a week at an offsite clinic. R53 stated she ate her supper meal "between 6:15 [p.m.] and 6:30 [p.m.]" which was approximately an hour prior. R53 stated she recalled Phoslo was supposed to be given with meals but added she "never gets it like that" with the staff often giving the medication before or after the meal. R53 stated she was unsure of her last phosphate level or if it was elevated.

On 7/12/22, at 7:44 p.m. LPN-C and the DON were interviewed. LPN-C stated he provided the Phoslo to R53 after 7:00 p.m. as it was scheduled for 8:00 p.m. in the MAR. LPN-C and the DON both acknowledged the label and physician orders which directed to give the medication with meals, and the DON added he would "look into this" to determine what happened. During subsequent interview on 7/13/22, at 10:37 a.m., the DON stated they were unable to get R53's Atorvastatin and Pyridoxine from the pharmacy last evening so the medications were not given as ordered. The DON stated R53's Phoslo should have been given with meals, as directed, and he had just adjusted the MAR to better reflect the specific administration times ordered. This was important to do as Phoslo "helps the absorption" of phosphate consumed in R53's dietary intake. However, the DON stated he was not sure if these omitted medications and incorrectly timed medications would be considered errors or not.

R53's MAR, dated 6/1/22 to 6/30/22, identified an order for Phoslo 667 mg with directions, "Give 3 capsule by mouth three times a day for Renal Insuff. Take 3 capsules TID [three times daily] with meals," along with outlined hours the medication was to be administered. These hours

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VICTORY HEALTH & REHABILITATION CENTEI	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

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21545	Continued From page 35 included 8:00 a.m., 2:00 p.m. and 8:00 p.m. from 6/1/22 to 6/17/22, when the hours were changed to 8:00 a.m., 12:00 p.m., and 8:00 p.m. This order had a recorded start date of 5/31/22, and all doses were recorded as administered at these times unless R53 was on LOA and/or hospitalized. Further, R53's MAR, dated 7/1/22 to 7/14/22, identified the same order and administration times as the June 2022 MAR, with all doses recorded as administered at these times unless R53 was on LOA and/or hospitalized. On 7/14/22, at 9:34 a.m. dialysis registered nurse (RN)-P and dialysis physician assistant (PA)-A were interviewed via telephone. RN-P verified R53 received dialysis at their site and PA-A stated Phoslo should be given with "the first bite" of food at meals to be effective. RN-P stated R53's most recent phosphate level was drawn on 6/30/22, and was elevated at 7.0 mg/dl (milligrams per deciliter; normal adult range 2.5 to 4.5 mg/dl). PA-A stated R53's Phoslo being given outside of meal times would cause the medication to be "completely ineffective," and that could likely be contributing to R53's elevated phosphate levels given the period of time the staff were giving it outside of those times. When interviewed on 7/14/22, at 10:25 a.m., the consulting pharmacist (CP) stated he had not encountered issues with missed medications or untimely re-ordering in the past medication cart audits, nor had the pharmacy contacted him voicing such issues. CP stated medications should be reordered when there is about a three-day supply left to allow adequate time for processing, filling and delivering the medication. CP stated missed Atorvastatin and Pyridoxine doses due to a lack of supply would constitute medication errors; however, CP added it was not	21545		

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21545	Continued From page 36 likely to be a significant risk to the patient. Further, CP reviewed Phoslo and verified it was best given with meals and could "theoretically" lead to elevated phosphate levels in the blood as the medication binds with food and reduces the reabsorption of phosphate. A provided Administering Medications policy, dated 2019, identified medications would be administered in " ... a safe and timely manner, as prescribed." The policy outlined, "Medications are administered in accordance with prescriber orders, including any required time frame," and were to be given " ... within one (1) hour of their prescribed time, unless otherwise specified." Further, a provided Adverse Consequence and Medication Errors policy, dated 2014, identified a medication error was defined as " ... the preparation or administration of drugs or biological which is not in accordance with physician's orders, manufacturer specifications, or accepted professional standards and principles of the professional(s) providing services." The policy listed several examples of medication errors which included, "Omission - a drug is ordered but not administered," and, "Wrong time." SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures for medication errors and unavailable medications. The director of nursing or designee could develop a system to educate staff and develop a monitoring system to ensure medication were correctly administered and reordered appropriately. The quality assurance committee could monitor these measures to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty One	21545		

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21545	Continued From page 37 (21) days	21545		
21565	MN Rule 4658.1325 Subp. 4 Administration of Medications Self Admin Subp. 4. Self-administration. A resident may self-administer medications if the comprehensive resident assessment and comprehensive plan of care as required in parts 4658.0400 and 4658.0405 indicate this practice is safe and there is a written order from the attending physician. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to assess safety of self-administration of medications for 1 of 1 residents (R9) who was self-administering medications after staff set-up and had inhalers at bedside. Findings include: R9's quarterly Minimum Data Set (MDS) dated 7/9/22, indicated R9 was mildly cognitively impaired, was independent with bed mobility and transfers. R9's Admission Record dated 7/15/22, indicated R9 had diagnoses that included chronic obstructive pulmonary disease (COPD - lung disease). R9's care plan date 4/14/22, included R9 had asthma related to COPD, and interventions of give medications as ordered, monitor/document side effects and effectiveness, give nebulizer treatments and oxygen as ordered. The care plan also included R9 had COPD related to smoking,	21565	Corrected	8/30/22

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21565	Continued From page 38 and an intervention of give aerosol or bronchodilators as ordered and monitor for side effects and effectiveness. R9's Self Administration of Medications Assessment dated 4/1/21, indicated R9 did not wish to self-administer medications. R9's Order Summary Report dated 7/15/22, included the following: " Albuterol Sulfate Nebulization Solution 2.5 milligrams (mg)/0.5 milliliters (mL), 3 mL, inhale orally every four hours as needed for wheezing/shortness of breath (SOB) " Incruse Ellipta Aerosol Powder Breath Activated 62.5 micrograms (mcg)/inhale (Umeclidinum Bromide), One inhalation, inhale orally one time a day for COPD " Salmeterol Xinafoate Aerosol Powder Breath Activated 50 mcg/dose (Serevent), One puff, inhale orally two times per day for Chronic Obstructive Lung Disease " Ipratropium Albuterol Solution 0.5-2.5 (3) mg/3 mL. 3 ml inhale orally every four hours as needed for chronic lung disease. The Order Summary Report lacked an order for medication self-administration. During interview on 7/14/22, at 7:47 a.m. R9 opened the top drawer of his nightstand where two prescription inhalers were visible inside the drawer in a denture cup. R9 confirmed he stored his own inhalers in the drawer. On 7/15/22, at 9:38 a.m. R9 was observed in his	21565		

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21565	Continued From page 39 room self-administering a nebulizer treatment. R9 stated he was having a hard time breathing and asked the nurse for it, as he generally did when he needed it. He confirmed he also kept his inhalers in his top drawer and used them both twice per day, once in the morning and once at night, and they helped his breathing. He stated he 'handled' those himself. R9 opened his top drawer where one Incuse inhaler with 13 remaining doses and one Serevent inhaler with 28 remaining doses were observed. R9 stated he was still trying to get another inhaler because one was nearly empty. R9 reached into a plastic grocery bag which hung on the back of his wheelchair and removed an Albuterol inhaler with ten doses remaining. He stated he used the Albuterol inhaler if needed when he left the building. During interview on 7/15/22, at 9:56 a.m. trained medication aide (TMA)-A stated she brought R9's nebulizer treatment to his room that morning where R9 used it independently. She stated a licensed practical nurse (LPN) or registered nurse (RN) completed self-administration assessments and teaching, and R9 was allowed to administer his own treatments and keep inhalers in his room because he needed to use them frequently. She stated staff asked residents who self-administered how many doses they took and documented it. During interview on 7/15/22, at 10:11 a.m. LPN-E stated residents needed a provider order to keep inhalers at bedside and stated she would have no idea how many times a resident used them. During interview on 7/15/22, at 10:17 a.m. RN-C stated most resident inhalers were stored in the medication carts unless they had orders allowing	21565		

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21565	Continued From page 40 a resident to keep them at bedside. She stated the facility did not have any residents who self-administered inhalers, but if a resident asked to self-administer staff completed an assessment. RN-C was unsure if any residents could self-administer nebulizer treatments. During interview on 7/15/22, at 10:22 a.m. director of nursing (DON) stated inhalers were normally kept in the medication cart. DON stated he had not seen any residents self-administer any inhalers, but if there was an order it was ok, although he would discourage it because there was no way to monitor it. He stated they did have a self-administration assessment when a resident requested to keep inhalers at bedside to make sure they were safe. He stated standard practice was the nurse stayed and watched residents during nebulizer treatments, and staff did not leave the resident unless they had a medication self-administration order. He stated it was important to complete an assessment to ensure the resident could safely take the medications and would not take too many or too few doses. DON reviewed R9's medical record and confirmed he did not have a medication self-administration assessment or provider order to self-administer medications. The facility policy Administering Medications dated 4/2019, indicated residents may self-administer their own medications only if the attending physician, in conjunction with the interdisciplinary care planning team, has determined that they have the decision-making capacity to do so safely. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON), or designee, could review applicable policies and procedures to	21565		

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21565	Continued From page 41 ensure residents' are assessed to determine if medication self-administration was appropriate and provide staff education regarding self-administration of medications. The quality assurance committee could monitor for compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21565		
21620	MN Rule 4658.1345 Labeling of Drugs Drugs used in the nursing home must be labeled in accordance with part 6800.6300. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure prescribed medications were appropriately and accurately labeled with current physician-ordered administration instructions to reduce the risk of administration error for 2 of 4 residents (R25, R38) observed to receive medication during the survey. Findings include: R25's Twin Cities Physicians order, dated 6/24/22, identified a physician order which read, "Patient is requesting Baclofen scheduled instead of PRN [as-needed] - Please contact Dr. [name] regarding this." The same order then had black-colored handwritten directions by the director of nursing (DON) which read, "T.O. [telephone order] every 8 hrs [hours] scheduled." The telephone order was dated 6/24/22.	21620	Corrected	8/30/22

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21620	Continued From page 42 On 7/12/22, at 5:32 p.m., licensed practical nurse (LPN)-B prepared medications for R25 in the hallway from a mobile cart. LPN-B presented the Baclofen 20 milligram (mg) medication card to the surveyor for review; however, the directions on the label of the medication card directed, "1 TAB BY MOUTH THREE TIMES DAILY AS NEEDED FOR MUSCLE SPASMS." There was no other directions or guidance displayed on the label despite the physician order from 6/24/22, directing the medication to be given on a scheduled basis and not just as-needed. Further, the label listed a fill-date of 6/27/22. LPN-B reviewed the label and stated the label was incorrect and should have an "order change" sticker placed on it. This was important to do so others "don't get confused by the label" when giving the medication. LPN-B then reviewed the other Baclofen medication cards present in the mobile cart for R25 and stated there were multiple cards with the same incorrect administration directions on them. LPN-B reiterated the labels should have a sticker affixed to them to alert the nurse the orders had changed, which is done to help prevent a medication error. R38's Twin Cities Physicians order, dated 6/20/22, identified a physician order to discontinue R38's current citalopram (an antidepressant medication) orders, and begin, "Citalopram 20 mg PO QD [by mouth daily]." On 7/14/22, at 7:50 a.m. trained medication aide (TMA)-B prepared R38's medications at a mobile cart outside his room. TMA-B presented R38's citalopram 10 mg medication card to the surveyor which directed, "GIVE 1 TABLET BY MOUTH ONE TIME A DAY FOR DEPRESSION." There was no other directions or guidance displayed on	21620		

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21620	Continued From page 43 the label despite the physician order from 6/20/22, directing the medication be increased (to 20 mg daily) and the current dose being 10 mg in strength. Further, the label listed a fill-date of 7/3/22. TMA-B reviewed R38's MAR and the label and stated she would administer the medication according to the MAR and the label was inaccurate. TMA-B stated a sticker should have been placed on the label when the order changed to alert staff to double check the orders adding the physician orders and labels "should match." When interviewed on 7/14/22, at 10:08 a.m., the director of nursing (DON) stated labels should have a 'directions changed' sticker placed on them when physician orders get modified. This was important to do as it helps the staff ensure the correct medication and dose were being given to help "avoid [an] error." Further, the DON stated medication cart audits were routinely completed and there had been no concerns with inaccurate labeling present to him prior to the survey. On 7/14/22 at 10:25 a.m. the consulting pharmacist (CP) was interviewed. CP explained labels should have a sticker placed on them when physician orders change to alert the staff adding "the ideal situation" is for the physician orders and medication labels to match. This was important to do so staff are able to verify the correct medication and dose were being given to the patient. A provided Labeling of Medication Containers policy, dated 2019, identified all medications maintained in the nursing home were to be properly labeled in accordance with current state and federal guidelines. The policy outlined only the dispensing pharmacy could label or alter the label on a medication container and nursing staff	21620		

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21620	Continued From page 44 were to inform the pharmacy of any changes in physician orders for a medication. However, the policy lacked any process or guidance on how staff were to respond to current medication supply labels when orders were changed in-between routine cycle fills by the dispensing pharmacy. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON) and consulting pharmacist should review, revise, or create policies and procedures for proper labeling and storage of medications. Nursing and/or medication aide staff should be educated to those changes. The DON or designee, and pharmacist, should routinely audit all medications and storage to ensure compliance. The results of those audits should be taken to QAPI ongoing to determine compliance. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21620		
21695	MN Rule 4658.1415 Subp. 4 Plant Housekeeping, Operation, & Maintenance Subp. 4. Housekeeping. A nursing home must provide housekeeping and maintenance services necessary to maintain a clean, orderly, and comfortable interior, including walls, floors, ceilings, registers, fixtures, equipment, lighting, and furnishings. This MN Requirement is not met as evidenced by: Based on observation and interview the facility failed maintain a sanitary environment for 2 of 2 (R18 and R3) residents reviewed for	21695	Corrected	8/30/22

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21695	Continued From page 45 environmental cleanliness. Finding include: Outdoor environment R18's significant change Minimum Data Set (MDS) dated 5/20/22, indicated R18 had moderately impaired cognition and needed extensive assist with activities of daily living (ADLs). R18's diagnoses included dementia without behavior disturbance, major depressive disorder, and paranoid schizophrenia. R18's care plan dated 9/23/21, included, "[R18] [has] impaired cognitive function/dementia or impaired thought processes r/t [related to] Dementia, Disease Process, short term memory loss." The care plan instructed, "Provide the resident, with a homelike environment." On 7/11/22, at 8:00 a.m. survey team arrived at the facility to begin the recertification survey. Surveyor observed a queen-sized mattress laying in the grass between the parking area and road. The mattress was observed to be visibly soiled and had fraying along 2 edges and full light-brown discoloration from what appeared to be caused by rain and exposure to other outdoor elements. During an interview on 7/11/22, at 8:14 a.m. family member (FM)-A stated she had seen the mattress near the parking area for about 2 weeks. FM-A added, "I called the city to have it removed. I was told it was the nursing home's responsibility. If that was in their front lawn at home, it would not still be there. This is their [resident's] home. It shouldn't be left here either." During an interview on 7/13/22, at 10:03 a.m. the administrator stated she was aware of the	21695		

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21695	Continued From page 46 mattress one the property near road. The administrator stated, "I noticed last week. I guess we could pull it over to our dumpster." Indoor environment R3's quarterly MDS dated 7/12/22, indicated intact cognition and independence with activities of daily living. R3's diagnoses included Wernicke's encephalopathy and alcohol dependence. On 7/12/22, at 12:49 p.m. writer observed the bottom third of R3's window blinds were soiled with a dried brown matter. R3 stated the blinds had been soiled and unchanged since she admitted about 4 months ago. R3 added, "It looks unclean. It bothers me." R3 also pointed out multiple spots of dried brown matter covering the lower half of 1 of the 2 privacy curtains in the room. The spots were too numerous to count and ranged from the size of a fingertip to the size of a fist. The other privacy curtain was soiled with approximately 7 - 3/4" brown smudges around the middle of the curtain and 1 - 2/3" dark reddish-brown spot. R3 stated, "I think that's dried blood." R3 added, the blinds or the privacy curtains had not been cleaned or replaced since she admitted to the facility approximately 4 months ago." During an interview on 7/14/22, at 8:13 a.m. housekeeper (HK)-A stated she cleaned R3's room daily. HK-A observed the blinds in R3's room and stated, "It looks like something has been spilled or sprayed on them." HK-A added, "It needs to be cleaned." HK-A observed the privacy curtains in R3's room and stated, "There are spots of something on there. It is dirty." HK-A stated housekeepers are expected to ensure the blinds and privacy curtains are clean and in good	21695		

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21695	Continued From page 47 repair while doing the daily cleaning in each resident's room. HK-A was not aware of any established schedule for cleaning or replacing privacy curtains. During an interview on 7/14/22, at 8:27 a.m. the administrator stated housekeeping staff is expected to wipe down all surfaces in the residents' rooms daily and if there is anything visibly unclean it needs to be addressed immediately. This would include the window blinds and privacy curtains. The administrator stated she was unsure if there was an established schedule for cleaning or replacing racy curtains and stated, "That would be up to the housekeeping department." The facility policy, "Homelike Environment," dated 2021, included, "The facility staff and management maximizes, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. These characteristics include: a. clean, sanitary and orderly environment. SUGGESTED METHOD OF CORRECTION: The administrator, housekeeping supervisor, or designee could ensure a housekeeping program was developed to ensure ongoing maintenance and preventative houekeeping schedule was completed for the facility and grounds on a routine basis. The facility could create policies and procedures, educate staff on these changes and perform environmental rounds/audits periodically to ensure maintenance and ongoing housekeeping is adequately completed within the facilty and the grounds. The facility could report those findings to the quality assurance performance improvement (QAPI) committee for	21695		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00166	A. BUILDING: _____ B. WING _____	C 07/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VICTORY HEALTH & REHABILITATION CENTEI	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21695	Continued From page 48 further recommendations to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21695		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
October 19, 2022

****PLEASE NOTE THAT HEALTH AND LIFE SAFETY CODE SURVEYS ARE BEING PROCESSED IN SEPERATE ENFORCEMENT CYCLES.****

Administrator
Victory Health & Rehabilitation Center
512 49th Avenue North
Minneapolis, MN 55430

RE: CCN: 245544
Cycle Start Date: May 6, 2022

Dear Administrator:

Please note that this facility has been chosen as a Special Focus Facility (SFF). CMS' policy of progressive enforcement means that any SFF nursing home that reveals a pattern of persistent poor quality is subject to increasingly stringent enforcement action, including stronger civil monetary penalties, denial of payment for new admissions and/or termination of the Medicare provider agreement.

On May 24, 2022, we notified you a remedy was imposed. On September 8, 2022 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 August 30, 2022.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective June 8, 2022 be discontinued as of August 30, 2022. (42 CFR 488.417 (b))

In our letter of May 24, 2022, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from May 16, 2022. This does not apply to or affect any previously imposed NATCEP loss.

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us