DEPARTMENT OF HEALTH AND HUMAN SERVICES — **CENTERS FOR MEDICARE & MEDICAID SERVICES**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: Z36P

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00953

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245184**

2.STATE VENDOR OR MEDICAID NO.
(L2) **690925600**

3. NAME AND ADDRESS OF FACILITY
(L3) **ROCHESTER EAST HEALTH SERVICES**
(L4) **501 EIGHTH AVENUE SOUTHEAST**
(L5) **ROCHESTER, MN** (L6) **55904**

4. TYPE OF ACTION: **2** (L8)

1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **04/04/2017**

6. DATE OF SURVEY **12/17/2021** (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

01 Hospital	05 HHA	09 ESRD	13 PTIP	22 CLIA
02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	
03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	
04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	

FISCAL YEAR ENDING DATE: (L35)
12/31

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **111** (L18)
13.Total Certified Beds **111** (L17)

10.THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

* Code: **A*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	111			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE Date :
Elizabeth Silkey, Unit Supervisor 01/11/2022 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Melissa Poepping, Enforcement Specialist 01/11/2022 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
X 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible (L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION
09/01/1972
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
01111
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
12/16/2021
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
January 11, 2022

CMS Certification Number (CCN): 245184

Administrator
Rochester East Health Services
501 Eighth Avenue Southeast
Rochester, MN 55904

Dear Administrator:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective December 16, 2021 the above facility is certified for:

111 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 111 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status. If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and/or Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
January 11, 2022

Administrator
Rochester East Health Services
501 Eighth Avenue Southeast
Rochester, MN 55904

RE: CCN: 245184
Cycle Start Date: October 21, 2021

Dear Administrator:

On December 13, 2021, we notified you a remedy was imposed. On December 17, 2021 the Minnesota Department of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of December 16, 2021.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective December 1, 2021 be discontinued as of December 16, 2021. (42 CFR 488.417 (b))

However, as we notified you in our letter of November 16, 2021, 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 December 1, 2021. 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,

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

NOTICE OF TOTAL AMOUNT OF ASSESSMENT
FOR NURSING HOMES

January 11, 2022

Administrator
Rochester East Health Services
501 Eighth Avenue Southeast
Rochester, MN 55904

RE: Project Number

Dear Administrator:

On December 13, 2021, a Notice of Assessment for Noncompliance with Correction Orders with an imposed a daily fine in the amount of $700.00 was electronically issued to the above facility. An acknowledgement was electronically received by the Department stating that the violation(s) had been corrected. A reinspection was held on December 17, 2021 and it was determined that compliance with the licensing rules was attained.

Therefore, the total amount of the assessment is $700.00. In accordance with Minnesota Statutes, § 144A.10, subdivision 7, the costs of the reinspection, totaling $174.00, are to be added to the total amount of the assessment. You are required to submit a check, made payable to the Commissioner of Finance, Treasury Division, in the amount of $874.00 within 15 days of the receipt of this notice. That check should be forwarded to:

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

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

Sincerely,

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

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

DEPARTMENT OF HEALTH AND HUMAN SERVICES — **CENTERS FOR MEDICARE & MEDICAID SERVICES**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

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And/Or Approved Waivers Of The Following Requirements:
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___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

* Code: **B*** (L12)

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Melissa Poepping, Enforcement Specialist 01/10/2022 (L20)

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25. LTC EXTENSION DATE:
(L27)

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A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
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05-Fail to Meet Health/Safety
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00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
01111
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
12/16/2021
(L33)

DETERMINATION APPROVAL

Electronically delivered
December 13, 2021

Administrator
Rochester East Health Services
501 Eighth Avenue Southeast
Rochester, MN 55904

RE: CCN: 245184
Cycle Start Date: October 20, 2021

Dear Administrator:

On November 16, 2021, we informed you of imposed enforcement remedies.

On December 9, 2021, the Minnesota Department of Health completed a revisit 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 isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

The deficiency(ies) not corrected is/are as follows:

F0677 -- S/S: D -- 483.24(a)(2) -- Adl Care Provided For Dependent Residents
F0690 -- S/S: D -- 483.25(e)(1)-(3) -- Bowel/bladder Incontinence, Catheter, Uti

As a result of the revisit findings:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective December 1, 2021, will remain in effect.

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 December 1, 2021. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective December 1, 2021.

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 November 16, 2021, 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 December 1, 2021.

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" tag), i.e., the plan of correction should be directed to:

Elizabeth Silkey, Unit Supervisor
Mankato District Office
Licensing and Certification Program

Health Regulation Division
Minnesota Department of Health
12 Civic Center Plaza, Suite #2105
Mankato, Minnesota 56001
Email: elizabeth.silkey@state.mn.us
Office: (507) 344-2742 Mobile: (651) 368-3593

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 April 21, 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.

Feel free to contact me if you have questions.

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245184	A. BUILDING _____ B. WING _____	R-C 12/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCHESTER EAST HEALTH SERVICES	501 EIGHTH AVENUE SOUTHEAST ROCHESTER, MN 55904

(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 000}	INITIAL COMMENTS On 12/9/21, an onsite revisit was conducted to follow up on deficiencies related to a standard abbreviated survey exited 10/21/21. The facility was found to be NOT in compliance with the requirements of 42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities. 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 that substantial compliance with the regulations has been attained.	{F 000}		
{F 677} SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide ADL (activities of daily living) care to 1 of 1 resident (R4) reviewed for ADLs and who was dependent upon staff for grooming assistance. Findings include: R4's facesheet printed 12/9/21, included diagnoses of morbid obesity, diabetes, paranoid	{F 677}	677 It is the policy of the facility to provide ADL (Activities of Daily Living) care to those who are dependent on staff for grooming needs.	12/16/21

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

Electronically Signed | 12/15/2021

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
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{F 677}	Continued From page 1 personality disorder and mild cognitive impairment. R4's quarterly Minimum Data Set (MDS) assessment dated 10/8/21, indicated R4 had refused to completed the brief interview for mental status, had adequate hearing and vision, clear speech, was able to make self understood and could understand others. R4 required extensive assistance of one staff for personal hygiene. R4's Order Summary Report indicated R4 was to have a weekly bath on Monday evenings. If R4 refused, she was to be re-approached three times. Staff were to document all refusals and methods of re-approaches in PCC (Point Click Care - the electronic medical record) progress notes. R4's plan of care dated 1/21/20, indicated hygiene was important to R4 and the goal was to maintain hygiene and health. In addition, the care plan indicated R4 had an ADL self -care deficit related to impaired cognition and mobility, and would have facial hair trimmed as needed with the assist of one staff. On 11/26/21, the care plan was updated to include: R4 often refused assistance but also did not attempt to complete on her own; had an electric razor in her room. During an interview on 12/9/21, at 8:52 a.m., the administrator described a program that had been implemented called Guardian Angel rounds, where leadership staff did audits of residents five days a week for 31 various criteria, such as: call light within reach, floor clean, resident shaved, resident nails clean and trimmed. The administrator provided a completed Guardian	{F 677}	Resident(s) involved: R4 had facial hair removal done with assistance from Executive Director and going forward with the Executive Director or nursing staff or other staff daily as needed. R4's guardian was contacted and R4 was provided with an electric razor and provided to her to be kept in her room which was used. Education was provided to resident on how to use the electric razor, a return demonstration was observed, and no concerns were noted by the Executive Director. R4s care plan was reviewed and updated. Resident's task in POC (Point of Care) were updated to include removing facial hair, this will cue staff to assist with the task or document a refusal. All assigned team members responsible for completing guardian angel rounds were reeducated on what to do if item is found to be not completed or in place. Bath sheets were updated to include the task of shaving needs and includes an area to document refusals. Residents with Potential to be affected: All residents have the potential to be affected. Special focus on residents used during the "Guardian Angel" rounds or manager on duty rounds daily this system change will ensure problems do not reoccur. Needs for facial hair grooming are addressed with nursing staff and assistance with nail care and facial hair grooming tasks are provided as needed. All residents are observed for ADL needs	

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
ROCHESTER EAST HEALTH SERVICES	501 EIGHTH AVENUE SOUTHEAST ROCHESTER, MN 55904

(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 677}	Continued From page 2 Angel checklist from 12/8/21, completed by social services (SS)-A. R4 was listed on the checklist. For the question "is the resident shaved (no chin hair on ladies)," the response was written as "n" for "no," indicating R4 was not shaven. However, there were no comments written in the comment section to indicate follow up action was taken. There was a handwritten comment about R4 which indicated "R4 will not allow to straighten room or throw out empty bottles," but nothing about chin hairs. The plan of correction indicated the Guardian Angel rounds checklist would be the facility audit. During an interview and observation on 12/9/21, at 9:11 a.m., in R4's room, R4 was sitting on the side of her bed. R4 had long white hairs on her chin and neck of varying lengths of approximately 1/4 inch to 2 inches. Some hairs were curled. A pink and white electric razor was observed on R4's overbed table next to her bed. When asked if she used the razor, R4 stated she did not know how to use it as it didn't come with instructions, and it didn't have a blade. R4 stated she would like to use it; that she would like to have her chin hairs trimmed, adding "why do you think I have a razor? Yes, I want them shaved, but no one helps me." When asked if she declined assistance from staff when they offered, R4 replied, "Why would I do that, they don't offer." During an interview on 12/9/21, at 9:20 a.m., nursing assistant (NA)-A stated she was aware of R4's chin hair and that R4 was capable of using her razor; they reminded her, but she didn't use it. When asked if R4 knew how to use the electric razor, NA-A stated she thought so, but did not know if R4 was shown how to use it.	{F 677}	during guardian angel rounds results reported to appropriate staff and in the morning meeting for follow up. Angel rounds are completed at least 4-5 days a week to ensure compliance manager on duty rounds are completed on the weekend. Activity department continues to offer nail care weekly. Nursing staff will document refusals on bath sheet. Facility Administrator assisted resident R4 with trimming chin hairs on 12/14/2021. Resident tasks in POC (Point of Care) were updated to include shaving needs. Education: All guardian angel staff were provided reeducation by the executive director on steps to take if an audit item is not completed. Guardian angel round staff to continue to note all items on the guardian angel audit form including shaving/facial hair. All nursing staff were reeducated on 12/16/2021 or before their next shift on what to do if a resident refuses assistance with ADLs (Activities of Daily Living), updated bath sheet, and completing tasks in POC (Point of Care). Monitoring: To ensure ongoing compliance the executive director to complete audits 2xs time weekly beginning the week of 12-13- 2021 on resident R4 and ongoing for at least three months. All residents will be reviewed for facial hair beginning 12-16-21 and trimmed or documented refusal of refusal.	

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	245184	A. BUILDING _____ B. WING _____	R-C 12/09/2021

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{F 677}	Continued From page 3 During an interview on 12/9/21, at 9:40 a.m., licensed practical nurse (LPN)-A was not aware of R4's chin hairs, "I didn't notice," adding no one had informed her either. LPN-A stated R4 probably refused to have her chin hairs trimmed, but LPN-A had not documented a refusal because she had not been aware of it. During an interview on 12/9/21, at 11:25 a.m., trained medication aide (TMA)-A stated she was not aware of of R4's chin and neck hair, adding R4 often refused cares. TMA-A did not recall if she had informed a nurse of refusals pertaining to R4's chin hairs. During an interview on 12/9/21, at 11:46 a.m., the director of nursing (DON) was not aware of R4's long chin and neck hairs, but stated R4 refused to be shaved. When informed there was no documentation of refusals noted in R4's record, the DON stated notes about R4's chin hair might be on her paper bath sheets and would look. The DON confirmed that if a female resident wanted her chin hairs trimmed, staff should assist the resident, and if the resident refused, it should be documented. On 12/9/21, at 2:05 p.m., the DON stated there were no bath sheets for R4 since 12/1/21, and admitted there was no mention in R4's record of facial hair or refusal to have facial hair trimmed. Re-education provided to nursing staff following the re-certification survey from October 2021, was reviewed. Nursing staff received a paper learning packet which included a policy titled Shaving the Resident, dated June 2017, and an associated quiz. The policy indicated the equipment to use when shaving a resident, and	{F 677}	Guardian angel rounds will be completed 4-5 times a week for three months that began on 12-1-2021. The guardian angel round audits will be reviewed by the executive director or designee during morning meetings. The results of the audits will be reviewed by the QAPI (Quality Assurance and Performance Improvement) committee monthly for trends and any needs for adjustment of audit schedules or content, as well as any further educational need and the guardian angel rounds checklist will be our audits.	

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{F 677}	Continued From page 4 documentation guidelines which may include date, time, condition of residents skin, and how resident tolerated the procedure. The associated quiz included questions: 1) Ensuring a residents facial hair is groomed according to how they feel comfortable will improve the residents morale and promote dignity: True or False. 2) Assisting residents with ADL's that they are unable to completed on their own is an expectation of the care we provide at our center: True or False. 2) What should the CNA do if the resident refuses assistance with completing an ADL? (Answer: inform the nurse).	{F 677}		
{F 690} SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and	{F 690}		12/16/21

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{F 690}	Continued From page 5 (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to monitor, implement interventions and provide risk versus benefits for 1 of 1 resident (R5) who was independendently performing self urinary catheter cares. Findings include: R5 was admitted to the facility on 7/20. Diagnosis listed on the diagnosis sheet in the medical record included: muscle weakness, right artificial shoulder joint, paraplegia (damage to the spinal cord causing paralysis of all or part of the trunk, legs or pelvic organs), neuromuscular dysfunction of the bladder (lacks bladder control), injury of the spinal cord, osteoarthritis (wearing down of the protective tissue at the end of the bones), diabetes mellitus (too much sugar in the blood), chronic kidney disease (loss of kidney function to eliminate waste from the body) and placement of a urostomy (an opening in the abdomen that re-directs urine away from the bladder that's diseased or injured). Observation on 12/9/21, at 11:00 a.m. R5 was in	{F 690}	F-690¿(D)¿ It is the policy of the facility¿to ensure¿education, assessments and monitoring for catheter care for residents who independently perform self-urinary catheter cares.¿ ¿ ¿ ¿ Resident(s) involved:¿R5 Resident was provided reeducation on her ostomy/catheter drainage care by DON and designee present. Education was provided on procedure, infection control practices, and encouraged allowing assistance to manage urostomy. Adequate ostomy/catheter supplies were provided and will be monitored by nursing staff for supply availability weekly. Resident #5 will be observed and	

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{F 690}	Continued From page 6 her room watching TV. There was a very strong odor of urine throughout the room (the odor could be smelled in the hallway prior to enetering the room). There was a leg drainage bag hooked to the side of the bed, containing urine. The end of the tubing was not covered and resting on the side of the bed. There were no alcohol swabs or catheter covers noted in the residents room. R5 stated she had completed her ostomy/catheter care that morning. R5 indicated she had been doing her own ostomy/catheter care for 30 years. When questioning R5 about the use of alcohol swabs and rinsing the catheter drainage bags, she indicated she thought she used alcohol swabs to clean the end of the tube, but confirmed she did not empty or rinse the drainage bags. R5 also indicated she did not have any connector caps to cover the end of the drainage bag tubing. R5 could not recall facility staff teaching her ostomy/catheter care, but indicated she did not need any teaching because she could do it herself. R5 also could not recall facility staff reviewing the risk of not implementing proper infection control (IC) practices, when providing own ostomy/catheter care. Review of the quarterly minimum data set (MDS) dated 4/23/21 identified R5 as having a brief interview status (BIMS) of "15" (no impairment in cognition). R5 required extensive assistance with activities of daily living (ADL's) including toileting and personal cares. The MDS indicated the staff did all the effort and R5 does none to complete the activity. R5 was able to eat independently. The MDS identified R5 to have a ostomy. R5 exhibited only 1 behavior that included verbal aggression towards others. No behaviors of being resistive or refusing cares identified on MDS. The MDS identified R5 to have impairment of upper	{F 690}	monitored for proper technique and infection control practices and if unable to self-administer staff will offer to assist with ostomy/catheter care. Orders were updated in PCC (Point Click Care) to include offering assistance to resident with urostomy care, monitoring availability of supplies, charting refusals of assistance with ADLs, monitoring for a urinary drainage bag cover and catheter cap is in place and encouraging infection control practices. An additional odor managing device has been placed in the room and room continues to be on the odor control special focus list for the housekeeping department. Resident's care plan has been reviewed and revised. ¿ Residents with Potential to be affected:¿All center residents¿that have¿their own ostomy catheters and¿desire to perform self-urinary catheter cares¿are at risk to be affected.¿Adequate ostomy/catheter supplies will be provided by facility. Currently, there are no other residents that perform their own self-urinary catheter cares. ¿ Education:¿Nursing staff educated by the DON/Designee by 12/1/2021¿or before their next shift begins. Current nursing and agency staff will be educated by the	

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{F 690}	Continued From page 7 and lower extremeties Review of the annual MDS dated 7/16/21, identified the resident as having a BIMS of "14" (meaning minimal impairment in cognition). R5 required extensive assistance with ADL's, including toileting and personal care. R5 was able to independely feed herself. The MDS identified R5 to have a ostomy. The MDS identified R5 as having mild depressive symptoms but did not exhibit any behaviors. The MDS identified R5 to have impairment of upper and lower extremeties. Review of a progress note dated 11/30/21, indicated facility staff observed R5 change her catheter bag and had not utilized gloves. The progress note indicated R5 stated she was immune to her own germs and gloves were too bulky to wear. The progress note also indicated R5 did not utilize alcohol swabs to cleanse the end of the catheter tubing before connecting the tubes. R5 stated she had been doing her own cares for 37 years, and when staff completes her cares the ostomy leaks. The progress note indicated facility staff educated R5 to utilize gloves when providing self ostomy/catheter cares and to use alcohol swabs to cleanse the tubing connector. A note was sent to the provider for review of the demonstrated technique by R5. Review of a communication note to the provider dated 11/30/21, included the results of R5's ostomy/catheter return demonstration technique. The note requested an order for R5 to continue to provide self ostomy/catheter care, even though R5 was unable to appropriately do independently. R5's current plan of care revised on 11/30/21, identified R5 as having a urinary ostomy related	{F 690}	Director of Nursing on ostomy/catheter care including tubing securement, prior to continuing work and proper supplies. Agency staff and new hires will be trained on catheter care during orientation by the Director of Nursing or Designee. Reeducation will be provided to nurses on 12/16/2021 or prior to their next shift on ostomy/catheter care, offering assistance for residents that manage their own urostomy, maintaining adequate ostomy/catheter supplies, and providing education as needed to resident. ¿ Monitoring:¿To ensure ongoing compliance the Director of Nursing/Designee¿to complete audits weekly on verifying that catheter cap and dignity bag is placed on catheter bags, proper supplies present, and odor management ongoing for at least three months. The results of the audits will be reviewed by the QAPI committee for trends¿and¿any needs for adjustment of audit schedules or content, as well as any further educational needs.¿ F-690 (D) It is the policy of the facility to ensure education, assessments and monitoring for catheter care for residents who independently perform self-urinary catheter cares. Resident(s) involved: R5 Resident was provided reeducation on her	

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{F 690}	Continued From page 8 to impaired mobility, physical limitations, infection, neuromuscular dysfunction of the bladder related to paraplegia at age 19 and pyelonephritis. Interventions included: ok for the resident to apply urostomy appliance and empty and change drainage bags, report changes in amount, frequency and color and odor of urine and report signs and symptoms of a urinary tract infection (UTI). The care plan identified R5 with a self care deficit related to being paraplegic and physical limitations. Interventions included: assist with daily hygiene, grooming, dressing and oral cares and mechanical lift for transfers. The care plan did not include a review with R5 of the risks associated with providing self ostomy/catheter care. Review R5's progress notes from 10/21/21 to 12/9/21, did not include any refusals of ostomy/catheter cares, nor a risk versus benefits after identifying R5 was unable to appropriately provide self ostomy/catheter care. Although R5 was educated on the proper technique of ostomy/catheter care to prevent infections, R5 had not been observed or monitored after that time for proper technique nor was there a plan in place to offer assitance, monitor or supply the resident with catheter care supplies. R5 also was not informed of the risks associated with providing selfcare of her ostomy/catheter when she was identified not to utilize proper IC technique with ostomy/catheter cares. Interview on 12/9/21, at 11:00 a.m. nursing assistant (NA)-M indicated R5 provides her own ostomy/catheter cares in the morning and at night. NA-M indicated she did not think R5 was	{F 690}	ostomy/catheter drainage care by DON and designee present. Education was provided on procedure, infection control practices, and encouraged allowing assistance to manage urostomy. Adequate ostomy/catheter supplies were provided and will be monitored by nursing staff for supply availability weekly. Resident #5 will be observed and monitored for proper technique and infection control practices and if unable to self-administer staff will offer to assist with ostomy/catheter care. Orders were updated in PCC (Point Click Care) to include offering assistance to resident with urostomy care, monitoring availability of supplies, charting refusals of assistance with ADLs, monitoring for a urinary drainage bag cover and catheter cap is in place and encouraging infection control practices. An additional odor managing device has been placed in the room and room continues to be on the odor control special focus list for the housekeeping department. Resident□s care plan has been reviewed and revised. Residents with Potential to be affected: All center residents that have their own ostomy catheters and desire to perform self-urinary catheter cares are at risk to be affected. Adequate ostomy/catheter supplies will be provided by facility. Currently, there are no other residents that perform their own self-urinary catheter cares. Education: Nursing staff educated by the	

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{F 690}	Continued From page 9 implementing appropriate IC practices because of the strong urine smell in her room. NA-M further indicated R5 did not cover the end of the catheter tubing. NA-M indicated she did not offer assistance, because R5 has refused assistance in the past. Interview on 12/9/21, at 11:15 a.m. licensed practical nurse (LPN)-A indicated R5 had been providing self ostomy/catheter care, because she had refused assistance in the past. LPN-A indicated did not think R5 followed proper IC techniques, when providing self cares. LPN-A further indicated she was unsure of who was responsible for stocking R5's ostomy/catheter supplies. LPN-A was unaware R5 did not have alcohol swabs or drainage bag covers in her room. Interview on 12/9/21, at 11:55 a.m. director of nursing (DON) stated R5 did not follow proper IC procedures when conducting a return demonstration, with the resident on 11/30/21. The DON stated R5 did not wear gloves, use alcohol or rinse the drainage bag when providing self ostomy/catheter care. The DON stated she provided R5 education, but was unsure if R5 was following proper IC practices. The DON indicated she was unsure because she had not monitored or followed up with R5, after she had been educated. The DON stated that even though the resident was assessed and deemed inappropriate for care of the ostomy, a risk versus benefits had not been done. Interview on 12/9/21, at 12:00 p.m. the facility nurse consultant (NC) confirmed when R5 was identified not utilizing proper IC techniques for self ostomy/catheter care, a risk versus benefits	{F 690}	DON/Designee by 12/1/2021 or before their next shift begins. Current nursing and agency staff will be educated by the Director of Nursing on ostomy/catheter care including tubing securement, prior to continuing work and proper supplies. Agency staff and new hires will be trained on catheter care during orientation by the Director of Nursing or Designee. Reeducation will be provided to nurses on 12/15/2021 or prior to their next shift on ostomy/catheter care, offering assistance for residents that manage their own urostomy, maintaining adequate ostomy/catheter supplies, and providing education as needed to resident. Monitoring: To ensure ongoing compliance the Director of Nursing/Designee to complete audits weekly on verifying that catheter cap and dignity bag is placed on catheter bags, proper supplies present, and odor management ongoing for at least three months. The results of the audits will be reviewed by the QAPI committee for trends and any needs for adjustment of audit schedules or content, as well as any further educational needs.	

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{F 690}	Continued From page 10 should have been reviewed with the resident. The NC also indicated R5 should have continued to be monitored, offered assistance and provided supplies when providing self cares. NC- further indicated facility staff should be offering assist daily and documenting when the resident refuses.	{F 690}		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF ASSESSMENT FOR NONCOMPLIANCE WITH CORRECTION ORDERS FOR NURSING HOMES

Electronically delivered

December 13, 2021

Administrator
Rochester East Health Services
501 Eighth Avenue Southeast
Rochester, MN 55904

Re: CCN: 245184
Cycle Start Date: December 13, 2021

Dear Administrator:

On December 9, 2021, survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on October 21, 2021 with orders received by you electronically on November 16, 2021.

State licensing orders issued pursuant to the last survey completed on October 21, 2021, found not corrected at the time of this December 9, 2021 revisit and subject to penalty assessment are as follows:

0910 -- MN Rule 4658.0525 Subp. 5 A.B -- Rehab - Incontinence	$350.00
0920 -- MN Rule 4658.0525 Subp. 6 B -- Rehab - ADLs	$350.00

The details of the violations noted at the time of this revisit completed on December 9, 2021 (listed above) are on the attached Minnesota Department of Health Statement of Deficiencies-Licensing Orders Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags. It is not necessary to develop a plan of correction, electronically acknowledge and date this form and submit to the Minnesota Department of Health if there are no new orders issued.

Therefore, in accordance with Minnesota Statutes, § 144A.10, you will be assessed an amount of $700.00 per day beginning on the day you receive this notice.

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

Elizabeth Silkey, Unit Supervisor
Mankato District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
12 Civic Center Plaza, Suite #2105
Mankato, Minnesota 56001
Email: elizabeth.silkey@state.mn.us
Office: (507) 344-2742 Mobile: (651) 368-3593

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

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

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

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

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

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

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

Sincerely,

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

Enclosure

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

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{2 000}	Initial Comments	{2 000}		

*****ATTENTION******

NH LICENSING CORRECTION ORDER

In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected.

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

INITIAL COMMENTS:
On 12/9/21 an onsite revisit was completed to follow up on licensing orders issued from the survey exited 10/21/21. The correction order(s) issued at (State tag 0910 and State Tag 0920) were NOT corrected. The uncorrected order(s) will remain in effect and will be reviewed at the next onsite visit. The order(s) will be reviewed for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00953	A. BUILDING: _____ B. WING _____	R-C 12/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCHESTER EAST HEALTH SERVICES	501 EIGHTH AVENUE SOUTHEAST ROCHESTER, MN 55904

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{2 000}	Continued From page 1 possible penalty assessment.	{2 000}		
{2 910}	MN Rule 4658.0525 Subp. 5 A.B Rehab - Incontinence Subp. 5. Incontinence. A nursing home must have a continuous program of bowel and bladder management to reduce incontinence and the unnecessary use of catheters. Based on the comprehensive resident assessment, a nursing home must ensure that: A. a resident who enters a nursing home without an indwelling catheter is not catheterized unless the resident's clinical condition indicates that catheterization was necessary; and B. a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This MN Requirement is not met as evidenced by: Uncorrected based on the following findings. The original licensing order issued on 10/21/21 will remain in effect. Penalty assessment issued. Based on observation, interview and document review the facility failed to monitor, implement interventions and provide risk versus benefits for 1 of 1 resident (R5) who was independently performing self urinary catheter cares. Findings include: R5 was admitted to the facility on 7/20. Diagnosis listed on the diagnosis sheet in the medical	{2 910}	F-690 (D) It is the policy of the facility to ensure education, assessments and monitoring for catheter care for residents who independently perform self-urinary catheter cares. Resident(s) involved: R5 Resident was provided reeducation on her ostomy/catheter drainage care by DON and designee present. Education was provided on procedure, infection control practices, and encouraged allowing	12/16/21

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{2 910}	Continued From page 2 record included: muscle weakness, right artificial shoulder joint, paraplegia (damage to the spinal cord causing paralysis of all or part of the trunk, legs or pelvic organs), neuromuscular dysfunction of the bladder (lacks bladder control), injury of the spinal cord, osteoarthritis (wearing down of the protective tissue at the end of the bones), diabetes mellitus (too much sugar in the blood), chronic kidney disease (loss of kidney function to eliminate waste from the body) and placement of a urostomy (an opening in the abdomen that re-directs urine away from the bladder that's diseased or injured). Observation on 12/9/21, at 11:00 a.m. R5 was in her room watching TV. There was a very strong odor of urine throughout the room (the odor could be smelled in the hallway prior to enetering the room). There was a leg drainage bag hooked to the side of the bed, containing urine. The end of the tubing was not covered and resting on the side of the bed. There were no alcohol swabs or catheter covers noted in the residents room. R5 stated she had completed her ostomy/catheter care that morning. R5 indicated she had been doing her own ostomy/catheter care for 30 years. When questioning R5 about the use of alcohol swabs and rinsing the catheter drainage bags, she indicated she thought she used alcohol swabs to clean the end of the tube, but confirmed she did not empty or rinse the drainage bags. R5 also indicated she did not have any connector caps to cover the end of the drainage bag tubing. R5 could not recall facility staff teaching her ostomy/catheter care, but indicated she did not need any teaching because she could do it herself. R5 also could not recall facility staff reviewing the risk of not implementing proper infection control (IC) practices, when providing own ostomy/catheter care.	{2 910}	assistance to manage urostomy. Adequate ostomy/catheter supplies were provided and will be monitored by nursing staff for supply availability weekly. Resident #5 will be observed and monitored for proper technique and infection control practices and if unable to self-administer staff will offer to assist with ostomy/catheter care. Orders were updated in PCC (Point Click Care) to include offering assistance to resident with urostomy care, monitoring availability of supplies, charting refusals of assistance with ADLs, monitoring for a urinary drainage bag cover and catheter cap is in place and encouraging infection control practices. An additional odor managing device has been placed in the room and room continues to be on the odor control special focus list for the housekeeping department. Resident's care plan has been reviewed and revised. Residents with Potential to be affected: All center residents that have their own ostomy catheters and desire to perform self-urinary catheter cares are at risk to be affected. Adequate ostomy/catheter supplies will be provided by facility. Currently, there are no other residents that perform their own self-urinary catheter cares. Education: Nursing staff educated by the DON/Designee by 12/1/2021 or before their next shift begins. Current nursing and agency staff will be educated by the Director of Nursing on ostomy/catheter care including tubing securement, prior to	

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{2 910}	Continued From page 3 Review of the quarterly minimum data set (MDS) dated 4/23/21 identified R5 as having a brief interview status (BIMS) of "15" (no impairment in cognition). R5 required extensive assistance with activities of daily living (ADL's) including toileting and personal cares. The MDS indicated the staff did all the effort and R5 does none to complete the activity. R5 was able to eat independently. The MDS identified R5 to have a ostomy. R5 exhibited only 1 behavior that included verbal aggression towards others. No behaviors of being resistive or refusing cares identified on MDS. The MDS identified R5 to have impairment of upper and lower extremeties Review of the annual MDS dated 7/16/21, identified the resident as having a BIMS of "14" (meaning minimal impairment in cognition). R5 required extensive assistance with ADL's, including toileting and personal care. R5 was able to independely feed herself. The MDS identified R5 to have a ostomy. The MDS identified R5 as having mild depressive symptoms but did not exhibit any behaviors. The MDS identified R5 to have impairment of upper and lower extremeties. Review of a progress note dated 11/30/21, indicated facility staff observed R5 change her catheter bag and had not utilized gloves. The progress note indicated R5 stated she was immune to her own germs and gloves were too bulky to wear. The progress note also indicated R5 did not utilize alcohol swabs to cleanse the end of the catheter tubing before connecting the tubes. R5 stated she had been doing her own cares for 37 years, and when staff completes her cares the ostomy leaks. The progress note indicated facility staff educated R5 to utilize gloves when providing self ostomy/catheter cares	{2 910}	continuing work and proper supplies. Agency staff and new hires will be trained on catheter care during orientation by the Director of Nursing or Designee. Reeducation will be provided to nurses on 12/15/2021 or prior to their next shift on ostomy/catheter care, offering assistance for residents that manage their own urostomy, maintaining adequate ostomy/catheter supplies, and providing education as needed to resident. Monitoring: To ensure ongoing compliance the Director of Nursing/Designee to complete audits weekly on verifying that catheter cap and dignity bag is placed on catheter bags, proper supplies present, and odor management ongoing for at least three months. The results of the audits will be reviewed by the QAPI committee for trends and any needs for adjustment of audit schedules or content, as well as any further educational needs.	

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{2 910}	Continued From page 4 and to use alcohol swabs to cleanse the tubing connector. A note was sent to the provider for review of the demonstrated technique by R5. Review of a communication note to the provider dated 11/30/21, included the results of R5's ostomy/catheter return demonstration technique. The note requested an order for R5 to continue to provide self ostomy/catheter care, even though R5 was unable to appropriately do independently. R5's current plan of care revised on 11/30/21, identified R5 as having a urinary ostomy related to impaired mobility, physical limitations, infection, neuromuscular dysfunction of the bladder related to paraplegia at age 19 and pyelonephritis. Interventions included: ok for the resident to apply urostomy appliance and empty and change drainage bags, report changes in amount, frequency and color and odor of urine and report signs and symptoms of a urinary tract infection (UTI). The care plan identified R5 with a self care deficit related to being paraplegic and physical limitations. Interventions included: assist with daily hygiene, grooming, dressing and oral cares and mechanical lift for transfers. The care plan did not include a review with R5 of the risks associated with providing self ostomy/catheter care. Review R5's progress notes from 10/21/21 to 12/9/21, did not include any refusals of ostomy/catheter cares, nor a risk versus benefits after identifying R5 was unable to appropriately provide self ostomy/catheter care. Although R5 was educated on the proper technique of ostomy/catheter care to prevent infections, R5 had not been observed or monitored after that time for proper technique nor	{2 910}		

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{2 910}	Continued From page 5 was there a plan in place to offer assitance, monitor or supply the resident with catheter care supplies. R5 also was not informed of the risks associated with providing selfcare of her ostomy/catheter when she was identified not to utilize proper IC technique with ostomy/catheter cares. Interview on 12/9/21, at 11:00 a.m. nursing assistant (NA)-M indicated R5 provides her own ostomy/catheter cares in the morning and at night. NA-M indicated she did not think R5 was implementing appropriate IC practices because of the strong urine smell in her room. NA-M further indicated R5 did not cover the end of the catheter tubing. NA-M indicated she did not offer assistance, because R5 has refused assistance in the past. Interview on 12/9/21, at 11:15 a.m. licensed practical nurse (LPN)-A indicated R5 had been providing self ostomy/catheter care, because she had refused assistance in the past. LPN-A indicated did not think R5 followed proper IC techniques, when providing self cares. LPN-A further indicated she was unsure of who was responsible for stocking R5's ostomy/catheter supplies. LPN-A was unaware R5 did not have alcohol swabs or drainage bag covers in her room. Interview on 12/9/21, at 11:55 a.m. director of nursing (DON) stated R5 did not follow proper IC procedures when conducting a return demonstration, with the resident on 11/30/21. The DON stated R5 did not wear gloves, use alcohol or rinse the drainage bag when providing self ostomy/catheter care. The DON stated she provided R5 education, but was unsure if R5 was following proper IC practices. The DON indicated	{2 910}		

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{2 910}	Continued From page 6 she was unsure because she had not monitored or followed up with R5, after she had been educated. The DON stated that even though the resident was assessed and deemed inappropriate for care of the ostomy, a risk versus benefits had not been done. Interview on 12/9/21, at 12:00 p.m. the facility nurse consultant (NC) confirmed when R5 was identified not utilizing proper IC techniques for self ostomy/catheter care, a risk versus benefits should have been reviewed with the resident. The NC also indicated R5 should have continued to be monitored, offered assistance and provided supplies when providing self cares. NC- further indicated facility staff should be offering assist daily and documenting when the resident refuses.	{2 910}		
{2 920}	MN Rule 4658.0525 Subp. 6 B Rehab - ADLs Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that: B. a resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This MN Requirement is not met as evidenced by: Uncorrected based on the following findings. The original licensing order issued on 10/21/21 will remain in effect. Penalty assessment issued. Based on observation, interview and document review, the facility failed to provide ADL (activities of daily living) care to 1 of 1 resident (R4) reviewed for ADLs and who was dependent upon	{2 920}	677 It is the policy of the facility to provide ADL (Activities of Daily Living) care to those who are dependent on staff for grooming needs. Resident(s) involved: R4 had facial hair	12/16/21

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{2 920}	Continued From page 7 staff for grooming assistance. Findings include: R4's facesheet printed 12/9/21, included diagnoses of morbid obesity, diabetes, paranoid personality disorder and mild cognitive impairment. R4's quarterly Minimum Data Set (MDS) assessment dated 10/8/21, indicated R4 had refused to completed the brief interview for mental status, had adequate hearing and vision, clear speech, was able to make self understood and could understand others. R4 required extensive assistance of one staff for personal hygiene. R4's Order Summary Report indicated R4 was to have a weekly bath on Monday evenings. If R4 refused, she was to be re-approached three times. Staff were to document all refusals and methods of re-approaches in PCC (Point Click Care - the electronic medical record) progress notes. R4's plan of care dated 1/21/20, indicated hygiene was important to R4 and the goal was to maintain hygiene and health. In addition, the care plan indicated R4 had an ADL self -care deficit related to impaired cognition and mobility, and would have facial hair trimmed as needed with the assist of one staff. On 11/26/21, the care plan was updated to include: R4 often refused assistance but also did not attempt to complete on her own; had an electric razor in her room. During an interview on 12/9/21, at 8:52 a.m., the administrator described a program that had been implemented called Guardian Angel rounds,	{2 920}	removal done with assistance from Executive Director and going forward with the Executive Director or nursing staff or other staff daily as needed. R4's guardian was contacted and R4 was provided with an electric razor and provided to her to be kept in her room which was used. Education was provided to resident on how to use the electric razor, a return demonstration was observed, and no concerns were noted by the Executive Director. R4s care plan was reviewed and updated. Resident's task in POC (Point of Care) were updated to include removing facial hair, this will cue staff to assist with the task or document a refusal. All assigned team members responsible for completing guardian angel rounds were reeducated on what to do if item is found to be not completed or in place. Bath sheets were updated to include the task of shaving needs and includes an area to document refusals. Residents with Potential to be affected: All residents have the potential to be affected. Special focus on residents used during the "Guardian Angel" rounds or manager on duty rounds daily this system change will ensure problems do not reoccur. Needs for facial hair grooming are addressed with nursing staff and assistance with nail care and facial hair grooming tasks are provided as needed. All residents are observed for ADL needs during guardian angel rounds results reported to appropriate staff and in the morning meeting for follow up. Angel rounds are completed at least 4-5 days a week to ensure compliance manager on duty	

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{2 920}	Continued From page 8 where leadership staff did audits of residents five days a week for 31 various criteria, such as: call light within reach, floor clean, resident shaved, resident nails clean and trimmed. The administrator provided a completed Guardian Angel checklist from 12/8/21, completed by social services (SS)-A. R4 was listed on the checklist. For the question "is the resident shaved (no chin hair on ladies)," the response was written as "n" for "no," indicating R4 was not shaven. However, there were no comments written in the comment section to indicate follow up action was taken. There was a handwritten comment about R4 which indicated "R4 will not allow to straighten room or throw out empty bottles," but nothing about chin hairs. The plan of correction indicated the Guardian Angel rounds checklist would be the facility audit. During an interview and observation on 12/9/21, at 9:11 a.m., in R4's room, R4 was sitting on the side of her bed. R4 had long white hairs on her chin and neck of varying lengths of approximately 1/4 inch to 2 inches. Some hairs were curled. A pink and white electric razor was observed on R4's overbed table next to her bed. When asked if she used the razor, R4 stated she did not know how to use it as it didn't come with instructions, and it didn't have a blade. R4 stated she would like to use it; that she would like to have her chin hairs trimmed, adding "why do you think I have a razor? Yes, I want them shaved, but no one helps me." When asked if she declined assistance from staff when they offered, R4 replied, "Why would I do that, they don't offer." During an interview on 12/9/21, at 9:20 a.m., nursing assistant (NA)-A stated she was aware of R4's chin hair and that R4 was capable of using her razor; they reminded her, but she didn't use it.	{2 920}	rounds are completed on the weekend. Activity department continues to offer nail care weekly. Nursing staff will document refusals on bath sheet. Facility Administrator assisted resident R4 with trimming chin hairs on 12/14/2021. Resident tasks in POC (Point of Care) were updated to include shaving needs. Education: All guardian angel staff were provided reeducation by the executive director on steps to take if an audit item is not completed. Guardian angel round staff to continue to note all items on the guardian angel audit form including shaving/whiskers. All nursing staff were reeducated on 12/16/2021 or before their next shift on what to do if a resident refuses assistance with ADLs (Activities of Daily Living), updated bath sheet, and completing tasks in POC (Point of Care). Monitoring: To ensure ongoing compliance the executive director to complete audits 2xs time weekly beginning the week of 12-13- 2021 on resident R4 and ongoing for at least three months. Guardian angel rounds will be completed 4-5 times a week for three months that began on 12-1-2021. The guardian angel round audits will be reviewed by the executive director or designee during morning meetings. The results of the audits will be reviewed by the QAPI (Quality Assurance and Performance Improvement) committee monthly for trends and any needs for adjustment of audit schedules or content, as well as any further educational need and the guardian angel rounds checklist will be our audits.	

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{2 920}	Continued From page 9 When asked if R4 knew how to use the electric razor, NA-A stated she thought so, but did not know if R4 was shown how to use it. During an interview on 12/9/21, at 9:40 a.m., licensed practical nurse (LPN)-A was not aware of R4's chin hairs, "I didn't notice," adding no one had informed her either. LPN-A stated R4 probably refused to have her chin hairs trimmed, but LPN-A had not documented a refusal because she had not been aware of it. During an interview on 12/9/21, at 11:25 a.m., trained medication aide (TMA)-A stated she was not aware of of R4's chin and neck hair, adding R4 often refused cares. TMA-A did not recall if she had informed a nurse of refusals pertaining to R4's chin hairs. During an interview on 12/9/21, at 11:46 a.m., the director of nursing (DON) was not aware of R4's long chin and neck hairs, but stated R4 refused to be shaved. When informed there was no documentation of refusals noted in R4's record, the DON stated notes about R4's chin hair might be on her paper bath sheets and would look. The DON confirmed that if a female resident wanted her chin hairs trimmed, staff should assist the resident, and if the resident refused, it should be documented. On 12/9/21, at 2:05 p.m., the DON stated there were no bath sheets for R4 since 12/1/21, and admitted there was no mention in R4's record of facial hair or refusal to have facial hair trimmed. Re-education provided to nursing staff following the re-certification survey from October 2021, was reviewed. Nursing staff received a paper learning packet which included a policy titled	{2 920}		

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{2 920}	Continued From page 10 Shaving the Resident, dated June 2017, and an associated quiz. The policy indicated the equipment to use when shaving a resident, and documentation guidelines which may include date, time, condition of residents skin, and how resident tolerated the procedure. The associated quiz included questions: 1) Ensuring a residents facial hair is groomed according to how they feel comfortable will improve the residents morale and promote dignity: True or False. 2) Assisting residents with ADL's that they are unable to completed on their own is an expectation of the care we provide at our center: True or False. 2) What should the CNA do if the resident refuses assistance with completing an ADL? (Answer: inform the nurse).	{2 920}		

DEPARTMENT OF HEALTH AND HUMAN SERVICES **CENTERS FOR MEDICARE & MEDICAID SERVICES**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: Z36P

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00953

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245184**
2.STATE VENDOR OR MEDICAID NO.
(L2) **690925600**

3. NAME AND ADDRESS OF FACILITY
(L3) **ROCHESTER EAST HEALTH SERVICES**
(L4) **501 EIGHTH AVENUE SOUTHEAST**
(L5) **ROCHESTER, MN** (L6) **55904**

4. TYPE OF ACTION: **2** (L8)
1. Initial **2. Recertification**
3. Termination **4. CHOW**
5. Validation **6. Complaint**
7. On-Site Visit **9. Other**
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **04/04/2017**

6. DATE OF SURVEY **10/21/2021** (L34)

8. ACCREDITATION STATUS: __ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

01 Hospital	**05 HHA**	**09 ESRD**	**13 PTIP**	**22 CLIA**
02 SNF/NF/Dual	**06 PRTF**	**10 NF**	**14 CORF**	
03 SNF/NF/Distinct	**07 X-Ray**	**11 ICF/IID**	**15 ASC**	
04 SNF	**08 OPT/SP**	**12 RHC**	**16 HOSPICE**	

FISCAL YEAR ENDING DATE: (L35)
12/31

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **111** (L18)
13.Total Certified Beds **111** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	111			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE Date :
Wendy Buckholz, HFE NE II 12/09/2021 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Melissa Poepping, Enforcement Specialist 12/10/2021 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
____ 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION
09/01/1972
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
01111
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Electronically delivered
November 16, 2021

Administrator
Rochester East Health Services
501 Eighth Avenue Southeast
Rochester, MN 55904

RE: CCN: 245184
Cycle Start Date: October 21, 2021

Dear Administrator:

On October 21, 2021, a survey was completed at your facility by the Minnesota Department(s) of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

REMEDIES

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

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective December 1, 2021.

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

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective December 1, 2021. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective December 1, 2021.

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

This Department is also recommending that CMS impose:

- Civil money penalty (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS RO

only if CMS agrees with our recommendation.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $11,160; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by December 1, 2021 the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Rochester East Health Services will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from December 1, 2021. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions.

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

ELECTRONIC PLAN OF CORRECTION (ePOC)

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

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

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

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies

(those preceded by a "F" tag), and emergency preparedness deficiencies (those preceded by an “E” tag), i.e., the plan of correction should be directed to:

Elizabeth Silkey, Unit Supervisor
Mankato District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
12 Civic Center Plaza, Suite #2105
Mankato, Minnesota 56001
Email: elizabeth.silkey@state.mn.us
Office: (507) 344-2742 Mobile: (651) 368-3593

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 April 21, 2022 if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 488.412 and § 488.456.

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

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your

hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

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 (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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

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

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

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245184	A. BUILDING _____ B. WING _____	C 10/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCHESTER EAST HEALTH SERVICES	**501 EIGHTH AVENUE SOUTHEAST ROCHESTER, MN 55904**

(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 10/18/21 - 10/21/21, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On 10/18/21 - 10/21/21, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility 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: H5184117C (MN53165), however NO deficiencies were cited due to actions implemented by the facility prior to survey: The following complaints were found to be SUBSTANTIATED: H5184145C (MN76193), with a deficiency cited at F725. The following complaints were found to be UNSUBSTANTIATED: H5184116C (MN58136), H5184144C (MN77085), H5184146C (MN74058), H5184147C (MN68345), H5184148C (MN71891), and H5184149C (MN63111) . The facility's plan of correction (POC) will serve as your allegation of compliance upon the	F 000		

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

Electronically Signed | 11/26/2021

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F 000	Continued From page 1 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 550 SS=E	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her	F 550		12/1/21

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F 550	Continued From page 2 rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to provide a dignified dining experience for 6 of 6 residents (R215, R30, R44, R45, R60, R52) who required assistance with dining. Findings Include: During an observation on 10/19/21 during breakfast on the 3rd floor dining room: 8:18 a.m., R45 was served breakfast meal and was sitting at table with R44 who was being assisted to eat her breakfast. 8:38 a.m., R45 remains sitting at table with breakfast in front of her. R45 had pushed her wheelchair away from the table. 8:56 a.m., nursing assistant (NA)-D sat down at table next to R45, scooted her up to the table, heated R45's breakfast tray in the microwave and assisted R45 to eat. 9:22 a.m., R45 finished her breakfast and remained sitting at the table.	F 550	F-550 (D) It is the policy of the facility to ensure that residents are provided a dignified dining experience who require assistance with dining. Actions Taken: R44, R45, R60 and R52's plan of care for dining and nutrition were reviewed and revised to include individualized interventions. R215 and R30 were discharged. Dining Room monitoring has been initiated. Resident(s) involved: R215, R30, R44, R45, R60, and R52 Staff assisting with feeding assistance educated on dignified dining experience annual survey process Management team and weekend manger to offer additional assistance to dining experience. Residents with Potential to be affected: All center residents that require assistance	

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F 550	Continued From page 3 During an observation on 10/20/21, during the breakfast meal on the 3rd floor dining room: 7:30 a.m., R45 was seated at a table in the dining room with wheelchair back reclined to a 60 degree angle. R45 was periodically sitting herself straight up in the chair, then laying back down. 7:47 a.m., R45 remains reclined in wheelchair and has attempted to sit up straight 3 times but was unable to hold her position sitting straight. 7:58 a.m., R45 sat up straight than reclined back down. 8:03 a.m., R45 sat up and layed back down three times and began grabbing towards the table and yelling out. 8:04 a.m., NA-E indicated they lay R45 back because otherwise she scoots forward and has fallen out of her wheelchair. NA-E stated R45 will usually relax and fall asleep with the back reclined. NA-D then moved the back of the wheelchair to a partially reclined position, at a 30 degree angle. 8:03 a.m., breakfast trays were delivered to floor 3 dining room. 8:09 a.m., breakfast was set in front of R45. 8:10 a.m., breakfast was served to R215 and R44 who were seated at the same table; breakfast was also served to R52 and R60 who were seated at the same table. 8:19 a.m., R215, R44, R52, and R60 remain seated with breakfast in front of them waiting for assistance. 8:30 a.m., transportation assistant (TA) sat down and assisted R215 with eating. Did not heat her french toast or bacon. 8:31 a.m., trained medication assistant (TMA)-B returned to R45's table and removed lid from meal and started to assist R45. Did not heat meal. 8:32 a.m., R44, R52, and R60 remained seated in	F 550	with eating have potential to be affected. Education: All staff educated for dignified and prompt feeding assistance by the DON/Designee by 12/1/2021 or before their next shift begins. Monitoring: To ensure ongoing compliance the DON/Designee/Facility Staff to complete feeding assistance audits starting weekly 12-1-2021 Audit all 3 meals weekly, monitor for prompt feeding assistance and that food is reheated as needed for meals at least 1 meal daily x 8 weeks. The results of the audits will be reviewed by the QAPI committee for trends and any needs for adjustment of audit schedules or content, as well as any further educational needs. 12/1/2021	

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F 550	Continued From page 4	F 550		

wheelchair at table with breakfast in front of them.
8:36 a.m., NA-E sat at table with R60 and started to assist with feeding; NE-E did not reheat R60's meal. R52 remained seated at the same table with her meal in front of her
8:51 a.m., R44 remains sitting at table with breakfast in front of her.
8:55 a.m., NA-E completed assisting R60, took residents tray to the cart, washed her hands, then went to assist R52 with her meal.
9:04 a.m., TA sat next to R44, 55 minutes after being served her tray and began assisting R44 with her meal. R44's pureed french toast and bacon was not reheated prior to assisting R44.
9:05 a.m., NA-E indicated they had a call in today and are short people to assist residents with eating. NA-E indicated they usually have 2 NA's, the nurse or TMA and one other staff member to assist with feeding residents so running very late today with only one TMA, 1 NA and one other staff member assisting. NA-E further stated that over the weekend R30 began requiring feeding assist and had a new admission 4 days ago requiring assistance with meals also.
9:22 a.m., TMA-B indicated they were short of help today and had a call in. When questioned if someone else could come assist, she indicated they were busy as other floors were short of help also.

During observation on 10/20/21 on 3rd floor during lunch: 12 residents were present.
12:24 p.m., R45 is in dining room, sitting at table with wheelchair reclined 30 degrees yelling out. TMA-B assisted R45 by leaning her back to a 60 degree angle. R45 continued to yell out.
12:32 p.m., R45 continues to yell out, NA-B set her up straight. R45 continued to yell out and was mumbling. Lunch trays were delivered to

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F 550	Continued From page 5	F 550		

the floor.
12:35 p.m., R45 continues to yell out and was laid back in her chair. R45 continued to yell out 4 more time prior to being assisted with meal
12:36 p.m., Tray delivery began to residents in dining room.
12:38 p.m., R45 was served her tray.
12:44 p.m., NA-E continues to deliver trays to residents in the dining room. R215 sitting at table was served her lunch.
12:45 p.m., R30 and R52 were seated in the dining room and received their meal.
12:50 p.m., TMA-B began to assist R45 to eat.
12:52 p.m., R44 was served her lunch.
12:56 p.m., R44 and R215 remain with food in front of them at the table waiting for assistance to eat.
1:16 p.m., NA-E sat down next to R215 and began assisting her with her lunch. Tray was not reheated and included soft shell tacos with meat, cheese, lettuce and tomatoes. R44 continues seated at table with R215 waiting for assistance. R30 and R52 also continue to sit at table in dining room waiting for assistance.
1:18 p.m., the director of nursing arrived on the floor and stated she would see if someone from another floor could come assist residents still waiting for assistance.
1:26 p.m., R44 remains sitting at table with her meal in front of her awaiting assistance.
1:28 p.m., RN-D entered the 3rd floor dining room and sat with R30 to assist with lunch. RN-D did not warm up the meal. R30 did not immediately accept the food; RN-D put the cover back on the meal and told resident she would let her "rest a little bit" then would come back to check on her. RN-D left the table, washed her hands, then returned to assist R30. .
1:31 p.m., NA-E sat next to R44 and began

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F 550	Continued From page 6	F 550		

assisting her to eat with a fork. R44 was served pureed taco meat, lettuce and tomatoes. Food was not reheated.
1:33 p.m., RN-D left R30's table, and went to R60's table and proceeding to assist R60 with eating her meal. R30 had only eaten approximately 0-25% of her meal and did not attempt to feed herself after RN-D exited to assist another resident
1:44 p.m., NA-E sat down with R30 and offered assistance and encouragement to eat. R30 accepted the assistance.

R45
R45's Admission record, printed 10/20/21, identified a diagnoses of Alzheimer's disease, chronic pain syndrome, and low back pain.

R45's quarterly, Minimum Data Set (MDS) assessment, dated 9/6/21, identified severe cognitive impairment, and required extensive assist of 1 person with eating.

R45's care plan dated 6/28/21, identified a problem with physical functioning related to mobility and self care impairment. Interventions included assist of 1 with oral care, bed mobility, dressing, locomotion and personal hygiene. The care plan did not include assistance with eating.

R215
R215's admission record printed 10/21/21, indicated an admission date of 10/15/21, and identified a diagnoses of dementia with Lewy Bodies (abnormal deposits of a protein which leads to problems with thinking, movement, behavior, and mood), displaced fracture of humerus (upper) left arm, displaced fracture of left clavicle, and fracture of one rib.

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R215's admission MDS assessment was not completed.

R215's baseline care plan dated 10/15/21, identified R215 has diagnosis of dementia resulting in cognitive loss, diminished decision making capabilities and safety and security issues and was placed in the secure Alzheimer's care unit. Interventions included to establish predictable care routines as much as possible to decrease confusion. The care plan did not address assistance with eating.

R44
R44's admission record, identified a diagnoses of Alzheimer's disease, and dementia with behavioral disturbance.

R44's annual, MDS assessment, dated 9/4/21, identified severe cognitive impairment, and required 1 person extensive assist with eating.

R44's care plan dated was requested but none received.

R30
R30's Admission Record, printed 10/21/21, indicated diagnoses including vascular dementia with behavioral disturbance and delusional disorder.

R30's Minimum Date Set (MDS) assessment dated 8/21/21, indicated the resident had severe cognitive impairment and required supervision with eating.

R30's care plan indicated an ADL (activities of daily living) self care deficit as evidenced by need

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for verbal cues, set-up and reminders to complete ADL cares related to diagnosis of dementia. Interventions included to assist with daily hygiene, grooming, dressing, oral care, and eating as needed.

R52
R52's Admission record, printed 10/21/21, indicated diagnoses including Alzheimer's disease and dementia without behavioral disturbance.

R52's quarterly MDS dated 9/16/21, indicated the resident had severe cognitive impairment and required extensive assistance with eating.

R52 care plan printed 10/21/21, directed staff to assist resident with dining when needed.

R60
R60's Admission Record, printed 10/21/21, indicated diagnoses including dementia without behavioral disturbance and Parkinson's disease.

R60's quarterly MDS dated 9/28/21, indicated the resident had severe cognitive impairment and required extensive assistance with eating.

R60's care plan printed 10/21/21, indicated the resident will have ADL (activities of daily living) needs met with staff assistance.

During interview on 10/20/21, at 11:15 a.m. the director of nursing (DON) indicated a call in occurred for 3rd floor that morning so staffing was an issue. The DON confirmed her expectation is when the tray is served, residents should be assisted to eat with minimal waiting time.

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F 550	Continued From page 9 A policy on dignified dining was requested and none received.	F 550		
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 determine if the practice of self-administration of medications (SAM) was safe for 1 of 1 resident (R42) observed to self-administer eye drops. Findings include: R42's admission form printed 10/21/21, included a diagnosis of paranoid schizophrenia, altered mental status, anxiety disorder, cataract and glaucoma. R42's admission Minimum Data Set (MDS) assessment dated 9/7/21, included severe cognitive impairment requiring extensive assistance with activities for daily living and supervision of one person for eating. Provider orders dated 10/14/21, included Cosopt Solution 22.3-6.8 mg/ml to instill one drop in both eyes two times a day for glaucoma and natural balance tears solution 0.1-0.3% to instill 1 drop in both eyes three times a day for dry eyes. Physician orders did not identify an order for self administration.	F 554	F-554 (D) It is the policy of the facility to ensure that self-administration of medication (SAM) is deemed safe for residents who desires such need. Immediate action: After assessment R42 had a Self-Administration of Medication Assessment completed and is not a candidate for self-administration and care plan and mar have been indicated to this. This residents will not be allowed to self-administer medication. Care plan was updated to reflect change . Resident(s) involved: R42 Residents with Potential to be affected: All center residents that desire to self-administer medications, specifically eye drops, are at risk to be affected and all residents indicating their desire to self-administer medications and other residents revived self-administration will be reviewed quarterly and with significant changes on and all residents and have the potential to be affected. Facility audit completed on all self-administration orders to ensure assessment and MD	12/1/21

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F 554	Continued From page 10 R42's plan of care dated 9/10/21, included R42 had an alteration in visual acuity related to glaucoma, but interventions did not include self-administration of eye drops. During interview and observation on 10/20/21, at 7:41 a.m., trained medication assistant (TMA)-A was observed during medication administration for R42. While preparing medications, TMA-A stated R42 was given Cosopt eye drops in both eyes an hour earlier and liked to administer them herself. TMA-A brought natural balance tears solution 0.1-0.3% to R42's bedside and handed her the bottle. R42 then took the bottle and put one drop in both eyes and handed the eye drops back to TMA-A. TMA-A returned the eye drop bottle to the cart and indicated she wasn't sure if a self medication assessment was completed and did not believe she had seen an order for R42 to self administer eye drops. During interview on 10/21/21, at 9:45 a.m., TMA-A confirmed no order for self administration of eye drops was found and added that R42 refuses to let staff administer them to her. TMA-A indicated she monitored R42 during the self administration of eye drops and had notified a nurse prior that R42 was requesting to self administer but was unable to indicate whom or when she notified the nurse. During interview on 10/20/21, at 10:00 a.m., the director of nursing (DON) confirmed residents should not self administer eye drops without a physician order and prior to an assessment completed by a registered nurse. The DON confirmed neither were completed. Policy review titled "Medication Self	F 554	orders are in place. All residents that want to self-administer will be reviewed to have a Self-Administration of Medication Assessment completed. Care plans will be reviewed and updated as needed to reflect any change. Self-Administration of Medication Assessments will be completed on admission if resident desires self-administration and reviewed quarterly and with significant changes. All Nursing staff will receive re-education regarding policy, and documentation for completion of the Self Administration of Medication by the DON or designee. Education: Nursing staff educated by the DON/Designee by 12/1/2021 or before their next shift begins on safe self-administration of medication for residents and ongoing monitoring of those residents' for safety nursing recommendations for or against self-administration will be given to Don for final approval. Monitoring: To ensure ongoing compliance the DON/Designee/Facility Staff to complete audit 3 residents who self-administer (focus on eye drops) medications for Self-Med UDA, Care Plan and MD orders, weekly x 8 weekly. The results of the audits will be reviewed by the QAPI committee for trends and any needs for adjustment of audit schedules or content, as well as any further educational needs to make sure solutions are sustained. 12/1/2021	

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F 554	Continued From page 11 Administration" dated 6/1/17 included: - Residents are not permitted to administer or retain any medication in his or her room unless their attending physician writes an order for self-administration of the medication and the resident is assessed.	F 554		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide ADL (activities of daily living) care to 2 of 2 resident (R4 and R11) reviewed for ADLs and who were dependent upon staff for grooming. Findings include: R4's facesheet printed 10/21/21, included diagnoses of morbid obesity, diabetes, paranoid personality disorder and mild cognitive impairment. R4's quarterly Minimum Data Set (MDS) assessment dated 10/8/21, indicated R4 had refused to completed the brief interview for mental status, had adequate hearing and vision, clear speech, was able to make self understood and could understand others. R4 required extensive assistance of one staff for personal hygiene. R4's plan of care dated 1/21/20, indicated	F 677	677 It is the policy of the facility to¿provide ADL (activities of daily living) care¿to those who are dependent on staff for grooming needs.¿ ¿ ¿ Resident(s) involved:¿R4 had facial hair removal done with assistance from nursing staff. R4's guardian was contacted and R4 was provided with an electric razor and provided to her to be kept in her room. R4s care plan was reviewed and updated. R11 had nail care completed by nursing staff. R11's care plan was reviewed and updated. ¿ Residents with Potential to be affected:¿All residents' appearance of nails and facial hair was observed by staff members. Special focus on residents used during the "Guardian Angel" rounds	12/1/21

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F 677	Continued From page 12 hygiene was important to R4 and the goal was to maintain hygiene and health. In addition, the care plan indicated R4 had an ADL self -care deficit related to impaired cognition and mobility, and would have facial hair trimmed as needed with the assist of staff. During an interview and observation on 10/18/21, at 3:22 p.m., many white whiskers of varying lengths were observed on and under R4's chin, along with multiple long (approximately 1-2 inch) white hairs on her neck. When asked if she was aware of the hair, R4 stated she was not happy about it, but she didn't have a razor. R4 stated the facility didn't supply razors; she had asked several times. During an interview on 10/21/21, at 10:08 p.m., when asked how nursing assistants (NA's) managed chin hair on female residents, trained medication aide (TMA)-A stated NA's shaved the hair on bath day with disposable razors. Shaving cream and an ample supply of disposable blue razors where observed in the supply closet. When asked specifically about R4, TMA-A acknowledged R4 had chin hair, adding if a resident was diabetic and did not have their own razor, she did not shave them due to the risk of nicking the face, and instead informed the nurse. TMA-A did not recall telling a nurse that R4's chin needed to be shaved. During an interview on 10/21/21, at 10:17 a.m., licensed practical nurse (LPN)-A stated diabetic residents needed to have their own electric razor in order to shave chin hair, and family or guardian would need to supply it. LPN-A was aware of R4's whiskers and neck hair, but acknowledged she had never asked the social worker to contact R4's	F 677	or manager on duty rounds daily this system change will ensure problems do not reoccur. Needs for nail care or facial hair grooming were addressed immediately with nursing staff and assistance with nail care and facial hair grooming tasks were provided. All center residents that¿are dependent on staff for grooming needs¿are at risk of being affected.¿All residents are observed for ADL needs during guardian angel rounds results reported to appropriate staff and in morning meeting for follow up. Angel rounds are completed at least 5 days a week to ensure compliance manager on duty rounds are completed on the weekend. Activity department continues to offer nail care weekly and facility staff will document refusal. ¿ Education:¿Nursing staff and all guardian angel staff educated by the DON/Designee/ facility staff by 12/1/2021¿or before their next shift begins.¿Education included providing nail care and shaving/grooming to a resident. ¿ Monitoring:¿To ensure ongoing compliance the DON/Designee/Facility Staff to complete audits¿on 5 residents weekly beginning the week of 12-1 2021 and ongoing for at least three months. The results of the audits will be reviewed by the QAPI committee monthly for trends¿and¿any needs for adjustment of audit schedules or content, as well as any further educational need and the guardian angel rounds checklist will be our audits. The audit will be focusing on verifying that	

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F 677	Continued From page 13 guardian to purchase an electric razor. During an interview on 10/21/21, at 10:40 a.m., the social worker (SW)-A stated she could facilitate getting electric razors for residents, adding nursing staff just needed to tell her. Informed R4 had chin hair and according to the nursing staff, would need an electric razor to remove the hair since she was diabetic. SW-A stated "we just had R4's care conference yesterday, I could have asked the guardian. The guardian would say yes, she has the money for that." SW-A stated she would email the guardian right away and ask. During an interview on 10/21/21, at 1:57 p.m., the director of nursing (DON) stated she would expect staff to address female residents with chin hair. When the DON was informed that nursing staff stated they could not use a disposable razor to cut facial hair if the resident was diabetic, the DON stated nurses were allowed to shave a diabetic resident who had chin hair using a disposable razor, or they could request the family or guardian provide an electric razor. The DON stated this resident sometimes refused care and that may be why she had whiskers, but admitted refusal for shaving chin hair had not been documented by staff. R11 R11's facesheet printed 10/2/21, included diagnoses stroke and dementia. R11's quarterly Minimum Data Set (MDS) assessment date 7/24/21, indicated R11 was not able to complete the brief interview for mental status, had minimal difficulty hearing, impaired vision, clear speech, was usually understood and	F 677	general grooming needs have been met and also an opportunity for residents to provide feedback of care received.	

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could usually understand. R4 required extensive assistance of one staff for personal hygiene.

R11's plan of care dated 1/15/20, indicated hygiene was important to R11 and the goal was to maintain hygiene and health. In addition, the care plan dated 1/14/21, indicated R11 had an ADL self-care deficit related to dementia, physical and visual impairment, and R11 would have assistance with daily hygiene and grooming.

During an interview and observation on 10/20/21, 08:25 a.m., R11 stated his fingernails were rough as he rubbed a finger across the nail of this left thumb. Fingernails noted to be long and jagged, especially his left thumbnail, thick and pale yellow in color. R11 stated he would like his nails trimmed.

During an interview on 10/20/21, at 12:29 a.m., (NA)-C stated NA's cleaned and trimmed resident fingernails on bath day. NA did not recall giving R11 a bath on 10/6/21. NA-C was given the "NAR bath day worksheet" she filled out that day which had no markings for "Nail care: fingers." NA-C was asked what it meant when there was no marking, and stated that meant the nurse needed to look at the residents fingernails when they looked at the residents skin. Together observed R11's nails. NA-C picked up R11's hands and looked at his nails and said, they should be trimmed and admitted they were long and that the left thumbnail was jagged.

During an interview on 10/20/21, at 1:45 p.m., together with the DON, observed R11's nails. The DON admitted they were jagged and "a little long." The DON stated she expected them to be trimmed, and R11 "needed a good filing at least."

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Informed the DON that R11's bath sheet for 10/6/21, was blank for nail care. The DON stated no checkmark for fingernails did not mean they weren't looked at....it meant the resident did not need nail care.

During an interview on 10/21/21, at 4:45 p.m., due to conflicting explanation of what a checkmark or no checkmark meant for nail care on the bath day worksheet, the DON was asked to clarity. The DON stated if nail care was checked off, it meant the NA cleaned, trimmed and filed the nails. If there was no checkmark, that indicated the resident was on coumadin or was diabetic and the nurse would need to look at the nails. R11 was neither diabetic or on a blood thinning medication.

Bath day worksheets for R11 indicated:
9/13/21: nail care for fingers: "ok"
9/20/21: nail care for fingers was not checked, which according to the DON meant nails were to be addressed by the nurse.
10/6/21: nail care for fingers was not checked, which according to the DON meant nails were to be addressed by the nurse.
10/13/21: nail care for fingers was checked, which according to the DON meant R11's nails were cleaned, trimmed and filed. The observation of R11's fingernails a week later on 10/20/21, showed them to be long and left thumbnail jagged.

During an observation on 10/21/21, at 12:30 p.m., observed R11's nails to still be long, but left thumbnail was no longer jagged.

Facility policy titled Personal Needs, with revised date of October 2016, indicated the facility strived

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F 677	Continued From page 16 to promote a healthy environment by meeting the personal needs of the residents. Personal care and ADL support would be provided according to the residents care plan. Compliance with care delivery needs and interventions would be determined by observation of care delivery. Personal care and support included grooming, nail care and shaving.	F 677		
F 684 SS=G	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively assess, monitor and implement interventions including completion of dressing changes and administer ordered antibiotic treatment for 1 of 3 residents (R43) with non-pressure related wounds. In addition, the facility failed to ensure elevation of swollen legs and utilization of compression wraps. This deficient practice resulted in actual harm for R43, who acquired an additional wound on the left lower leg and the medial and lateral wounds increased by 3-4 centimeters each in size. In addition, the facility failed to ensure treatment orders were provided as ordered for 1 of 3 resident (R4) reviewed for wound care who was	F 684	It is the policy of the facility to access, monitor and implement interventions including completion of dressing changes, elevation of legs, utilization of compression wraps and administration of ordered antibiotic treatment for non-pressure related wounds. Immediate Action: R43- Wounds were assessed and measured. Weekly non pressure wound tracker initiated and wounds are measured every 7 days. Physician orders and care plan were reviewed and revised. R4- Wounds were assessed and measured. Weekly non pressure wound	12/1/21

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F 684	Continued From page 17 at risk for non-pressure related wounds, Findings include: R43 was admitted to the facility on 5/27/21. Diagnosis listed on the diagnosis sheet in the medical record included: cellulitis (inflammation of the subcutaneous connective tissue) of the left lower leg, non-pressure chronic ulcer (a break in the skin or mucous membrane) of the lower left leg, type 2 diabetes mellitus, venous insufficiency (veins unable to adequately circulate the blood), lymphedema (lymphatic system blockage causing swelling in the arms or legs), peripheral vascular disease (circulation condition that narrows blood vessels causing reduced blood flow to the limbs) and arteriosclerotic heart disease (ASHD) (a build up of cholesterol plaques in the walls of the arteries, causing obstruction of blood flow). R43's quarterly Minimum Data Set (MDS) assessment dated 9/3/21, identified R43 as having a brief interview for mental status (BIMS) score of "12" indicating the resident had minor impairment in cognition. The MDS indicated R43 required extensive assistance with activities of daily living (ADL's). The MDS indicated R43 had 2 non-pressure related ulcers. The MDS identified interventions including non-surgical dressing to feet as well as ointments. R43's discharge MDS assessment dated 9/21/21, identified R43 as having a BIMS score of "12" indicating the resident had only minor impairment in cognition. The MDS indicated R43 required extensive assistance with ADL's. The MDS indicated R43 had a non-pressure related ulcer on the lower left leg.	F 684	tracker initiated and wounds are measured every 7 days. Physician orders and care plan were reviewed and revised. All nurses educated on skin care or prior to wound care on their next scheduled shift If any abnormalities are observed during skin assessments, they are to be reported immediately to the, and the Director of Nursing and the physician or medical director when appropriate Resident(s) involved: R4, R43 Residents with Potential to be affected: Center residents have non-pressure related wounds or risk for such wounds are at risk to be affected. A skin sweep was completed on all residents. Wounds were assessed, measured, and a weekly wound tracker was initiated. Care plans were reviewed and revised. Education: Nursing staff educated by the DON/Designee by 12/1/2021 or before their next shift begins. Policy and procedures have been updated for Charting and documentation, Pressure and non-pressure wounds and Dressing change. All nurses demonstrated competency of performing a wound dressing change by 12/1/2021 or prior to wound care on their next scheduled shift. Reviewing the physician order and demonstrating proper wound care orders that match the physician order is included in the dressing change competency. Monitoring: To ensure ongoing compliance the DON/Designee to complete audits 2 residents, who have	

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F 684	Continued From page 18 R43's current care plan dated 6/9/21 identified R43 as having impairment in skin integrity related to a venous ulcer (see wound assessment) . Interventions listed: provide treatment as ordered, monitor for redness, warmth, swelling and drainage, report progress or decline to provider and assess and measure all skin integrity areas per policy. The care plan identified R43 as having impairment ADL's due to a self-care deficit that included respiratory failure, congestive heart failure (CHF) (when the heart does not pump blood like it should) and chronic obstructive pulmonary disease (COPD) (inflammation in the lungs that causes obstruction of airflow). Although the care plan directed to see the wound assessment for R43's lower leg ulcer, there was no wound assessment in the medical record. In addition, it was noted in R43's history to have swollen legs as well as orders for compression wraps, this was not included in the plan of care nor were interventions. Review of a discharge hospital progress note dated 9/21/21, indicated R43 was hospitalized from 9/12//21 to 9/21/21, with a diagnosis of cellulitis in the legs, gastrointestinal bleed, acute kidney disease (when kidneys fail to filter body waste from the blood) and a low hemoglobin (HGB). (protein in the blood that carries oxygen to the body). The note dictated by medical doctor (MD)-A indicated R43 had chronic venous status ulcers to the lower left leg (medial and lateral). Wound care treatments were recommended for a few days to stabilize her healing prior to discharge. Physical therapy with advanced wound therapy was recommended on an out patient basis after discharge. The discharge notes did not include R43's wound progress or measurements while in the hospital.	F 684	active wounds, for completion of dressing change, already completed dressing validation, elevation of legs, use of compression wraps and completion of MD orders, weekly skin checks, weekly wound measurements, 3x weekly x 8 weeks, then weekly x 4 week The results of the audits will be reviewed by the QAPI committee for trends and any needs for adjustment of audit schedules or content, as well as any further educational needs. Admission/Readmission checklist updated to include verifying that medications are available for residents and all discharge orders or progress notes are reviewed for follow up appointments. Morning meeting form updated to include reviewing for follow up appointments. Director of Nursing to review new/revised orders and mediation and treatment administration records for completion of task.	

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Recommendations included follow up with outpatient wound care for R43.

Review of a facility re-admission skin assessment dated 9/21/21, identified R43 as having a vascular skin concern on the front lower left leg. The assessment did not include a description of the skin concern.

There were no other skin assessments completed since the re-admission assessment on 9/21/21, of which only indicated R43 had a vascular skin concern. There was no documentation describing the condition of the wound.

On 10/18/21, at 2:40 p.m. R43 was observed to have several fluid filled blisters on her left lower leg. R43's left lower leg was shiny, swollen and pinkish in color. There was a Kerlix wrap on the left lower leg, but the dressing was partially off exposing the blisters. R43 was sitting in her wheelchair with her legs down. R43 indicated she was unsure if the wounds were worsening or getting better, but that they were still painful. R43 indicated that her wound dressings often would fall down her leg, exposing the wounds. R43 further indicated that staff do not always replace the dressing when this happens.

On 10/20/21, at 12:30 p.m.. R43 was observed sitting in a wheelchair with her legs down. R43's left leg remained pinkish, swollen and shiny. There was a dressing on the leg that was coming off, exposing several fluid filled blisters. R43 stated she had cellulitis in her legs. R43 indicated she had blisters that would come and go, but was unsure if she had any other open areas. Ace wraps were on the lower leg, but were falling

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down as well.

On 10/21/21, at 12:30 p.m. registered nurse (RN)-A was observed to change R43's lower left leg dressing. R43 had a 9.0 cm by 8.0 cm open area on the lower front part of the left leg. A 7.0 cm by 6.0 cm open area on the outer part of the lower left leg and a 6.0 cm by 6.0 cm open area on the outer back of the left leg. The dressings were noted to have yellowish colored drainage on the gauze when removed. The center of the wounds were pinkish in color with maceration (skin broken down by moisture) on the edges of each ulcer. There were several fluid filled blisters surrounding the ulcers. Interview with RN-A indicated she did not routinely measure or document the description of R43's lower leg wounds, because she thought that was only done with PU's. RN-A stated the lateral wound on the lower left leg was new and did not have when the resident returned from the hospital. RN-A indicated she observed R43's wound daily and had last observed on 10/20/21. RN-A stated R43 continues to get fluid filled blisters that form and then heal, as well as swelling in the legs RN-A also confirmed there were no discharge notes from the hospital stay, that included measurements or the description of the lower left leg wounds. RN-A also confirmed there were no measurements or description of the wound after returning from the hospital, or when the new ulcer on the lateral left leg had been identified. R43 complained of pain during the dressing change, but had received pain medication prior.

R43's current physicians orders dated 10/1/21 to 10/31/21, included a dressing change to the lower left extremity ulcer. The order included to cleanse the lower left leg wound with saline and apply a

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acetic acid (antimicrobial agent to treat infections) compress. Apply silicone barrier cream (skin protectant) to wound perimeter and cover with a wet aquacel Ag (antimicrobial dressing) followed by a ABD pad (absorbent dressing). Change daily and as needed. The orders also included to assess the wound daily. The physicians orders also included an order dated 10/8/21, for Cipro 500 milligrams (mg) twice daily (BID) for 10 days and penicillin V 250 mg four times a day (QID) for 10
days.

Review of a progress note by doctor of podiatry medicine (PDM)-A dated 9/30/21, indicated R43 was seen to re-evaluate the lower left leg medial and lateral ulcerations. R43 was also seen for debridement of the lower left leg ulcers. The progress note identified the medial and lateral ulcers of the lower left leg to have slough tissue in the wound bed. Wound measurements were done before debridement and after debridement and listed below:

Medial ulcer of the left lower leg
Pre-debridement- 3.8 cm length by 3.9 cm width and 0.4 cm depth
Post-debridement- 3.8 cm length by 3.9 cm width and 0.4 cm depth

Lateral ulcer of the left lower leg
Pre-debridement- 7.7 cm length by 4.0 cm width and 0.3 cm depth
Post-debridement- 7.7 cm length by 4.0 cm width and 0.3 cm depth

Review of a progress note by PDM-A dated 10/7/21, identified R43 as having ulcerations of the medial and lateral aspects of the lower left

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extremity. The progress note indicated there was increased redness of R43's left lower extremity and worsening of the skin of the periwound. A culture was completed which was positive for pseudomonas and enterococcus (bacteria). The progress note also indicated R43 was to have compressive wraps on, but did not during the appointment. The progress note identified the medial ulceration on the lower left leg having no slough tissue present and no new epithelial tissue present. The ulceration on the lateral aspect of the lower left leg identified the ulcer to have no slough tissue or epithelial tissue in the wound. The note indicated there was increased erythema and skin breakdown of the periwound which appears to be drainage from the wound bed. Erythema present of the left lower extremity. The note further indicated R43 had been seen previously at the advanced would healing clinic (AWHC) on 9/30/21, and had increased redness of her left lower extremity and worsening skin of the periwound. The ulcerations of the lower left extremity are unchanged since last visit, although measurement were not included with this visit. R43 has numerous comorbidities which are making it difficult for the ulcerations to heal. In addition to the progress note, there was a notation included under "special considerations" indicating a volunteer at the facility relates R43 had not been receiving as much help with dressing changes. The volunteer added this was due to lack of staff available.

R43's medication administration record (MAR) dated 10/1/21-10/31/21, included a order for Cipro and penicillin V. Both antibiotics were ordered by the provider on 10/8/21, in the afternoon. The MAR showed both medications were not given until 10/13/21, 6 days after the

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medication had been ordered. R43 had missed 9 doses of Cipro and 18 doses of Penicillin V.

R43's treatment administration record (TAR) dated 10/1/21-10/31/21, showed no documentation on 10/4 or 10/21, that the treatment to R43's wounds had been done.

Although R43 had an outpatient visit from the PDM on 10/7/21, to evaluate R32's lower left leg ulcers there were no measurements completed to monitor healing. The only measurements that had been completed since the residents hospital stay on 9/21/21 were on 10/21/21, when the surveyor requested RN-A to measure and assess the resident's wounds.

A voice message was left for PDM-A on 10/21/21, at 1:30 p.m. to inquire on R43's lower leg wounds, with no response. A phone conversation with PDM-A's clinic nurse on 11/9/21, at 3:00 p.m. to have provider return a call when available. There was no response.

Interview with RN-A on 10/21/21, at 12:30 p.m. verified R43's left leg ulcers had not been assessed to appropriately monitor the healing of the wounds. RN-A also confirmed there had been no documentation by the facility related to the description of the wounds when returning from the hospital on 9/21/21. RN-A further stated there were times that she was responsible for over 40 residents and and did not always get to R43's dressing changes, but confirmed she had signed them off on the treatment administrative record (TAR), due to the current staffing shortage (1 licensed nurse for 43 residents).

Interview on 10/21/21, at 1:00 p.m. the director of

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nursing (DON) indicated it was not required for the staff to measure/document on non-pressure related wounds. The DON indicated only PU were measured , described and documented. RN-A further stated staff were to monitor healing with observations, when changing the dressing. RN-A indicated she was not aware that the dressing were not always getting done. DON stated that the staff are not required to measure skin wounds unless it is caused by a pressure ulcer and that they just monitor by observations. The DON confirmed she was unable to find any weekly skin documentation for R43 in the past couple of months.

Interview on 11/5/21, at 2:00 p.m. the DON confirmed the ordered Cipro and Penicillin V had not been started until 10/13/21, missing several doses of both medications. The DON stated the medications were missed from 10/8 -10/12, because the order did not get transcribed to the MAR, so the nursing staff didn't see the order.

Although the facility was aware of R43's lower left leg wounds, skin breakdown risk and edema, the staff did not comprehensively assess, monitor or implement all interventions to prevent further skin breakdown, to determine if wounds were improving or needing further interventions to promote healing. Interventions that had not been implemented included: administering antibiotics per order (causing a delay in treatment), elevating edematous legs, applying compression wraps and changing dressings to the lower left leg wounds, as ordered. This failure occurred from 9/21/21 to 10/20/21, (after return from hospital) and resulted in a new skin breakdown on the back of the left lower leg, and worsening of the wounds on the medial and lateral left leg. The

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medial wound increased by 5.2 cm in length and 4.1 cm in width. The lateral wound increased by 2.0 cm in width. The new breakdown on the back of the leg measured 6.0 cm in length by 6.0 cm in width.

Review of the facility policy Pressure and Non-Pressure Injuries dated 8/2/21, indicated upon admission/re-admission a head to toe evaluation will be completed on every resident and will be documented on the evaluation form. If skin is compromised initiate a injury tracker form (1 per wound) and assess weekly. Initiate a comprehensive skin integrity care plan based on the residents history, risk factors and current skin assessment conditions. Report any changes to the physician.

R4

R4's facesheet printed 10/21/21, included diagnoses of cellulitis of leg (skin infection), lymphedema (swelling of leg due to build-up of lymph fluid), venous insufficiency (failure of veins to adequately circulate blood), morbid obesity, diabetes, paranoid personality disorder and mild cognitive impairment.

R4's quarterly Minimum Data Set (MDS) assessment dated 10/8/21, indicated R4 declined to complete a brief interview for mental status, did not exhibit any behaviors - including rejection of care, had adequate hearing and vision, clear speech, was able to make self understood and could understand others. R4 did not walk and required extensive assistance of two staff for bed mobility, transfers and toileting. R4 was frequently incontinent of urine and always incontinent of stool. R4 had an infection of her foot requiring a dressing.

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Physician orders included:
3/23/21: Wash feet with soap and water every evening.
10/8/21: Use skin marker, mark area of redness and notify provider if worsening. Assess every shift.
10/15/21: Right lower extremity and right dorsum (top) foot and right lower abdominal panniculus (a sheet of fat tissue in the lower abdominal area): acetic acid soaks two times a day for 7 days.

R4's plan of care dated 1/21/20, indicated R4 had actual skin integrity break related to mobility and incontinence at that time, and a goal indicated skin would show signs of progressive healing without signs of infection. The care plan did not identify current skin infection and treatments ordered to enhance healing and reduce infection. In addition, the care plan indicated R4 displayed signs of mood and behavior possibly related to paranoid personality disorder and a goal indicated R4 would not refuse cares important to her health. Interventions included education on the importance of receiving cares and R4's refusals would be monitored.

Record review indicated R4 was seen by a physician or nurse practitioner on 9/29, 10/4, 10/8, 10/11, and 10/14. The 9/29, note reiterated importance of R4 wrapping her legs due to lymphedema; but there were ongoing refusals by R4 to wrap them. The 10/4, note indicated R4 was being seen following communication from nursing that when R4's shoes were removed at bedtime, maggots were noted crawling out of her right shoe and in between her toes. R4 had open areas to the right foot: one at the dorsum and the other at the lower part of the shin, both laterally. The 10/8, note indicated R4 was being seen

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regarding worsening pain, redness, and warmth of lower right extremity, and worsening edema. An antibiotic was started. The 10/11, note indicated follow-up of right lower extremity cellulitis, with the redness subsiding. The 10/14, note indicated R4 had no resolution of right lower leg cellulitis and another antibiotic was started.

During an interview and observation on 10/18/21, at 3:51 p.m., R4 was in a hospital gown, and was sitting on the side of her bed, facing the door with her legs over the side of the bed. R4's bare feet rested directly on the tile floor. Significant edema was noted to both lower legs and feet. The right lower leg and foot were reddened, and areas of skin on dorsum of the right foot were peeling. R4 had a panniculus which hung over the outer aspect of her right thigh and over the side of the bed. The right side of the panniculus was slightly reddened as compared to the left side. No obvious open areas during a quick observation when R4 lifted her gown to show her panniculus.

During an interview on 10/19/21, at 2:56 p.m., when asked if staff had recently been soaking her right foot and panniculus with a special solution, R4 stated her foot had been soaked maybe twice since arriving to the facility a year and a half ago. No soaking supplies observed in room except for a white plastic basin, upside down on the floor between her bed and wall, toward the top of the bed. R4 stated no one had been washing her feet either. No signs of black marker markings on reddened area of skin on right leg or right foot, as ordered, to indicate improved or worsening redness.

During an interview on 10/20/21, at 8:17 a.m., when asked what kinds of skin treatments R4

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had, licensed practical nurse (LPN)-A stated, "If she would let me do anything with her wounds -- she refuses." LPN-A opened the TAR (treatment administration record), and stated, "See the 2's? Those are refusals." When asked about soaks for foot and panniculus with acetic acid, LPN-A stated, "I don't know anything about that." LPN-A was asked to look at the order, but could not find it until it was pointed out, then she read it. LPN-A confirmed the order was added on 10/15/21, and admitted she was unaware this order existed and therefore had not performed the treatment. When pointed out that R4 had multiple wound care orders, LPN-A was asked how many wounds R4 had and she stated she didn't know. LPN-A was unaware of the physician order dated 10/8, to mark R4's areas of redness with a skin marker either, stating she never saw that order, and shrugged her shoulders when asked how she knew if the wound was worsening or improving. It was noted on the MAR (medication administration record) that LPN-A had signed off marking the areas of redness on 10/11, 10/13, 10/14, 10/17, and 10/20.

During an interview on 10/20/21, at 11:44 a.m., when asked if R4 had foot and panniculus soaks, the director of nursing (DON) looked at the physician orders in the electronic medical record (EMR) and stated "not at this time," adding that R4 was very non-compliant and that the provider was aware of her non-compliance. The order for the acetic acid soak dated 10/15/21, was pointed out and the DON stated "Oh, that started on the 15th." When asked if it were being done, the DON looked at the TAR and stated the evening shift had been doing it consistently and identified the two nurses who had documented performing the treatment. The DON also stated that LPN-A

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ROCHESTER EAST HEALTH SERVICES	501 EIGHTH AVENUE SOUTHEAST ROCHESTER, MN 55904

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had signed off that she performed it on 10/17. The DON was informed that when the acetic acid soaks were pointed out to LPN-A, she did not know anything about it. When asked if it were possible LPN-A signed off as performing the treatment when she had not, the DON stated, "I can't say." Requested to look at R4's skin with the both the DON and LPN-A.

During an observation and interview on 10/20/21, at 1:59 p.m. in R4's room with LPN-A and DON, R4's skin and acetic acid soak treatment were observed. R4's panniculus had generalized, slight redness; skin was smooth and intact except for one dime size scab noted. The center of R4's abdomen had a healed vertical scar with a small scab at the proximal end. Right lower leg, middle section had closed, blistered skin. Dorsum of right foot had peeling skin. No open wounds noted. LPN-A was asked how the cellulitis of R4's right lower leg and foot looked to her and she stated "slightly better." LPN-A stated to the DON, "I didn't know about this [order for acetic acid soaks] till she [surveyor] asked me about it this morning." After the treatment was over, again asked LPN-A and DON if LPN-A had been doing this treatment prior to today and LPN-A stated she would have to go back and look at the R4's record.

During a telephone interview on 10/21/21, at 9:02 a.m., registered nurse (RN)-A was asked if she was aware of a new treatment for R4's skin using an acetic acid soak. RN-A stated she was not aware. When brought to her attention that she initialed performing the treatment twice on 10/18, RN-A stated, "I might have signed off on it at the end of the shift and not done it." RN-A further stated, "I didn't know about this order and we are

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constantly rushed; we can't do everything. Everyone is frustrated; I get done what I can." When asked if she washed R4's feet with soap and water, RN-A replied no. When informed she initialed that she did soak R4's feet several times this month, RN-A replied, "Okay." RN-A had not told the DON or administrator how she felt about her workload.

During a telephone interview on 10/21/21, at 9:06 a.m., (RN)-C was asked if she was aware of a new treatment for R4's skin using an acetic acid soak, RN-C stated, "I offered the treatment to R4, but she refused to let me clean her abdomen and feet." Asked again if she was aware of a new order for acetic acid soak, RN-C stated, no, she had not seen the order, then stated she offered the acetic acid soak to R4 and R4 refused. RN-C stated she had filled out an SBAR (situation, background, assessment, recommendation) documentation to the physician about the refusal and that it should be in R4's record. RN-C stated she also sent a copy of the SBAR to the DON. According to an interview with the DON on 10/21, at 1:57 p.m., there was no SBAR documented about this in R4's EMR, nor did she receive a copy of an SBAR.

During an interview on 10/21/21, at 10:21 a.m., when informed staff say she refused care a lot of the time, R4 stated "how can I refuse if they don't asked me!" Stated they aren't asking her things that she is allegedly refusing.

During an interview on 10/21/21, at 1:57 p.m. with the DON and the corporate director of clinical services (DCS)-C, both confirmed it was the expectation that nurses carry out physician orders unless a resident refused. The DON stated R4

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often refused care and treatment. The DON stated the physician had been been informed of R4's refusals and that multiple SBAR's regarding refusals has been sent to the physician. This documentation was requested. The DON admitted there was no SBAR in R4's record from 10/20, nor did she receive communication from an RN about a refusal. The DON and DCS-C were informed three nurses were unaware of the 10/15, order for acetic acid soaks yet they documented they performed the treatment. In addition, the nurses admitted they were not washing R4's feet, nor were they marking the area of redness on her skin, yet documenting these treatments had been performed. The DCS-C stated the process for nurses being aware of new physician orders needed to be improved, that she expected nurses to complete orders as directed, and expected nurses to be truthful in their documentation.

During an interview on 10/21/21, at 3:48 p.m., based upon the request for SBAR documentation to physicians pertaining to R4's refusals of care, the DCS-C provided three pieces of documentation: 1) SBAR dated 10/2/21, for change of condition, 2) Nursing home orders dated 10/4/21, and 3) History and physical note dated 9/29/21. None were SBAR's indicating refusal of care. Only the history and physical note dated 9/29/21, read: "R4's plan of care calls for daily application of Solaris Velcro ready wraps to control lower extremity lymphedema, but not currently being used due to non-compliance." The DCS-C admitted these documents did not address the refusals that the staff and the DON had been reporting to the surveyor, and added "we need to fix that."

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F 684	Continued From page 32 A facility policy for carrying out physician orders was requested, and a policy titled "Medication Orders" was received which did not address carrying out physician orders.	F 684		
F 685 SS=D	Treatment/Devices to Maintain Hearing/Vision CFR(s): 483.25(a)(1)(2) §483.25(a) Vision and hearing To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility must, if necessary, assist the resident- §483.25(a)(1) In making appointments, and §483.25(a)(2) By arranging for transportation to and from the office of a practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing assistive devices. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 1 of 1 resident (R42) received proper assistive device of a hearing amplifier to maintain hearing abilities. Finding include: R42's admission Minimum Data Set (MDS) assessment dated 9/7/21, identified R42 had severe cognitive impairment, moderate difficulty with hearing, used a hearing aid or other hearing appliance, required extensive assistance with transfers, bed mobility, toileting, dressing, and personal hygiene. The MDS identified R42 had medical diagnoses of weakness, anemia, end stage renal disease (kidney disease), vision	F 685	F-685 (D) It is the policy of the facility to ensure residents receive proper assistive devices, such as a hearing amplifier, to maintain hearing abilities. Resident(s) involved: R42 Resident #42s was provided two hearing amplifiers by the nursing home and was still in the resident's purse during the survey and after the survey. The executive director will monitor the availability of resident 42's hearing amplifier weekly or as needed. Residents with Potential to be affected: All	12/1/21

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F 685	Continued From page 33 impairment, and received dialysis treatment R42's care plan printed 10/19/21, indicated R42 had a hearing impairment as evidenced by hearing loss and used amplifier; interventions included attempt to minimize excess noise and communication device of amplifier, maintain, and use amplifier. Nurse progress note dated 8/31/21, at 2:40 p.m. indicated R42 was alert and oriented, very hard of hearing, needed hearing aids but used an amplifier, does not have one [amplifier] with her, and R42 was given one of the facilities amplifiers to use. On 10/19/21, at 9:11 a.m. R42 was observed and interviewed in her room, R42 stated she was extremely hard of hearing, when asked if she wore hearing aides or had a device to assist with hearing the resident stated she did not. During the interview with R42, a loud voice and repetition in questions was required. On 10/19/21, at 1:55 p.m. nursing assistant (NA)-A indicated R42 was hard of hearing and confirmed R42 used an amplifier when she first arrived at the facility, however NA-A stated R42's amplifier was not able to be located currently. NA-A was observed in R42's room and attempted to locate the amplifier and was unsuccessful. On 10/20/21, at 7:56 a.m. NA-C stated R42 was hard of hearing and had no hearing aids or hearing amplifier and NA-C stated, but she [R42] should. On 10/20/21, at 12:16 p.m. R42 and family member (FM)-A were observed in R42's room.	F 685	center residents have hearing impairments and with hearing, devices are at risk to be affected. No other residents were identified as having the need for hearing devices that have not already been identified. The Facility guardian angel rounds will observe all residents who need hearing amplification to ensure that a hearing amplifier is available if needed. The Social Worker will, in conjunction with the resident and/or responsible party, take the necessary actions to provide a hearing amplifier. Guardian Angel rounds are completed daily on all residents Education: Staff educated on proper devices to aide in hearing by the DON/Designee/Facility Staff by 12/1/2021 or before their next shift to ensure proper devices to aide in hearing. Monitoring: To ensure ongoing compliance the DON/Designee/Facility Staff weekly beginning the week of 12-1-2021 an Audit 2 residents, who utilize assistive devices for hearing, to ensure devices are properly placed weekly x 8 weeks and ongoing for at least three months. The results of the audits will be reviewed by the QAPI committee for trends and any needs for adjustment of audit schedules or content, as well as any further educational needs.	

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F 685	Continued From page 34 FM-A stated R42 was provided a hearing amplifier from the social worker (SW) when she was admitted, however he had not observed R42 use the device and was not able to find the amplifier in R42's room or know the location of the amplifier. During the interview with R42, a loud voice and repetition was required, R42 stated she had not used the amplifier and confirmed she was very hard of hearing. On 10/21/21, at 9:36 a.m. interview with social worker (SW) stated R42 admission assessment verified R42 was hard of hearing and was provided a hearing amplifier at admission. SW stated R42 was admitted to a room on first floor, and had transferred to second floor room. The SW indicated staff were expected to move the amplifier to R42's transferred room. The SW indicated she would provide R42 with a replacement hearing amplifier. Policy titled care of the hearing impaired resident dated 12/16 indicated: - Arrange for consultation with an otologist if needed - Provide pencil and paper or magic slate to communicate in writing or an erasable board, if the resident is able.	F 685		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain.	F 690		12/1/21

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F 690	Continued From page 35 §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to educate, assess and monitor catheter care for 1 of 1 resident (R5) who was independendently performing self urinary catheter cares. Findings include: R5 was admitted to the facility on 7/8/20. Diagnosis listed on the diagnosis sheet in the	F 690	F690 POC Correction It is the policy of the facility to ensure education, assessments, and monitoring for catheter care for residents who independently perform self-urinary catheter cares Resident(s) involved: R5	

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F 690	Continued From page 36 medical record included: muscle weakness, right artificial shoulder joint, paraplegia (damage to the spinal cord causing paralysis of all or part of the trunk, legs or pelvic organs), neuromuscular dysfunction of the bladder (lacks bladder control), injury of the spinal cord, osteoarthritis (wearing down of the protective tissue at the end of the bones), diabetes mellitus (too much sugar in the blood), chronic kidney disease (loss of kidney function to eliminate waste from the body) and placement of a urostomy (an opening in the abdomen that re-directs urine away from the bladder that's diseased or injured. Observation on 10/18/21, at 3:43 p.m. R5 was in her room watching TV. There was a strong odor of urine throughout the room. There was a urinal hanging ona commode in the room, that had urine in it. R5 stated she has a urostomy that she manages herself. Observation and interview on 10/20/21, at 8:30 a.m. R5 was in her room rummaging through papers on her table. There was a strong odor of urine throughout the room. There was a catheter bag hanging on the night stand. Half of the bag was filled with urine. There was no cap on the end of the tubing (connector) and hanging down on the floor. R5 stated she takes care of her urostomy herself and that she also switches her drainage bag and leg bag in the morning and at night. R5 indicated she did not always clean the ends of the tubing (connector) when switching her bags. R5 further indicated she did not rinse her bags either. R5 stated she empties the urine into the urinal and places it on the commode and the staff will empty the urinal. R5 stated she also washes around her stoma every day. R5 indicated she has had a urostomy most of her life	F 690	Immediate Action: R5 was observed demonstrating catheter care by Director of Nursing. Education was provided to resident including infection control practices and proper technique of task by Director of Nursing . Observation of demonstration technique was reviewed with the resident's primary physician and orders new were obtained. Care Plan was updated. on a quarterly basis and as needed on proper technique and infection control practices while provided self-catheter care. Residents with potential to be affected: All residents with catheters were reviewed. No other residents were identified as independently performing self urinary catheter cares. Education: Nursing staff were educated by the Director of Nursing/Designee by 12/1/2021 or before their next shift begins. Monitoring: To ensure ongoing compliance the Director of Nursing/designee to complete audits weekly beginning 12/1/21 and ongoing for at least three months. The results of the audits will be reviewed by QAPI committee for trends and any needs for adjustment of audit scheduled or content, as well as any further educational needs.	

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and she was capable of taking care of it.

Review of the quarterly minimum data set (MDS) assessment dated 4/23/21 identified R5 as having a brief interview status (BIMS) of "15" (no impairment in cognition). R5 required extensive assistance with activities of daily living (ADL's) including toileting and personal cares. The MDS indicated the staff did all the effort and R5 does none to complete the activity. R5 was able to eat independently. The MDS identified R5 to have a ostomy. R5 exhibited only 1 behavior that included verbal aggression towards others. No behaviors of being resistive or refusing cares identified on MDS. The MDS identified R5 to have impairment of upper and lower extremeties

Review of the annual MDS assessment dated 7/16/21, identified the resident as having a BIMS of "14" (meaning minimal impairment in cognition). R5 required extensive assistance with ADL's, including toileting and personal care. R5 was able to independely feed herself. The MDS identified R5 to have a ostomy. The MDS identified R5 as having mild depressive symptoms but did not exhibit any behaviors. The MDS identified R5 to have impairment of upper and lower extremeties.

Review of the current bowel and bladder evaluation dated 4/16/21, indicated R5 was continent of bladder. There was no documentation related to R5 having an ostomy.

R5's current plan of care dated 4/16/21, identified R5 as having a urinary ostomy related to impaired mobility, physical limitations, infection, neuromuscular dysfunction of the bladder related to paraplegia at age 19 and pyelonephritis.

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Interventions included: provide ostomy care as needed, report changes in amount, frequency and color and odor of urine and report signs and symptoms of a urinary tract infection (UTI). The care plan identified R5 with a self care deficit related to being paraplegic and physical limitations. Interventions included: assist with daily hygiene, grooming, dressing and oral cares and mechanical lift for transfers. The care plan did not include R5 independently performing her own ostomy/catheter care nor did it include target behaviors that included R5 had been refusing catheter/ostomy care.

R5's progress notes for the past year, did not include an assessment/training or any documentation pertaining to self ostomy/catheter cares.

During the survey, the surveyor attempted to observe R5 performing self ostomy/catheter care during the survey, but the resident refused.

Review of R5's urinalysis (UA's) results in the past year, showed R5 has not had a urine tract infection since 8/2/20.

Interview on 10/20/21, at 9:00 a.m. registered nurse (RN)-A indicated R5 has been taking care of her ostomy since admission. RN-A indicated she was unsure if R5 had been assessed or trained to provide self ostomy care. RN-A stated she did not think that R5 was fully capable of providing self ostomy/catheter care. RN-A verified R5's room often spells of strong urine. RN-A confirmed she had not re-assessed R5's capabilities of providing her own ostomy care.

Interview on 10/20/21, at 9:15 a.m. nursing

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F 690	Continued From page 39 assistant (NA)-A indicated R5 had been taking care of her own ostomy/catheter care. NA-A indicated the staff will empty the urinal when full and measure the output, but that was all that they did. NA-A was aware of the strong urine smell but thought it was because sometimes the urinal sits for a while before staff gets to it. NA-A also stated she had not attempted to provide ostomy care, because she had been told by other NA staff that R5 would refuse. Interview on 10/20/21, at 9:30 a.m. nursing assistant NA-B indicated R5 had been taking care of her own ostomy/catheter care for as long as she can remember. NA-A indicated the staff will empty the urinal when full and measure the output, but that was all that they did. NA-B felt R5 could use assistance with her cares, but that she was told the resident would refuse. NA-B indicated she had taken care of R5 for over a year. Interview on 10/21/21, at 1:45 p.m. NA-C stated R5 takes care of her ostomy care and will empty the leg bag and catheter bag in a urinal. NA-C stated then the staff will empty. NA-C indicated staff did not assist R5 with any of her ostomy/catheter care and was unsure if R5 was taking care of her catheter bags properly. A policy was requested related to assessment and self care of ostomy's/catheter drainage bags.	F 690		
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	F 698		12/1/21

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F 698	Continued From page 40 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 monitor dialysis treatment, utilize communication form with dialysis, provide a comprehensive dialysis care plan to reflect emergency care, and monitor fluid restriction for 1 of 1 residents (R42) receiving hemodialysis. Findings include: R42's admission Minimum Data Set (MDS) assessment dated 9/7/21, identified R42 had severe cognitive impairment, required extensive assistance with transfers, bed mobility, toileting, dressing, and personal hygiene. The MDS identified R42 had medical diagnoses of weakness, anemia, end stage renal disease (kidney disease), vision impairment, and received dialysis treatment. R42's care plan printed 10/19/21, indicated R42 was at risk for nutritional status change related to increased nutrient needs and interventions included: renal diet with regular textures and regular consistency,1.5 L [liter] fluid restriction, alternation in kidney function due to end stage renal (kidney) disease, evidenced by hemodialysis and interventions included: assessment of skin condition weekly by licensed nurse, check access site daily fistula/graft/catheter-signs of infection (redness, harness, swelling, pain, drainage elevated temperature, body chills), observe for post dialysis hangover - vital signs, mental status,	F 698	It is the policy of the facility¿to monitor dialysis treatment, utilize communication form with dialysis, provide a comprehensive¿dialysis¿care plan to reflect emergency care and monitor fluid restriction for those receiving hemodialysis.¿ ¿ Immediate action: All water mugs were removed from the resident's room. Resident's husband was educated on the risks of not following the ordered fluid restriction and he was asked to no longer bring in drinks for residents unless reviewed with staff to allow for substitution of what is provided to her. Fluid restriction was reviewed in the care plan and the physician orders. All resident orders were reviewed to verify that the treatment administration record includes required daily assessments. Resident's profile was updated with dialysis center name and phone number. Communication forms are available to staff at nurse's stations. Interdisciplinary team to verify daily in morning meeting that communication form had been sent with resident to dialysis center. Resident's care plan was reviewed and revised. Resident(s) involved:¿R42 ¿ Residents with Potential to be affected:¿Center residents¿who receive	

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F 698	Continued From page 41 excessive weight gain between treatments, nausea, vomiting, weakness, headache, severe leg cramps , observe for signs and symptoms of bleeding, hematuria bleeding gums, tarry stool, increased bruising. R42's treatment administration record (TAR) and the order summary report printed 10/19/21, indicated AV [Arteriovenous], fistula thrill and bruit checked daily, check dialysis catheter dressing daily for redness, drainage, or warmth -Notify NP [nurse practitioner] if any of these symptoms present every evening shift, and 1.5 L [liter] fluid restrictions, no water mug and dialysis Tuesday, Thursday, and Saturday at 11:00 am. Nutrition assessment dated 9/8/21, indicated renal diet and fluid restriction of 1.5 L fluid restriction. On 10/19/21, at 9:24 a.m. R42 was observed in her room and seated on her bed. A covered blue handled insulated mug, one opened six ounce diet ginger ale can, one unopened six ounce can of diet ginger ale, coffee in a brown handled mug, and an approximate 4-ounce clear plastic glass half filled with water was on R42's bedside table. R42 indicated the staff provided her too much to drink and she indicated she wasn't supposed to drink the amount the staff bring her, and further indicated she saved the drinks for later. R42 stated she had a dialysis catheter on her upper right chest area, and R42 pulled down her top and revealed a right tunneled catheter placed near the right subclavian (upper neck area) covered with a transparent dressing. R42 indicated the dialysis clinic monitored her dialysis site and she further indicated the facility staff had not monitored the dialysis access site.	F 698	hemodialysis¿are at risk to be affected.¿Currently no other residents receive hemodialysis. ¿ Education:¿Nursing staff educated on hemodialysis including recommended fluid consumption the restriction on fluids by the Director of Nursing/Designee by 12/1/2021¿or before their next shift begins.¿Staff will ensure communication form sent with hemodialysis. ¿ Monitoring:¿To ensure ongoing compliance the Director of Nursing/Designee¿to begin weekly beginning the week off 12-1 2021 and ongoing for at least three months. The results of the audits will be reviewed by the QAPI committee for trends¿and¿any needs for adjustment of audit schedules or content, as well as any further educational needs.¿The morning meeting with the interdisciplinary team was updated to include daily review of residents with dialysis. Director of Nursing will review daily charting to verify completion of the treatment administration record and assessments.	

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On 10/19/21, at 1:55 p.m. an interview with nursing assistant (NA)-A stated R42 was not on a special diet or fluid restriction and indicated R42 drank coffee, diet ginger ale, and received a water pitcher.

On 10/19/21, at 2:25 p.m. registered nurse (RN)-A stated she has worked at the facility for nine weeks and was an agency nurse. RN-A stated hand off shift report was not received on R42 today and she was the nurse responsible for R42 today. RN-A stated yesterday and today [10/18/21 and 10/19/21] R42's dialysis site was not assessed and further indicated she was not aware R42's current dialysis site location. RN-A stated R42 had no dressings or skin treatments ordered. RN-A confirmed she was expected to assess R42 yesterday and did not have time. RN-A stated if R42 was on a fluid restriction and/or renal diet that was the responsibility of dietary staff.

On 10/20/21, at 7:37 a.m. licensed practical nurse (LPN)-A stated she was not aware of any dressing or skin treatments ordered to monitor or assess for R42. LPN-A stated R42 was not on a special diet and further stated "just" an allergy to wheat flour and chocolate.

On 10/20/21, at 7:56 a.m. an interview with NA-C stated staff were to limit the amount of fluids R42 drank and confirmed R42 should not have a mug of water on her bedside table.

On 10/20/21, at 8:10 a.m. the second floor nursing station desk was observed with an envelope with R42's name and included the dialysis communication form from 10/19/21 and

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was blank and not filled out by the facility.

On 10/20/21, at 10:30 a.m. during a phone interview with registered nurse (RN)-B stated she was an RN at the dialysis facility R42 received dialysis at on Tuesdays, Thursday, and Saturday . RN-B indicated R42's dialysis access site was a right tunneled subclavian catheter placed and indicated the dialysis nursing staff change R42's dressing. RN-B further indicated the facility staff were expected to assess the dialysis site daily for signs and symptoms of infection and ensure the dressing was intact and notify dialysis of concerns.

On 10/20/21, at 11:03 a.m. an interview with the director of nursing (DON) indicated R42's care plan or medical record were expected to identify R42's dialysis facility, who to call for dialysis emergency, and expected staff send the facility's communication form filled out with the resident to dialysis. DON stated she was unaware of R42's care plan specific to dialysis.

On 10/20/21, at 11:59 a.m. an interview with LPN-A stated she was not aware if R42 had a dressing or dialysis catheter site and confirmed as the nurse she was expected to monitor and assess dialysis access sites and confirmed she was expected to be aware of R42's dialysis catheter site and location. LPN-A confirmed she was not aware of a dressing on the subclavian tunneled dialysis site for R42.

On 10/21/21, at 12:45 p.m. during an interview NA-B and TMA-B, NA-B indicated the facility's communication form that was sent with resident's to provider appointments was not expected to go with R42 from the facility to the dialysis center.

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However, TMA-B indicated the facility was expected to send R42 with a communication form to dialysis. NA-B stated she was not aware the communication form was expected to be sent to dialysis, but indicated the nurse or the NA would be responsible to send the form to dialysis with R42. NA-B confirmed with the health unit coordinator (HUC) and verified R42 had a communication form the HUC provided, and nursing or NAs were expected to fill out the form with information and sent with R42 to dialysis. NA-B confirmed the facility failed to send a communication form with the resident to dialysis.

On 10/21/21, at 11:47 a.m. the DON stated she was responsible for R42's care plan and stated she had not time to look at care plan to see if catheter care was on the care plan or included in the medical record. The DON stated she expected nursing staff to be aware of R42's dialysis access site location and monitor the site for signs and symptoms of infection, and expected the dialysis communication form filled out by staff and sent with R42 to dialysis

Policy titled Hemodialysis dated 4/13/21, indicated:
-Determine where the dialysis procedure will take place
-Obtain a clear understanding of roles and responsibilities between the facility and the dialysis center and define in writing this will include but not limited to the following:
- Responsibility of monitoring lab values
- How physicians orders will be validated
- How provider orders will be communicated during the nursing staff
-Assure daily assessment documentation of fistula or graft site

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F 698	Continued From page 45 -Monitor fluid status of residents and maintain fluid restrictions as ordered by the provider or dialysis center -Manage special dietary regime and dietary restrictions as ordered -Utilize dialysis center communication for continuity of care between the facility and dialysis	F 698		
F 725 SS=F	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced	F 725		12/1/21

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F 725	Continued From page 46 by: Based on observation, interview and document review, the facility failed to ensure sufficient staffing to provide routine assistance with activities of daily living (ADL's) of grooming, personal hygiene and for 2 of 2 residents (R4 and R11) who required assistance and were dependent on staff for ADL's, provide dignified dining experience for 6 of 6 residents (R215, R2, R44, R45, R60, R30) who required assistance with dining, provide treatment and services for non-pressure related skin concerns for 2 of 3 residents (R43, R4) who required assistance, monitor dialysis treatment, and fluid restrictions for 1 of 1 residents (R42) receiving hemodialysis. This deficient practice had the potential to affect all 64 residents who resided in the facility. Findings include: Interview on 10/18/21, at 3:25 p.m. R53 expressed concerns of short staffing. R53 stated her call light does not get answered timely when she needs assistance. R53 indicated it takes up to 45 minutes at times for the staff to come and assist her. R53 indicated it seemed worse on the weekends. Interview on 10/18/21, at 3:37 p.m. R4 expressed concerns of a facility staffing shortage. R4 indicated she has to wait for lengthily periods of time to get assistance after she puts her call light on. R4 stated the staff were always in a rush to take care of her because they had so many other residents to attend to. Interview on 10/18/21, at 5:33 p.m. R39 expressed concerns of short staffing. R39 stated the past 2 nights she had her call light on to	F 725	Immediate action: The Guardian Angel and weekend manager programs on duty were implemented by 12-1-2021 the program updated and improved which is our specific point of contact for every resident on a daily basis when available. These programs proactively solicit feedback from all residents and checks patient / resident room for housekeeping, infection control, safety etc. the programs observe and follow up on issues with approximately 50 items related to ADL's and c cognitively impaired resident be included to ensure care needs are met are housekeeping etc., cognitively impaired residents are included to and staff will observe and be proactive and anticipate residents needs and ensure care needs are met Also, action has been taken to help to enhance staffing and to ensure the deficient practice does not recur as of the survey as the center has obtained (hired) 4 to 5 Nurses and 4 to 5 certified nursing assistants from a combination of our staff and agency facility has completed their interview, orientation, and staff are in training process. Resident(s) involved: R4, R11, R215, R2, R44, R45, R60, R3, R43 and R42 all residents met with and reviewed by the DON or Executive Director or the guardian angel management team for adl's needs as soon as possible and before 12-1-2021. Dialysis's residents reviewed by DON, currently facility doesn't have any dialysis residents.	

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F 725	Continued From page 47 assist her with toileting. R39 indicated she was incontinent from head to toe. R39 indicated she yelled out loudly until the next door neighbor came and went to get help at the sedk but there was no one there or in the hall. R39 was unsure how long she had to wait, but it was at least 45 minutes During a resident council group interview on 10/20/21, at 10:00 a.m. R10, R11, R18, R21, R23, R24, R26, R34, R35, R42, R48, and R54 were in attendance. These residents expressed concerns related to staffing. The residents stated staff worked short a lot of the time. The residents indicated it took up to an hour for their call lights to be answered and assisted with their activities of daily living (ADL's) The residents indicated this occurred at various times of the day and happened at least daily. The residents further indicated staff were always in a hurry when assisting them, because they did not have the time to get everything done if they did not. The residents stated these concerns were brought forward to management months ago, but felt staffing had not improved. See the below deficiencies that were issued that included short staffing Refer to F550: The facility failed to provide a dignified dining experience for 6 of 6 residents (R215, R2, R44, R45, R60, R30) who required assistance with dining. Refer to F677: The facility failed to provide ADL (activities of daily living) care to 2 of 2 resident (R4 and R11) reviewed for ADLs and who were dependent upon staff for grooming.	F 725	Residents with Potential to be affected: All center residents who need routine assistance with activities of daily living (ADL's) of grooming, personal hygiene, dignified dining experience, treatment and services for non-pressure related skin concerns and monitoring dialysis treatment and fluids restrictions for those receiving hemodialysis are at risk to be affected. All residents will be part of the guardian angle program so the problem doesn't reoccur. The system change is The Guardian Angel program which accomplishes several objectives: Provide an additional "friend" or contact for the patient Get to know the patients better Proactively solicit feedback daily from all patients Communicate with patients' family regularly Act as a communication bridge for patients with other departments Check patient / resident room for housekeeping, infection control, safety issues. Education: Staff educated by the DON/Designee/Facility Staff by 12/1/2021 or before their next shift begins managers educated on the guardian angel program and all staff educated on sufficient staffing and what it means to be aware of and meet all the residents needs including but limited to person centered care Adl's, nail/shaving care infection=n control safety. Monitoring: To ensure ongoing compliance Audits, using Guardian Angel	

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F 725	Continued From page 48 Refer to F684. The facility failed to monitor, assess and provide treatment for non-pressure related skin concerns for 1 of 3 residents (R43) who had a skin wound, and failed to ensure activities of daily living (ADLs) were provided, including nail care, for 1 of 4 residents (R25) reviewed who were dependant on staff for activities of daily living. Refer to F684: The facility failed to comprehensively assess, monitor and implement interventions including completion of dressing changes and administer ordered antibiotic treatment for 1 of 3 residents (R43) with non-pressure related wounds. In addition, the facility failed to ensure elevation of swollen legs and utilization of compression wraps. In addition, the facility failed to ensure treatment orders were provided as ordered for 1 of 3 resident (R4) reviewed for wound care who was at risk for non-pressure related wounds, Refer to F698. The facility failed to monitor dialysis treatment, utilize communication form with dialysis, provide a comprehensive dialysis care plan to reflect emergency care, and monitor fluid restriction for 1 of 1 residents (R42) receiving hemodialysis. Interview on 10/19/21, at 2:25 p.m. registered nurse (RN)-A indicated she has worked at the facility for nine weeks and was an agency nurse. RN-A indicated hand off shift report was not received on residents on the second floor (east wing) at times. RN-A stated she was expected to assess R42's change in condition on 10/18/21, and did not have time due to the shortage of nurses and working short.	F 725	Rounds, 5 residents weekly x 8 weeks. Also results from the guardian angel rounds will be reviewed daily in the morning meeting also the DON/Designee review Guardian Angel audits weekly beginning the of 12-1-2021 and ongoing for at least three months. The results of the audits will be reviewed by the QAPI committee for trends and any needs for adjustment of audit schedules or content, as well as any further educational needs	

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Interview on 10/20/21, at 7:37 a.m. licensed practical nurse (LPN)-A indicated because of working short, she was not able to complete all resident treatments during her shift. LPN-A indicated she was the only nurse for the east and west wing on second floor and staffing should include a nurse for both wings. LPN-A indicated treatments included dressing changes. LPN-A further indicated nursing staff were expected to assess the electronic medical record (EMR) dashboard daily for resident alerts. LPN-A indicated the EMR residents alerts included when a resident had not had a bowel movement for 72 hours. LPN-A stated she was expected to monitor the dashboard daily. However LPN-A indicted she had not looked at the dashboard on a regular basis.

Observation and interview on 10/20/21, at 9:05 a.m. observed that not all residents that needed assist with eating were getting assisted with their meal. There were 2 staff assisting the residents. NA-E indicated the staff were short today because a NA had called in sick. NA-E indicated that was why there was not enough staff to assist the residents who needed help with eating breakfast. NA-E indicated on a regular day there are 2 NA's, a licensed nurse or a TMA on the 3rd floor and usually another staff person who is trained to assist with feeding. NA-E stated there was only 1 TMA and 1 NA working.

When interviewed on 10/20/21, at 9:22 a.m. trained medication aid (TMA)-B confirmed being short one nursing assistant (NA) on the third floor memory care unit that day. When asked if the facility ever floated staff from other floors to help TMA-B confirmed sometimes that happened. TMA-A further stated that probably wouldn't

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happen that day as the second floor was also "swamped" and only had three NA's working the floor when there should be four. Upon subsequent interview at 11:51 a.m., TMA-B confirmed neither she nor NA-E (the only other staff working on the third floor) had received a break that day. TMA-A further confirmed they had started their shift at 6:00 a.m. NA-E was also interviewed at that time as had just gotten off the phone attempting to call supervisory staff to request assistance with resident care. NA-E confirmed she was the only NA working on the third floor that shift and further confirmed residents weren't getting turned and toileted every two hours per their plan of care. NA-E further stated feeling like she wasn't doing her job and also was afraid for a resident who was impulsive with transfers and without another set of eyes feared he would fall. NA-E confirmed she had called called several different staff requesting assistance who either had not answered the call or had not gotten back to her.

During interview on 10/20/21, at 11:15 a.m., the director of nursing (DON) confirmed a NA had called in ill today, and was scheduled on the 3rd floor. The DON verified there were not enough staff to assist all residents that needed help with eating their breakfast, in a timely manner.

During a telephone interview on 10/21/21, at 9:02 a.m., RN-A was asked if she was aware of a new treatment for R4's skin using an acetic acid soak. RN-A stated she was not aware of this. Acetic acid soaks to R4's right lower extremity, right dorsum (top) foot, and right lower abdominal panniculus (a sheet of fat tissue in the lower abdominal area), twice a day for seven days had been ordered on 10/15/21. When brought to her

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F 725	Continued From page 51	F 725		

attention that she initialed performing the treatment twice on 10/18, RN-A stated, "I might have signed off on it at the end of the shift and not done it." RN-A further stated, "I didn't know about this order and we are constantly rushed; we can't do everything. Everyone is frustrated; I get done what I can." When asked if she washed R4's feet with soap and water, RN-A replied no. When informed she initialed that she did soak R4's feet several times this month, RN-A replied, "Okay." RN-A had not told the DON or administrator how she felt about her workload.

Interview on 10/21/21, at 10:00 a.m. RN-A indicated she was currently the only full time licensed floor nurse. RN-A indicated she often will work a double shift due to call ins or short staff.. RN-A stated last month the licensed nurse that was working on the 2nd floor resigned, and was replaced with a TMA. RN-A indicated there are 43 residents on the 2nd floor, and many of them have treatments that include dressing changes to wounds and pressure ulcers (PU), gastric tube feedings and include tracheostomies RN-A stated that not all treatments get done at times. RN-A further indicated that often there are only 3 NA's on the 2nd floor when there usual is 4 NA's, to take care of 43 residents.

Interview on 10/21/21, at 10:30 a.m., NA-B indicated she works the 2nd floor and is responsible for an average of 13-15 residents at a time. NA-B indicated she felt most resident cares were provided, but not always timely. NA-B stated when this happens the residents become anxious and upset. NA-A confirmed there is often 3 NA's to 43 residents on a daily basis.

Interview on 10/21/21, at 10:15 a.m. the facility

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F 725	Continued From page 52 human resource director (HRD) staff. confirmed there was a facility staffing shortage. The facility HRD s indicated they try and fill the shifts with on-call staff, contracted staff as well as double shifts. The facility HRD indicated the facility did not have a mandated requirement for staff to stay and cover the open shift if they were unable to replace the open shift, and then they staff work short. The facility HRD further indicated the facility offers incentives to fill in an open shift, to try and get it covered. The facility HRD indicated staffing is determined by acuity levels and census. The facility HRD indicated the facility has had a loss of staff to going back to school or resign in the past month. A total of 3 full time licensed staff and 3 full time NA's, who had not been replaced as of yet. The facility HRD stated they have reached out to contracted agencies, but found that they were short as well. The facility HRD further stated the have been recruiting in various ways but currently do not have any applicants. The current staffing schedules per acuity and census includes: Day shift- 2nd floor (2 licensed nurses and 4 NA's) Due to shortage 1 nurse has been replaced with a TMA Evening shift-2nd floor (2 licensed nurses and 4 NA's) Due to shortage 1 nurse has been replaced with a TMA Night shift- 2nd floor (1 licensed nurse and 2 NA's) There are 43 residents on the 2nd floor Day shift-3rd floor (1 licensed nurse and 2 NA's) Due to shortage 1 nurse has been replaced with a TMA	F 725		

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F 725	Continued From page 53 Evening shift-3rd floor (1 licensed nurse and 2 NA's) Due to shortage 1 nurse has been replaced with a TMA Night shift-3rd floor (1 licensed nurse and 1 NA) There are 21 residents on the 3rd floor Review of the schedule for the past 3 months (from 8/1/21 to 10/18/21), noted there were 32 open shifts that had not been replaced and 20 shifts for staff call ins. Staff overtime hours: 8/21- 193.59 9/21- 149.59 10/21-10/20/21- 58.08 Current opening for NA's: Day shift- 3 full time NA's Evening shift- 3 full time NA's Nights- 1 full time NA Current opening for licensed staff: Day shift- 4 full time nurses Evening shift- 4 full time nurses Night shift- 2 full staff nurses Nurse managers: 2 full time nurses Interview on 10/21/21, at 11:30 a.m. the DON confirmed the above interview with the facility HRD. The DON indicated in the past month they have had several staff resign or go back to school that had been seasonal. The DON indicated contracted staff are utilized but there are very few because they are short staffed as well. The DON confirmed the staffing schedule for each floor that was identified above, and that	F 725		

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not always are they fully scheduled due to call ins or open shifts that that could not be replaced. The DON indicated they try to replace these open shifts with contracted staff, on-call staff and part-time staff before they ask the full time staff. The DON indicated they offer all staff incentives for picking up additional hours as well. The DON indicated she had not been aware of staff not completing their work or not providing cares because of being short. The DON indicated she was aware that during shortage times, residents were not always assisted with meals timely. The DON indicated they try and do the best that they can to replace staff. The DON indicated all 3 of the nurse managers had resigned, otherwise they would assist with meals when short. The DON indicated she was unsure of what more they could do, because they had already closed the 1st floor short term care unit.

Review of the Facility Assessment Tool updated on 10/18/21, included the following:
73 residents requiring assistance with dressing, 51 with bathing, 55 with transfers, 40 with eating, 74 with toileting and 25 with mobility needs. The staffing plan indicated a 1:22 ratio of licensed staff for day shift and evening shift and 1:40 on the night shift. For direct care staff (NA's) 1:10 on 2nd floor day and evening shift and 1:8 on the 3rd floor. The ratio on the night shift is 1:14. The assessment indicated staff assignments are kept as consistent as possible working within individual staff members scheduled hours and maintaining appropriate trained staff in each area

Policy titled Nurse Staffing dated October 2017, indicated
-Our facility provides sufficient numbers of staff with the skills and competency necessary to

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F 725	Continued From page 55 provide care and services for all residents in accordance with resident care plans and facility assessment. Staffing requirements :a nursing home must have on duty at all times of sufficient number of qualified nursing personnel including registered nurses, licensed practical nurses, and nursing assistants to meet the needs of all the residents at the nurses station . Review of a facility policy Nursing Staffing Sufficiency dated 6/1/17, indicated nursing staff is efficient for each unit if: -if there is adequate staff to meet direct care needs, assessments and supervision -the workloads for direct care staff are reasonable -residents and family do not report insufficient staff meeting needs of the residents -staff are responsive to resident needs with call lights being answered promptly -the facility ensures each resident receives nursing care in accordance with his/her plan of care -sufficient nursing staff contribute to identified quality of care and life.	F 725		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide	F 755		12/1/21

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F 755	Continued From page 56 pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to implement a system to ensure controlled medications were accurately reconciled prior to destruction to prevent potential loss or diversion. This practice had the potential to affect the 6 residents identified for destruction of medications. Findings include: During observation and interview on 10/21/21, at 10:12 a.m., during tour of second floor medication room, trained medication assistant (TMA)-B indicated narcotics are destroyed at the time they are removed from the cart and is documented on the "Resident Controlled Substance Record" on	F 755	F-755 (D) It is the policy of the facility to ensure controlled medications are accurately reconciled prior to destruction to prevent potential loss or diversion. Action Taken: Re-education was provided to all nurses on the medication destruction policy and procedure including proper procedure for documenting medication destruction. Post test was also completed to demonstrate competency from nursing staff. Resident(s) involved: (none listed on SOD)	

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F 755	Continued From page 57 the bottom portion, in a separate box titled "Medication Disposition Record" (MDR). Once the book is full, it is turned into the director of nursing (DON) who maintains the records. Upon review of the narcotic destruction book, multiple entries were noted to not be completed in the MDR section of the form. TMA-B confirmed they were incomplete and indicated she was told to fill out the bottom portion which included date, quantity destroyed, quantity sent with resident, 2 nursing signatures and comment section. Review of Resident Controlled Substance Record MDR section revealed: -Oxycodone 5 mg, 18 received. No administrations were listed. Discontinued date of 5/28/21 with 2 staff signatures. No date of destruction, quantity destroyed or reconciliation of amount remaining was completed. -Hydromorphone 1 mg half tab, with amount received 26 1/2 tablets. Ten entries were present with last listed as 5/16/21 at 10:24 p.m. with 17 remaining tablets which was crossed out. Previous entry was 5/16/21 at 12:20 a.m., with 18 tablets remaining. Medication discontinue date was not included. Destroyed date was 5/17/21 with 2 unreadable signatures present. No quantity destroyed or reconciliation of amount remaining was completed. -Hydromorphone 1 mg/ml (liquid) with 60 ml's received. Thirty administrations occurred with amount remaining documented as 30 ml's. A date of 5/17/21 was present and destroyed written with 2 unreadable signatures present. No quantity destroyed or reconciliation of amount remaining was completed.	F 755	Residents with Potential to be affected: All center residents who have orders for controlled substances are at risk to be affected. Education: Nursing staff educated by the DON/Designee by 12/1/2021 or before their next shift begins on the proper system for medication destruction policy and procedure including proper procedure for documenting medication destruction to ensure doesn't reoccur. Monitoring: To ensure ongoing compliance the DON/Designee/Facility Staff to complete audits weekly beginning the week of 12-1-2021 and ongoing weekly for 8 weeks. Destruction of controlled medication record will be audited to verify completion and accuracy of task and documentation, including presence of two nurses .The audits will be on destruction of controlled medication record. The results of the audits will be reviewed by the QAPI committee for trends and any needs for adjustment of audit schedules or content, as well as any further educational needs. 12/1/2021	

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F 755	Continued From page 58 -Hydromorphone 1 mg (1/2 tab) with amount received documented as 30. Zero entries to administration was present. Medication discontinued and destroyed with date of 5/17/21 and two unreadable signatures present. No quantity destroyed or reconciliation of amount remaining was completed. -Lorazepam 2mg/1 ml (liquid) with 30 ml's received and 2 entries for administration present. Destroyed 5/17/21 present with 2 unreadable signatures. No quantity destroyed or reconciliation of amount remaining was completed. -Oxycodone 5 mg with 10 received. No entries present for administration. Discontinued 5/25/21 present with unreadable signatures. No date quantity destroyed or reconciliation of amount remaining was completed. During interview on 10/21/21 at 11:15 a.m., the director of nursing confirmed staff are required to have 2 nursing staff count and reconcile medication amount remaining by counting and comparing with quantity to be destroyed prior to destruction of narcotic medications. The DON further confirmed their process included completing the bottom portion of the Resident Controlled Substance Record, which she confirmed on the above entries was not completed. A policy on destruction of narcotic medications was requested and not received.	F 755		
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6)	F 757		12/1/21

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F 757	Continued From page 59 §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to provide rationale related pharmacist recommendation for a gradual dose reduction (GDR) of omeprazole (a proton pump inhibitor that decreases the amount of acid produced in the stomach), and Tessalon Perles (a medication used to suppress coughs) for 2 of 5 residents (R23, R30) reviewed for unnecessary medications. Findings include: R23's Admission Record (face sheet) printed 10/21/21, indicated an admission date of 11/3/20, and diagnoses including dementia with Lewy	F 757	F-757 (D) It is the policy of the facility to provide rationale related pharmacist recommendations for gradual dose reduction (GDR) of omeprazole and Tessalon Perles, potential unnecessary medications. Action Taken: R23 and R30 pharmacist consultant recommendations were reviewed with their primary physician. Recommendations were addressed and orders received.	

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F 757	Continued From page 60 bodies and interstitial pulmonary disease (a disease causing scarring of the lungs). R23's Order Summary Report printed 10/21/21, indicated an order for Tessalon Perles capsule, give 100 mg (milligrams) by mouth two times a day for cough. R23's Note to Attending Physician/Prescriber, dated 8/19/21, indicated a recommendation by the consulting pharmacist to decrease Tessalon Perles to 100 mg by mouth daily. R23's medical record did not include evidence the physician had responded to the recommendation or provided rationale for continued use. R30's Admission Record printed 10/21/21, indicated an admission date of 4/3/19, and diagnoses including gastro-esophageal reflux disease (GERD-occurs when the lower esophageal sphincter (LES) does not close properly, so stomach contents leak back, or reflux, into the esophagus), and other specified disorders of bone density and structure. R30's Order Summary Report printed 10/21/21, indicated an order for omeprazole capsule delayed release. Give 20 mg by mouth one time a day for GERD. R30's Note to Attending Physician/Prescriber, dated 3/23/20, indicated a recommendation by the consulting pharmacist to reduce omeprazole dose to 20 mg by mouth daily on Monday, Wednesday, and Friday for six doses then discontinue. Monitor for GI (gastro-intestinal) symptoms. R30's medical record did not include evidence the physician had responded to the recommendation or provided rationale for	F 757	Resident(s) involved: R23 and R30 Residents with Potential to be affected: All center residents who have orders for potentially unnecessary medications are at risk to be affected. Director nursing reviewed all unaddressed pharmacist recommendations with the pharmacist. All of these recommendations presented to the physicians and addressed. Education: Director of Clinical Services provided education to the Director of Nursing on procedures for the pharmacist consultant recommendations. Including amount of time physician must review and respond to the recommendations and what to do if the center is having difficulty getting physician to review and respond to recommendations. Monitoring: To ensure ongoing compliance the DON/Designee to complete audits on 5 residents monthly for completion of gradual dose reductions/pharmacist recommendations x 3 months. The results of the audits will be reviewed by the QAPI committee for trends and any needs for adjustment of audit schedules or content, as well as any further educational needs. 12/1/2021	

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F 757	Continued From page 61 continued use. When interviewed on 10/21/21, at 4:55 p.m. the director of nursing (DON) confirmed the physician had not addressed the recommendation for reduction for R23's Tessalon Perles and R30's omeprazole. DON further stated during the Covid-19 pandemic it had been difficult to get a response back from the physician related to pharmacy recommendations. The policy titled, Unnecessary Drugs, dated 6/1/18, indicated: An unnecessary drug is any drug when used: 1. In excessive dose (including duplicate therapy) or 2. For excessive duration or 3. Without adequate monitoring or 4. Without adequate indications/reason for its use or 5. In the presence of adverse consequences which indicate the dose should be reduced or discontinued or 6. Any combination of the reasons above.	F 757		
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---	F 758		12/1/21

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F 758	Continued From page 62 §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a 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 monitor for abnormal involuntary movements for 2 of 4 residents (R23, R39) reviewed on anti-psychotic medication.	F 758	F-758 (D) It is the policy of the facility to monitor for abnormal involuntary movements for residents on anti-psychotic medication. Action Taken: The task of scheduling the	

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F 758	Continued From page 63 Findings include: R23's Diagnosis Report printed 10/21/21, indicated diagnoses including dementia with Lewy bodies (abnormal deposits of a protein which leads to problems with thinking, movement, behavior, and mood), and dementia with behavioral disturbance. R23's quarterly Minimum Data Set (MDS) assessment dated 8/13/21, included a brief interview for mental status (BIMS) score of 13 indicating intact cognition. The MDS further indicated the resident received an antipsychotic medication daily. R23's Order Summary Report printed 10/21/21, indicated an order for Seroquel (an anti-psychotic medication) 12.5 mg (milligrams) by mouth one time daily; and Seroquel 25 mg by mouth at bedtime. R23's care plan printed 10/21/21, indicated the resident had an order for anti-psychotic medication with potential for associated drug related complications. Interventions included to complete an AIMS (abnormal involuntary movement scale) baseline assessment and every 6 months per facility protocol. Further review of R23's medical record revealed the last AIMS assessment had been completed on 11/27/20. R23's Nursing Recommendations form from the consulting pharmacist dated 9/27/21, indicated R23 had a current order for Seroquel. The form further indicated that antipsychotics require routine monitoring for adverse events such as Tardive Dyskinesia (involuntary and repetitive body movements). The standard of practice is to	F 758	Abnormal Involuntary Movement Scale assessment for nurses to assess during MDS reference period at admission, quarterly, and with change in condition. The Director of Nursing will review the order listing report daily for new anti-psychotic medication orders and will complete an assessment with all new orders for a baseline assessment. Resident(s) involved: R23 and R39 now have a completed Abnormal Involuntary Movement Scale assessment. Residents with Potential to be affected: Center residents who have orders for anti-psychotics are at risk to be affected. All residents with these orders have been reviewed for the completion of Abnormal Involuntary Movement Scale assessment. Education: Nursing staff educated by the Director of Nursing/Designee/Facility Staff by 12/1/2021 or before their next shift begins. Monitoring: To ensure ongoing compliance the Director of Nursing/Designee to Audit 5 residents, who have orders for anti-psychotic medications monthly for completion of Abnormal Involuntary Movement Scale assessment if indicated x 3 months. The audits will be reviewed by the QAPI committee for trends and any needs for adjustment of audit schedules or content, as well as any further educational needs. 12/1/2021	

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F 758	Continued From page 64	F 758		

obtain a baseline abnormal involuntary movement (AIMS) assessment at baseline and at least every 6 months thereafter. Recommendation to complete AIMS assessment.

R39's Admission Record (face sheet) printed 10/21/21, indicated an admission date of 8/25/21, and diagnoses including dementia with Lewy bodies and hallucinations.

R39's admission MDS assessment dated 9/1/21, included a brief interview for mental status (BIMS) score of 6 indicating severe cognitive impairment. The MDS further indicated the resident received an antipsychotic medication daily.

R39's Order Summary Report printed 10/20/21, included orders for Seroquel 50 mg by mouth one time daily; Seroquel 75 mg by mouth at bedtime; and Seroquel 25 mg by mouth as needed for overnight behavioral dyscontrol.

R39's Nursing Recommendations form from the consulting pharmacist dated 9/27/21, indicated R39 had a current order for Seroquel. The form further indicated that antipsychotics require routine monitoring for adverse events such as Tardive Dyskinesia. The standard of practice is to obtain a baseline abnormal involuntary movement (AIMS) assessment at baseline and at least every 6 months thereafter. Recommendation to complete AIMS assessment for this new admission.

When interviewed on 10/21/21, at 4:53 p.m. the director of nursing (DON) confirmed R23's last AIMS assessment was conducted on 11/27/20 (almost one year ago) and R39's medical record did not include evidence an AIMS assessment

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F 758	Continued From page 65 had ever been completed. A policy on anti-psychotic medication monitoring was requested but not received by the end of the survey.	F 758		
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 and interview, the facility failed to ensure doses of controlled substances were stored in a manner to reduce the risk of	F 761	F-761 (D) It is the policy of the facility to ensure doses of controlled substances are stored in a manner to reduce the risk	12/1/21

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F 761	Continued From page 66 theft and/or diversion in 1 of 3 refrigerators and emergency kit (E-kit) observed for medication storage. This had the potential to affect all residents in the facility. Findings include: During tour of medication room on second floor on 10/21/21, at 10:12 a.m., trained medication aide (TMA)-B opened the medication room door with a key. TMA-B indicated the director of nursing (DON) and the nurses working for the day, have keys to the medication room. When requested to open the refrigerator, TMA-B used a key on a chain bolted to the side of the refrigerator to open the paddle lock on the refrigerator door. Inside the refrigerator, was a liquid bottle of lorazepam intensol (a schedule IV, controlled medication) 2mg/ml. TMA-B indicated they used to have the locked refrigerator key on their key ring with the door key, but a few years ago, they got attached to the refrigerator. Tour of nurses station, and three medication storage room at 11:11 a.m. also included a key to open the paddle lock on refrigerator door affixed to refrigerator. During observation and interview on 11/20/21, at 11:20 a.m., the director of nursing (DON) entered nurses station floor 1 medication room with a key. A paddle lock was present on the refrigerator and the key was attached to the refrigerator, which the DON used to open the refrigerator. The refrigerator was empty and the DON indicated the medication room on floor 1 was currently not in use for residents medications at this time, however, did store the E-kit. During interview on 11/20/21, at 11:25 a.m., the	F 761	of theft and/or diversion. Actions: Keys were removed from side of refrigerators containing controlled medications and Ekit. The nurse now secures the key to the medication room and the lock on the refrigerators containing controlled medications and Ekit. A procedure requiring all entry and securement of the EKit to be verified by two nurses. A log is now in place to document this procedure. Resident(s) involved: (none listed on SOD) Residents with Potential to be affected: Potential to affect all residents in the facility. Education: Nursing staff educated by the DON/Designee/Facility Staff by 12/1/2021 or before their next shift begins. Monitoring: To ensure ongoing compliance the DON/Designee to complete audits weekly beginning the and ongoing for at least three months. The results of the audits will be reviewed by the QAPI committee for trends and any needs for adjustment of audit schedules or content, as well as any further educational needs. 12/1/2021	

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F 761	Continued From page 67 DON indicated the E-kit is paddle locked and the only way to access the E-kit is by filling out a form titled "Emergency Kit/Order Usage Form" and faxing it to the pharmacy then phoning the pharmacy and receiving the paddle lock code. The DON confirmed since floor 1 is empty, the E-kit isn't verified as present or locked and secured as there is no way to access the E-kit without pharmacy approving and giving the code. Upon inspection of the E-kit, 2 compartments were present that included upper tray and lower box. Two secure holes to hook the paddle lock through was present with the paddle lock securing only the bottom box. A snap lock was present on the top tray, which was opened and revealed alprazolam (schedule IV) 0.25 mg, clonazepam (schedule IV), lorazepam (schedule IV), pregabalin (class V) and tramadol 50 mg (schedule IV). The five medications are included on the Drug Enforcement Administration, Diversion Control Division list of controlled substances and regulated chemicals. The DON indicated staff must have missed securing the paddle lock to the upper tray only securing the bottom box and confirmed the controlled medications were not double locked. The DON indicated this is a newer process for staff and she would contact the pharmacy to get this remedied. A policy titled "Storage of Medication" dated 6/1/17 included: -All controlled drugs are stored under double-lock and key.	F 761		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must -	F 812		12/1/21

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F 812	Continued From page 68 §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure dishwashing sanitization was appropriately monitored. In addition, the facility failed to date-mark opened containers of food in a kitchen refrigerator and to ensure pans were completely dry before storing. Furthermore, the facility failed to ensure an adequately trained dietary supervisor oversaw and supervised all aspects of dietary services and ensured dietary cooks and aides received comprehensive training upon hire and on-going. This had the potential to affect all 65 residents who were served food from the kitchen. In addition, the facility failed to ensure proper infection control practices were followed while preparing food for 7 of 7 residents (R216, R2, R37, R38, R16, R215 and R44) and while assisting residents with their meal (R215) during 1 of 3 meals observed.	F 812	F-812 (F) It is the policy of the facility to ensure dishwashing sanitization is appropriately monitored, opened food is dated in kitchen refrigerator and pans are completely dry before storing. It is also the policy of the facility to ensure an adequately trained dietary supervisor oversees and supervises all aspects of dietary services and ensures dietary cooks and aides receive comprehensive training upon hire and ongoing. This includes proper infection control practices being followed while preparing, serving and assisting residents with their meals. Immediate actions: Paper products used in the kitchen for residents until Ecolab service tech who services dish machine could service the machine which was the next day. All machines were inspected	

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F 812	Continued From page 69 Findings include: During the initial kitchen observation and interview on 10/18/21, at 1:45 p.m., observed dietary aide (DA)-C placing dishes through the Ecolab dishmachine. Rinse dial indicated a temperature of 130 degrees Fahrenheit (F) and wash dial was at 158 degrees F. A vial of Ecolab chlorine test paper strips were noted on top of the dish machine. The cap was off the vial, the vial was dusty and the paper label on the vial was faded to gray. The strips expired on 10-1-20. DA-C did not know if the dish machine sanitized dishes with hot water or chemical. During an interview and observation on 10/18/21, at 1:59 p.m., while standing in the dishmachine room, cook (C)-C stated he did not know if the dish machine sanitized with hot water or chemical. C-C provided a clipboard with a form titled Dish Machine Log for October 2021. The log had 13 columns for date, wash and rinse temperatures, ppm (parts per million) and staff initials for each meal service of breakfast, lunch and dinner. The logs for October and September were reviewed and noted that all of the readings were basically the same, three times a day for two months. C-C stated he did not write on this log -- another cook and the manager did. C-C pointed to the bottom of the log which indicated temperature and ppm standards of: High temp wash 150 - 160 F. High temp rinse 180 F. Chemical sanitizing (low temp): Wash 120-140 F. Rinse 120-140 F. Manufacturer recommended PPM: _____ (no number was written in this blank).	F 812	and are in good working condition. All expired temperature strips were disposed of and replaced with strips that were not expired. An audit of all opened food was completed to determine that all were within time according to the safe food storage guidelines. Dietary manager and all staff educated by district manager or designee on proper procedure for checking temperature of dish machine, food labeling, food stacking and drying and education on proper infection control practices are being followed while preparing, serving and assisting residents with their meals. Temperature monitor log was revised to include target temperature range for the dishwasher and direction to staff on what to do if the temperature is not in range. A procedure is posted near the dish washer with directions on how to properly check temperatures of the dishwasher; including checking expiration dates of temperature strips. Resident(s) involved: R216. R2. R37. R38, R16, R215 and R44 the facility staffed immediately educated to date-mark opened containers of food in a kitchen refrigerator and to ensure pans were completely dry before storing. the facility failed to ensure an adequately trained dietary supervisor oversaw The dietary manger was trained in aspects of dietary services and ensured dietary cooks and aides received comprehensive training upon hire and on-going by the regional manager or designees. And staff was educated on proper infection control	

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F 812	Continued From page 70 Standing in front of the dish machine, C-C explained the temperature readings on the dials. When ask how the ppm reading was obtained, C-C stated he didn't know how to measure that. The facility policy was requested, and C-C presented a policy titled Warewashing, revised date of 9/2017, which indicated the dining services staff would be knowledgeable in the proper technique for processing dirty dishware, but it did not provide guidance on how to measure ppm for chemical sanitization of dishware. During a telephone interview on 10/18/21, at 2:47 p.m., the Ecolab representative (ER)-G stated the facility used chemical to sanitize dishes in their dish machine. During an interview and observation on 10/18/21, at 2:50 p.m., with C-C, multiple jelly roll pans were stacked one on top of another, upside down. C-C was asked to pick up a few of the top pans and the top two were still wet on the inside surface. Three multi-tiered wire carts that held pans and other kitchenware, did not have a solid bottom shelf. Multiple plastic cutting boards were observed stacked vertically, one against the other. During an interview and observation on 10/19/21, at 12:08 p.m., (C)-B stated chemical was used in the dish machine to sanitize dishes. While standing in front of the dish machine, C-B was asked how ppm of the chemical sanitizing solution was measured, and he replied they used the test strips that were on top of the dish machine. C-B admitted it did not look like the test strips had been used in a while and verified they	F 812	practices while assisting residents with their meal during 1 of 3 meals observed. Residents with Potential to be affected: All residents at the facility are at risk to be affected. Education: All dietary staff re-educated again on before the next shift by the DON/Designee/Facility Staff/designee by 12/1/2021 or before their next shift begins on proper use of dish machine, and also education on Staff Testing Dishwashing Temps and Recording Properly on Log Checking Temp Strips f food labeling or Expiration Date Proper Drying/Stacking of Dishes Labeling and Food Storage weekly beginning the week of 12-1-2021 3 times weekly and ongoing for at least three months. proper infection control practices are being followed while preparing, serving and assisting residents with their meals. All staff educated on hand washing procedure and frequency. Hand washing competency completed on 12/1/21 or by their next shift. Monitoring: To ensure ongoing compliance the DON/Designee/ Facility staff to complete audits All dietary staff re-educated again on before the next shift by the DON/Designee/Facility Staff/designee by 12/1/2021 or before their next shift begins on proper use of dish machine, and also education on Staff Testing Dishwashing Temps and Recording Properly on Log Checking Temp Strips f food labeling or Expiration Date Proper Drying/Stacking of Dishes	

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F 812	Continued From page 71 had an expiration date of 10/1/20. C-B then admitted he did not know how to test ppm, even though he admitted to writing 100 ppm and initialing the dish machine log on multiple days in October. During an interview and observation on 10/19/21, at 12:48 p.m. dietary manager (DM)-A stated chemical was used in the dish machine to sanitize dishes. When asked how the ppm of the chemical sanitizing solution was determined, DM-A stated with strips. DM-A then admitted she did not know how to test ppm and admitted she wrote 100 ppm on the log and initialed it, but didn't actually test the ppm. Together viewed the Ecolab chlorine test paper strips on top of the dish machine and DM-A verified they had expired on 10/1/20. DM-A went to her office and took a padded mailing envelope out of a desk drawer and displayed testing strips, including Ecolab chlorine test paper strips, adding she was aware of these, but did not know what they were for. DM-A stated she would contact Ecolab for training. During an interview and observation on 10/19/21, at 1:40 p.m., the administrator was brought to the kitchen and explained staff did not know how to do required testing to measure chemical sanitation and that staff had been documenting ppm on the dish machine log without actually testing it. The administrator stated the kitchen staff were contracted workers and have had a lot of turn over, and the current staff had not received adequate training. The administrator stated he would contact Ecolab to do staff training as soon as possible. During an interview and observation 10/19/21, at	F 812	Labeling and Food Storage weekly beginning the week of 12-1-2021 3 times weekly and ongoing for at least three months. proper infection control practices are being followed while preparing, serving and assisting residents with their meals. All staff educated on hand washing procedure and frequency. Hand washing competency completed on 12/1/21 or by their next shift. weekly beginning the week of 12-1-2021 3 times weekly and ongoing for at least three months. The results of the audits will be reviewed by the QAPI committee for trends and any needs for adjustment of audit schedules or content, as well as any further educational needs. 12/1/2021	

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F 812	Continued From page 72	F 812		

2:02 p.m., with C-B in the walk-in refrigerator, observed a large white pail of Papettis brand table-ready, peeled hard boiled eggs; 25 pounds in liquid. The pail had been opened, but had no date-opened marking. C-B stated they were good for seven days after opening and thought the pail was opened on 10/14/21. Other foods without date-opened markings included cooked macaroni in a plastic container with cover and ham slices in a plastic container with cover. C-B removed the macaroni and ham from the refrigerator, stating they should have been marked when placed in the refrigerator and would discard them.

During an interview on 10/19/21, at 2:11 p.m., C-B stated the hard boiled eggs were good until the manufacturer date of 11/21. At 2:21 p.m., with DM-A and C-B, C-B stated he called his boss and was told the eggs were good for seven days and since they could not confirm the date opened, would discard them.

During an interview on 10/20/21, at 10:12 a.m., DM-A stated she spoke to her district manager on the phone and received instructions on how to test ppm on the dish machine sanitization solution and would be training the rest of the kitchen staff. DM-A explained that the district manager told her to dip an (unexpired) Ecolab chlorine test paper into water that was on dishes that had just come through the dish machine. DM-A stated she had done that and recorded 50 ppm on the dish machine log. When asked what the required ppm was, DM-A stated she did not know. Requested DM-A to run a test load and measure the ppm with the Ecolab chorine test strips. When doing so, the sanitizing solution failed, testing at 10 ppm, verified by DM-A.

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F 812	Continued From page 73	F 812		

During an interview on 10/20/21, at 11:32 a.m., the administrator was informed when DM-A measured the ppm of the sanitizing solution in the dish machine, it failed. The administrator stated he would contact Ecolab again and have kitchen staff start using disposable dishware for meal service in the meantime.

During a telephone interview on 10/21/21, at 8:40 a.m., registered dietician (RD)-H stated she worked part-time on Mondays and as needed remotely, for the dietary contracted service like the rest of the dietary workers. Has ServSafe certification. RD-H stated she did not really provide guidance to the dietary staff, but was there for questions. RD-H stated she did monthly sanitation audits and had been focusing on hand hygiene within the kitchen. RD-H stated she learned about dish machine temperatures as part of her education, but did not know proper temperatures for heat or ppm for chemical sanitization. RD-H stated she looked at the dish machine log to make sure staff were recording the information, but would not be able to identify incorrect water temperatures or ppm.

During a telephone interview on 10/21/21, at 12:31 p.m., the district manager for the contracted service (DMCS)-I stated she was also a registered dietician. DMCS-I stated DM-A started on 8/2/21, adding that DM-A was initially hired as a manager-in-training to go through their training program. DMCS-I stated that the prior manager had not worked out so DM-A had been put into the manager position, adding "she is a go-getter." DMCS-I stated she was onsite initially to train DM-A, and when she needed help with the dish machine this week, DM-A called her and she walked her through it. Furthermore, DMCS-I

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stated she oversaw this account and DM-A's training was through her, adding it's been "Training on the fly - she calls and asks questions; I've been there as much as I can." DMCS-I was informed DM-A and C-B had admitted they did not know how to measure ppm and and did not actually check ppm on the dish machine, yet they filled in the ppm on the log. DMCS-I stated the expectation was for staff to be properly trained on monitoring and measuring temperatures and ppm on the dish machine, and not to falsify information if they didn't know how to do something. DMCS-I could not recall specially if she trained DM-A on this, nor could she confirm if either DM-A or C-B had this training online. DMCS-I stated there was no orientation record or checklist, but would provide online training records.

Review of online training records for DM-A, C-B and C-C indicated completion of the following modules:
1. Cleaning and Sanitizing: content included using a cleaning solution in a bucket to clean surfaces.
2. Pots and Warewashing: content included a chemical sanitizing agent would be mixed with the final rinse water and sprayed onto to the Ware during the final rinse cycle. The temperature of the water and sanitizer mixture must be maintained at a temperature no lower than 120. Defer to the manufacturers guidelines and state/federal regulations. The training did not include guidance for monitoring and measuring ppm. This training also included a section on "wet nesting" which occurred when clean pans, plates, cups, and bowls were stacked together without completely drying first. This action could result in a breeding ground for bacteria, even on clean items.

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F 812	Continued From page 75 3. Receiving and Storage of Food: content included receiving and storing refrigerator foods. 4. Labeling and Dating: content included labeling and dating leftovers with the dated prepared and the use-by date. During an interview on 10/21/21, at 3:58 p.m., reviewed kitchen findings with the administrator, including lack of knowledge to monitor and measure sanitization solution of dish machine, wet pans, and food not labeled when opened. The administrator stated he expected the staff would have had the required training for these things, but they have had so much turnover and it had been difficult to secure trained staff. The administrator stated with a contracted service, they had to work with whomever the service hired. In addition, the administrator stated that based on interactions with DM-A thus far, he believed she would be a good manager as she is responsive and is on top of things, and just needed more time and training. Facility policy titled Warewashing, with revised dated of 9/2017, indicated all dishware would be cleaned and sanitized after each use. Staff would be knowledgeable in the proper technique for processing dirty dishware through the dish machine and proper handling of sanitized dishware. All dish machine water temperatures would be maintained in accordance with the manufacturer recommendations for high or low temperature machines. Temperature and/or sanitization concentration logs would be completed as appropriate, and that all dishware would be air dried and properly stored. Facility policy titled Receiving, with revised dated of 9/2017, indicated safe food storage procedures	F 812		

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for time and temperature control would be practiced in the transport, delivery, and subsequent storage of all food items. All food items would be labeled and dated either through manufacturer packaging or staff notation.

Facility policy titled Food Storage: Cold Foods, with revised dated of 9/2017, indicated all food would be stored in wrapped or covered containers, labeled and dated.
Infection Control Practices

During observation on 10/20/21, at 8:13 a.m. transport assistant (TA) was observed seated at table with R30 encouraging her to eat. TA picked up a piece of bacon with her bare hands and handed it to the resident then continued to feed R30 oatmeal with a spoon. At 8:15 a.m., TA again was observed picking up apiece of bacon with her bare hands and handing it to R30 to eat.

On 10/20/21, at 8:29 a.m. TA washed hands then sat down at another table in the dining room to assist R215. TA was observed to cut up R215's bacon using bare hands to secure the bacon while trying to cut it in bite-size pieces.

When interviewed on 10/20/21, at 9:26 a.m. TA confirmed she should not have been touching the bacon with her bare hands when assisting residents with eating.

On 10/20/21, at 12:48 p.m. NA-E was observed delivering a Styrofoam container to R38 with the resident's lunch. The meal included two soft shell tacos. NA-E picked up one of R38's taco's with her bare hands and demonstrated to R38 how to pick it up and eat it. NA-E then placed the taco back into the container, washed her hands, then

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continued to pass out meals to other residents.

During observation on 10/20/21, at 12:44 p.m., nursing assistant (NA)-E served R216 tacos in a Styrofoam container with ground beef, tomatoes, lettuce all in separate serving cups and soft taco shell on bottom of container. NA-E used fork to put ingredients on the taco shell, then added sour cream. NA-E then picked up the soft taco shell and molded them closed with her bare hands and demonstrated for the resident how to pick it up. Did not observe hand hygiene after touching Styrofoam container and touching food, or between residents. The process was repeated for R2, R37 and R16.

During observation on 10/20/21, at 1:16 p.m., NA-E opened R215's Styrofoam container with soft shell taco shell, ground beef, tomatoes, lettuce in separate serving cups. NA-E used a fork to put ingredients on taco shell, then added sour cream in an individual packet and spread with the fork. NA-E picked up taco shell with her bare hands molding it closed and offered R215 a bite of the taco. NA-E continued to use bare hands on taco to assist R215 to take 3 bites of taco. NA-E then set down taco, cut taco in half and using both hands offered another bite. NA-E then took R215's hands and put them on the taco shell and R215 attempted to take a bite but taco fell apart. NA-E using her bare hands took the taco from R215 and gave her 3 more bites and removed Styrofoam container picking up the banana bread with her hands and sitting it on a napkin in front of R15.

During observation on 10/20/21, at 1:31 p.m., NA-E sat down by R44, opened Styrofoam container then touched the top of the straw with

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F 812	Continued From page 78 her bare hands and offered a drink of juice. R44 took a drink of the juice. During interview on 10/21/21, at 4:10 p.m., the director of nursing (DON) confirmed staff should never touch food directly with their hands whether washed or unwashed unless they have gloves on or are using a pair of silverware or tongs. A facility policy titled Dining Services Department Policy and Procedure Manual last revised 9/2017, did include infection control considerations but only included the nursing staff shall be responsible for verifying meal accuracy and delivery of meals to residents/patients.	F 812		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment	F 880		12/1/21

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F 880	Continued From page 79 conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of	F 880		

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F 880	Continued From page 80 infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to follow Centers for Medicare and Medicaid Services (CMS) and Centers for Disease Control (CDC) guidelines by appropriately implementing measures to prevent the spread of COVID-19 when the facility failed to ensure personal protective equipment (PPE) including masks, were worn correctly by dietary staff, and failed to ensure hand hygiene was performed by staff when delivering meal trays. In addition the facility failed to ensure hand sanitizer was available for hand hygiene. In addition, the facility failed to ensure room cleanliness when maggots were discovered in the shoe and on the foot of 1 of 1 resident (R4), reviewed for wound care. Furthermore, the facility failed to ensure proper infection control practices during a dressing change for 1 of 1 resident (R4) reviewed for wound care. In addition, the facility failed to consistently provide the necessary care and services in the management of tube feedings to prevent infection for 2 of 2 residents (R27, R51) reviewed for tube feedings. The deficient practices had the potential to affect all 65 residents who resided in the facility. Findings include: R4 R4's facesheet printed 10/21/21, included diagnoses of cellulitis of leg (skin infection), lymphedema (swelling of leg due to build-up of	F 880	F-880 (F) see attachments It is the policy of the facility to ensure proper personal protective equipment (PPE) including masks, are worn correctly by dietary staff, that hand hygiene is performed by staff when delivering meal trays, hand sanitizer is available for hand hygiene, room cleanliness is completed, use of proper infection control practices during wound care and with care and services for residents with tube feedings. Immediate Action(s): R4□s room cleaned on 10/20/21 by housekeeper to address bedrails and surfaces without personal items. Guardian Angel will continue to offer to tidy up clutter in room on visits. Foot soaking supplies placed and organized in her room. R27□s tube feeding was labeled with date and time opened and tubing capped after each use and staff will discarded if no date present. Reminder posted on tube feeding pump. R51□s tube feeding end cap was placed and a new syringe was dated and provided for use. Reminder posted on tube feeding pump.	

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F 880	Continued From page 81 lymph fluid), venous insufficiency (failure of veins to adequately circulate blood), morbid obesity, diabetes, paranoid personality disorder and mild cognitive impairment. R4's quarterly Minimum Data Set (MDS) assessment dated 10/8/21, indicated R4 declined to complete a brief interview for mental status, did not exhibit any behaviors - including rejection of care, had adequate hearing and vision, clear speech, was able to make self understood and could understand others. R4 did not walk and required extensive assistance of two staff for bed mobility, transfers and toileting. R4 was frequently incontinent of urine and always incontinent of stool. R4 had an infection of her foot requiring a dressing. Physician orders included: 3/23/21: Wash feet with soap and water every evening. 10/15/21: Right lower extremity and right dorsum (top) foot and right lower abdominal panniculus (a sheet of fat tissue in the lower abdominal area): acetic acid soaks two times a day for 7 days. R4's plan of care dated 1/21/20, indicated R4 had actual skin integrity break related to mobility and incontinence at that time, and a goal indicated skin would show signs of progressive healing without signs of infection. The care plan did not identify current skin infection and treatments ordered to enhance healing and reduce infection. During an interview and observation on 10/18/21, at 3:51 p.m., R4 who in a hospital gown, and was sitting on the side of her bed, facing the door with her legs over the side of the bed. R4's bare feet rested directly on the tile floor. Tile floor was dull	F 880	Additional hand sanitizer dispensers were placed throughout facility near resident rooms starting 10/20/21 by housekeeper supervisor. Hand sanitizer was placed at all cooler stations. Facility immediately identified rooms to deep cleaned weekly going forward. Management immediately began rounds multiple times per day to ensure proper mask and /face shield goggle use. All nurses demonstrated competency in wound dressing changes, including infection control procedures. All residents with current infection had care plans reviewed and revised as needed. Resident(s) involved: R4, R27 and R51 reviewed for corrective actions around specific concerns noted; charts reviewed for potential ill effects and care plans reviewed by Director of Nursing and/or Designee by 12/1/2021. Residents with Potential to be affected: All residents at the facility are at risk to be affected related to meal services, hand hygiene, room cleanliness and proper PPE usage. Like residents reviewed for tube feeding practices and wound care. RCA: Facilities QAPI Committee met on 11/24/21 (including Medical Director and Governing Body) to discuss root cause to identify the problem(s) that resulting in the potential deficiency and developed interventions and corrective action plans	

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F 880	Continued From page 82 and looked dirty with dark smudges. Multiple surfaces in the room were covered with R4's personal items and some facility supplies (boxes of gloves), on three overbed tables, a small bedside dresser, the window sill, and open storage next to the window. The only surface not covered was half of the overbed table closest to the bed. On the floor next to the bed, papers and envelopes were scattered about. On the commode were balled up elastic leg wraps and some clean towels. Black shoes were noted under an overbed table. A white rectangular plastic basin, upside down, was noted on the floor between bed and wall. During an interview on 10/19/21, at 2:56 p.m., when asked if staff washed her feet every day, R4 stated her feet had been soaked maybe twice since arriving to the facility a year and a half ago. No soaking supplies observed in room except for the white rectangular plastic basin, upside down on the floor. A progress noted dated 10/2/2021, at 12:02 a.m. indicated, During bedtime cares we removed her shoes on her right foot had maggots crawling out of her shoe and between her toes. The bottom of her right heel is very dry but not open. Her right leg and foot have ongoing edema and redness. Bilateral feet soaked, bed bath given, shoes cleaned and sprayed. Will continue to monitor. Advised resident to leave her shoes off when sleeping to let her feet air out. During an interview on 10/20/21, at 8:17 a.m., when asked about maggots on R4's feet, licensed practice nurse (LPN)-A stated she was unaware of that. Informed it was in the progress notes dated 10/2/21; then she read, stating that was	F 880	to prevent recurrence. Education: Center Staff re-educated by DON and/or designee by 12/1/2021 on proper personal protective equipment (PPE) including masks, are worn correctly by dietary staff, that hand hygiene is performed by staff when delivering meal trays, hand sanitizer is available for hand hygiene, room cleanliness is completed, use of proper infection control practices during wound care and with care and services for residents with tube feedings. Monitoring: To ensure ongoing compliance the DON/Designee to complete the following audits: cleaning and disinfection of resident use equipment/environmental, all shifts, daily x 1 week, then 3x weekly various shifts x 7 weeks. Hand hygiene audits on all shifts, daily x 1 week, then 3x weekly various shifts x 7 weeks. PPE audits all shifts, 4 x weekly for 1 week, then twice weekly for 7 weeks. Tube feeding audits, 4 x weekly for 1 week, then twice weekly for 7 weeks. The results of the audits will be reviewed by the QAPI committee for trends and any needs for adjustment of audit schedules or content, as well as any further educational needs. 12/1/2021	

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something that should have been communicated to her.

During an interview on 10/20/21, at 8:42 a.m., nursing assistant (NA)-A stated she was aware of the maggots, adding R4 was "wearing her shoes and wouldn't let us change them...almost have to fight her to do it, and we can't do that."

During an interview on 10/20/21, 12:47 p.m., noted the surface of the overbed table closest to the bed -- the one R4 used most often, was soiled. Half of the surface was cluttered with R4's personal items, including multiple condiments. The remaining surface was visibly soiled as evidenced by swirls of light grayish material. The metal coated bed rails were heavily soiled with finger prints and smudges. In addition, the floor was dirty with dark smudges. The housekeeping supervisor (HS)-A was brought in to look at R4's room and he validated that the surfaces needed to be cleaned and that they must have been overlooked by the other housekeeper. HS-A added housekeeping didn't like to disturb residents, but rooms should still be cleaned. HS-A stated he cleaned the floor the day prior, but only the areas not covered by pieces of equipment or furniture. HS-A admitted housekeeping did not routinely pick up or move items in resident rooms to clean under them.

During an interview on 10/20/21, 1:12 p.m., housekeeper (H)-B admitted he didn't want to move things in R4's room when he cleaned, and stated he would go back and clean the bedrails and the surfaces that didn't have R4's personal items on them.

During an interview and observation on 10/20/21,

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F 880	Continued From page 84 at 1:59 p.m. in R4's room with licensed practical nurse (LPN)-A and the director of nursing (DON), LPN-A placed non-sterile 4x4's and gauze wrap directly on top of a book on R4's overbed table (the gauze dressings were not in packaging). Half of the overbed table was covered with condiments and personal items. The side that had the book setting on it, had dried material and smudges on the surface. With non-sterile gloves, LPN-A dipped 4x4 pieces of gauze into acetic acid solution in a cup, and squeezed it out (most of the liquid dripped to the floor). LPN-A placed the moist 4x4 gauze on R4's lower right leg and and wrapped the leg with gauze while the DON held R4's leg. While holding the leg, the DON's long and unrestrained hair touched R4's leg in the area where the skin was red and the gauze was being applied. In the hallway after the treatment was completed, LPN-A and the DON were asked how they thought the treatment went, and both said good. LPN-A and the DON were informed of infection control breaches: placing dressing material directly on an unclean surface, the DON's hair touching R4's leg at the site the dressing was being applied, and medicated solution allowed to drip on the floor and which was not cleaned up until pointed out. Both stated they were unaware of these observations. The DON stated she would talk to the nurses about how to improve this dressing application process, adding proper technique was expected during treatments to prevent cross contamination and infection. The DON admitted R4 was already vulnerable to infection with cellulitis of her lower right leg. During a telephone interview on 10/21/21, at 9:02 a.m., registered nurse (RN)-A was asked if she washed R4's feet with soap and water, RN-A	F 880		

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replied no. When informed she initialed that she did soak R4's feet several times this month, RN-A replied, "Okay." RN-A admitted: "I might have signed off on it at the end of the shift and not done it." RN-A further stated, "We are constantly rushed; we can't do everything. Everyone is frustrated; I get done what I can." RN-A had not told the DON or administrator how she felt about her workload.

During a telephone interview on 10/21/21, at 9:06 a.m., (RN)-C stated, "I offered the treatment to R4, but she refused to let me clean her abdomen and feet." RN-C stated she had filled out SBAR (situation, background, assessment, recommendation) documentation to the physician about the refusal and that it should be in R4's record. RN-C stated she also sent a copy of the SBAR to the DON. According to an interview with the DON on 10/21, at 1:57 p.m., there was no SBAR documented about this in R4's EMR, nor did she receive a copy of an SBAR.

During an interview on 10/21/21, at 1:57 p.m. the DON and the corporate director of clinical services (DCS) where asked when they became aware of R4 having maggots in her shoe and on her foot. The DON stated the identification of maggots occurred on Saturday 10/2, and she became aware of it on Monday 10/4. When asked what action had been taken after the discovery of the maggots, the DON stated the night nurse informed the physician. In addition, the DON stated deep cleaning had been done in R4's room. Discussed current condition of room, and if deep cleaning had occurred two weeks ago, how could the current condition be explained? The DON stated R4 refused to let them move things in her room in order to clean. The DON admitted

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ROCHESTER EAST HEALTH SERVICES	501 EIGHTH AVENUE SOUTHEAST ROCHESTER, MN 55904

(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
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staff were responsible for picking up and cleaning R4's room as she was not physically capable to pick things up off the floor, or to organize her personal items. The DCS stated resident rooms needed to be maintained in a clean and neat manner and she would assess R4's room. The DON stated she felt the maggots occurred when R4 urinated on her shoes and then refused to remove her shoes. There was no documentation or observation of R4 urinating onto her shoes, her feet, or the floor.

Facility policy titled Dressing Change, Clean, dated 6/2017, indicated the purpose was to protect the wound, prevent infection and promote healing. The procedural steps indicated to create a clean field with paper towels or towelette drape. Documentation included to date and time the dressing change, document the wound size, site, depth, color and drainage, and progress of healing.

Facility policy titled Cleaning Resident Rooms, dated 6/1/2017, indicated to carefully removed items on top of furniture to dust and then replace items exactly as they were. Clean top of window sills. Using all-purpose cleaner, clean countertops and front of cabinets. Sweep or vacuum the floor of the room that is not obstructed by furniture. Move small pieces of furniture to vacuum under or around it. Use spot remover for carpets. Note: this facility did not have carpet in resident rooms.

Masks

--During an observation on 10/18, at 6:08 p.m., Covid 19 unvaccinated dietary aide (DA)-B with mask below nose, dropped off tray cart on 2nd floor, west wing. Standing within several feet of

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staff, informed them the cart was there.
--During an observation on 10/19, at 12:11 p.m., Covid 19 vaccinated (DA)-A wore mask below her nose as she worked along side Covid 19 unvaccinated dietary manager (DM)-A dishing food from steam table.
--During an interview and observation on 10/20, at 7:48 a.m., Covid 19 unvaccinated (C)-B had no mask on. Mask was observed in his breast pocket. C-B stated he didn't wear a mask in the kitchen; "can't breathe and it would be a hazard."
--During an interview on 10/19, at 1:55 p.m., the director of nursing (DON) who was also the infection control nurse stated dietary workers were contracted staff, "but when they were in the building, should follow our policy and wear a mask." Reviewed facility policy: Pandemic Preparedness and Response dated 3/23/21, which indicated all healthcare personnel would wear well-filling facemasks that always cover the mouth and nose where they might encounter residents or co-workers. The DON stated she would talk to the dietary staff and the manager about wearing facemasks properly.
--During an interview on 10/19, at 2:02 p.m., C-B had mask on and stated "I called my boss, we need to wear a mask. I didn't know that. I sent a message to everyone in kitchen; we didn't know that."
--During an observation on 10/21, at 10:10 a.m., C-B had no mask on as he was walking about the kitchen with other staff members present.
--During an observation on 10/21, at 10:21 a.m., in the entrance to the kitchen near the dishwashing room, DA-A and C-B were standing talking, about a foot away from each other, both with masks below their nose.
--During an observation on 10/21, at 12:02 p.m., DA-A and C-C were standing shoulder to

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shoulder at steam table plating lunch, both with masks below their nose.

Hand Hygiene

--During an observation on 10/18/21, at 6:12 p.m., (NA)-F came out of room 211 after taking a tray in and pulled the door shut with her hand upon exiting, then proceeded to fill cups with juice and milk for R48 in room 204, then coffee for room 213, all without performing hand hygiene. At 6:14 p.m., (NA)-G took a tray to the dining room for R1; moved R1's baseball cap which had been sitting on the table, out of the way with his hand, then set the tray down. No hand hygiene performed afterwards. Went back to cart to deliver trays to rooms.
--During an interview on 10/18/21, at 6:21 p.m., NA-F admitted she did not clean her hands in between delivering trays and filling beverage cups stating hand sanitizer was not available in hallways and they had to work fast to get the trays delivered. In addition, NA-F admitted staff did not assist residents in cleaning their hands before meal trays were delivered, nor were they encouraged to do so. NA-F stated residents could clean their hands in their bathroom.
--During an interview on 10/19/21, at 2:42 p.m., the DCS stated staff were expected to sanitize hands prior to entering residents rooms and was not aware that hand sanitizer dispensers were not located outside or inside the resident's rooms, or in the hallways on each unit. Furthermore, DCS was not aware that the few hand sanitizer dispensers that were available, were empty. DCS stated she would make sure they got filled right away.
--During an interview on 10/19/21, at 2:50 p.m., the administrator stated hand sanitizer was on

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backorder and the staff were expected to carry hand sanitizer in their pockets. In addition, a container of hand sanitizer was to be on each medication cart in each hallway. A copy of the backorder invoice for hands sanitizer was requested and not received.
--During an observation and interview on 10/20/21, at 10:30 a.m. HS-A was observed unpacking wall mount hand sanitizer dispensers and stated he would start hanging them.
--During an observation on 10/21/21, at 9:07 a.m., (NA)-B filled two navy colored insulated mugs with ice from a large picnic-type cooler on 2nd floor using the scoop from a pouch attached to the side of the cooler. No hand hygiene was performed prior to filling the mugs. Multiple undocumented observations were made of staff walking up to the cooler and scooping ice from the cooler to fill resident cups and mugs without performing hand hygiene. No hand sanitizer dispenser near/next to the cooler.
--During an observation on 10/20/21, at 12:43 p.m., observed R10 wheel up to the cooler on 2nd floor in her wheelchair, and by herself filled her own orange pumpkin cup with pink top and straw, using the scoop in the pouch on side of cooler, touching the scoop to the rim of her cup. DM-A arrived shortly after and was informed of this. She removed the cooler from the unit to clean and replace.
--During an interview on 10/21/21, at 11:42 a.m., the DCS and DON stated staff were expected to sanitize their hands prior to entering a residents room entered and had received training and ongoing education related to hand hygiene.

On 10/18/21, at 4:00 p.m. an the east and west wing on the second floor was observed and lacked the availability of hand sanitizer outside or

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F 880	Continued From page 90 inside the residents' rooms. On 10/19/21, at 8:44 a.m. on first floor adjacent to the elevator doors a hand sanitizer dispenser was observed, however the dispenser was empty. On 10/19/21, at 8:46 a.m. a wall hand sanitizer dispenser was observed outside of room room 321, however the dispenser was empty On 10/19/21, at 2:09 p.m. nursing assistant (NA)-A stated hand sanitizer were not easily accessible throughout the facility and created difficulty to wash her hands when she entered and/or exited resident rooms, NA-A stated staff do not wash or sanitizer their hands frequent as we needed. NA-A stated she went room to room at times, without hands sanitized or washed, when hand sanitizer was not available. NA-A stated staff were supposed to get hand sanitizer, but have not received them yet. On 10/19/21, at 2:42 p.m. the Senior Director of Clinical Services (DCS) stated staff were expected to sanitize hands prior to resident's room entered, and included the staff who delivered meal trays were expected to sanitize hands prior to resident's room entered. The DCS was not aware hand sanitizers were not located outside or inside the resident's rooms, and further stated she expected the hand sanitizers available for staff inside or outside of the resident's rooms. The DCS indicated she would ensure the hand sanitizer dispensers in the empty hand sanitizers throughout the facility were filled. On 10/19/21, 2:50 p.m. an interview with administrator stated hands sanitizer was on backorder and the administrator stated staff were	F 880		

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expected to carry hand sanitizer in their pockets and hand sanitizer was expected on the medication carts of each hall. A copy of the backorder of the hands sanitizer was requested and not received.

On 10/21/21, at 11:42 an during an interview with director of nursing (DON), the DON stated staff were expected to sanitize their hands prior to entering a residents room and indicated staff received training and ongoing education related to hand hygiene.

Facility policy titled Source Control ad Distancing Measure - Covid 19, dated 4/16/21, indicated: nursing home populations were at high risk of being affected by Covid-19 and other pathogens. The measures outlined in the policy may help reduce the spread of droplets when a person talks, sneezes, or coughs and thereby reduce the spread of Covid 19 by someone who is infected, but does not know it. All healthcare personnel would wear well-filling facemasks that always cover the mouth and nose when in the facility where they might encounter residents or co-workers.

Facility policy titled Pandemic Preparedness and Response dated 3/23/21, indicated staff should perform hand hygiene according to CDC guidelines, including before and after contact with residents, contaminated surfaces or equipment. Place alcohol based hand rub in every resident room if supply numbers are adequate. Have hand sanitizer available and strategically placed throughout the center.
Tube feedings

R51

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R51's admission record, printed on 10/20/21 included diagnosis of multiple sclerosis, type 2 diabetes mellitus, and adult failure to thrive.

R51's significant change Minimum Data Set (MDS) assessment dated 9/16/21 indicated moderate cognitive impingement, a percutaneous endoscopic gastrostomy (PEG), (a surgery to place a feeding tube) tube and totally dependant on staff staff for feeding assistance with 51% or more of feeding by tube feeding.

R51's plan of care dated 9/24/21, indicated R51 was at risk for nutritional status change related to dysphagia (swallowing difficulty) and need for tube feeding. Interventions included Isosource 1.5 calories given three times a day with 2 cans during first feeding and one can at subsequent feedings.

During observation on 10/18/21, at 6:03 p.m., tube feeding (TF) bag with approximately 500 cc of formula was hanging on a pole with purple tubing end, (end that connects to PEG tube) uncovered and unlabeled. Licensed practical nurse (LPN)-C indicated the TF system comes prefilled with the solution and the tubing already connected to the bag and is changed daily by the night shift. LPN-B proceeded to aspirate residual (checking amount in the stomach, which indicates how rapidly stomach is emptying), which was greater than 100 cc. LPN-C indicated she would hook up TF later.

During observation on 10/19/21, at 2:45 p.m., TF bag with approximately 600 cc of formula remaining was hanging on a pole with tubing end uncovered with no date on bag or tubing of when opened.

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F 880	Continued From page 93 During observation on 10/20/21, at 8:21 a.m., R51's TF was connected to R51 and running with bag hanging on pole and approximately 800 cc in the bag, with no date present on bag or tubing for when opened. During observation on 10/20/21, at 10:37 a.m., R51 was sleeping in bed. TF was unhooked from R51 with no end on tubing. Approximately 600 cc remains in the bag. During observation on 10/21/21, at 8:34 a.m., LPN-A prepared medications for administration through PEG tube. A new syringe was brought into the room by LPN-A, but did not fit end of PEG tube. LPN-A then picked up a syringe from bedside table that was undated and out of original package and used syringe to administer medications via the PEG tube. LPN-A id not cleanse syringe or PEG tube sites prior to connection. LPN-A found R51's tube feeding (TF) bag was empty. LPN-A hung a new prefilled bag of Isosource 1.5 calories, labeled it with open date and administered via pump. LPN-A indicated all tube feeding bags and tubings should be labeled and are changed on evening shift. LPN-A further stated she normally would not use an undated, used syringe, but didn't have time to go get another syringe. During observation and interview on 10/20/21, at 9:05 a.m., LPN-A indicated the tubing should be capped in between feedings which are three times a day. LPN-A confirmed one bag is used daily and usually hung by night shift, which is discarded by evening shift after the 6:00 p.m. feeding.	F 880		

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During observation on 10/21/21, at 2:15 p.m., R51 was not present in her room and administration pump was beeping. The TF bag with approximately 1000 cc of formula remaining in bag and tubing were hanging on the pole. The end of the tubing was uncovered.

R27
R27's Admission Record printed 10/21/21, indicated R27 was admitted 8/11/21, diagnoses included dysphasia (difficulty in swallowing food or liquid), sepsis (infection), acute and chronic respiratory failure, and moderate protein calorie malnutrition.

R27's 5 day scheduled Minimum Data Set (MDS) assessment dated 8/18/21, indicated severe cognitive impairment, activities of daily living (ADL) required two person physical assist, and nutrition approach was a feeding tube with 51% or more of feeding by tube feeding.

R27's order summary report printed 10/21/21, indicated enteral feed order three times a day for Replete intermittent gravity, 6 cans per day, change tube feeding set and bag daily in the morning.

On 10/18/21, at 6:00 p.m. R27 was observed in his room, laying on his bed. R27, and a metal stand with a empty and unlabeled tube feeding (TF) bag was hanging on the pole with clear unlabeled tubing with an uncapped purple end.

On 10/21/21, at 9:00 a.m. R27 was observed in his room and with metal pole and a bag hung with tubing; a purple tip was visible and uncapped at the end of the tube. LPN-A stated she was not aware a cap needed to cover the end of the tube

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F 880	Continued From page 95 feeding attachment when disconnected from the resident and not in use. R27's bedside table had a clear plastic piece and resembeled a cap for the end of a tube feeding . During interview on 10/21/21, at 11:12 a.m., the director of nursing (DON) confirmed tube feeding bag need to be labeled with date and time opened and end of tubing capped after each use and discarded if no date present. The DON also confirmed LPN-A should not have used a syringe that was open and unlabeled. A policy and procedure titled "Enteral Nutritional Therapy (Tube Feeding) dated June 2017 was reviewed, but did not address, labeling of opened tubing, syringes or formula or ensuring end of tubing remains covered.	F 880		

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 10/20/2021. At the time of this survey, ROCHESTER HEALTH SERVICES EAST was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		11/26/2021

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

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K 000	Continued From page 1 Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. ROCHESTER HEALTH SERVICES EAST is a 3 story building with a full basement. The building was constructed in 1968 and was determined to be Type II (222) construction. The facility is fully protected throughout by an automatic sprinkler system and has a fire alarm system with smoke detection in corridors and spaces open to the corridors which is monitored for automatic fire department notification.	K 000		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCHESTER EAST HEALTH SERVICES	**501 EIGHTH AVENUE SOUTHEAST** **ROCHESTER, MN 55904**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 2 The facility has a capacity of 111 beds and had a census of 63 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 211 SS=D	Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain clear accessibility to an exit in accordance with NFPA 101 (2012 edition), Life Safety Code, sections 19.2.1 and 7.1.10.1. This deficient condition could have an isolated impact on the residents within the facility. Findings include: On 10/20/2021 at 09:45 AM, it was revealed by observation in the Kitchen that a cart was located directly in front of the exit door, creating obstructed access to the means of egress. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 211	PLAN OF CORRECTION Please accept the following as the facility's plan of correction. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. K211	12/1/21

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	245184	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**10/20/2021**

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K 211	Continued From page 3	K 211	The Maintenance Director the exit door area of the kitchen area and cart was removed with the engineer present. An audit was performed on the facility and no other issues were found. The Maintenance Director or designee will inspect all exit doors daily basis when present. This task is part of the facility's preventative maintenance program. The Maintenance Director or designee and the Executive Director will monitor to ensure future compliance. Date of Completion: 12/1/2021 K353 The Maintenance Directors. The electrical cord was immediately removed with the knowledge of the LSC engineer. An audit was performed on the facility and no other issues were found. The Maintenance Director or designee will inspect all sprinklers on a weekly basis. This task is part of the facility's preventative maintenance program. The Maintenance Director or designee and the Executive Director will monitor to ensure future compliance. Date of Completion: 12/1/2021 K355 K355: Portable Fire Extinguishers During the tour the Maintenance Director the cart in front of the exit door area of the fire extinguisher was removed with the engineer present. An audit was performed	

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K 211	Continued From page 4	K 211	on the facility and no other issues were found. The Maintenance Director or designee will inspect all exit door area of the fire extinguisher when present. This task is part of the facility's preventative maintenance program. The Maintenance Director or designee and the Executive Director will monitor to ensure future compliance. Date of Completion: 12/1/2021	
K 353 SS=D	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the sprinkler system in accordance with NFPA 101 (2012 edition), Life Safety Code, sections 9.7.5, and NFPA 25 (2011	K 353	K353 The Maintenance Directors. The electrical cord was immediately removed with the	12/1/21

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K 353	Continued From page 5 edition), Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, section 5.2.2.2. These deficient findings could have an isolated impact on the residents within the facility. Findings include: On 10/20/2021 at 09:25 AM, it was revealed by observation on the 2nd Floor in the Housekeeping / Data Room that data cabling was resting on that sprinkler piping and that other data cabling was attached to the sprinkler piping support system. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 353	knowledge of the LSC engineer. An audit was performed on the facility and no other issues were found. The Maintenance Director or designee will inspect all sprinklers on a weekly basis. This task is part of the facility□s preventative maintenance program. The Maintenance Director or designee and the Executive Director will monitor to ensure future compliance. Date of Completion: 12/1/2021	
K 355 SS=D	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the accessibility of portable fire extinguishers in accordance with NFPA 101 (2012 edition), Life Safety Code, sections 19.3.5.12 and 9.7.4.1, and NFPA 10 (2010 edition), Standard for Portable Fire Extinguishers, section 6.1.3.3. This deficient condition could have an isolated impact on the residents within the facility.	K 355	K355 K355: Portable Fire Extinguishers During the tour the Maintenance Director the cart in front of the exit door area of the fire extinguisher was removed with the engineer present. An audit was performed on the facility and no other issues were	12/1/21

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K 355	Continued From page 6 Findings include: On 10/20/2021 at 09:45 AM, it was revealed by observation in the Kitchen that carts were located in front of the fire extinguishers, creating obstructed access to the fire extinguishers. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 355	found. The Maintenance Director or designee will inspect all exit door area of the fire extinguisher when present. This task is part of the facility□s preventative maintenance program. The Maintenance Director or designee and the Executive Director will monitor to ensure future compliance. Date of Completion: 12/1/2021	

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
November 16, 2021

Administrator
Rochester East Health Services
501 Eighth Avenue Southeast
Rochester, MN 55904

Re: State Nursing Home Licensing Orders
Event ID: Z36P11

Dear Administrator:

The above facility was surveyed on October 18, 2021 through October 21, 2021 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:

Elizabeth Silkey, Unit Supervisor
Mankato District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
12 Civic Center Plaza, Suite #2105
Mankato, Minnesota 56001
Email: elizabeth.silkey@state.mn.us
Office: (507) 344-2742 Mobile: (651) 368-3593

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

Please feel free to call me with any questions.

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00953	A. BUILDING: _____ B. WING _____	C 10/21/2021

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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 10/18/21 - 10/21/21, a licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found NOT in compliance with the MN State Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you have reviewed	2 000		

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2 000	Continued From page 1 these orders and identify the date when they will be completed. The following complaints were found to be SUBSTANTIATED: H5184117C (MN53165), however NO licensing orders were cited due to actions implemented by the facility prior to survey: The following complaints were found to be SUBSTANTIATED: H5184145C (MN76193), with a deficiency cited at MN 4658.0510 Subp. 1 The following complaints were found to be UNSUBSTANTIATED: H5184116C (MN58136), H5184144C (MN77085), H5184146C (MN74058), H5184147C (MN68345), H5184148C (MN71891), and H5184149C (MN63111) . Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html The State licensing	2 000		

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2 000	Continued From page 2 orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 800	MN Rule 4658.0510 Subp. 1 Nursing Personnel; Staffing requirements Subpart 1. Staffing requirements. A nursing home must have on duty at all times a sufficient number of qualified nursing personnel, including registered nurses, licensed practical nurses, and nursing assistants to meet the needs of the residents at all nurses' stations, on all floors, and in all buildings if more than one building is involved. This includes relief duty, weekends, and vacation replacements. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure sufficient staffing to provide routine assistance with	2 800	It is the policy of the facility¿to¿ensure sufficient staffing to provide routine assistance with activities of daily living	12/1/21

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2 800	Continued From page 3 activities of daily living (ADL's) of grooming, personal hygiene and for 2 of 2 residents (R4 and R11) who required assistance and were dependent on staff for ADL's, provide dignified dining experience for 6 of 6 residents (R215, R2, R44, R45, R60, R30) who required assistance with dining, provide treatment and services for non-pressure related skin concerns for 2 of 3 residents (R43, R4) who required assistance, monitor dialysis treatment, and fluid restrictions for 1 of 1 residents (R42) receiving hemodialysis. This deficient practice had the potential to affect all 64 residents who resided in the facility. Findings include: Interview on 10/18/21, at 3:25 p.m. R53 expressed concerns of short staffing. R53 stated her call light does not get answered timely when she needs assistance. R53 indicated it takes up to 45 minutes at times for the staff to come and assist her. R53 indicated it seemed worse on the weekends. Interview on 10/18/21, at 3:37 p.m. R4 expressed concerns of a facility staffing shortage. R4 indicated she has to wait for lengthily periods of time to get assistance after she puts her call light on. R4 stated the staff were always in a rush to take care of her because they had so many other residents to attend to. Interview on 10/18/21, at 5:33 p.m. R39 expressed concerns of short staffing. R39 stated the past 2 nights she had her call light on to assist her with toileting. R39 indicated she was incontinent from head to toe. R39 indicated she yelled out loudly until the next door neighbor came and went to get help at the sedk but there was no one there or in the hall. R39 was unsure	2 800	(ADL’s) of grooming, personal¿hygiene, dignified dining experience, treatment and services for non-pressure related skin concerns¿and¿monitoring dialysis treatment and fluids¿restrictions¿for¿those receiving hemodialysis.¿ ¿ Immediate action: The Guardian Angel and weekend manager on duty program updated and improved which is our specific point of contact. These programs proactively solicit feedback from all residents and checks patient / resident room for housekeeping, infection control, safety. Additional staff hired ¿ Resident(s) involved:¿R4,¿R11, R215,¿R2,¿R44,¿R45,¿R60,¿R3,¿R43 and R42¿ ¿ Residents with Potential to be affected:¿Center residents¿who¿need¿routine assistance with activities of daily living (ADL’s) of grooming, personal hygiene, dignified dining experience, treatment and services for non-pressure related skin concerns and monitoring dialysis treatment and fluids restrictions for those receiving hemodialysis¿are at risk to be affected.¿ ¿ Education:¿Staff educated by the DON/Designee/Facility Staff by 12/1/2021¿or before their next shift begins.¿ ¿ Monitoring:¿To ensure ongoing compliance the DON/Designee¿to complete audits weekly beginning the and	

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2 800	Continued From page 4 how long she had to wait, but it was at least 45 minutes During a resident council group interview on 10/20/21, at 10:00 a.m. R10, R11, R18, R21, R23, R24, R26, R34, R35, R42, R48, and R54 were in attendance. These residents expressed concerns related to staffing. The residents stated staff worked short a lot of the time. The residents indicated it took up to an hour for their call lights to be answered and assisted with their activities of daily living (ADL's) The residents indicated this occurred at various times of the day and happened at least daily. The residents further indicated staff were always in a hurry when assisting them, because they did not have the time to get everything done if they did not. The residents stated these concerns were brought forward to management months ago, but felt staffing had not improved. See the below deficiencies that were issued that included short staffing Refer to F550: The facility failed to provide a dignified dining experience for 6 of 6 residents (R215, R2, R44, R45, R60, R30) who required assistance with dining. Refer to F677: The facility failed to provide ADL (activities of daily living) care to 2 of 2 resident (R4 and R11) reviewed for ADLs and who were dependent upon staff for grooming. Refer to F684. The facility failed to monitor, assess and provide treatment for non-pressure related skin concerns for 1 of 3 residents (R43) who had a skin wound, and failed to ensure activities of daily living (ADLs) were provided, including nail care, for 1 of 4 residents (R25)	2 800	ongoing for at least three months. The results of the audits will be reviewed by the QAPI committee for trends¿and¿any needs for adjustment of audit schedules or content, as well as any further educational needs.¿	

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2 800	Continued From page 5 reviewed who were dependant on staff for activities of daily living. Refer to F684: The facility failed to comprehensively assess, monitor and implement interventions including completion of dressing changes and administer ordered antibiotic treatment for 1 of 3 residents (R43) with non-pressure related wounds. In addition, the facility failed to ensure elevation of swollen legs and utilization of compression wraps. In addition, the facility failed to ensure treatment orders were provided as ordered for 1 of 3 resident (R4) reviewed for wound care who was at risk for non-pressure related wounds, Refer to F698. The facility failed to monitor dialysis treatment, utilize communication form with dialysis, provide a comprehensive dialysis care plan to reflect emergency care, and monitor fluid restriction for 1 of 1 residents (R42) receiving hemodialysis. Interview on 10/19/21, at 2:25 p.m. registered nurse (RN)-A indicated she has worked at the facility for nine weeks and was an agency nurse. RN-A indicated hand off shift report was not received on residents on the second floor (east wing) at times. RN-A stated she was expected to assess R42's change in condition on 10/18/21, and did not have time due to the shortage of nurses and working short. Interview on 10/20/21, at 7:37 a.m. licensed practical nurse (LPN)-A indicated because of working short, she was not able to complete all resident treatments during her shift. LPN-A indicated she was the only nurse for the east and west wing on second floor and staffing should include a nurse for both wings. LPN-A indicated	2 800		

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2 800	Continued From page 6	2 800		

treatments included dressing changes. LPN-A further indicated nursing staff were expected to assess the electronic medical record (EMR) dashboard daily for resident alerts. LPN-A indicated the EMR residents alerts included when a resident had not had a bowel movement for 72 hours. LPN-A stated she was expected to monitor the dashboard daily. However LPN-A indicted she had not looked at the dashboard on a regular basis.

Observation and interview on 10/20/21, at 9:05 a.m. observed that not all residents that needed assist with eating were getting assisted with their meal. There were 2 staff assisting the residents. NA-E indicated the staff were short today because a NA had called in sick. NA-E indicated that was why there was not enough staff to assist the residents who needed help with eating breakfast. NA-E indicated on a regular day there are 2 NA's, a licensed nurse or a TMA on the 3rd floor and usually another staff person who is trained to assist with feeding. NA-E stated there was only 1 TMA and 1 NA working.

When interviewed on 10/20/21, at 9:22 a.m. trained medication aid (TMA)-B confirmed being short one nursing assistant (NA) on the third floor memory care unit that day. When asked if the facility ever floated staff from other floors to help TMA-B confirmed sometimes that happened. TMA-A further stated that probably wouldn't happen that day as the second floor was also "swamped" and only had three NA's working the floor when there should be four. Upon subsequent interview at 11:51 a.m., TMA-B confirmed neither she nor NA-E (the only other staff working on the third floor) had received a break that day. TMA-A further confirmed they had started their shift at 6:00 a.m. NA-E was also

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interviewed at that time as had just gotten off the phone attempting to call supervisory staff to request assistance with resident care. NA-E confirmed she was the only NA working on the third floor that shift and further confirmed residents weren't getting turned and toileted every two hours per their plan of care. NA-E further stated feeling like she wasn't doing her job and also was afraid for a resident who was impulsive with transfers and without another set of eyes feared he would fall. NA-E confirmed she had called called several different staff requesting assistance who either had not answered the call or had not gotten back to her.

During interview on 10/20/21, at 11:15 a.m., the director of nursing (DON) confirmed a NA had called in ill today, and was scheduled on the 3rd floor. The DON verified there were not enough staff to assist all residents that needed help with eating their breakfast, in a timely manner.

During a telephone interview on 10/21/21, at 9:02 a.m., RN-A was asked if she was aware of a new treatment for R4's skin using an acetic acid soak. RN-A stated she was not aware of this. Acetic acid soaks to R4's right lower extremity, right dorsum (top) foot, and right lower abdominal panniculus (a sheet of fat tissue in the lower abdominal area), twice a day for seven days had been ordered on 10/15/21. When brought to her attention that she initialed performing the treatment twice on 10/18, RN-A stated, "I might have signed off on it at the end of the shift and not done it." RN-A further stated, "I didn't know about this order and we are constantly rushed; we can't do everything. Everyone is frustrated; I get done what I can." When asked if she washed R4's feet with soap and water, RN-A replied no. When informed she initialed that she did soak

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2 800	Continued From page 8 R4's feet several times this month, RN-A replied, "Okay." RN-A had not told the DON or administrator how she felt about her workload. Interview on 10/21/21, at 10:00 a.m. RN-A indicated she was currently the only full time licensed floor nurse. RN-A indicated she often will work a double shift due to call ins or short staff.. RN-A stated last month the licensed nurse that was working on the 2nd floor resigned, and was replaced with a TMA. RN-A indicated there are 43 residents on the 2nd floor, and many of them have treatments that include dressing changes to wounds and pressure ulcers (PU), gastric tube feedings and include tracheostomies RN-A stated that not all treatments get done at times. RN-A further indicated that often there are only 3 NA's on the 2nd floor when there usual is 4 NA's, to take care of 43 residents. Interview on 10/21/21, at 10:30 a.m., NA-B indicated she works the 2nd floor and is responsible for an average of 13-15 residents at a time. NA-B indicated she felt most resident cares were provided, but not always timely. NA-B stated when this happens the residents become anxious and upset. NA-A confirmed there is often 3 NA's to 43 residents on a daily basis. Interview on 10/21/21, at 10:15 a.m. the facility human resource director (HRD) staff. confirmed there was a facility staffing shortage. The facility HRD s indicated they try and fill the shifts with on-call staff, contracted staff as well as double shifts. The facility HRD indicated the facility did not have a mandated requirement for staff to stay and cover the open shift if they were unable to replace the open shift, and then they staff work short. The facility HRD further indicated the facility offers incentives to fill in an open shift, to	2 800		

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2 800	Continued From page 9 try and get it covered. The facility HRD indicated staffing is determined by acuity levels and census. The facility HRD indicated the facility has had a loss of staff to going back to school or resign in the past month. A total of 3 full time licensed staff and 3 full time NA's, who had not been replaced as of yet. The facility HRD stated they have reached out to contracted agencies, but found that they were short as well. The facility HRD further stated the have been recruiting in various ways but currently do not have any applicants. The current staffing schedules per acuity and census includes: Day shift- 2nd floor (2 licensed nurses and 4 NA's) Due to shortage 1 nurse has been replaced with a TMA Evening shift-2nd floor (2 licensed nurses and 4 NA's) Due to shortage 1 nurse has been replaced with a TMA Night shift- 2nd floor (1 licensed nurse and 2 NA's) There are 43 residents on the 2nd floor Day shift-3rd floor (1 licensed nurse and 2 NA's) Due to shortage 1 nurse has been replaced with a TMA Evening shift-3rd floor (1 licensed nurse and 2 NA's) Due to shortage 1 nurse has been replaced with a TMA Night shift-3rd floor (1 licensed nurse and 1 NA) There are 21 residents on the 3rd floor Review of the schedule for the past 3 months (from 8/1/21 to 10/18/21), noted there were 32 open shifts that had not been replaced and 20 shifts for staff call ins.	2 800		

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2 800	Continued From page 10 Staff overtime hours: 8/21- 193.59 9/21- 149.59 10/21-10/20/21- 58.08 Current opening for NA's: Day shift- 3 full time NA's Evening shift- 3 full time NA's Nights- 1 full time NA Current opening for licensed staff: Day shift- 4 full time nurses Evening shift- 4 full time nurses Night shift- 2 full staff nurses Nurse managers: 2 full time nurses Interview on 10/21/21, at 11:30 a.m. the DON confirmed the above interview with the facility HRD. The DON indicated in the past month they have had several staff resign or go back to school that had been seasonal. The DON indicated contracted staff are utilized but there are very few because they are short staffed as well. The DON confirmed the staffing schedule for each floor that was identified above, and that not always are they fully scheduled due to call ins or open shifts that that could not be replaced. The DON indicated they try to replace these open shifts with contracted staff, on-call staff and part-time staff before they ask the full time staff. The DON indicated they offer all staff incentives for picking up additional hours as well. The DON indicated she had not been aware of staff not completing their work or not providing cares because of being short. The DON indicated she was aware that during shortage times, residents were not always assisted with meals timely. The	2 800		

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2 800	Continued From page 11 DON indicated they try and do the best that they can to replace staff. The DON indicated all 3 of the nurse managers had resigned, otherwise they would assist with meals when short. The DON indicated she was unsure of what more they could do, because they had already closed the 1st floor short term care unit. Review of the Facility Assessment Tool updated on 10/18/21, included the following: 73 residents requiring assistance with dressing, 51 with bathing, 55 with transfers, 40 with eating, 74 with toileting and 25 with mobility needs. The staffing plan indicated a 1:22 ratio of licensed staff for day shift and evening shift and 1:40 on the night shift. For direct care staff (NA's) 1:10 on 2nd floor day and evening shift and 1:8 on the 3rd floor. The ratio on the night shift is 1:14. The assessment indicated staff assignments are kept as consistent as possible working within individual staff members scheduled hours and maintaining appropriate trained staff in each area Policy titled Nurse Staffing dated October 2017, indicated -Our facility provides sufficient numbers of staff with the skills and competency necessary to provide care and services for all residents in accordance with resident care plans and facility assessment. Staffing requirements :a nursing home must have on duty at all times of sufficient number of qualified nursing personnel including registered nurses, licensed practical nurses, and nursing assistants to meet the needs of all the residents at the nurses station . Review of a facility policy Nursing Staffing Sufficiency dated 6/1/17, indicated nursing staff is efficient for each unit if:	2 800		

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2 800	Continued From page 12 -if there is adequate staff to meet direct care needs, assessments and supervision -the workloads for direct care staff are reasonable -residents and family do not report insufficient staff meeting needs of the residents -staff are responsive to resident needs with call lights being answered promptly -the facility ensures each resident receives nursing care in accordance with his/her plan of care -sufficient nursing staff contribute to identified quality of care and life. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) and administrator could review and revise policies and procedures related to sufficient nurse staffing and educate staff. The DON or designee, could conduct audits to ensure compliance and report results to the quality assurance committee. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	2 800		
2 910	MN Rule 4658.0525 Subp. 5 A.B Rehab - Incontinence Subp. 5. Incontinence. A nursing home must have a continuous program of bowel and bladder management to reduce incontinence and the unnecessary use of catheters. Based on the comprehensive resident assessment, a nursing home must ensure that: A. a resident who enters a nursing home without an indwelling catheter is not catheterized unless the resident's clinical condition indicates that catheterization was necessary; and B. a resident who is incontinent of bladder receives appropriate treatment and services to	2 910		12/1/21

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2 910	Continued From page 13 prevent urinary tract infections and to restore as much normal bladder function as possible. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to educate, assess and monitor catheter care for 1 of 1 resident (R5) who was independendently performing self urinary catheter cares. Findings include: R5 was admitted to the facility on 7/8/20. Diagnosis listed on the diagnosis sheet in the medical record included: muscle weakness, right artificial shoulder joint, paraplegia (damage to the spinal cord causing paralysis of all or part of the trunk, legs or pelvic organs), neuromuscular dysfunction of the bladder (lacks bladder control), injury of the spinal cord, osteoarthritis (wearing down of the protective tissue at the end of the bones), diabetes mellitus (too much sugar in the blood), chronic kidney disease (loss of kidney function to eliminate waste from the body) and placement of a urostomy (an opening in the abdomen that re-directs urine away from the bladder that's diseased or injured. Observation on 10/18/21, at 3:43 p.m. R5 was in her room watching TV. There was a strong odor of urine throughout the room. There was a urinal hanging ona commode in the room, that had urine in it. R5 stated she has a urostomy that she manages herself. Observation and interview on 10/20/21, at 8:30	2 910	It is the policy of the facility¿to¿ensure sufficient staffing to provide routine assistance with activities of daily living (ADL's) of grooming, personal¿hygiene, dignified dining experience, treatment and services for non-pressure related skin concerns¿and¿monitoring dialysis treatment and fluids¿restrictions¿for¿those receiving hemodialysis.¿ ¿ Immediate action: The Guardian Angel and weekend manager on duty program updated and improved which is our specific point of contact. These programs proactively solicit feedback from all residents and checks patient / resident room for housekeeping, infection control, safety. Additional staff hired ¿ Resident(s) involved:¿R4,¿R11, R215,¿R2,¿R44,¿R45,¿R60,¿R3,¿R43 and R42¿ ¿ Residents with Potential to be affected:¿Center residents¿who¿need¿routine assistance with activities of daily living (ADL's) of grooming, personal hygiene, dignified dining experience, treatment and services for non-pressure related skin concerns and monitoring dialysis treatment and	

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2 910	Continued From page 14 a.m. R5 was in her room rummaging through papers on her table. There was a strong odor of urine throughout the room. There was a catheter bag hanging on the night stand. Half of the bag was filled with urine. There was no cap on the end of the tubing (connector) and hanging down on the floor. R5 stated she takes care of her urostomy herself and that she also switches her drainage bag and leg bag in the morning and at night. R5 indicated she did not always clean the ends of the tubing (connector) when switching her bags. R5 further indicated she did not rinse her bags either. R5 stated she empties the urine into the urinal and places it on the commode and the staff will empty the urinal. R5 stated she also washes around her stoma every day. R5 indicated she has had a urostomy most of her life and she was capable of taking care of it. Review of the quarterly minimum data set (MDS) assessment dated 4/23/21 identified R5 as having a brief interview status (BIMS) of "15" (no impairment in cognition). R5 required extensive assistance with activities of daily living (ADL's) including toileting and personal cares. The MDS indicated the staff did all the effort and R5 does none to complete the activity. R5 was able to eat independently. The MDS identified R5 to have a ostomy. R5 exhibited only 1 behavior that included verbal aggression towards others. No behaviors of being resistive or refusing cares identified on MDS. The MDS identified R5 to have impairment of upper and lower extremeties Review of the annual MDS assessment dated 7/16/21, identified the resident as having a BIMS of "14" (meaning minimal impairment in cognition). R5 required extensive assistance with ADL's, including toileting and personal care. R5 was able to independely feed herself. The MDS	2 910	fluids restrictions for those receiving hemodialysis¿are at risk to be affected.¿	

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2 910	Continued From page 15 identified R5 to have a ostomy. The MDS identified R5 as having mild depressive symptoms but did not exhibit any behaviors. The MDS identified R5 to have impairment of upper and lower extremeties. Review of the current bowel and bladder evaluation dated 4/16/21, indicated R5 was continent of bladder. There was no documentation related to R5 having an ostomy. R5's current plan of care dated 4/16/21, identified R5 as having a urinary ostomy related to impaired mobility, physical limitations, infection, neuromuscular dysfunction of the bladder related to paraplegia at age 19 and pyelonephritis. Interventions included: provide ostomy care as needed, report changes in amount, frequency and color and odor of urine and report signs and symptoms of a urinary tract infection (UTI). The care plan identified R5 with a self care deficit related to being paraplegic and physical limitations. Interventions included: assist with daily hygiene, grooming, dressing and oral cares and mechanical lift for transfers. The care plan did not include R5 independently performing her own ostomy/catheter care nor did it include target behaviors that included R5 had been refusing catheter/ostomy care. R5's progress notes for the past year, did not include an assessment/training or any documentation pertaining to self ostomy/catheter cares. During the survey, the surveyor attempted to observe R5 performing self ostomy/catheter care during the survey, but the resident refused. Review of R5's urinalysis (UA's) results in the	2 910		

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2 910	Continued From page 16 past year, showed R5 has not had a urine tract infection since 8/2/20. Interview on 10/20/21, at 9:00 a.m. registered nurse (RN)-A indicated R5 has been taking care of her ostomy since admission. RN-A indicated she was unsure if R5 had been assessed or trained to provide self ostomy care. RN-A stated she did not think that R5 was fully capable of providing self ostomy/catheter care. RN-A verified R5's room often spells of strong urine. RN-A confirmed she had not re-assessed R5's capabilities of providing her own ostomy care. Interview on 10/20/21, at 9:15 a.m. nursing assistant (NA)-A indicated R5 had been taking care of her own ostomy/catheter care. NA-A indicated the staff will empty the urinal when full and measure the output, but that was all that they did. NA-A was aware of the strong urine smell but thought it was because sometimes the urinal sits for a while before staff gets to it. NA-A also stated she had not attempted to provide ostomy care, because she had been told by other NA staff that R5 would refuse. Interview on 10/20/21, at 9:30 a.m. nursing assistant NA-B indicated R5 had been taking care of her own ostomy/catheter care for as long as she can remember. NA-A indicated the staff will empty the urinal when full and measure the output, but that was all that they did. NA-B felt R5 could use assistance with her cares, but that she was told the resident would refuse. NA-B indicated she had taken care of R5 for over a year. Interview on 10/21/21, at 1:45 p.m. NA-C stated R5 takes care of her ostomy care and will empty the leg bag and catheter bag in a urinal. NA-C	2 910		

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2 910	Continued From page 17 stated then the staff will empty. NA-C indicated staff did not assist R5 with any of her ostomy/catheter care and was unsure if R5 was taking care of her catheter bags properly. A policy was requested related to assessment and self care of ostomy's/catheter drainage bags. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON), or designee, could review all residents with catheters in place to ensure proper assessments and care planning has been completed; then inservice staff pertaining to conducting a comprehensive assessment of a catheter. The DON or designee could then monitor the appropriate staff for adherence to the policies and procedures. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 910		
2 920	MN Rule 4658.0525 Subp. 6 B Rehab - ADLs Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that: B. a resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide ADL (activities of daily living) care to 2 of 2 resident (R4 and R11) reviewed for ADLs and who were dependent upon staff for grooming.	2 920	It is the policy of the facility¿to¿ensure sufficient staffing to provide routine assistance with activities of daily living (ADL's) of grooming, personal¿hygiene, dignified dining experience, treatment and	12/1/21

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2 920	Continued From page 18 Findings include: R4's facesheet printed 10/21/21, included diagnoses of morbid obesity, diabetes, paranoid personality disorder and mild cognitive impairment. R4's quarterly Minimum Data Set (MDS) assessment dated 10/8/21, indicated R4 had refused to completed the brief interview for mental status, had adequate hearing and vision, clear speech, was able to make self understood and could understand others. R4 required extensive assistance of one staff for personal hygiene. R4's plan of care dated 1/21/20, indicated hygiene was important to R4 and the goal was to maintain hygiene and health. In addition, the care plan indicated R4 had an ADL self -care deficit related to impaired cognition and mobility, and would have facial hair trimmed as needed with the assist of staff. During an interview and observation on 10/18/21, at 3:22 p.m., many white whiskers of varying lengths were observed on and under R4's chin, along with multiple long (approximately 1-2 inch) white hairs on her neck. When asked if she was aware of the hair, R4 stated she was not happy about it, but she didn't have a razor. R4 stated the facility didn't supply razors; she had asked several times. During an interview on 10/21/21, at 10:08 p.m., when asked how nursing assistants (NA's) managed chin hair on female residents, trained medication aide (TMA)-A stated NA's shaved the hair on bath day with disposable razors. Shaving	2 920	services for non-pressure related skin concerns¿and¿monitoring dialysis treatment and fluids¿restrictions¿for¿those receiving hemodialysis.¿ ¿ Immediate action: The Guardian Angel and weekend manager on duty program updated and improved which is our specific point of contact. These programs proactively solicit feedback from all residents and checks patient / resident room for housekeeping, infection control, safety. Additional staff hired ¿ Resident(s) involved:¿R4,¿R11, R215,¿R2,¿R44,¿R45,¿R60,¿R3,¿R43 and R42¿ ¿ Residents with Potential to be affected:¿Center residents¿who¿need¿routine assistance with activities of daily living (ADL's) of grooming, personal hygiene, dignified dining experience, treatment and services for non-pressure related skin concerns and monitoring dialysis treatment and fluids restrictions for those receiving hemodialysis¿are at risk to be affected.¿	

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2 920	Continued From page 19	2 920		

cream and an ample supply of disposable blue razors where observed in the supply closet. When asked specifically about R4, TMA-A acknowledged R4 had chin hair, adding if a resident was diabetic and did not have their own razor, she did not shave them due to the risk of nicking the face, and instead informed the nurse. TMA-A did not recall telling a nurse that R4's chin needed to be shaved.

During an interview on 10/21/21, at 10:17 a.m., licensed practical nurse (LPN)-A stated diabetic residents needed to have their own electric razor in order to shave chin hair, and family or guardian would need to supply it. LPN-A was aware of R4's whiskers and neck hair, but acknowledged she had never asked the social worker to contact R4's guardian to purchase an electric razor.

During an interview on 10/21/21, at 10:40 a.m., the social worker (SW)-A stated she could facilitate getting electric razors for residents, adding nursing staff just needed to tell her. Informed R4 had chin hair and according to the nursing staff, would need an electric razor to remove the hair since she was diabetic. SW-A stated "we just had R4's care conference yesterday, I could have asked the guardian. The guardian would say yes, she has the money for that." SW-A stated she would email the guardian right away and ask.

During an interview on 10/21/21, at 1:57 p.m., the director of nursing (DON) stated she would expect staff to address female residents with chin hair. When the DON was informed that nursing staff stated they could not use a disposable razor to cut facial hair if the resident was diabetic, the DON stated nurses were allowed to shave a diabetic resident who had chin hair using a

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2 920	Continued From page 20	2 920		

disposable razor, or they could request the family or guardian provide an electric razor. The DON stated this resident sometimes refused care and that may be why she had whiskers, but admitted refusal for shaving chin hair had not been documented by staff.

R11
R11's facesheet printed 10/2/21, included diagnoses stroke and dementia.

R11's quarterly Minimum Data Set (MDS) assessment date 7/24/21, indicated R11 was not able to complete the brief interview for mental status, had minimal difficulty hearing, impaired vision, clear speech, was usually understood and could usually understand. R4 required extensive assistance of one staff for personal hygiene.

R11's plan of care dated 1/15/20, indicated hygiene was important to R11 and the goal was to maintain hygiene and health. In addition, the care plan dated 1/14/21, indicated R11 had an ADL self-care deficit related to dementia, physical and visual impairment, and R11 would have assistance with daily hygiene and grooming.

During an interview and observation on 10/20/21, 08:25 a.m., R11 stated his fingernails were rough as he rubbed a finger across the nail of this left thumb. Fingernails noted to be long and jagged, especially his left thumbnail, thick and pale yellow in color. R11 stated he would like his nails trimmed.

During an interview on 10/20/21, at 12:29 a.m., (NA)-C stated NA's cleaned and trimmed resident fingernails on bath day. NA did not recall giving R11 a bath on 10/6/21. NA-C was given the "NAR bath day worksheet" she filled out that day which

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2 920	Continued From page 21 had no markings for "Nail care: fingers." NA-C was asked what it meant when there was no marking, and stated that meant the nurse needed to look at the residents fingernails when they looked at the residents skin. Together observed R11's nails. NA-C picked up R11's hands and looked at his nails and said, they should be trimmed and admitted they were long and that the left thumbnail was jagged. During an interview on 10/20/21, at 1:45 p.m., together with the DON, observed R11's nails. The DON admitted they were jagged and "a little long." The DON stated she expected them to be trimmed, and R11 "needed a good filing at least." Informed the DON that R11's bath sheet for 10/6/21, was blank for nail care. The DON stated no checkmark for fingernails did not mean they weren't looked at....it meant the resident did not need nail care. During an interview on 10/21/21, at 4:45 p.m., due to conflicting explanation of what a checkmark or no checkmark meant for nail care on the bath day worksheet, the DON was asked to clarity. The DON stated if nail care was checked off, it meant the NA cleaned, trimmed and filed the nails. If there was no checkmark, that indicated the resident was on coumadin or was diabetic and the nurse would need to look at the nails. R11 was neither diabetic or on a blood thinning medication. Bath day worksheets for R11 indicated: 9/13/21: nail care for fingers: "ok" 9/20/21: nail care for fingers was not checked, which according to the DON meant nails were to be addressed by the nurse. 10/6/21: nail care for fingers was not checked, which according to the DON meant nails were to	2 920		

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2 920	Continued From page 22 be addressed by the nurse. 10/13/21: nail care for fingers was checked, which according to the DON meant R11's nails were cleaned, trimmed and filed. The observation of R11's fingernails a week later on 10/20/21, showed them to be long and left thumbnail jagged. During an observation on 10/21/21, at 12:30 p.m., observed R11's nails to still be long, but left thumbnail was no longer jagged. Facility policy titled Personal Needs, with revised date of October 2016, indicated the facility strived to promote a healthy environment by meeting the personal needs of the residents. Personal care and ADL support would be provided according to the residents care plan. Compliance with care delivery needs and interventions would be determined by observation of care delivery. Personal care and support included grooming, nail care and shaving. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could ensure that residents who are unable to carry out activities of daily living receive the necessary services to maintain grooming needs. The director of nursing or designee could implement audit tools to monitor compliance. Audit results could be reported to the QAPI committee for further recommendations related to ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 920		
21015	MN Rule 4658.0610 Subp. 7 Dietary Staff Requirements- Sanitary conditi	21015		12/1/21

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21015	Continued From page 23 Subp. 7. Sanitary conditions. Sanitary procedures and conditions must be maintained in the operation of the dietary department at all times. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure proper infection control practices were followed while preparing food for 7 of 7 residents (R216, R2, R37, R38, R16, R215 and R44) and while assisting residents with their meal (R215) during 1 of 3 meals observed. Finding include: During observation on 10/20/21, at 8:13 a.m. transport assistant (TA) was observed seated at table with R30 encouraging her to eat. TA picked up a piece of bacon with her bare hands and handed it to the resident then continued to feed R30 oatmeal with a spoon. At 8:15 a.m., TA again was observed picking up apiece of bacon with her bare hands and handing it to R30 to eat. On 10/20/21, at 8:29 a.m. TA washed hands then sat down at another table in the dining room to assist R215. TA was observed to cut up R215's bacon using bare hands to secure the bacon while trying to cut it in bite-size pieces. When interviewed on 10/20/21, at 9:26 a.m. TA confirmed she should not have been touching the bacon with her bare hands when assisting residents with eating. On 10/20/21, at 12:48 p.m. NA-E was observed	21015	It is the policy of the facility¿to ensure dishwashing sanitization is appropriately monitored, opened food is dated in kitchen refrigerator and¿pans are completely dry before storing.¿It is also the policy of the facility to ensure an adequately trained dietary supervisor oversees and supervises all aspects¿of dietary¿services and ensures¿dietary¿cooks¿and¿aides¿receive comprehensive training upon hire and ongoing.¿This includes proper infection control practices being followed¿while preparing, serving and assisting residents with their meals.¿ ¿ ¿ Immediate actions: Paper products used in the kitchen for residents until Ecolab service tech who services dish machine could service the machine which was the next day. Resident(s) involved:¿ R216. R2. R37. R38, R16,¿R215 and R44¿ ¿ Residents with Potential to be affected:¿All residents at the facility are at risk¿to be affected.¿ ¿ Education:¿All dietary staff educated before the next shift by the	

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21015	Continued From page 24 delivering a Styrofoam container to R38 with the resident's lunch. The meal included two soft shell tacos. NA-E picked up one of R38's taco's with her bare hands and demonstrated to R38 how to pick it up and eat it. NA-E then placed the taco back into the container, washed her hands, then continued to pass out meals to other residents. During observation on 10/20/21, at 12:44 p.m., nursing assistant (NA)-E served R216 tacos in a Styrofoam container with ground beef, tomatoes, lettuce all in separate serving cups and soft taco shell on bottom of container. NA-E used fork to put ingredients on the taco shell, then added sour cream. NA-E then picked up the soft taco shell and molded them closed with her bare hands and demonstrated for the resident how to pick it up. Did not observe hand hygiene after touching Styrofoam container and touching food, or between residents. The process was repeated for R2, R37 and R16. During observation on 10/20/21, at 1:16 p.m., NA-E opened R215's Styrofoam container with soft shell taco shell, ground beef, tomatoes, lettuce in separate serving cups. NA-E used a fork to put ingredients on taco shell, then added sour cream in an individual packet and spread with the fork. NA-E picked up taco shell with her bare hands molding it closed and offered R215 a bite of the taco. NA-E continued to use bare hands on taco to assist R215 to take 3 bites of taco. NA-E then set down taco, cut taco in half and using both hands offered another bite. NA-E then took R215's hands and put them on the taco shell and R215 attempted to take a bite but taco fell apart. NA-E using her bare hands took the taco from R215 and gave her 3 more bites and removed Styrofoam container picking up the banana bread with her hands and sitting it on a	21015	DON/Designee/Facility Staff/designee by 12/1/2021¿or before their next shift begins.¿ ¿ Monitoring:¿To ensure ongoing compliance the DON/Designee/ Facility staff to complete audits weekly beginning the and ongoing for at least three months. The results of the audits will be reviewed by the QAPI committee for trends¿and¿any needs for adjustment of audit schedules or content, as well as any further educational needs.¿	

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21015	Continued From page 25 napkin in front of R15. During observation on 10/20/21, at 1:31 p.m., NA-E sat down by R44, opened Styrofoam container then touched the top of the straw with her bare hands and offered a drink of juice. R44 took a drink of the juice. During interview on 10/21/21, at 4:10 p.m., the director of nursing (DON) confirmed staff should never touch food directly with their hands whether washed or unwashed unless they have gloves on or are using a pair of silverware or tongs. A facility policy titled Dining Services Department Policy and Procedure Manual last revised 9/2017, did include infection control considerations but only included the nursing staff shall be responsible for verifying meal accuracy and delivery of meals to residents/patients. SUGGESTED METHOD FOR CORRECTION: The administrator and the dietician could review and revise food service policies and procedures to assure that food is served in a sanitary manner. Staff could be trained as necessary. The certified dietary manager could monitor the service of food preparation on a periodic basis. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	21015		
21134	MN RULE 4658.0670 Supb. 2. Dishwashing; Sanitation, storage Sanitization; storage. All utensils and equipment must be thoroughly cleaned, and food-contact	21134		12/1/21

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21134	Continued From page 26 surfaces of utensils and equipment must be given sanitization treatment and must be stored in such a manner as to be protected from contamination. Cleaned and sanitized equipment and utensils must be handled in a way that protects them from contamination. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure dishwashing sanitization was appropriately monitored. In addition, the facility failed to date-mark opened containers of food in a kitchen refrigerator and to ensure pans were completely dry before storing. Furthermore, the facility failed to ensure an adequately trained dietary supervisor oversaw and supervised all aspects of dietary services and ensured dietary cooks and aides received comprehensive training upon hire and on-going. This had the potential to affect all 65 residents who were served food from the kitchen. Findings include: During the initial kitchen observation and interview on 10/18/21, at 1:45 p.m., observed dietary aide (DA)-C placing dishes through the Ecolab dishmachine. Rinse dial indicated a temperature of 130 degrees Fahrenheit (F) and wash dial was at 158 degrees F. A vial of Ecolab chlorine test paper strips were noted on top of the dish machine. The cap was off the vial, the vial was dusty and the paper label on the vial was faded to gray. The strips expired on 10-1-20. DA-C did not know if the dish machine sanitized dishes with hot water or chemical. During an interview and observation on 10/18/21, at 1:59 p.m., while standing in the dishmachine	21134	It is the policy of the facility¿to ensure dishwashing sanitization is appropriately monitored, opened food is dated in kitchen refrigerator and¿pans are completely dry before storing.¿It is also the policy of the facility to ensure an adequately trained dietary supervisor oversees and supervises all aspects¿of dietary¿services and ensures¿dietary¿cooks¿and¿aides¿receive comprehensive training upon hire and ongoing.¿This includes proper infection control practices being followed¿while preparing, serving and assisting residents with their meals.¿ ¿ ¿ Immediate actions: Paper products used in the kitchen for residents until Ecolab service tech who services dish machine could service the machine which was the next day. Resident(s) involved:¿ R216. R2. R37. R38, R16,¿R215 and R44¿ ¿ Residents with Potential to be affected:¿All residents at the facility are at risk¿to be affected.¿ ¿ Education:¿All dietary staff educated before the next shift by the	

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21134	Continued From page 27 room, cook (C)-C stated he did not know if the dish machine sanitized with hot water or chemical. C-C provided a clipboard with a form titled Dish Machine Log for October 2021. The log had 13 columns for date, wash and rinse temperatures, ppm (parts per million) and staff initials for each meal service of breakfast, lunch and dinner. The logs for October and September were reviewed and noted that all of the readings were basically the same, three times a day for two months. C-C stated he did not write on this log -- another cook and the manager did. C-C pointed to the bottom of the log which indicated temperature and ppm standards of: High temp wash 150 - 160 F. High temp rinse 180 F. Chemical sanitizing (low temp): Wash 120-140 F. Rinse 120-140 F. Manufacturer recommended PPM: _____ (no number was written in this blank). Standing in front of the dish machine, C-C explained the temperature readings on the dials. When ask how the ppm reading was obtained, C-C stated he didn't know how to measure that. The facility policy was requested, and C-C presented a policy titled Warewashing, revised date of 9/2017, which indicated the dining services staff would be knowledgeable in the proper technique for processing dirty dishware, but it did not provide guidance on how to measure ppm for chemical sanitization of dishware. During a telephone interview on 10/18/21, at 2:47 p.m., the Ecolab representative (ER)-G stated the facility used chemical to sanitize dishes in their dish machine.	21134	DON/Designee/Facility Staff/designee by 12/1/2021¿or before their next shift begins.¿ ¿ Monitoring:¿To ensure ongoing compliance the DON/Designee/ Facility staff to complete audits weekly beginning the and ongoing for at least three months. The results of the audits will be reviewed by the QAPI committee for trends¿and¿any needs for adjustment of audit schedules or content, as well as any further educational needs.¿	

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21134	Continued From page 28 During an interview and observation on 10/18/21, at 2:50 p.m., with C-C, multiple jelly roll pans were stacked one on top of another, upside down. C-C was asked to pick up a few of the top pans and the top two were still wet on the inside surface. Three multi-tiered wire carts that held pans and other kitchenware, did not have a solid bottom shelf. Multiple plastic cutting boards were observed stacked vertically, one against the other. During an interview and observation on 10/19/21, at 12:08 p.m., (C)-B stated chemical was used in the dish machine to sanitize dishes. While standing in front of the dish machine, C-B was asked how ppm of the chemical sanitizing solution was measured, and he replied they used the test strips that were on top of the dish machine. C-B admitted it did not look like the test strips had been used in a while and verified they had an expiration date of 10/1/20. C-B then admitted he did not know how to test ppm, even though he admitted to writing 100 ppm and initialing the dish machine log on multiple days in October. During an interview and observation on 10/19/21, at 12:48 p.m. dietary manager (DM)-A stated chemical was used in the dish machine to sanitize dishes. When asked how the ppm of the chemical sanitizing solution was determined, DM-A stated with strips. DM-A then admitted she did not know how to test ppm and admitted she wrote 100 ppm on the log and initialed it, but didn't actually test the ppm. Together viewed the Ecolab chlorine test paper strips on top of the dish machine and DM-A verified they had expired on 10/1/20. DM-A went to her office and took a padded mailing envelope out of a desk drawer	21134		

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21134	Continued From page 29	21134		

and displayed testing strips, including Ecolab chlorine test paper strips, adding she was aware of these, but did not know what they were for. DM-A stated she would contact Ecolab for training.

During an interview and observation on 10/19/21, at 1:40 p.m., the administrator was brought to the kitchen and explained staff did not know how to do required testing to measure chemical sanitation and that staff had been documenting ppm on the dish machine log without actually testing it. The administrator stated the kitchen staff were contracted workers and have had a lot of turn over, and the current staff had not received adequate training. The administrator stated he would contact Ecolab to do staff training as soon as possible.

During an interview and observation 10/19/21, at 2:02 p.m., with C-B in the walk-in refrigerator, observed a large white pail of Papettis brand table-ready, peeled hard boiled eggs; 25 pounds in liquid. The pail had been opened, but had no date-opened marking. C-B stated they were good for seven days after opening and thought the pail was opened on 10/14/21. Other foods without date-opened markings included cooked macaroni in a plastic container with cover and ham slices in a plastic container with cover. C-B removed the macaroni and ham from the refrigerator, stating they should have been marked when placed in the refrigerator and would discard them.

During an interview on 10/19/21, at 2:11 p.m., C-B stated the hard boiled eggs were good until the manufacturer date of 11/21. At 2:21 p.m., with DM-A and C-B, C-B stated he called his boss and was told the eggs were good for seven days and since they could not confirm the date opened,

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21134	Continued From page 30 would discard them. During an interview on 10/20/21, at 10:12 a.m., DM-A stated she spoke to her district manager on the phone and received instructions on how to test ppm on the dish machine sanitization solution and would be training the rest of the kitchen staff. DM-A explained that the district manager told her to dip an (unexpired) Ecolab chlorine test paper into water that was on dishes that had just come through the dish machine. DM-A stated she had done that and recorded 50 ppm on the dish machine log. When asked what the required ppm was, DM-A stated she did not know. Requested DM-A to run a test load and measure the ppm with the Ecolab chorine test strips. When doing so, the sanitizing solution failed, testing at 10 ppm, verified by DM-A. During an interview on 10/20/21, at 11:32 a.m., the administrator was informed when DM-A measured the ppm of the sanitizing solution in the dish machine, it failed. The administrator stated he would contact Ecolab again and have kitchen staff start using disposable dishware for meal service in the meantime. During a telephone interview on 10/21/21, at 8:40 a.m., registered dietician (RD)-H stated she worked part-time on Mondays and as needed remotely, for the dietary contracted service like the rest of the dietary workers. Has ServSafe certification. RD-H stated she did not really provide guidance to the dietary staff, but was there for questions. RD-H stated she did monthly sanitation audits and had been focusing on hand hygiene within the kitchen. RD-H stated she learned about dish machine temperatures as part of her education, but did not know proper temperatures for heat or ppm for chemical	21134		

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sanitization. RD-H stated she looked at the dish machine log to make sure staff were recording the information, but would not be able to identify incorrect water temperatures or ppm.

During a telephone interview on 10/21/21, at 12:31 p.m., the district manager for the contracted service (DMCS)-I stated she was also a registered dietician. DMCS-I stated DM-A started on 8/2/21, adding that DM-A was initially hired as a manager-in-training to go through their training program. DMCS-I stated that the prior manager had not worked out so DM-A had been put into the manager position, adding "she is a go-getter." DMCS-I stated she was onsite initially to train DM-A, and when she needed help with the dish machine this week, DM-A called her and she walked her through it. Furthermore, DMCS-I stated she oversaw this account and DM-A's training was through her, adding it's been "Training on the fly - she calls and asks questions; I've been there as much as I can." DMCS-I was informed DM-A and C-B had admitted they did not know how to measure ppm and and did not actually check ppm on the dish machine, yet they filled in the ppm on the log. DMCS-I stated the expectation was for staff to be properly trained on monitoring and measuring temperatures and ppm on the dish machine, and not to falsify information if they didn't know how to do something. DMCS-I could not recall specially if she trained DM-A on this, nor could she confirm if either DM-A or C-B had this training online. DMCS-I stated there was no orientation record or checklist, but would provide online training records.

Review of online training records for DM-A, C-B and C-C indicated completion of the following modules:

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21134	Continued From page 32 1. Cleaning and Sanitizing: content included using a cleaning solution in a bucket to clean surfaces. 2. Pots and Warewashing: content included a chemical sanitizing agent would be mixed with the final rinse water and sprayed onto to the Ware during the final rinse cycle. The temperature of the water and sanitizer mixture must be maintained at a temperature no lower than 120. Defer to the manufacturers guidelines and state/federal regulations. The training did not include guidance for monitoring and measuring ppm. This training also included a section on "wet nesting" which occurred when clean pans, plates, cups, and bowls were stacked together without completely drying first. This action could result in a breeding ground for bacteria, even on clean items. 3. Receiving and Storage of Food: content included receiving and storing refrigerator foods. 4. Labeling and Dating: content included labeling and dating leftovers with the dated prepared and the use-by date. During an interview on 10/21/21, at 3:58 p.m., reviewed kitchen findings with the administrator, including lack of knowledge to monitor and measure sanitization solution of dish machine, wet pans, and food not labeled when opened. The administrator stated he expected the staff would have had the required training for these things, but they have had so much turnover and it had been difficult to secure trained staff. The administrator stated with a contracted service, they had to work with whomever the service hired. In addition, the administrator stated that based on interactions with DM-A thus far, he believed she would be a good manager as she is responsive and is on top of things, and just needed more time and training.	21134		

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21134	Continued From page 33 Facility policy titled Warewashing, with revised dated of 9/2017, indicated all dishware would be cleaned and sanitized after each use. Staff would be knowledgeable in the proper technique for processing dirty dishware through the dish machine and proper handling of sanitized dishware. All dish machine water temperatures would be maintained in accordance with the manufacturer recommendations for high or low temperature machines. Temperature and/or sanitization concentration logs would be completed as appropriate, and that all dishware would be air dried and properly stored. Facility policy titled Receiving, with revised dated of 9/2017, indicated safe food storage procedures for time and temperature control would be practiced in the transport, delivery, and subsequent storage of all food items. All food items would be labeled and dated either through manufacturer packaging or staff notation. Facility policy titled Food Storage: Cold Foods, with revised dated of 9/2017, indicated all food would be stored in wrapped or covered containers, labeled and dated. SUGGESTED METHOD OF CORRECTION: The dietary director or designee could develop and implement policy and procedure to ensure all staff have been educated and are following regulation to monitor dishmachine sanitation requirements. Audits could be conducted to ensure compliance and results brought to the quality committee for review. The dietary director or designee could develop and implement policy and procedure to ensure all staff have been educated and are following regulation to ensure dishes and pans are thoroughly dried before stacking/storing. Audits could be conducted to	21134		

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21134	Continued From page 34 ensure compliance and results brought to the quality committee for review. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21134		
21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to follow Centers for Medicare and Medicaid Services (CMS) and Centers for Disease Control (CDC) guidelines by appropriately implementing measures to prevent the spread of COVID-19 when the facility failed to ensure personal protective equipment (PPE) including masks, were worn correctly by dietary staff, and failed to ensure hand hygiene was performed by staff when delivering meal trays. In addition the facility failed to ensure hand sanitizer was available for hand hygiene. In addition, the facility failed to ensure room cleanliness when maggots were discovered in the shoe and on the foot of 1 of 1 resident (R4), reviewed for wound care. Furthermore, the facility failed to ensure proper infection control practices during a dressing change for 1 of 1 resident (R4) reviewed for wound care. In addition, the facility failed to consistently provide the necessary care and services in the management of tube feedings to prevent infection for 2 of 2 residents (R27, R51)	21375	It is the policy of the facility¿to ensure¿proper¿personal protective equipment (PPE) including masks, are worn correctly by¿dietary¿staff,¿that hand hygiene is¿performed¿by staff when delivering meal trays, hand sanitizer is available for hand hygiene, room cleanliness¿is completed,¿use of proper infection control practices during wound care¿and with¿care and services for¿residents¿with tube feedings.¿ ¿ Immediate Action(s):¿ R4's room cleaned on 10/20/21 by housekeeper to address bedrails and surfaces without personal items.¿ Additional hand¿sanitizer dispensers were placed¿throughout facility near resident rooms¿starting 10/20/21¿by housekeeper¿supervisor.¿ ¿ Resident(s) involved:¿R4, R27 and	12/1/21

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21375	Continued From page 35 reviewed for tube feedings. The deficient practices had the potential to affect all 65 residents who resided in the facility. Findings include: R4 R4's facesheet printed 10/21/21, included diagnoses of cellulitis of leg (skin infection), lymphedema (swelling of leg due to build-up of lymph fluid), venous insufficiency (failure of veins to adequately circulate blood), morbid obesity, diabetes, paranoid personality disorder and mild cognitive impairment. R4's quarterly Minimum Data Set (MDS) assessment dated 10/8/21, indicated R4 declined to complete a brief interview for mental status, did not exhibit any behaviors - including rejection of care, had adequate hearing and vision, clear speech, was able to make self understood and could understand others. R4 did not walk and required extensive assistance of two staff for bed mobility, transfers and toileting. R4 was frequently incontinent of urine and always incontinent of stool. R4 had an infection of her foot requiring a dressing. Physician orders included: 3/23/21: Wash feet with soap and water every evening. 10/15/21: Right lower extremity and right dorsum (top) foot and right lower abdominal panniculus (a sheet of fat tissue in the lower abdominal area): acetic acid soaks two times a day for 7 days. R4's plan of care dated 1/21/20, indicated R4 had actual skin integrity break related to mobility and incontinence at that time, and a goal indicated skin would show signs of progressive healing	21375	R51¿reviewed for corrective actions around specific concerns noted; charts reviewed¿for potential ill effects¿and¿care plans reviewed by¿DON¿and/or Designee by¿12/1/2021.¿ ¿ Residents with Potential to be affected:¿All residents at the facility are at risk to be affected related to meal services, hand hygiene, room cleanliness and¿proper PPE usage. Like residents reviewed for tube feeding practices and wound care.¿ ¿ RCA:¿¿Facilities QAPI Committee met on 11/24/21¿(including Medical Director and Governing Body) to discuss root cause¿to identify¿the problem(s) that resulting in the potential deficiency and developed interventions¿and corrective action plans to prevent recurrence.¿ ¿ Education:¿Center Staff re-educated by DON and/or designee by 12/1/2021 on proper personal protective equipment (PPE) including masks, are worn correctly by dietary staff, that hand hygiene is performed by staff when delivering meal trays, hand sanitizer is available for hand hygiene, room cleanliness is completed, use of proper infection control practices during wound care and with care and services for residents with tube feedings.¿ ¿ Monitoring:¿To ensure ongoing compliance the DON/Designee¿to complete¿the following¿audits:¿cleaning and disinfection of resident use equipment/environmental, all¿shifts, daily x 1 week,¿then 3x weekly various shifts x	

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21375	Continued From page 36 without signs of infection. The care plan did not identify current skin infection and treatments ordered to enhance healing and reduce infection. During an interview and observation on 10/18/21, at 3:51 p.m., R4 who in a hospital gown, and was sitting on the side of her bed, facing the door with her legs over the side of the bed. R4's bare feet rested directly on the tile floor. Tile floor was dull and looked dirty with dark smudges. Multiple surfaces in the room were covered with R4's personal items and some facility supplies (boxes of gloves), on three overbed tables, a small bedside dresser, the window sill, and open storage next to the window. The only surface not covered was half of the overbed table closest to the bed. On the floor next to the bed, papers and envelopes were scattered about. On the commode were balled up elastic leg wraps and some clean towels. Black shoes were noted under an overbed table. A white rectangular plastic basin, upside down, was noted on the floor between bed and wall. During an interview on 10/19/21, at 2:56 p.m., when asked if staff washed her feet every day, R4 stated her feet had been soaked maybe twice since arriving to the facility a year and a half ago. No soaking supplies observed in room except for the white rectangular plastic basin, upside down on the floor. A progress noted dated 10/2/2021, at 12:02 a.m. indicated, During bedtime cares we removed her shoes on her right foot had maggots crawling out of her shoe and between her toes. The bottom of her right heel is very dry but not open. Her right leg and foot have ongoing edema and redness. Bilateral feet soaked, bed bath given, shoes cleaned and sprayed. Will continue to monitor.	21375	7 weeks. Hand hygiene audits on all shifts, daily x 1 week,¿then 3x weekly various shifts x 7 weeks.¿PPE audits all shifts, 4 x weekly for 1 week, then twice weekly for 7 weeks.¿ ¿ ¿ The results of the audits will be reviewed by the QAPI committee for trends¿and¿any needs for adjustment of audit schedules or content, as well as any further educational needs.¿	

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21375	Continued From page 37 Advised resident to leave her shoes off when sleeping to let her feet air out. During an interview on 10/20/21, at 8:17 a.m., when asked about maggots on R4's feet, licensed practice nurse (LPN)-A stated she was unaware of that. Informed it was in the progress notes dated 10/2/21; then she read, stating that was something that should have been communicated to her. During an interview on 10/20/21, at 8:42 a.m., nursing assistant (NA)-A stated she was aware of the maggots, adding R4 was "wearing her shoes and wouldn't let us change them...almost have to fight her to do it, and we can't do that." During an interview on 10/20/21, 12:47 p.m., noted the surface of the overbed table closest to the bed -- the one R4 used most often, was soiled. Half of the surface was cluttered with R4's personal items, including multiple condiments. The remaining surface was visibly soiled as evidenced by swirls of light grayish material. The metal coated bed rails were heavily soiled with finger prints and smudges. In addition, the floor was dirty with dark smudges. The housekeeping supervisor (HS)-A was brought in to look at R4's room and he validated that the surfaces needed to be cleaned and that they must have been overlooked by the other housekeeper. HS-A added housekeeping didn't like to disturb residents, but rooms should still be cleaned. HS-A stated he cleaned the floor the day prior, but only the areas not covered by pieces of equipment or furniture. HS-A admitted housekeeping did not routinely pick up or move items in resident rooms to clean under them. During an interview on 10/20/21, 1:12 p.m.,	21375		

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housekeeper (H)-B admitted he didn't want to move things in R4's room when he cleaned, and stated he would go back and clean the bedrails and the surfaces that didn't have R4's personal items on them.

During an interview and observation on 10/20/21, at 1:59 p.m. in R4's room with licensed practical nurse (LPN)-A and the director of nursing (DON), LPN-A placed non-sterile 4x4's and gauze wrap directly on top of a book on R4's overbed table (the gauze dressings were not in packaging). Half of the overbed table was covered with condiments and personal items. The side that had the book setting on it, had dried material and smudges on the surface. With non-sterile gloves, LPN-A dipped 4x4 pieces of gauze into acetic acid solution in a cup, and squeezed it out (most of the liquid dripped to the floor). LPN-A placed the moist 4x4 gauze on R4's lower right leg and and wrapped the leg with gauze while the DON held R4's leg. While holding the leg, the DON's long and unrestrained hair touched R4's leg in the area where the skin was red and the gauze was being applied. In the hallway after the treatment was completed, LPN-A and the DON were asked how they thought the treatment went, and both said good. LPN-A and the DON were informed of infection control breaches: placing dressing material directly on an unclean surface, the DON's hair touching R4's leg at the site the dressing was being applied, and medicated solution allowed to drip on the floor and which was not cleaned up until pointed out. Both stated they were unaware of these observations. The DON stated she would talk to the nurses about how to improve this dressing application process, adding proper technique was expected during treatments to prevent cross contamination and infection. The DON admitted R4 was already

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vulnerable to infection with cellulitis of her lower right leg.

During a telephone interview on 10/21/21, at 9:02 a.m., registered nurse (RN)-A was asked if she washed R4's feet with soap and water, RN-A replied no. When informed she initialed that she did soak R4's feet several times this month, RN-A replied, "Okay." RN-A admitted: "I might have signed off on it at the end of the shift and not done it." RN-A further stated, "We are constantly rushed; we can't do everything. Everyone is frustrated; I get done what I can." RN-A had not told the DON or administrator how she felt about her workload.

During a telephone interview on 10/21/21, at 9:06 a.m., (RN)-C stated, "I offered the treatment to R4, but she refused to let me clean her abdomen and feet." RN-C stated she had filled out SBAR (situation, background, assessment, recommendation) documentation to the physician about the refusal and that it should be in R4's record. RN-C stated she also sent a copy of the SBAR to the DON. According to an interview with the DON on 10/21, at 1:57 p.m., there was no SBAR documented about this in R4's EMR, nor did she receive a copy of an SBAR.

During an interview on 10/21/21, at 1:57 p.m. the DON and the corporate director of clinical services (DCS) where asked when they became aware of R4 having maggots in her shoe and on her foot. The DON stated the identification of maggots occurred on Saturday 10/2, and she became aware of it on Monday 10/4. When asked what action had been taken after the discovery of the maggots, the DON stated the night nurse informed the physician. In addition, the DON stated deep cleaning had been done in R4's

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room. Discussed current condition of room, and if deep cleaning had occurred two weeks ago, how could the current condition be explained? The DON stated R4 refused to let them move things in her room in order to clean. The DON admitted staff were responsible for picking up and cleaning R4's room as she was not physically capable to pick things up off the floor, or to organize her personal items. The DCS stated resident rooms needed to be maintained in a clean and neat manner and she would assess R4's room. The DON stated she felt the maggots occurred when R4 urinated on her shoes and then refused to remove her shoes. There was no documentation or observation of R4 urinating onto her shoes, her feet, or the floor.

Facility policy titled Dressing Change, Clean, dated 6/2017, indicated the purpose was to protect the wound, prevent infection and promote healing. The procedural steps indicated to create a clean field with paper towels or towelette drape. Documentation included to date and time the dressing change, document the wound size, site, depth, color and drainage, and progress of healing.

Facility policy titled Cleaning Resident Rooms, dated 6/1/2017, indicated to carefully removed items on top of furniture to dust and then replace items exactly as they were. Clean top of window sills. Using all-purpose cleaner, clean countertops and front of cabinets. Sweep or vacuum the floor of the room that is not obstructed by furniture. Move small pieces of furniture to vacuum under or around it. Use spot remover for carpets. Note: this facility did not have carpet in resident rooms.

Masks

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21375	Continued From page 41 --During an observation on 10/18, at 6:08 p.m., Covid 19 unvaccinated dietary aide (DA)-B with mask below nose, dropped off tray cart on 2nd floor, west wing. Standing within several feet of staff, informed them the cart was there. --During an observation on 10/19, at 12:11 p.m., Covid 19 vaccinated (DA)-A wore mask below her nose as she worked along side Covid 19 unvaccinated dietary manager (DM)-A dishing food from steam table. --During an interview and observation on 10/20, at 7:48 a.m., Covid 19 unvaccinated (C)-B had no mask on. Mask was observed in his breast pocket. C-B stated he didn't wear a mask in the kitchen; "can't breathe and it would be a hazard." --During an interview on 10/19, at 1:55 p.m., the director of nursing (DON) who was also the infection control nurse stated dietary workers were contracted staff, "but when they were in the building, should follow our policy and wear a mask." Reviewed facility policy: Pandemic Preparedness and Response dated 3/23/21, which indicated all healthcare personnel would wear well-filling facemasks that always cover the mouth and nose where they might encounter residents or co-workers. The DON stated she would talk to the dietary staff and the manager about wearing facemasks properly. --During an interview on 10/19, at 2:02 p.m., C-B had mask on and stated "I called my boss, we need to wear a mask. I didn't know that. I sent a message to everyone in kitchen; we didn't know that." --During an observation on 10/21, at 10:10 a.m., C-B had no mask on as he was walking about the kitchen with other staff members present. --During an observation on 10/21, at 10:21 a.m., in the entrance to the kitchen near the dishwashing room, DA-A and C-B were standing talking, about a foot away from each other, both	21375		

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with masks below their nose.
--During an observation on 10/21, at 12:02 p.m., DA-A and C-C were standing shoulder to shoulder at steam table plating lunch, both with masks below their nose.

Hand Hygiene

--During an observation on 10/18/21, at 6:12 p.m., (NA)-F came out of room 211 after taking a tray in and pulled the door shut with her hand upon exiting, then proceeded to fill cups with juice and milk for R48 in room 204, then coffee for room 213, all without performing hand hygiene. At 6:14 p.m., (NA)-G took a tray to the dining room for R1; moved R1's baseball cap which had been sitting on the table, out of the way with his hand, then set the tray down. No hand hygiene performed afterwards. Went back to cart to deliver trays to rooms.
--During an interview on 10/18/21, at 6:21 p.m., NA-F admitted she did not clean her hands in between delivering trays and filling beverage cups stating hand sanitizer was not available in hallways and they had to work fast to get the trays delivered. In addition, NA-F admitted staff did not assist residents in cleaning their hands before meal trays were delivered, nor were they encouraged to do so. NA-F stated residents could clean their hands in their bathroom.
--During an interview on 10/19/21, at 2:42 p.m., the DCS stated staff were expected to sanitize hands prior to entering residents rooms and was not aware that hand sanitizer dispensers were not located outside or inside the resident's rooms, or in the hallways on each unit. Furthermore, DCS was not aware that the few hand sanitizer dispensers that were available, were empty. DCS stated she would make sure they got filled right away.

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21375	Continued From page 43 --During an interview on 10/19/21, at 2:50 p.m., the administrator stated hand sanitizer was on backorder and the staff were expected to carry hand sanitizer in their pockets. In addition, a container of hand sanitizer was to be on each medication cart in each hallway. A copy of the backorder invoice for hands sanitizer was requested and not received. --During an observation and interview on 10/20/21, at 10:30 a.m. HS-A was observed unpacking wall mount hand sanitizer dispensers and stated he would start hanging them. --During an observation on 10/21/21, at 9:07 a.m., (NA)-B filled two navy colored insulated mugs with ice from a large picnic-type cooler on 2nd floor using the scoop from a pouch attached to the side of the cooler. No hand hygiene was performed prior to filling the mugs. Multiple undocumented observations were made of staff walking up to the cooler and scooping ice from the cooler to fill resident cups and mugs without performing hand hygiene. No hand sanitizer dispenser near/next to the cooler. --During an observation on 10/20/21, at 12:43 p.m., observed R10 wheel up to the cooler on 2nd floor in her wheelchair, and by herself filled her own orange pumpkin cup with pink top and straw, using the scoop in the pouch on side of cooler, touching the scoop to the rim of her cup. DM-A arrived shortly after and was informed of this. She removed the cooler from the unit to clean and replace. --During an interview on 10/21/21, at 11:42 a.m., the DCS and DON stated staff were expected to sanitize their hands prior to entering a residents room entered and had received training and ongoing education related to hand hygiene. On 10/18/21, at 4:00 p.m. an the east and west wing on the second floor was observed and	21375		

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lacked the availability of hand sanitizer outside or inside the residents' rooms.

On 10/19/21, at 8:44 a.m. on first floor adjacent to the elevator doors a hand sanitizer dispenser was observed, however the dispenser was empty.

On 10/19/21, at 8:46 a.m. a wall hand sanitizer dispenser was observed outside of room room 321, however the dispenser was empty

On 10/19/21, at 2:09 p.m. nursing assistant (NA)-A stated hand sanitizer were not easily accessible throughout the facility and created difficulty to wash her hands when she entered and/or exited resident rooms, NA-A stated staff do not wash or sanitizer their hands frequent as we needed. NA-A stated she went room to room at times, without hands sanitized or washed, when hand sanitizer was not available. NA-A stated staff were supposed to get hand sanitizer, but have not received them yet.

On 10/19/21, at 2:42 p.m. the Senior Director of Clinical Services (DCS) stated staff were expected to sanitize hands prior to resident's room entered, and included the staff who delivered meal trays were expected to sanitize hands prior to resident's room entered. The DCS was not aware hand sanitizers were not located outside or inside the resident's rooms, and further stated she expected the hand sanitizers available for staff inside or outside of the resident's rooms. The DCS indicated she would ensure the hand sanitizer dispensers in the empty hand sanitizers throughout the facility were filled.

On 10/19/21, 2:50 p.m. an interview with administrator stated hands sanitizer was on backorder and the administrator stated staff were

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expected to carry hand sanitizer in their pockets and hand sanitizer was expected on the medication carts of each hall. A copy of the backorder of the hands sanitizer was requested and not received.

On 10/21/21, at 11:42 an during an interview with director of nursing (DON), the DON stated staff were expected to sanitize their hands prior to entering a residents room and indicated staff received training and ongoing education related to hand hygiene.

Facility policy titled Source Control ad Distancing Measure - Covid 19, dated 4/16/21, indicated: nursing home populations were at high risk of being affected by Covid-19 and other pathogens. The measures outlined in the policy may help reduce the spread of droplets when a person talks, sneezes, or coughs and thereby reduce the spread of Covid 19 by someone who is infected, but does not know it. All healthcare personnel would wear well-filling facemasks that always cover the mouth and nose when in the facility where they might encounter residents or co-workers.

Facility policy titled Pandemic Preparedness and Response dated 3/23/21, indicated staff should perform hand hygiene according to CDC guidelines, including before and after contact with residents, contaminated surfaces or equipment. Place alcohol based hand rub in every resident room if supply numbers are adequate. Have hand sanitizer available and strategically placed throughout the center.

Tube feedings

R51

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21375	Continued From page 46 R51's admission record, printed on 10/20/21 included diagnosis of multiple sclerosis, type 2 diabetes mellitus, and adult failure to thrive. R51's significant change Minimum Data Set (MDS) assessment dated 9/16/21 indicated moderate cognitive impingement, a percutaneous endoscopic gastrostomy (PEG), (a surgery to place a feeding tube) tube and totally dependant on staff staff for feeding assistance with 51% or more of feeding by tube feeding. R51's plan of care dated 9/24/21, indicated R51 was at risk for nutritional status change related to dysphagia (swallowing difficulty) and need for tube feeding. Interventions included Isosource 1.5 calories given three times a day with 2 cans during first feeding and one can at subsequent feedings. During observation on 10/18/21, at 6:03 p.m., tube feeding (TF) bag with approximately 500 cc of formula was hanging on a pole with purple tubing end, (end that connects to PEG tube) uncovered and unlabeled. Licensed practical nurse (LPN)-C indicated the TF system comes prefilled with the solution and the tubing already connected to the bag and is changed daily by the night shift. LPN-B proceeded to aspirate residual (checking amount in the stomach, which indicates how rapidly stomach is emptying), which was greater than 100 cc. LPN-C indicated she would hook up TF later. During observation on 10/19/21, at 2:45 p.m., TF bag with approximately 600 cc of formula remaining was hanging on a pole with tubing end uncovered with no date on bag or tubing of when opened.	21375		

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21375	Continued From page 47 During observation on 10/20/21, at 8:21 a.m., R51's TF was connected to R51 and running with bag hanging on pole and approximately 800 cc in the bag, with no date present on bag or tubing for when opened. During observation on 10/20/21, at 10:37 a.m., R51 was sleeping in bed. TF was unhooked from R51 with no end on tubing. Approximately 600 cc remains in the bag. During observation on 10/21/21, at 8:34 a.m., LPN-A prepared medications for administration through PEG tube. A new syringe was brought into the room by LPN-A, but did not fit end of PEG tube. LPN-A then picked up a syringe from bedside table that was undated and out of original package and used syringe to administer medications via the PEG tube. LPN-A id not cleanse syringe or PEG tube sites prior to connection. LPN-A found R51's tube feeding (TF) bag was empty. LPN-A hung a new prefilled bag of Isosource 1.5 calories, labeled it with open date and administered via pump. LPN-A indicated all tube feeding bags and tubings should be labeled and are changed on evening shift. LPN-A further stated she normally would not use an undated, used syringe, but didn't have time to go get another syringe. During observation and interview on 10/20/21, at 9:05 a.m., LPN-A indicated the tubing should be capped in between feedings which are three times a day. LPN-A confirmed one bag is used daily and usually hung by night shift, which is discarded by evening shift after the 6:00 p.m. feeding. During observation on 10/21/21, at 2:15 p.m., R51 was not present in her room and	21375		

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administration pump was beeping. The TF bag with approximately 1000 cc of formula remaining in bag and tubing were hanging on the pole. The end of the tubing was uncovered.

R27
R27's Admission Record printed 10/21/21, indicated R27 was admitted 8/11/21, diagnoses included dysphasia (difficulty in swallowing food or liquid), sepsis (infection), acute and chronic respiratory failure, and moderate protein calorie malnutrition.

R27's 5 day scheduled Minimum Data Set (MDS) assessment dated 8/18/21, indicated severe cognitive impairment, activities of daily living (ADL) required two person physical assist, and nutrition approach was a feeding tube with 51% or more of feeding by tube feeding.

R27's order summary report printed 10/21/21, indicated enteral feed order three times a day for Replete intermittent gravity, 6 cans per day, change tube feeding set and bag daily in the morning.

On 10/18/21, at 6:00 p.m. R27 was observed in his room, laying on his bed. R27, and a metal stand with a empty and unlabeled tube feeding (TF) bag was hanging on the pole with clear unlabeled tubing with an uncapped purple end.

On 10/21/21, at 9:00 a.m. R27 was observed in his room and with metal pole and a bag hung with tubing; a purple tip was visible and uncapped at the end of the tube. LPN-A stated she was not aware a cap needed to cover the end of the tube feeding attachment when disconnected from the resident and not in use. R27's bedside table had a clear plastic piece and resembeled a cap for

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21375	Continued From page 49 the end of a tube feeding . During interview on 10/21/21, at 11:12 a.m., the director of nursing (DON) confirmed tube feeding bag need to be labeled with date and time opened and end of tubing capped after each use and discarded if no date present. The DON also confirmed LPN-A should not have used a syringe that was open and unlabeled. A policy and procedure titled "Enteral Nutritional Therapy (Tube Feeding) dated June 2017 was reviewed, but did not address, labeling of opened tubing, syringes or formula or ensuring end of tubing remains covered. The DON (Director of Nursing) or designee could review/revise facility policies to ensure they contain all components of an infection control program, including proper PPE, hand hygiene and care of tube feedings. The DON or designee could re-educate staff on these components. The DON or designee could conduct audits to ensure compliance and results brought to the quality committee for review. 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	21426		12/1/21

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21426	Continued From page 50 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: Based on interview and document review, the facility failed to maintain documentation of tuberculosis symptom screening and failed to administer the tuberculin two step skin test for 3 of 5 employees (LPN-B, NA-D, and an activities employee) with no previous history of tuberculosis testing. Findings include: The Facility Tuberculosis (TB) Risk Assessment Worksheet for Health Care Settings Licensed by the Minnesota Department of Health (MDH), completed 7/24/21, identified the facility as low risk for TB infections. Employee files were reviewed and contained the following: Licensed practical nurse (LPN)-A was on hired 9/9/21, LPN-A's employee file contained a chest X-ray, dated 8/20, to rule out TB, but did not contain a symptom screen for active TB	21426	It is the policy of the facility¿to¿provide rationale related pharmacist¿recommendations¿for gradual dose reduction (GDR) of omeprazole and Tessalon Perles, potential unnecessary medications.¿ ¿ ¿ ¿ Resident(s) involved:¿R23 and R30¿ ¿ Residents with Potential to be affected:¿Center residents¿who have orders for¿potentially unnecessary medications¿are at risk to be affected.¿ ¿ Education:¿Director of Clinical Services provided education to the Director of Nursing.¿ ¿ Monitoring:¿To ensure ongoing compliance the DON/Designee¿to	

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21426	Continued From page 51 symptoms when hired. Nursing assistant (NA)-D was hired on 7/29/21, NA-D employee file contained a TB screen completed on 7/29/21, a negative TB skin test on 6/15/21, but did not contain a step two TB skin test. Activities employer (AE)-A was hired on 8/17/21, AE-A employee file contained a TB screen completed on 9/14/21, however did not contain a TB skin test, TB blood test, or chest x-ray. On 10/20/21, at 12:44 p.m. the admissions coordinator confirmed there was no additional TB information in the employee files. Facility policy titled: Infection Prevention and Control Manual TB expose Control Plan dated 2017, indicated all staff will have an initial two step Tuberculin Skin Test (TST) for hire, and a single step annual TST, unless otherwise indicated. Document titled North Shore Healthcare dated 2021, indicated Health Screenings: -The first TB test must be completed on or before the day an employee attends orientation. The second TB test must be conducted with the first three weeks of employment. Thereafter, an annual TB test may be required of all employees. SUGGESTED METHOD FOR CORRECTION: The director of nursing (DON) could review and revise policies and procedures for TB surveillance. The DON could educate all appropriate staff on the policies and procedures. The DON could monitor resident and employee TB screening to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21426	complete audits weekly beginning the and ongoing for at least three months. The results of the audits will be reviewed by the QAPI committee for trends¿and¿any needs for adjustment of audit schedules or content, as well as any further educational needs.¿	

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21535	MN Rule4658.1315 Subp.1 ABCD Unnecessary Drug Usage; General Subpart 1. General. A resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used: A. in excessive dose, including duplicate drug therapy; B. for excessive duration; C. without adequate indications for its use; or D. in the presence of adverse consequences which indicate the dose should be reduced or discontinued. In addition to the drug regimen review required in part 4658.1310, the nursing home must comply with provisions in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (1) found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system and the State Law Library. It is not subject to frequent change. This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to provide rationale related pharmacist recommendation for a gradual dose reduction (GDR) of omeprazole (a proton pump inhibitor that decreases the amount of acid produced in the stomach), and Tessalon Perles (a medication used to suppress coughs) for 2 of 5 residents (R23, R30) reviewed for unnecessary medications.	21535	It is the policy of the facility¿to ensure¿controlled medications are accurately reconciled prior to destruction to prevent potential loss or diversion.¿ ¿ ¿ ¿ Resident(s) involved:¿(none listed on SOD)¿ ¿	12/1/21

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21535	Continued From page 53 Findings include: R23's Admission Record (face sheet) printed 10/21/21, indicated an admission date of 11/3/20, and diagnoses including dementia with Lewy bodies and interstitial pulmonary disease (a disease causing scarring of the lungs). R23's Order Summary Report printed 10/21/21, indicated an order for Tessalon Perles capsule, give 100 mg (milligrams) by mouth two times a day for cough. R23's Note to Attending Physician/Prescriber, dated 8/19/21, indicated a recommendation by the consulting pharmacist to decrease Tessalon Perles to 100 mg by mouth daily. R23's medical record did not include evidence the physician had responded to the recommendation or provided rationale for continued use. R30's Admission Record printed 10/21/21, indicated an admission date of 4/3/19, and diagnoses including gastro-esophageal reflux disease (GERD-occurs when the lower esophageal sphincter (LES) does not close properly, so stomach contents leak back, or reflux, into the esophagus), and other specified disorders of bone density and structure. R30's Order Summary Report printed 10/21/21, indicated an order for omeprazole capsule delayed release. Give 20 mg by mouth one time a day for GERD. R30's Note to Attending Physician/Prescriber, dated 3/23/20, indicated a recommendation by the consulting pharmacist to reduce omeprazole dose to 20 mg by mouth daily on Monday, Wednesday, and Friday for six doses then	21535	Residents with Potential to be affected:¿Center residents¿who¿have orders for controlled substances are at risk to be affected.¿ ¿ Education:¿Nursing staff educated by the DON/Designee by 12/1/2021¿or before their next shift begins.¿ ¿ Monitoring:¿To ensure ongoing compliance the DON/Designee/Facility Staff to complete audits weekly beginning the and ongoing for at least three months. The results of the audits will be reviewed by the QAPI committee for trends¿and¿any needs for adjustment of audit schedules or content, as well as any further educational needs	

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discontinue. Monitor for GI (gastro-intestinal) symptoms. R30's medical record did not include evidence the physician had responded to the recommendation or provided rationale for continued use.

When interviewed on 10/21/21, at 4:55 p.m. the director of nursing (DON) confirmed the physician had not addressed the recommendation for reduction for R23's Tessalon Perles and R30's omeprazole. DON further stated during the Covid-19 pandemic it had been difficult to get a response back from the physician related to pharmacy recommendations.

The policy titled, Unnecessary Drugs, dated 6/1/18, indicated: An unnecessary drug is any drug when used: 1. In excessive dose (including duplicate therapy) or 2. For excessive duration or 3. Without adequate monitoring or 4. Without adequate indications/reason for its use or 5. In the presence of adverse consequences which indicate the dose should be reduced or discontinued or 6. Any combination of the reasons above.

SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designess and consulting pharmacist could review and revise policies and procedures for justification for continues use and monitoring of medication usage. The DON or designee, along with the pharmacist, could audit medication reviews on a regular basis to ensure compliance. The DON or designee, along with the quality committee could audit and monitor on a regular basis to ensure compliance

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

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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 determine if the practice of self-administration of medications (SAM) was safe for 1 of 1 resident (R42) observed to self-administer eye drops. Findings include: R42's admission form printed 10/21/21, included a diagnosis of paranoid schizophrenia, altered mental status, anxiety disorder, cataract and glaucoma. R42's admission Minimum Data Set (MDS) assessment dated 9/7/21, included severe cognitive impairment requiring extensive assistance with activities for daily living and supervision of one person for eating. Provider orders dated 10/14/21, included Cosopt Solution 22.3-6.8 mg/ml to instill one drop in both eyes two times a day for glaucoma and natural balance tears solution 0.1-0.3% to instill 1 drop in both eyes three times a day for dry eyes. Physician orders did not identify an order for self administration. R42's plan of care dated 9/10/21, included R42	21565	Immediate action:¿R42 is not a candidate for self-administration and care plan and mar have been indicated to this Resident(s) involved:¿R42¿ ¿ Residents with Potential to be affected:¿Center residents that¿desire to¿self-administer¿medications, specifically eye drops, are at risk to be affected.¿ ¿ Education:¿Nursing staff educated by the DON/Designee by 12/1/2021¿or before their next shift begins.¿ ¿ Monitoring:¿To ensure ongoing compliance the DON/Designee/Facility Staff¿to complete audits weekly beginning the and ongoing for at least three months and ongoing for at least three months. The results of the audits will be reviewed by the QAPI committee for trends¿and¿any needs for adjustment of audit schedules or content, as well as any further educational needs.	12/1/21

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had an alteration in visual acuity related to glaucoma, but interventions did not include self-administration of eye drops.

During interview and observation on 10/20/21, at 7:41 a.m., trained medication assistant (TMA)-A was observed during medication administration for R42. While preparing medications, TMA-A stated R42 was given Cosopt eye drops in both eyes an hour earlier and liked to administer them herself. TMA-A brought natural balance tears solution 0.1-0.3% to R42's bedside and handed her the bottle. R42 then took the bottle and put one drop in both eyes and handed the eye drops back to TMA-A. TMA-A returned the eye drop bottle to the cart and indicated she wasn't sure if a self medication assessment was completed and did not believe she had seen an order for R42 to self administer eye drops.

During interview on 10/21/21, at 9:45 a.m., TMA-A confirmed no order for self administration of eye drops was found and added that R42 refuses to let staff administer them to her. TMA-A indicated she monitored R42 during the self administration of eye drops and had notified a nurse prior that R42 was requesting to self administer but was unable to indicate whom or when she notified the nurse.

During interview on 10/20/21, at 10:00 a.m., the director of nursing (DON) confirmed residents should not self administer eye drops without a physician order and prior to an assessment completed by a registered nurse. The DON confirmed neither were completed.

Policy review titled "Medication Self Administration" dated 6/1/17 included:
- Residents are not permitted to administer or

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21565	Continued From page 57 retain any medication in his or her room unless their attending physician writes an order for self-administration of the medication and the resident is assessed. SUGGESTED METHOD OF CORRECTION: The administrator or director of nursing (DON) could review and revise policies/procedures and educate staff regarding medication self administration and ensuring a physician order for self administration is in place for self administration. The DON or designee, along with the quality committee could audit and monitor on a regular basis to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21565		
21610	MN Rule 4658.1340 Subp. 1 Medicine Cabinet and Preparation Area;Storage Subpart 1. Storage of drugs. A nursing home must store all drugs in locked compartments under proper temperature controls, and permit only authorized nursing personnel to have access to the keys. This MN Requirement is not met as evidenced by: Based on observation and interview, the facility failed to ensure doses of controlled substances were stored in a manner to reduce the risk of theft and/or diversion in 1 of 3 refrigerators and emergency kit (E-kit) observed for medication storage. This had the potential to affect all residents in the facility. Findings include:	21610	It is the policy of the facility¿to ensure¿doses of controlled substances are stored in a manner to reduce the risk of theft and/or diversion.¿ ¿ ¿ ¿ Resident(s) involved:¿(none listed on SOD)¿ ¿	12/1/21

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21610	Continued From page 58 During tour of medication room on second floor on 10/21/21, at 10:12 a.m., trained medication aide (TMA)-B opened the medication room door with a key. TMA-B indicated the director of nursing (DON) and the nurses working for the day, have keys to the medication room. When requested to open the refrigerator, TMA-B used a key on a chain bolted to the side of the refrigerator to open the paddle lock on the refrigerator door. Inside the refrigerator, was a liquid bottle of lorazepam intensol (a schedule IV, controlled medication) 2mg/ml. TMA-B indicated they used to have the locked refrigerator key on their key ring with the door key, but a few years ago, they got attached to the refrigerator. Tour of nurses station, and three medication storage room at 11:11 a.m. also included a key to open the paddle lock on refrigerator door affixed to refrigerator. During observation and interview on 11/20/21, at 11:20 a.m., the director of nursing (DON) entered nurses station floor 1 medication room with a key. A paddle lock was present on the refrigerator and the key was attached to the refrigerator, which the DON used to open the refrigerator. The refrigerator was empty and the DON indicated the medication room on floor 1 was currently not in use for residents medications at this time, however, did store the E-kit. During interview on 11/20/21, at 11:25 a.m., the DON indicated the E-kit is paddle locked and the only way to access the E-kit is by filling out a form titled "Emergency Kit/Order Usage Form" and faxing it to the pharmacy then phoning the pharmacy and receiving the paddle lock code. The DON confirmed since floor 1 is empty, the E-kit isn't verified as present or locked and secured as there is no way to access the E-kit	21610	Residents with Potential to be affected:¿Potential to affect all residents in the facility.¿ ¿ Education:¿Nursing staff educated by the DON/Designee/Facility Staff by 12/1/2021¿or before their next shift begins.¿ ¿ Monitoring:¿To ensure ongoing compliance the DON/Designee¿to complete audits weekly beginning the and ongoing for at least three months. The results of the audits will be reviewed by the QAPI committee for trends¿and¿any needs for adjustment of audit schedules or content, as well as any further educational needs.¿	

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without pharmacy approving and giving the code. Upon inspection of the E-kit, 2 compartments were present that included upper tray and lower box. Two secure holes to hook the paddle lock through was present with the paddle lock securing only the bottom box. A snap lock was present on the top tray, which was opened and revealed alprazolam (schedule IV) 0.25 mg, clonazepam (schedule IV), lorazepam (schedule IV), pregabalin (class V) and tramadol 50 mg (schedule IV). The five medications are included on the Drug Enforcement Administration, Diversion Control Division list of controlled substances and regulated chemicals. The DON indicated staff must have missed securing the paddle lock to the upper tray only securing the bottom box and confirmed the controlled medications were not double locked. The DON indicated this is a newer process for staff and she would contact the pharmacy to get this remedied.

A policy titled "Storage of Medication" dated 6/1/17 included:
-All controlled drugs are stored under double-lock and key.

SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON) or designee and consulting pharmacist could review and revise policies and procedures for proper storage of medications. Nursing staff could be educated as necessary to the importance of medication storage and securing of medications. The DON or designee, along with the pharmacist, could conduct audits on a regular basis to ensure compliance.

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

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21630	Continued From page 60	21630		
21630	MN Rule 4658.1350 Subp. 2 A.B. Disposition of Medications; Destruction Subp. 2. Destruction of medications. A. Unused portions of controlled substances remaining in the nursing home after death or discharge of a resident for whom they were prescribed, or any controlled substance discontinued permanently must be destroyed in a manner recommended by the Board of Pharmacy or the consultant pharmacist. The board or the pharmacist must furnish the necessary instructions and forms, a copy of which must be kept on file in the nursing home for two years. B. Unused portions of other prescription drugs remaining in the nursing home after the death or discharge of the resident for whom they were prescribed or any prescriptions discontinued permanently, must be destroyed according to part 6800.6500, subpart 3, or must be returned to the pharmacy according to part 6800.2700, subpart 2. A notation of the destruction listing the date, quantity, name of medication, prescription number, signature of the person destroying the drugs, and signature of the witness to the destruction must be recorded on the clinical record. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to implement a system to ensure controlled medications were accurately reconciled prior to destruction to prevent potential loss or diversion. This practice had the potential to affect the 6 residents identified for destruction of medications.	21630	It is the policy of the facility¿to ensure¿doses of controlled substances are stored in a manner to reduce the risk of theft and/or diversion.¿ ¿ ¿ ¿ Resident(s) involved:¿(none listed on	12/1/21

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21630	Continued From page 61 Findings include: During observation and interview on 10/21/21, at 10:12 a.m., during tour of second floor medication room, trained medication assistant (TMA)-B indicated narcotics are destroyed at the time they are removed from the cart and is documented on the "Resident Controlled Substance Record" on the bottom portion, in a separate box titled "Medication Disposition Record" (MDR). Once the book is full, it is turned into the director of nursing (DON) who maintains the records. Upon review of the narcotic destruction book, multiple entries were noted to not be completed in the MDR section of the form. TMA-B confirmed they were incomplete and indicated she was told to fill out the bottom portion which included date, quantity destroyed, quantity sent with resident, 2 nursing signatures and comment section. Review of Resident Controlled Substance Record MDR section revealed: -Oxycodone 5 mg, 18 received. No administrations were listed. Discontinued date of 5/28/21 with 2 staff signatures. No date of destruction, quantity destroyed or reconciliation of amount remaining was completed. -Hydromorphone 1 mg half tab, with amount received 26 1/2 tablets. Ten entries were present with last listed as 5/16/21 at 10:24 p.m. with 17 remaining tablets which was crossed out. Previous entry was 5/16/21 at 12:20 a.m., with 18 tablets remaining. Medication discontinue date was not included. Destroyed date was 5/17/21 with 2 unreadable signatures present. No quantity destroyed or reconciliation of amount remaining was completed. -Hydromorphone 1 mg/ml (liquid) with 60 ml's	21630	SOD)¿ ¿ Residents with Potential to be affected:¿Potential to affect all residents in the facility.¿ ¿ Education:¿Nursing staff educated by the DON/Designee/Facility Staff by 12/1/2021¿or before their next shift begins.¿ ¿ Monitoring:¿To ensure ongoing compliance the DON/Designee¿to complete audits weekly beginning the and ongoing for at least three months. The results of the audits will be reviewed by the QAPI committee for trends¿and¿any needs for adjustment of audit schedules or content, as well as any further educational needs.¿	

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received. Thirty administrations occurred with amount remaining documented as 30 ml's. A date of 5/17/21 was present and destroyed written with 2 unreadable signatures present. No quantity destroyed or reconciliation of amount remaining was completed.

-Hydromorphone 1 mg (1/2 tab) with amount received documented as 30. Zero entries to administration was present. Medication discontinued and destroyed with date of 5/17/21 and two unreadable signatures present. No quantity destroyed or reconciliation of amount remaining was completed.

-Lorazepam 2mg/1 ml (liquid) with 30 ml's received and 2 entries for administration present. Destroyed 5/17/21 present with 2 unreadable signatures. No quantity destroyed or reconciliation of amount remaining was completed.

-Oxycodone 5 mg with 10 received. No entries present for administration. Discontinued 5/25/21 present with unreadable signatures. No date quantity destroyed or reconciliation of amount remaining was completed.

During interview on 10/21/21 at 11:15 a.m., the director of nursing confirmed staff are required to have 2 nursing staff count and reconcile medication amount remaining by counting and comparing with quantity to be destroyed prior to destruction of narcotic medications. The DON further confirmed their process included completing the bottom portion of the Resident Controlled Substance Record, which she confirmed on the above entries was not completed.

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21630	Continued From page 63 A policy on destruction of narcotic medications was requested and not received. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could development and implement policies and procedures to destroy unused narcotic medications. The DON or designee could educate licensed staff on these policy and procedures. The DON or designee could then monitor the appropriate staff for adherence to the policies and procedures. TIME PERIOD FOR CORRECTION: Twenty One (21) Days	21630		
21805	MN St. Statute 144.651 Subd. 5 Patients & Residents of HC Fac.Bill of Rights Subd. 5. Courteous treatment. Patients and residents have the right to be treated with courtesy and respect for their individuality by employees of or persons providing service in a health care facility. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to provide a dignified dining experience for 6 of 6 residents (R215, R30, R44, R45, R60, R52) who required assistance with dining. Findings Include: During an observation on 10/19/21 during breakfast on the 3rd floor dining room: 8:18 a.m., R45 was served breakfast meal and	21805	¿ It is the policy of the facility during transfers of a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative when possible or as soon as possible. ¿ ¿ ¿Residents with Potential to be affected:¿Potential to affect all residents in	12/1/21

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21805	Continued From page 64 was sitting at table with R44 who was being assisted to eat her breakfast. 8:38 a.m., R45 remains sitting at table with breakfast in front of her. R45 had pushed her wheelchair away from the table. 8:56 a.m., nursing assistant (NA)-D sat down at table next to R45, scooted her up to the table, heated R45's breakfast tray in the microwave and assisted R45 to eat. 9:22 a.m., R45 finished her breakfast and remained sitting at the table. During an observation on 10/20/21, during the breakfast meal on the 3rd floor dining room: 7:30 a.m., R45 was seated at a table in the dining room with wheelchair back reclined to a 60 degree angle. R45 was periodically sitting herself straight up in the chair, then laying back down. 7:47 a.m., R45 remains reclined in wheelchair and has attempted to sit up straight 3 times but was unable to hold her position sitting straight. 7:58 a.m., R45 sat up straight than reclined back down. 8:03 a.m., R45 sat up and layed back down three times and began grabbing towards the table and yelling out. 8:04 a.m., NA-E indicated they lay R45 back because otherwise she scoots forward and has fallen out of her wheelchair. NA-E stated R45 will usually relax and fall asleep with the back reclined. NA-D then moved the back of the wheelchair to a partially reclined position, at a 30 degree angle. 8:03 a.m., breakfast trays were delivered to floor 3 dining room. 8:09 a.m., breakfast was set in front of R45. 8:10 a.m., breakfast was served to R215 and R44 who were seated at the same table; breakfast was also served to R52 and R60 who were seated at the same table.	21805	the facility.¿ ¿ Education:¿Nursing staff educated by the DON/Designee/Facility Staff by 12/1/2021¿or before their next shift begins.¿ ¿ Monitoring:¿To ensure ongoing compliance the DON/Designee¿to complete audits weekly beginning the and ongoing for at least three months. The results of the audits will be reviewed by the QAPI committee for trends¿and¿any needs for adjustment of audit schedules or content, as well as any further educational needs.¿ Residents with Potential to be affected:¿All residents at the facility are at risk¿to be affected.¿	

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21805	Continued From page 65 8:19 a.m., R215, R44, R52, and R60 remain seated with breakfast in front of them waiting for assistance. 8:30 a.m., transportation assistant (TA) sat down and assisted R215 with eating. Did not heat her french toast or bacon. 8:31 a.m., trained medication assistant (TMA)-B returned to R45's table and removed lid from meal and started to assist R45. Did not heat meal. 8:32 a.m., R44, R52, and R60 remained seated in wheelchair at table with breakfast in front of them. 8:36 a.m., NA-E sat at table with R60 and started to assist with feeding; NE-E did not reheat R60's meal. R52 remained seated at the same table with her meal in front of her 8:51 a.m., R44 remains sitting at table with breakfast in front of her. 8:55 a.m., NA-E completed assisting R60, took residents tray to the cart, washed her hands, then went to assist R52 with her meal. 9:04 a.m., TA sat next to R44, 55 minutes after being served her tray and began assisting R44 with her meal. R44's pureed french toast and bacon was not reheated prior to assisting R44. 9:05 a.m., NA-E indicated they had a call in today and are short people to assist residents with eating. NA-E indicated they usually have 2 NA's, the nurse or TMA and one other staff member to assist with feeding residents so running very late today with only one TMA, 1 NA and one other staff member assisting. NA-E further stated that over the weekend R30 began requiring feeding assist and had a new admission 4 days ago requiring assistance with meals also. 9:22 a.m., TMA-B indicated they were short of help today and had a call in. When questioned if someone else could come assist, she indicated they were busy as other floors were short of help also.	21805		

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21805	Continued From page 66 During observation on 10/20/21 on 3rd floor during lunch: 12 residents were present. 12:24 p.m., R45 is in dining room, sitting at table with wheelchair reclined 30 degrees yelling out. TMA-B assisted R45 by leaning her back to a 60 degree angle. R45 continued to yell out. 12:32 p.m., R45 continues to yell out, NA-B set her up straight. R45 continued to yell out and was mumbling. Lunch trays were delivered to the floor. 12:35 p.m., R45 continues to yell out and was laid back in her chair. R45 continued to yell out 4 more time prior to being assisted with meal 12:36 p.m., Tray delivery began to residents in dining room. 12:38 p.m., R45 was served her tray. 12:44 p.m., NA-E continues to deliver trays to residents in the dining room. R215 sitting at table was served her lunch. 12:45 p.m., R30 and R52 were seated in the dining room and received their meal. 12:50 p.m., TMA-B began to assist R45 to eat. 12:52 p.m., R44 was served her lunch. 12:56 p.m., R44 and R215 remain with food in front of them at the table waiting for assistance to eat. 1:16 p.m., NA-E sat down next to R215 and began assisting her with her lunch. Tray was not reheated and included soft shell tacos with meat, cheese, lettuce and tomatoes. R44 continues seated at table with R215 waiting for assistance. R30 and R52 also continue to sit at table in dining room waiting for assistance. 1:18 p.m., the director of nursing arrived on the floor and stated she would see if someone from another floor could come assist residents still waiting for assistance. 1:26 p.m., R44 remains sitting at table with her meal in front of her awaiting assistance.	21805		

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21805	Continued From page 67 1:28 p.m., RN-D entered the 3rd floor dining room and sat with R30 to assist with lunch. RN-D did not warm up the meal. R30 did not immediately accept the food; RN-D put the cover back on the meal and told resident she would let her "rest a little bit" then would come back to check on her. RN-D left the table, washed her hands, then returned to assist R30. . 1:31 p.m., NA-E sat next to R44 and began assisting her to eat with a fork. R44 was served pureed taco meat, lettuce and tomatoes. Food was not reheated. 1:33 p.m., RN-D left R30's table, and went to R60's table and proceeding to assist R60 with eating her meal. R30 had only eaten approximately 0-25% of her meal and did not attempt to feed herself after RN-D exited to assist another resident 1:44 p.m., NA-E sat down with R30 and offered assistance and encouragement to eat. R30 accepted the assistance. R45 R45's Admission record, printed 10/20/21, identified a diagnoses of Alzheimer's disease, chronic pain syndrome, and low back pain. R45's quarterly, Minimum Data Set (MDS) assessment, dated 9/6/21, identified severe cognitive impairment, and required extensive assist of 1 person with eating. R45's care plan dated 6/28/21, identified a problem with physical functioning related to mobility and self care impairment. Interventions included assist of 1 with oral care, bed mobility, dressing, locomotion and personal hygiene. The care plan did not include assistance with eating. R215	21805		

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21805	Continued From page 68 R215's admission record printed 10/21/21, indicated an admission date of 10/15/21, and identified a diagnoses of dementia with Lewy Bodies (abnormal deposits of a protein which leads to problems with thinking, movement, behavior, and mood), displaced fracture of humerus (upper) left arm, displaced fracture of left clavicle, and fracture of one rib. R215's admission MDS assessment was not completed. R215's baseline care plan dated 10/15/21, identified R215 has diagnosis of dementia resulting in cognitive loss, diminished decision making capabilities and safety and security issues and was placed in the secure Alzheimer's care unit. Interventions included to establish predictable care routines as much as possible to decrease confusion. The care plan did not address assistance with eating. R44 R44's admission record, identified a diagnoses of Alzheimer's disease, and dementia with behavioral disturbance. R44's annual, MDS assessment, dated 9/4/21, identified severe cognitive impairment, and required 1 person extensive assist with eating. R44's care plan dated was requested but none received. R30 R30's Admission Record, printed 10/21/21, indicated diagnoses including vascular dementia with behavioral disturbance and delusional disorder.	21805		

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21805	Continued From page 69	21805		

R30's Minimum Date Set (MDS) assessment dated 8/21/21, indicated the resident had severe cognitive impairment and required supervision with eating.

R30's care plan indicated an ADL (activities of daily living) self care deficit as evidenced by need for verbal cues, set-up and reminders to complete ADL cares related to diagnosis of dementia. Interventions included to assist with daily hygiene, grooming, dressing, oral care, and eating as needed.

R52
R52's Admission record, printed 10/21/21, indicated diagnoses including Alzheimer's disease and dementia without behavioral disturbance.

R52's quarterly MDS dated 9/16/21, indicated the resident had severe cognitive impairment and required extensive assistance with eating.

R52 care plan printed 10/21/21, directed staff to assist resident with dining when needed.

R60
R60's Admission Record, printed 10/21/21, indicated diagnoses including dementia without behavioral disturbance and Parkinson's disease.

R60's quarterly MDS dated 9/28/21, indicated the resident had severe cognitive impairment and required extensive assistance with eating.

R60's care plan printed 10/21/21, indicated the resident will have ADL (activities of daily living) needs met with staff assistance.

During interview on 10/20/21, at 11:15 a.m. the

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21805	Continued From page 70 director of nursing (DON) indicated a call in occurred for 3rd floor that morning so staffing was an issue. The DON confirmed her expectation is when the tray is served, residents should be assisted to eat with minimal waiting time. A policy on dignified dining was requested and none received. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could development and implement policies and procedures related to dignified dining. The DON or designee could educate staff on these policy and procedures. The DON or designee could then monitor the appropriate staff for adherence to the policies and procedures. TIME PERIOD FOR CORRECTION: Twenty One (21) Days	21805		
21925	MN St. Statute 144.651 Subd. 29 Patients & Residents of HC Fac.Bill of Rights Subd. 29. Transfers and discharges. Residents shall not be arbitrarily transferred or discharged. Residents must be notified, in writing, of the proposed discharge or transfer and its justification no later than 30 days before discharge from the facility and seven days before transfer to another room within the facility. This notice shall include the resident's right to contest the proposed action, with the address and telephone number of the area nursing home ombudsman pursuant to the Older Americans Act, section 307(a)(12). The resident, informed of this right, may choose to relocate before the notice period ends. The notice period may be shortened in situations outside the facility's	21925		12/1/21

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21925	Continued From page 71 control, such as a determination by utilization review, the accommodation of newly-admitted residents, a change in the resident's medical or treatment program, the resident's own or another resident's welfare, or nonpayment for stay unless prohibited by the public program or programs paying for the resident's care, as documented in the medical record. Facilities shall make a reasonable effort to accommodate new residents without disrupting room assignments. This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to ensure written transfer notices were provided to the resident or resident representative following a facility-initiated transfer to the hospital for 2 of 2 residents (R7, R42) reviewed for hospitalization. This had the potential to affect all 64 residents residing in the facility. Findings include: R7's admission record printed 10/21/21, identified initial admission date was 1/8/20, and most recent hospital stay was 10/16/21, through 10/19/21, and diagnoses indicated malignant neoplasm (cancerous tumor) of head, face, neck, and thyroid gland, and tracheotomy (air passage to help breathe). R7's discharge assessment return anticipated Minimum data set (MDS) dated 8/23/21, indicated on 8/23/21, R7 had an unplanned transfer to the hospital. The medical record lacked evidence written notice of the transfer had been provided to R7 or her representative on 8/23/21. R42's admission record printed 10/19/21,	21925	¿ It is the policy¿of the facility to the resident and/or 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. ¿ ¿ ¿ ¿ ¿ Residents with Potential to be affected:¿Potential to affect all residents in the facility.¿ ¿ Education:¿Nursing staff social work business office staff educated by the DON/Designee/Facility Staff by 12/1/2021¿or before their next shift begins.¿ ¿ Monitoring:¿To ensure ongoing compliance the DON/Designee¿to complete audits weekly beginning the and ongoing for at least three months. The results of the audits will be reviewed by the QAPI committee for trends¿and¿any	

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21925	Continued From page 72 indicated initial admission dates of 8/31/21, and most recent hospital stay was 10/11/21, through 10/14/21, and diagnosis included renal (kidney) disease, muscle weakness, anemia (lack of red blood cells), kidney failure, and altered mental status. Progress note dated 10/11/21, at 3:59 a.m. indicated R42 was transferred into the hospital. The medical record lacked evidence written notice of the transfer had been provided to R42 or her representative. On 10/21/21, at 9:36 a.m. an interview with the social worker (SW) confirmed the facility failed to provided notices of transfer to either resident [R7 or R42]or resident representative. On 10/21/21, at 11:00 a.m. during interview with the director of nursing (DON) and corporate regional executive stated the transfer forms were not being filled out and they expected the forms to be filled out. The DON stated nursing staff were expected to enter a progress note and stated the facility should have notified the resident or resident representative regarding facility-initiated transfers as required. Policy titled Discharge -Transfer of Resident dated 6/17, indicated: -to ensure safe departure from the facility -to provide sufficient information for continue care of the resident. -explain transfer and reason to the resident and/pre representative Give copy of singed transfer or discharge notice to resident and/or representative. -if emergency transfer form may be complete later, but as soon as possible	21925	needs for adjustment of audit schedules or content, as well as any further educational needs.¿	

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21925	Continued From page 73 SUGGESTED METHOD OF CORRECTION: The Director of Social Services or designee could develop, review, and/or revise policies and procedures to ensure the resident received written notification of all hospitalizations. The Director of Social Services or designee could educate all appropriate staff on the policies and procedures. The Director of Social Services or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21925		