Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
December 12, 2024

Administrator
Good Samaritan Society - International Falls
2201 Keenan Drive
International Falls, MN 56649

RE: CCN: 245318
Cycle Start Date: November 25, 2024

Dear Administrator:

On November 25, 2024, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Jen Bahr, RN, Regional Operations Supervisor
Bemidji District Office
Health Regulation Division
Minnesota Department of Health
705 5th Street NW, Suite A
Bemidji, Minnesota 56601-2933
Email: Jennifer.bahr@state.mn.us
Office: (218) 308-2104

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of

the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

If substantial compliance with the regulations is not verified by February 25, 2025 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by May 25, 2025 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 **and Minnesota Statute 144A.10 subd 15**, 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: **https://forms.web.health.state.mn.us/form/NHDisputeResolution**

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. 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.

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

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. 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:
https://forms.web.health.state.mn.us/form/NHDisputeResolution

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

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

Travis Z. Ahrens
State Fire Safety Supervisor
Health Care & Correctional Facilities
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
Email: travis.ahrens@state.mn.us
Web: www.sfm.dps.mn.gov
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245318	A. BUILDING _____ B. WING _____	C 11/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - INTERNATIONAL FALLS	2201 KEENAN DRIVE INTERNATIONAL FALLS, MN 56649

(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 11/19/24 through 11/25/24, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73 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 11/19/24 through 11/25/24, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was not in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaint was reviewed: H53181372C (MN00099731) with no deficiency issued. 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. 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 558	Reasonable Accommodations Needs/Preferences	F 558		1/6/25

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

Electronically Signed | 12/20/2024

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

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F 558 SS=D	Continued From page 1 CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure an electric wheelchair was maintained in working order for 1 of 1 resident (R23) reviewed for accommodation of needs. Findings include: R23's annual Minimum Data Set (MDS) dated 10/17/24, identified R23 had intact cognition and used a motorized wheelchair. R23 was independent with mobility once seated in his motorized wheelchair. Diagnoses included paraplegia, dependence on wheelchair and autonomic dysreflexia (a dangerous syndrome involving an overreaction of your autonomic nervous system). R23's care plan dated 3/15/24, identified R23 had limited physical mobility related to paraplegia from spinal cord injuries and weakness evidenced by R23's need for specialty wheelchair. The goal was for R23 to remain independent with locomotion in the facility. Interventions included use of motorized wheelchair in the facility. On 11/19/24, R23 was lying in bed watching television. A manual high back wheelchair was stored in the shower area of R23's room and a	F 558	Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. For the purposes of any allegation that the center is not in substantial compliance with federal requirements of participation, this response and plan of correction constitutes the center's allegation of compliance in accordance with section 7305 of the State Operations Manual 1. Resident R23's concerns regarding the operation of their power chair, including the battery and charger, will be entered into our TELS system to send a weekly maintenance order to the maintenance department. The wheelchair battery has been replaced with a new one and is in working order. 2. All residents needing assistive devices/equipment have the potential to be affected by the deficient practice. As a result, all residents using motorized	

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F 558	Continued From page 2 motorized wheelchair was positioned against the wall in the room. R23 stated lightning hit the nursing home building a few months ago and fried his motorized wheelchair. R23 did not know why the facility had not attempted to repair the chair for him. R23 was told he needed a new battery and that is all he had heard about it. The nurse reported the problem to maintenance and maintenance told R23 they were going to look into getting him a battery for the wheelchair and that was two to three months ago. The manual wheelchair the facility provided R23 to use was uncomfortable for him and he was unable to sit up straight when he was seated in it or recline the wheelchair back. R23 had autonomic dysreflexia and when he had a spell he would pass out and needed to be reclined back immediately. R23 was able to sit fully upright and to recline when needed in his motorized wheelchair. R23 owned the motorized wheelchair but felt it was the facility responsibility to repair because he knew it quit working when the building had been hit by lightning. His chair had been plugged in at the time and made a loud beeping noise and then did not work again after that. R23's medical record was reviewed and lacked evidence the facility had made any effort to assess, evaluate or discuss the broken motorized wheelchair with R23. During interview on 11/20/24, at 10:49 a.m. nursing assistant (NA)-A stated R23 did not use his motorized wheelchair. The facility had been hit by lightning about two and 1/2 months ago and R23's motorized wheelchair would not take a charge after that. R23 used the manual wheelchair when he would get out of bed, for special things like haircut or celebrations.	F 558	wheelchairs have been assessed and determined to be in working condition per manufacturer's guidelines. 3. To ensure systemic changes are sustained, education was provided by the DNS or designee to all staff on the policy "Accommodation of Resident Needs to ensure that repairs or maintenance on resident equipment including but not limited to power chairs are completed in a timely manner. 4. To ensure compliance, the administrator or designee will monitor tasks in the TELS system for 4 weeks, then monthly for 2 months to ensure tasks are completed in a timely manner. Audit results will be brought to the monthly QAPI committee for input on the need to increase, decrease, or discontinue audits. Date of correction: 1/6/25	

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F 558	Continued From page 3 When interviewed on 11/20/24, at 10:53 a.m. trained medication aide (TMA)-A stated R23's motorized wheelchair did not work, and it needed a new battery. TMA-A did not know who was helping R23 fix his wheelchair, he just knew it has not worked for at least a month. When interviewed on 11/20/24, at 11:00 a.m. registered nurse (RN)-C stated she was aware R23's motorized wheelchair was not working as the battery would not charge. RN-C stated she reported the issue to maintenance. RN-C was upset when she came back from her vacation and found R23's motorized wheelchair had not been fixed. R23's motorized wheelchair absolutely should be repaired. A joint interview was conducted on 11/20/24 with the director of nursing (DON) and maintenance staff (M)-A. The DON stated she was not aware R23's motorized wheelchair was not working and R23 had a right to have his motorized wheelchair in working order. M-A stated he was made aware of R23's wheelchair not working, and M-A told R23 to use the chair more and run down the battery before recharging it, as it was developing a memory. M-A was not aware the motorized wheelchair did not take a charge at all. R23 had mentioned something about a lightning strike but that had just messed up the facility's television programming and had not interfered with the facility's electrical equipment. The occupational therapist had stated any maintenance or repairs would have to go through R23 and/or his family but he was not sure if anyone had discussed the issue with R23. On 11/21/24, at 10:00 a.m. M-A stated he tried a	F 558		

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F 558	Continued From page 4 different charger with no success and now was looking into obtaining a different battery to try. M-A stated R23 had told him the chair had been plugged in during the lightning strike and had made a loud beeping sound, the damage could have been caused by the lightning strike, it was hard to tell. The facility's Accommodation of Resident Need policy dated 9/16/24, identified the resident had a right to reside and receive services with reasonable accommodation of resident needs and preferences. The facility should adapt or individualize things such as desires and unique needs such as furniture that enhances the resident's ability to maintain their independence.	F 558		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure medications were coded correctly on the Minimum Data Set (MDS) for 1 of 5 residents (R27) reviewed for unnecessary medications. Findings include: R27's quarterly MDS dated 10/9/24, identified R27 had severe cognitive impairment. Diagnoses included Alzheimer's, non-Alzheimer's dementia, diabetes, and depression. The MDS identified R27 received an antianxiety medication.	F 641	1. The MDS Coordinator's designated backup corrected R27□s medication to ensure accurate documentation supported coding for MDS on 11/25/24. 2. All residents have the potential to be affected by this deficient practice. As a result, all residents electronic medical records were reviewed to determine that there□s accurate documentation which supports coding for MDS. 3. To ensure systemic changes are sustained, education was provided by DNS to the MDS Coordinators and nursing staff on accuracy of assessments	1/6/25

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F 641	Continued From page 5 R27 medication administration report (MAR) for the month of October 2024, identified R27 received Trazodone (an antidepressant) for generalized anxiety disorder, restlessness, and agitation. The MAR/orders did not identify R27 was receiving an antianxiety medication during the MDS lookback period. During an interview on 11/25/24 at 3:14 p.m., registered nurse (RN)-B identified she did the most recent MDS for R27. When RN-B went over the medications for R27, RN-B reviewed medications by what they were used for and not specifically the class of medication. R27's was receiving an antidepressant to help with anxiety, and it was entered on the MDS as an antianxiety medication and not an antidepressant. RN-B stated it was important to ensure the MDS was accurate, so staff had the accurate data to care for R27. During an interview on 11/25/24 at 4:00 p.m., the director of nursing (DON) stated she would expect the MDS for R27 would be complete and accurate to enable others working with R27 to get a complete picture of care required for them. The facility's MDS 3.0 Resident Assessment Instrument (RAI) dated 8/27/24, identified each team member would review the electronic medical record and determine if there is accurate documentation which supported coding for the MDS.	F 641	and MDS 3.0 Assessment policy on 12/18/2024. 4. To ensure compliance, DNS or designee will conduct 5 random audits for 4 weeks, then monthly for 2 months. Audit results will be brought to the monthly QAPI committee for input on the need to increase, decrease, or discontinue audits. Date of correction: 1/6/25	
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	F 677		1/6/25

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F 677	Continued From page 6 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 assistance with toileting for 1 of 1 resident (R203) reviewed for activities of daily living and who were dependent on staff for their care. Findings include: R203's admission Minimum Data Set (MDS) dated 11/6/24, identified R203 had severe cognitive impairment and did not have behaviors. R203 required partial to moderate assistance with eating. R203 was dependent with toileting and transfers and was always incontinent of bowel and bladder. Diagnoses included malignant neoplasm of the sinus and brain, palliative care, moderate protein-calorie malnutrition, and pressure ulcer stage two of the sacral region. R203's care plan dated 10/31/24, identified R203 was dependent with most activities of daily living and was bedfast all or most of the time. R203 was incontinent of bowel and bladder. Staff were directed to check and change every two hours and as needed. During continuous observation on 11/20/24 from 4:30 p.m. to 7:10 p.m., R203 was awake, lying on her back in bed, dressed in a hospital gown. A pillow was positioned under R203's right foot. No other positioning devices were in use. R203's head of the bed was raised at 25-degree angle. -at 4:50 p.m. there was no change in R203's position. -at 5:22 p.m. there was no change in R203's	F 677	1. Staff repositioned Resident R203 and performed a check-and-change immediately upon notification of untimely cares. Staff received education and reviewed R203□s care plan during this time to ensure repositioning is completed as scheduled. 2. All residents with ADL dependency have the potential to be affected by this deficient practice. As a result, all ADL dependent resident care plans were reviewed to all staff to ensure they accurately reflect repositioning schedules. 3. To ensure systemic changes are sustained, education was provided by the DNS to all nursing staff regarding the Activities of Daily Living policy requirements and following resident□s care plan. 4. To ensure compliance, the DNS or designee will audit 8 random residents□ repositioning to ensure proper procedures are followed for 4 weeks, then monthly for 2 months. Audit results will be brought to the monthly QAPI committee for input on the need to increase, decrease, or discontinue audits. Date of correction: 1/6/25	

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F 677	Continued From page 7 position. -at 5:37 p.m. nursing assistant (NA)-N entered the room to record R203's supper meal choices. NA-N raised R203's head of the bed to a 35-degree angle and asked R203 what she would like for supper. NA-N told R203 she would return with a couple of pudding choices for her supper and then exited the room. NA-N did not check R203 for incontinence. -at 5:45 p.m. licensed practical nurse (LPN)-C entered R203's room and raised the head of the bed to an upright sitting position of 45 degrees. LPN-C administered medications and exited the room. LPN-C did not check R203 for incontinence before exiting the room. -At 5:50 p.m. R203's call light was put on. LPN-C and an unidentified NA entered room. R203 identified the call light was on by accident and nothing was needed. Both staff exited the room after turning off call light. R203 was not checked for incontinence or need for toileting and remained seated fully seated upright in bed. - At 5:57 p.m. R203 turned on her call light. R203 was seated in bed. the head of the bed was in an upright position. R203 had slid down in the bed and her head was hanging heavily to her right side with her chin in her chest. -At 6:11 p.m. R203 had not changed position. R203's head of the bed remained in full upright position. R203 was in slouched position in bed, leaning to her right side, with her chin in her chest. The call light remained on with steady green light over the door. -At 6:30 p.m. R203 had not changed position, the head of the bed remained in fully upright position. R203 has slouched further down in the bed with her head positioned halfway from top of bed to middle of bed. R203 leaning to her right side with her chin in her chest. The call light remained on.	F 677		

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F 677	Continued From page 8 -At 6:45 p.m. there was no change in position. -At 6:56 p.m. R203's head of the bed remained fully elevated at 45-degree angle. R203 was leaning heavily to her right side with her chin touching her chest and slouched down to the middle of the bed. The call light remained on. -At 7:06 p.m. NA-M and NA-N entered R203's room and lowered R203's head of the bed and checked R203 for incontinence. R203 was dry and did not require a brief change. During interview on 11/20/24, at 7:10 p.m. NA-M stated they just checked R203 for incontinence and she was dry. NA-M stated she had been told R203 was checked at 4:30 p.m. NA-M knew R203 needed to be checked and/or changed and repositioned every two hours. NA-M and NA-N were walking by and noticed R203 was leaning so far over to the right and nearly falling out of bed so they went in to reposition her. NA-M noticed R203's light was on and wondered why, which is why she walked down the hall to check. During interview on 11/25/24, at 2:30 p.m. NA-N stated she remembered going into R203's room on 11/20/24 and offering her supper. R203 refused supper but then NA-N offered pudding and R203 had agreed. NA-N stated she had not checked or changed R203 for incontinence at that time. When interviewed on 11/21/24, at 12:05 p.m. the director of nursing stated it was the facility's expectation staff were to check and change residents every two hours if the care plan directed them to do so. The facility policy Activities of Daily Living dated 12/4/23, identified any resident who was unable	F 677		

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	245318	A. BUILDING _____ B. WING _____	C 11/25/2024

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F 677	Continued From page 9 to carry out activities of daily living would receive necessary services to maintain good nutrition, grooming, personal and oral hygiene.	F 677		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide timely repositioning for 1 of 1 resident (R203) reviewed for pressure ulcers. Findings include: R203's admission Minimum Data Set (MDS) dated 11/6/24, identified R203 had severe cognitive impairment and did not have identified behaviors. R203 required substantial to maximum assistance with rolling side to side and sitting up. R203 was dependent with toileting and transfers and was always incontinent of bowel and bladder. R203 was at risk for pressure ulcer development and was admitted with a stage two unhealed	F 686	1. Staff repositioned Resident R203 and performed a check-and-change immediately upon notification of untimely care. Staff received education and reviewed R203□s care plan to ensure repositioning is completed as scheduled. 2. All ADL dependent residents have the potential to be affected by this deficient practice. As a result, ADL dependent residents□ care plans were reviewed to assess that their repositioning schedules align with pressure ulcer prevention. 3. To ensure systemic changes are sustained, the DNS provided education on the Pressure Ulcers policy to all nursing staff and on the importance of following	1/6/25

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F 686	Continued From page 10 pressure ulcer. A turn and reposition program was in place as well as a pressure reducing device for R203's bed. Diagnoses included malignant neoplasm of the sinus and brain, palliative care, moderate protein-calorie malnutrition, and pressure ulcer stage two of the sacral region. R203's care plan dated 10/31/24, identified R203 was dependent with most activities of daily living and was bedfast all or most of the time. R203 had actual impairment to skin integrity. Staff were directed to use extra caution with transfer and bed mobility to avoid injury to R203 skin, keep skin clean and dry and to turn and reposition R203 every two hours and as needed. R203's Braden Skin Assessment 10/31/24, scored 13 which identified a moderate risk for pressure ulcer development. During continuous observation on 11/20/24. 4;30 p.m. to 7:10 p.m. R203 was awake, lying on her back in bed, dressed in a hospital gown. A pillow was positioned under R203's right foot. No other positioning devices were in use. R203's head of the bed was raised at 25-degree angle. -at 4:50 p.m. there was no change in R203's position. -at 5:22 p.m. there was no change in R203's position. -at 5:37 p.m. homemaker (HMK)-A entered the room to record R203's supper meal choices. HMK-A raised R203's head of the bed to a 35-degree angle and exited the room. HMK-A made no attempt to move, shift R203's weight or reposition R203. -at 5:45 p.m. licensed practical nurse (LPN)-C entered R203's room and raised the head of the	F 686	the care plan for turning and positioning to prevent pressure ulcers. 4. To ensure compliance, the DNS or designee will audit 8 random residents repositioning to ensure proper procedures are followed for 4 weeks, then monthly for 2 months. Audit results will be brought to the monthly QAPI committee for input on the need to increase, decrease, or discontinue audits. Date of correction: 1/6/25	

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F 686	Continued From page 11 bed to an upright sitting position of 45 degrees. LPN-C administered medications and exited the room. LPN-C did not turn, shift R203's weight or reposition R203 before exiting the room. -at 5:50 p.m. R203's call light was put on. LPN-C and unidentified NA entered room. R203 indicated the call light was on by accident and nothing was needed. Both staff exited the room after turning off call light. Neither staff attempted to turn, reposition or move R203. R203 remained seated fully upright in bed. - 5:57 p.m. R203 turned on her call light. R203 remained seated fully upright in bed. R203 had slid down in the bed and her head was hanging heavily to her right side with her chin in her chest. -at 6:11 p.m. R203 had not changed position. R203's head of the bed remained in full upright position. R203 was in slouched position in bed, leaning to her right side, with her chin in her chest. The call light remained on with steady green light over the door. -at 6:30 p.m. R203 had not changed position. The head of the bed remained in fully upright position. R203 has slouched further down in the bed with her head positioned halfway from top of bed to middle of bed. R203 leaning to her right side with her chin in her chest. The call light remains on. -At 6:45 p.m. there is no change in position. -At 6:56 p.m. R203's head of the bed remained fully elevated at 45-degree angle.R203 was leaning heavily to her right side with her chin touching her chest and slouched down to the middle of the bed. The call light remained on. -At 7:06 p.m. NA-M and NA-N entered R203's room and lowered R203's head of the bed and turned and repositioned R203. R203 was not incontinent of bowel or bladder. R203's peri area had dry, intact skin. Coccyx wound healed with no redness noted. NA-M stated she had been told	F 686		

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F 686	Continued From page 12 R203 had been turned and repositioned at 4:30 p.m. NA-M knew R203 was to be checked and/or changed and repositioned every two hours. NA-M and NA-N had been walking by and noticed R203 was leaning so far over to the right and nearly falling out of bed, so they went in to reposition her. NA-M had noticed R203's light was on, and she had wondered why, which is why she walked down the hall to check. When interviewed on 11/21/24, at 12:05 p.m. the director of nursing stated it was the facility's expectation staff were to check and change residents every two hours if the care plan directed them to do so. The long call wait time would need to be looked in to. The facility policy Activities of Daily Living dated 12/4/23, identified any resident who was unable to carry out activities of daily living would receive necessary services to maintain good nutrition, grooming, personal and oral hygiene.	F 686		
F 699 SS=D	Trauma Informed Care CFR(s): 483.25(m) §483.25(m) Trauma-informed care The facility must ensure that residents who are trauma survivors receive culturally competent, trauma-informed care in accordance with professional standards of practice and accounting for residents' experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to comprehensively assess for trauma informed care to identify potential triggers	F 699	1. A new trauma assessment was completed for Resident R22. Specific triggers and interventions were entered	1/6/25

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F 699	Continued From page 13 and avoid potential re-traumatization for 1 of 1 resident (R22) reviewed who had a history of trauma. Findings include: R22's quarterly Minimum Data Set (MDS) dated 9/17/24, identified R22 had moderate cognitive impairment and exhibited behavior of verbal abuse to others four to six times per week and physical behaviors of hitting, scratching, pacing and wandering, one to three times per week. R22 also rejected care four to six times weekly. Diagnoses included chronic myeloid leukemia, anxiety, post traumatic stress disorder (PTSD) and dementia. R22's care plan with last revision date 10/11/24, identified R22 had impaired cognition and impaired thought process as well as behavior symptoms of hitting staff, name calling, throwing objects, sexual comments and unpredictable behaviors related to impaired cognition, anxiety and PTSD. Interventions included approach with soft tone of voice, let him know comments are inappropriate, redirect, use humor, divert attention about talking about his home or grandchildren. However, R22's care plan lacked individualized trauma-informed approaches or interventions and identification of triggers to avoid potential re-traumatization. R22's order summary report dated 11/21/24, identified R22 received Depakote 125 milligrams (mg) two times per day for post traumatic stress disorder. R22's telehealth psychiatric visit note dated 8/12/24, identified R22 had PTSD and a family	F 699	into R22□s care plan. 2. All residents have the potential to be affected by this deficient practice. All resident charts were audited to ensure a trauma assessment was completed upon admission. If the assessment showed the resident has trauma, staff were interviewed to ensure their care planned triggers are still accurate. 3. To ensure systemic changes are sustained, the DNS held an in-service education on the requirement for all staff to document or notify nursing leadership of any alarming comments said by a resident, as that may require another trauma-assessment. 4. To ensure compliance, all residents with new mood and behavior notes will be reviewed by the DNS or designee to determine the need of a new trauma assessment. Audits will be conducted by the DNS or designee five times a week, ongoing, as a part of our clinical stand-up meeting. Audit results will be brought to the monthly QAPI committee for input on the need to increase, decrease, or discontinue audits. 5. Date of correction: 1/6/25	

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F 699	Continued From page 14 member identified R22 served in the Vietnam war and had flashbacks of the war. R22's medical record lacked a comprehensive assessment for R22's PTSD, potential triggers and interventions. When interviewed on 11/19/24, at 1:00 p.m. family member (FM)-A reported R22 served in Vietnam and had a career as a fire chief. R22 had taken care of dismembered people and traumatic injuries that never seemed to bother him; however, R22 was taking the medication Depakote for PTSD. A joint interview was conducted with nursing assistant (NA)-B and trained medication assistant (TMA)-A on 11/20/24 at 2:00 p.m.. NA-B stated when she talked with R22 he would bring up his service and mention how he was near others who got blown up and/or how his general treated him. R22 did not seem anxious or upset when discussing these things with her. NA-B see how R22 could get upset with certain people depending on how R22 was spoken to. TMA-A stated he knew R22 would get angry if others mentioned they were in the service but did not serve in war. R22 would comment to them they did not know anything if they had not been in war and make angry comments. When interviewed on 11/21/24, at 8:15 a.m. registered nurse (RN)-C stated the diagnosis of PTSD should be assessed and care planned. R22's was not assessed or have a care plan related to R22's PTSD. It would be important to have the PTSD addressed on R22's plan of care to alert staff to what his triggers were.	F 699		

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F 699	Continued From page 15 During interview on 11/21/24, at 12:00 p.m. the director of nursing stated it would be important to assess and care plan a diagnosis of PTSD with interventions for staff to avoid known triggers, if any. On 11/24/24, at 10:45 a.m. R22 was observed sitting in recliner in his room fully dressed and watching television. R22 stated he had lost several of his fingers during a work accident while working at the local paper mill. R22 stated he served three years in Vietnam and then was the local fire chief and ran the fire department for the town in which he lived for many years before he eventually retired. R22 did not elaborate on his service in Vietnam or the fire department. The facility policy Trauma Informed Care dated 11/16/23, identified a trauma assessment was required within five days of admission and as needed. The interview would focus on understanding the resident's experience. Staff were directed to document how trauma was currently affecting the resident. Individualized care plan interventions were required to avoid re-traumatization.	F 699		
F 732 SS=C	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for	F 732		1/6/25

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F 732	Continued From page 16 resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to consistently post the census on the nurse staff posting; failed to identify when the posting changed due to call ins; and failed to retain the nurse staff posting for 18 months. This had the potential to affect all 50 residents residing in the facility and/or visitors who may wish to view the information. Findings include:	F 732	1. The posted staffing schedule has been updated with accurate information, including the census and any call-ins or picked-up shifts per posting regulations . 2. All residents in the facility have the potential to be affected by this deficient practice. As a result, all facility leadership have been trained and given access to the BIPA report to print updated staffing levels per posting nursing staffing	

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F 732	Continued From page 17 During an observation on 11/19/24 at 7:09 a.m., the staff posting was in a display case at the front entrance at the persons in charge list. The posting was dated Friday 11/15/24, and identified the census was 51 and listed the following staff scheduled working hours per shift for each nursing job class. However, the posting failed to identify the staff actually worked hours due to call-ins, vacations and/or staff shortages. The facility provided a print out that reflected staff timecard punches, however, an actual working staff schedule that reflected call-ins, staff shortages and/or vacations was requested, but not received. The nurse staff postings dated 10/8/24 through 11/15/24, were reviewed and identified the following dates were missing: 10/9/24 through 10/16/24, 10/18/24 through 10/20/24, 10/22/24, 10/25/24 through 10/27/24, 11/2/24, 11/3/24, 11/7/24, 11/9/24 through 11/12/24. Additionally, the nurse staff postings failed to identify if corrections had been completed to reflect staffing changes, including call ins. During an interview on 11/20/24 at 9:55 a.m., household coordinator (HC)-A stated she was responsible for the staff schedule and the nurse staff posting. HC-A posted the nurse staff posting in the display case at the front entrance Monday through Thursday when she was at the facility. HC-A printed the nurse staff posting on Thursday for the weekend and the charge nurse was responsible to post it. HC-A stated the facility had consistent staff shortages, especially on the evening shift. HC-A stated she had never thought of updating the nurse staff posting to reflect call-ins and/or changes in staffing numbers and	F 732	regulations and updating it with any changes. 3. To ensure systemic changes are sustained, the Nursing Staff Daily Posting Requirements policy and procedures was reviewed with all staff 12/18/24. For 7-day posting, weekend charge nurses and staff coordinator received direct education from DNS on updating and printing the BIPA report to meet the posting nursing staffing requirements. 4. To ensure compliance, random audits will be completed for 4 weeks, then monthly for 2 months. The results will be presented to the monthly QAPI committee for input on whether to increase, decrease, or discontinue audits. Date of correction: 1/6/25	

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F 732	Continued From page 18 was unsure how long the nurse staff postings should be retained, possibly a year. During an interview on 11/25/24 at 2:01 p.m., the director of nursing (DON) stated the nurse staff posting should be kept for 18 months and should be posted daily. The DON stated she was unaware the nurse staff posting should be updated to show changes in actual working staff, but it would allow residents and visitors to determine numbers of staff in the building. During an interview on 11/25/24 at 2:28 p.m., the administrator stated his expectation was have the census recorded and posted daily on the nurse staff posting form. A policy regarding the nurse staff posting was requested but not received.	F 732		
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist	F 756		1/6/25

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F 756	Continued From page 19 during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the consulting pharmacist (CP) identified and communicated to the facility the need for monitoring for potential adverse events for high- risk medications for 2 of 5 residents (R22, R37); and failed to identify the need to monitor for adverse behaviors for psychotropic medications for 1 of 5 residents (R37) reviewed for unnecessary medications. Findings include: R22's quarterly Minimum Data Set (MDS) dated 9/17/24, identified R22 had moderate cognitive impairment and exhibited behavior of verbal abuse to others four to six times per week and	F 756	1. The identified residents R22 and R37 had a comprehensive medication review completed by Consultant Pharmacist on 12/18/24. 2. All residents receiving high-risk medications and psychotropic medications have the potential to be affected by this deficient practice. These residents were audited by the DNS and Consultant Pharmacist to ensure proper monitoring parameters are in place. 3. To ensure systemic changes are sustained, the DNS or designee and Consultant Pharmacist will develop and implement a monthly standardized process for medication review, monitoring,	

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F 756	Continued From page 20 physical behaviors of hitting, scratching, pacing, and wandering, one to three times per week. R22 also rejected care four to six times weekly. The MDS identified R22 had received antidepressant medications daily. Diagnoses included chronic myeloid leukemia, anxiety, post-traumatic stress disorder (PTSD) and dementia. R22's signed Order Summary Report, dated 11/21/24, identified R22's current ordered medications and treatments at the nursing home. These included orders for: Gleevec (to treat myeloid leukemia) 400 milligrams (mg) daily, nurse to monitor for side effects and MD as needed, and venlafaxine (to treat depression) 75 mg daily. The summary listed an order which directed "Nurse to monitor for the following symptoms: weakness, dizziness, sudden changes in strength or mobility, nausea or vomiting, unusual bleeding, bruising, black or tarry stools, extreme fatigue. Swelling, redness and/or pain in upper or lower extremities, yellowing of the skin or eyes, swelling of the face, mouth, tongue, legs, ankles or feet, or sudden weight gain." R22's medical record lacked evidence R22 was being assessed or evaluated for adverse effects as ordered by the physician. R22's PharMerica Physician Recommendations dated 8/23/24, identified R22 was receiving venlafaxine and donepezil daily. The consultant pharmacist (CP) identified donepezil could cause side effects for aggression and agitation. A recommendation was made to increase venlafaxine and consider reducing R22's donepezil.	F 756	and communication of recommendations. This will include monthly drug regimen reviews, communication tools for pharmacist recommendations, and documentation requirements for follow-up. Nursing staff were educated by the DNS on medication monitoring requirements, documentation expectations, communication process for recommendations and follow-up procedures for identified concerns. 4. To ensure compliance, the DNS or designee and Consultant Pharmacist will conduct weekly random audits of 5 residents medication regimens for 4 weeks, then monthly for 2 months. Audit results will be brought to the monthly QAPI committee for input on the need to increase, decrease, or discontinue audits. Date of correction: 1/6/25	

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F 756	Continued From page 21 During interview on 11/21/24, at 11:11 a.m. registered nurse (RN)-C stated R22 did have an active order to monitor for side effects to his chemotherapy medication and so the order should be on his MAR to monitor. The MAR usually pulled from the resident orders but in R22's case, it had been entered incorrectly and did not get pulled over. It was the facility policy to monitor high risk medication and psychotropic medications for side effects every shift and document it was completed on the MAR or the TAR. RN-C had just discussed the need to monitor labs with residents on certain medications. Lab work was not part of the standing orders, and they relied on the primary physician to order labs as needed and so it frequently was missed. Pharmacy reviews were conducted monthly and review of recommendations January 2024 through November 2024, identified no further concerns or recommendations. The pharmacy reviews lacked evidence the CP identified the need and made the recommendation to the facility to monitor for psychotropic medication adverse effects as ordered. R37's quarterly MDS dated 8/9/24, identified R37 had intact cognition and no behavioral symptoms were identified. The MDS indicated R37 had consumed antidepressant, anticoagulant and diuretic medications daily. Diagnoses included chronic obstructive pulmonary disease (COPD), anxiety, atrial fibrillation (irregular heartbeat), and kidney disease. R37's signed Order Summary Report, dated 11/25/24, identified R37's current physician ordered medications and treatments at the	F 756		

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F 756	Continued From page 22 nursing home. These included orders for furosemide (a diuretic) 40 mg daily, lorazepam (an antianxiety) 0.5 mg at bedtime, methimazole (to treat hyperthyroid) 2.5 mg daily and Lexapro (an antidepressant) 10 mg daily. A hospital discharge summary dated 11/28/23, identified R37 had been hospitalized and treated for anemia with a hemoglobin of 6.4. R37's hemoglobin on discharge was 10.3 and medications changes were made to discontinue coumadin and to start aspirin 325 mg instead. R37's medical record lacked evidence R22 had annual blood work to assess, or evaluate for adverse effects, effectiveness of hyperthyroid treatment and monitoring for therapeutic dosages. R37's PharMerica Physician Recommendations dated 7/29/24, identified R37 received Lexapro and lorazepam daily with a recommendation to the physician to review the medications and consider a gradual dose reduction (GDR). The physician refused the recommendation due to R37 was stable with current dose. Pharmacy reviews were conducted monthly and review of recommendations January 2024 through November 2024, identified no further concerns or recommendations. The pharmacy reviews lacked evidence the CP identified the need and made the recommendation to the facility to monitor for psychotropic medication side effects as ordered or to track and monitor adverse behaviors for which the medications were ordered. During interview on 11/21/24, at 11:11 a.m. RN-C	F 756		

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F 756	Continued From page 23 stated R37 should have had lab work done to monitor for dehydration related to her diuretic medications as well as potassium level and hemoglobin to check for the need for supplementation related to the diuretic medications. RN-C had just discussed this with the director of nursing (DON) that some residents should have routine lab work done every six months to a year. Some of the physicians were on top of their residents to order labs and others were not. A joint interview was conducted with the DON and RN-D on 11/21/24, at 11:59 a.m. RN-D stated it was the facility's practice to monitor high risk and psychotropic medications every shift and staff were to document it was completed on the resident's TAR. The DON stated R37 should have symptoms of anxiety and depression monitored every shift. RN-D stated they never received recommendations from the pharmacist regarding need for lab work related to a resident's medications. RN-D commented it would be another check to ensure things were not missed and a good resource for the facility. During telephone interview on 11/25/24, at 3:49 p.m. the CP stated when charts were reviewed monthly the CP did check to ensure the facility was monitoring for side effects as well as adverse behaviors. The facility had been short staffed and had just resumed monthly behavior meetings, which the CP attended. The CP had been looking at each residents' charts for side effects and behavior monitoring and had told the facility to be sure to have specific behaviors to monitor on residents receiving psychotropic medications. The CP had made recommendations to try to reduce medications but felt the recommendations	F 756		

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F 756	Continued From page 24 were not considered because the psychiatric clinic would keep adding on more medications. The CP felt R37 should have some lab work drawn. Sometimes the resident or family would refuse but the CP was unsure why a recommendation to check lab work was not made for R37. The facility policy Consultant Pharmacist Services Provider Requirements dated 1/2023, identified regular and reliable pharmacist services were to be provided to residents of the facility. The consultant pharmacist would provide pharmaceutical care services.	F 756		
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §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	F 757		1/6/25

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F 757	Continued From page 25 section. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure adverse event monitoring was completed for high-risk medications 2 of 5 residents (R22, R37) reviewed for unnecessary medications. Findings include: R22's quarterly Minimum Data Set (MDS) dated 9/17/24, identified R22 had moderate cognitive impairment. Diagnoses included chronic myeloid leukemia and dementia. R22's signed Order Summary Report, dated 11/21/24, identified R22's current ordered medications and treatments at the nursing home. These included orders for: Gleevec (to treat myeloid leukemia) 400 milligrams (mg) daily, nurse to monitor for side effects and notify MD as needed. The summary listed an order which directed "Nurse to monitor for the following symptoms: weakness, dizziness, sudden changes in strength or mobility, nausea or vomiting, unusual bleeding, bruising, black or tarry stools, extreme fatigue. Swelling, redness and/or pain in upper or lower extremities, yellowing of the skin or eyes, swelling of the face, mouth, tongue, legs, ankles or feet, or sudden weight gain." R22's care plan dated 10/11/24, identified R22 consumed a non-cytotoxic oral chemotherapy with a goal to remain free of complications related to chemo therapy side effects. Interventions included drawing blood work as ordered, administering the medication as ordered, and	F 757	1. The identified residents R22 and R37 will have medication monitoring parameters implemented and lab work ordered as appropriate on 12/18/24. 2. All residents receiving high-risk medications have the potential to be affected by this deficient practice. The DNS and Consultant Pharmacist audited all residents receiving high risk medications to ensure proper monitoring and lab protocols are in place. 3. To ensure systemic changes are sustained, staff were educated by DNS on high-risk medication monitoring, documentation requirements, and adverse event reporting. Pharmacy Consultant and PCP received education on lab monitoring protocols too. 4. To ensure compliance, the DNS or designee and Consultant Pharmacist will conduct weekly audits of 5 residents medication regimens for 4 weeks, then monthly for 2 months. Audit results will be brought to the monthly QAPI committee for input on the need to increase, decrease, or discontinue audits. Date of correction: 1/6/25	

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F 757	Continued From page 26 monitor for chemotherapy complications and side effects. R22's Medication Administration Record (MAR), dated 11/2023, identified the order for Gleevec and recorded R22 received the medication, as ordered, on a daily basis. However, the MAR and Treatment Administration Record (TAR) both lacked evidence of monitoring for adverse effects of the medications. Further, R22's medical record was reviewed and lacked evidence R22 was being assessed, or evaluated for adverse effects as ordered by the physician. During interview on 11/21/24, at 11:11 a.m. registered nurse (RN)-C stated R22 did have an active order to monitor for side effects to his chemotherapy medication and so the order should be on his MAR or TAR to monitor. The MAR usually pulled from the resident orders but in R22's case, it had been entered incorrectly and did not get pulled over. It was the facility policy to monitor high risk medication for side effects every shift and document it was completed on the TAR. RN-C had just discussed the need to monitor labs with residents on certain medications. Lab work was not part of the standing orders and they relied the primary physician to order labs as needed and so it frequently was missed. R37's quarterly MDS dated 8/9/24, identified R37 had intact cognition and no behavioral symptoms were identified. The MDS indicated R37 had consumed anticoagulant and diuretic medications daily. Diagnoses included chronic obstructive pulmonary disease (COPD), atrial fibrillation (irregular heartbeat), and kidney disease.	F 757		

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F 757	Continued From page 27 R37's signed Order Summary Report, dated 11/25/24, identified R37's current physician ordered medications and treatments at the nursing home. These included orders for furosemide (a diuretic) 40 mg daily, potassium (a supplement) 10 milliequivalents daily, and methimazole (to treat hyperthyroid) 2.5 mg daily. R37's care plan with last revision date 8/13/24, identified R37 received diuretic therapy. Interventions included monitor for side effects based on clinical standards of practice and to monitor for symptoms of dehydration and encourage adequate fluid intake. R37's medical record lacked evidence annual lab work was completed to monitor for adverse effects and/or therapuetic drug levels of the high risk medications. R37's MAR, dated 11/2023, identified the orders for furosemide, methimazole and potassium and recorded R37 received the medications, as ordered, on a daily basis. However, the MAR and TAR both lacked evidence staff were monitoring for adverse effects of the medications. Further, R37's medical record was reviewed and lacked evidence R22 had annual blood work to assess, or evaluate for adverse effects, effectiveness of hyperthyroid treatment and monitoring for therapeutic dosages. During interview on 11/21/24, at 11:11 a.m. registered nurse RN-C stated R37 should have had lab work done to monitor for dehydration related to her diuretic medications as well as potassium level and hemoglobin to check for the need for supplementation related to the diuretic medications and history of anemia. RN-C had just	F 757		

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F 757	Continued From page 28 discussed this with the DON that some residents should have routine lab work done every six months to a year. Some of the physicians were on top of their residents to order labs and others were not. During joint interview on 11/21/24, at 11:59 a.m. with the director of nursing and RN-D, RN-D stated it was the facility's practice to monitor for adverse events with high risk medications every shift and staff were to document it was completed on the resident's TAR. During telephone interview on 11/25/24, at 3:49 p.m. the consultant pharmacist (CP) stated when charts were reviewed monthly the CP did check to ensure the facility was monitoring for side effects. The CP reviewed each resident charts individually for side effects. When a resident was receiving diuretic or thyroid medications, lab work was something the facility would want to look at. R37 should have lab work drawn and the CP was not sure why there had not been a recommendation to do so in the past year. The facility policy Medication Drug Regimen Review dated 2/28/24, identified the drug regimen review was a process that included medication reconciliation and review of all medications a resident was taking to identify and prevent potentially significant medication issues. A policy to monitor for side effects of medications was requested, however, none was received.	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.	F 758		1/6/25

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F 758	Continued From page 29 §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a 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	F 758		

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F 758	Continued From page 30 indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure adverse event monitoring was completed for 2 of 5 residents (R22, R37); and failed to monitor adverse behaviors for 1 of 5 residents (R37) reviewed for unnecessary medication use and were taking a psychotropic medication. Findings include: R22's quarterly Minimum Data Set (MDS) dated 9/17/24, identified R22 had moderate cognitive impairment and exhibited behaviors of verbal abuse to others four to six times per week and physical behaviors of hitting, scratching, pacing and wandering, one to three times per week. R22 also rejected care four to six times weekly. The MDS identified R22 had received antidepressant medications daily. Diagnoses included chronic myeloid leukemia, anxiety, post-traumatic stress disorder (PTSD) and dementia. R22's signed Order Summary Report, dated 11/21/24, identified R22's current ordered medications and treatments at the nursing home. These included orders for: venlafaxine (to treat depression) 75 mg daily. The summary listed an order which directed "Nurse to monitor for the following symptoms: weakness, dizziness, sudden changes in strength or mobility, nausea	F 758	1. The identified residents R22 and R37 have behavior monitoring implemented, and psychotropic medication reviews were completed 12/18/24. 2. All residents receiving psychotropic medications have the potential to be affected by this deficient practice. The DNS and Consultant Pharmacist has audited resident records to include proper monitoring. 3. To ensure systemic changes are sustained, nursing staff were educated by the DNS on behavior monitoring requirements, psychotropic medication monitoring, documentation expectations, and GDR process per facility policy. 4. To ensure compliance, the DNS or designee and Consultant Pharmacist will conduct weekly audits of 5 resident medication regimens for 4 weeks, then monthly for 2 months. Audit results will be brought to the monthly QAPI committee for input on the need to increase, decrease, or discontinue audits. Date of correction: 1/6/25	

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F 758	Continued From page 31 or vomiting, unusual bleeding, bruising, black or tarry stools, extreme fatigue. Swelling, redness and/or pain in upper or lower extremities, yellowing of the skin or eyes, swelling of the face, mouth, tongue, legs, ankles or feet, or sudden weight gain." R22's care plan dated 10/11/24, included interventions of report to nurse signs and symptoms of confusion, mood change, change in behavior, or ability to help with activities of daily living, suicidal ideation, constipation, shuffle gait, rigid muscles, diarrhea, appetite loss, weight loss, nausea and vomiting and fatigue. R22's Medication Administration Record (MAR), dated 11/2023, included the order for venlafaxine and identified R22 received the medication, as ordered, on a daily basis. However, the MAR and Treatment Administration Record (TAR) lacked evidence of an order to monitor for adverse effects of the medications. R22's medical record lacked evidence R22 was being assessed or evaluated for adverse effects as ordered by the physician. During interview on 11/21/24, at 11:11 a.m. registered nurse (RN)-C stated R22 did have an active order to monitor for side effects and so the order should be on the resident's MAR or TAR to monitor. The MAR and TAR usually pulled from the resident orders but in R22's case, it had been entered incorrectly and did not get pulled over. It was the facility policy to monitor high risk psychotropic medications for side effects every shift and document it was completed on the TAR. R37's quarterly MDS dated 8/9/24, identified R37	F 758		

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F 758	Continued From page 32 had intact cognition and no behavioral symptoms were identified. The MDS indicated R37 received antidepressant, and antianxiety medications daily. Diagnoses included chronic obstructive pulmonary disease (COPD), anxiety, atrial fibrillation (irregular heartbeat), and kidney disease. R37's signed Order Summary Report, dated 11/25/24, identified R37's current physician ordered medications and treatments at the nursing home. These included orders for lorazepam (an antianxiety) 0.5 mg at bedtime, and Lexapro (an antidepressant) 10 mg daily. R37's care plan with last revision date 8/13/24,identified R37 had depression and included interventions to help R37 meet this goal including consult with pharmacist, administer the medication as ordered, and monitor for complications and side effects such as confusion, mood change, change in behavior, or ability to help with activities of daily living, suicidal ideation, constipation. Staff were also directed to monitor and report if noted increased anger, labile mood or agitation, feeling threatened or thoughts of harming others, and possession of objects that could be used for weapons. R37's MAR dated 11/2023, identified the orders for lorazepam and Lexapro and recorded R37 received the medications, as ordered, on a daily basis. However, the MAR and TAR lacked evidence staff monitored for adverse effects of the medications. The MAR and TAR failed to identify behavioral symptoms to monitor, and track. R37's medical record lacked evidence R37's	F 758		

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F 758	Continued From page 33 behaviors were monitored, assessed, and reviewed to justify the daily medication administration. During joint interview on 11/21/24, at 11:59 a.m. with the director of nursing (DON) and RN-D, RN-D stated it was the facility's practice to monitor psychotropic medications every shift and staff were to document it was completed on the resident's TAR. The DON stated R37 should have symptoms of anxiety and depression monitored every shift. During telephone interview on 11/25/24, at 3:49 p.m. the consultant pharmacist (CP) stated when charts were reviewed monthly the CP did check to ensure the facility was monitoring for side effects as well as adverse behaviors. The facility had been short staffed and had just resumed monthly behavior monitoring meetings. During the meetings the facility staff and CP reviewed each residents' psychotropic medications and behavior monitoring. The CP also looked at each resident's chart individually and had made the recommendation to be sure to have specific individualized targeted behaviors for each resident and not just general. The CP was working on reviewing psychotropic medications and behavior monitoring and had planned to review the wing where R37 and R22 resided later in the week. She was not sure why she had not made recommendations to monitor side effects for the two residents or adverse behaviors for R37. Those were things the CP reviewed when she reviewed the resident charts monthly. The facility policy Psychotropic Medications dated 12/6/23, identified throughout the administration of psychotropic medications, mood and behavior	F 758		

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F 758	Continued From page 34 documentation must continue in order to monitor the effect the medication has on the behaviors, as well as monitoring for side effects. Staff were directed to monitor for effectiveness and potential adverse consequences of the medications.	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, interview and document review, the facility failed to ensure two insulin pens were labeled with the resident name for 1 of	F 761	1. The identified resident R154's insulin pens were properly labeled immediately. 2. All residents have the potential to be	1/6/25

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F 761	Continued From page 35 1 resident (R154) observed to receive insulin. Findings include: R154's Admission Record dated 11/25/24, identified R154 was admitted to the facility on 11/13/24. R154's Diagnosis Report dated 11/25/24, identified R154 was a Type 2 diabetic. R154's Order Summary Report dated 11/25/24, identified the following: 11/13/24, R154 was prescribed insulin lispro (Humalog) (a short acting insulin) with the following instructions: - insulin lispro (1 Unit Dial) Subcutaneous Solution Pen-injector 100 unit/milliliter (ml) Inject as per sliding scale: if 0 - 160 = 0 UNITS; 161 - 190 = 1 UNIT; 191 - 220 = 2 UNITS; 221 - 250 = 3 UNITS; 251 - 280 = 4 UNITS; 281 - 310 = 5 UNITS; 311 - 340 = 6 UNITS; 341 - 370 = 7 UNITS; 371 - 400 = 8 UNITS; 401 - 999 = 9 UNITS, subcutaneously three times a day for Type 2 diabetes. Give sliding scale dose in addition to scheduled dose. - Insulin Lispro (1 Unit Dial) Subcutaneous Solution Pen-injector 100 UNIT/ML give 25 Units before breakfast daily plus sliding scale; give 22 Units before lunch daily plus sliding scale; and give 21 Units before supper daily plus sliding scale. - 11/13/24, R154 was prescribed Toujeo Max SoloStar Subcutaneous Solution Pen-injector 300 unit/ml (insulin glargine) (a long acting insulin) inject 84 unit subcutaneously one time a day for Type 2 diabetes. During an observation on 11/19/24 at 8:59 a.m., licensed practical nurse (LPN)-A administered Humalog insulin and Toujeo to R154. Neither the	F 761	affected by this deficient practice. All current medication storage areas will be audited by DNS and Consultant Pharmacist to ensure proper labeling. 3. To ensure systemic changes are sustained, the DNS or designee will implement medication labeling checks during medication passes, create process for checking newly received medications, establish monthly pharmacy storage audits by nursing staff; quarterly by Consultant Pharmacist. Licensed nursing staff were educated by DNS on medication labeling requirements, storage procedures, documentation expectations, and checking procedures for new medications. 4. To ensure compliance, the DNS or designee will conduct weekly medication storage audits for 4 weeks, then monthly for 2 months. Consultant Pharmacist will conduct quarterly medication storage audits. Audit results will be brought to the monthly QAPI committee for input on the need to increase, decrease, or discontinue audits. Date of correction: 1/6/25	

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F 761	Continued From page 36 Humalog kwik pen or the Toujeo pen had a label identifying the pens belonged to R154. During an interview on 11/19/24 at 9:02 a.m., LPN-A stated the medication pens did not come with a label from the pharmacy but the boxes did. The boxes of medication were kept in the fridge in the medication room. When asked how she knew the pens belonged to R154, LPN-A stated R154 was the only diabetic resident on the unit who received injectable medication. The medication pens were stored in the top drawer of the medication cart and everyone just knew they belonged to R154. "I guess I could put her [R154] initials and room number on it." During an interview on 11/19/24 at 9:22 a.m., registered nurse (RN)-A stated all medication pens should be labeled when they come from the pharmacy. If not, staff should put a sticker with the resident's information on it. RN-A stated she was unaware R154's medication pens were unlabeled but would put a sticker on them. There was only one diabetic resident on the unit and R154 was just admitted to the facility on 11/13/24. RN-A stated a medication pen without a label was an infection control issue because staff shouldn't use a medication pen on the wrong resident. Also, R154 paid for that mediation, and it should be labeled with R154's name. During an interview on 11/25/24 at 3:44 p.m. the director of nursing (DON) stated she expected all medication pens to come from the pharmacy labeled or staff should place a resident sticker on the pen identifying who the pen belonged to. The facility policy Medication Ordering and Receiving from Pharmacy Provider Medications	F 761		

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F 761	Continued From page 37 and Medication Labels dated 1/2023, identified each prescription medication would be labeled to include: a. Resident's name b. Specific directions for use, including route of administration c. Medication name d. Strength of medication e. Prescriber's name f. Date medication is dispensed g. Quantity dispensed h. Expiration or end-of-use date, if not dispensed in original manufacturer packaging i. Name, address, and telephone number of dispensing pharmacy J. Prescription number k. Accessory/precautionary labels indicating storage requirements and special procedures. Example: "Shake well", "Take on empty stomach, one hour before or 2 hours after meals," "Do not crush". l. Dispensing pharmacist's initials m. Lot number of medication dispensed, if not dispensed in original manufacturer packaging, where required by state law n. Any other information required by state and federal Medication containers having soiled, damaged, incomplete, illegible, or makeshift labels are returned to the dispensing pharmacy for re-labeling or destroyed in accordance with the medication destruction policy.	F 761		
F 838 SS=F	Facility Assessment CFR(s): 483.71(a)(1)(3)(b)(1)(c)(1)-(5) §483.71 Facility assessment. The facility must conduct and document a facility-wide assessment to determine what	F 838		1/6/25

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F 838	Continued From page 38 resources are necessary to care for its residents competently during both day-to-day operations (including nights and weekends) and emergencies. The facility must review and update that assessment, as necessary, and at least annually. The facility must also review and update this assessment whenever there is, or the facility plans for, any change that would require a substantial modification to any part of this assessment. §483.71(a) The facility assessment must address or include the following: §483.71(a)(1) The facility's resident population, including, but not limited to: (i) Both the number of residents and the facility's resident capacity; (ii) The care required by the resident population, using evidence-based, data-driven "methods" that considering the types of diseases, conditions, physical and behavioral health needs, cognitive disabilities, overall acuity, and other pertinent facts that are present within that population, consistent with and informed by individual resident assessments as required under § 483.20; (iii) The staff competencies and skill sets that are necessary to provide the level and types of care needed for the resident population; (iv)The physical environment, equipment, services, and other physical plant considerations that are necessary to care for this population; and (v) Any ethnic, cultural, or religious factors that may potentially affect the care provided by the facility, including, but not limited to, activities and food and nutrition services. §483.71(a)(2) The facility's resources, including	F 838		

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F 838	Continued From page 39 but not limited to the following: (i) All buildings and/or other physical structures and vehicles; (ii) Equipment (medical and non- medical); (iii) Services provided, such as physical therapy, pharmacy, behavioral health, and specific rehabilitation therapies; (iv) All personnel, including managers, nursing and other direct care staff (both employees and those who provide services under contract), and volunteers, as well as their education and/or training and any competencies related to resident care; (v) Contracts, memorandums of understanding, or other agreements with third parties to provide services or equipment to the facility during both normal operations and emergencies; and (vi) Health information technology resources, such as systems for electronically managing patient records and electronically sharing information with other organizations. §483.71(a)(3) A facility-based and community-based risk assessment, utilizing an all-hazards approach as required in §483.73(a)(1). § 483.71(b) In conducting the facility assessment, the facility must ensure: § 483.71(b)(1) Active involvement of the following participants in the process: (i) Nursing home leadership and management, including but not limited to, a member of the governing body, the medical director, an administrator, and the director of nursing; and (ii) Direct care staff, including but not limited to, RNs, LPNs/LVNs, NAs, and representatives of the direct care staff, if applicable.	F 838		

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F 838	Continued From page 40 (iii) The facility must also solicit and consider input received from residents, resident representatives, and family members. §483.71(c) The facility must use this facility assessment to: §483.71(c)(1) Inform staffing decisions to ensure that there are a sufficient number of staff with the appropriate competencies and skill sets necessary to care for its residents' needs as identified through resident assessments and plans of care as required in § 483.35(a)(3). §483.71(c)(2) Consider specific staffing needs for each resident unit in the facility and adjust as necessary based on changes to its resident population. §483.71(c)(3) Consider specific staffing needs for each shift, such as day, evening, night, and adjust as necessary based on any changes to its resident population. §483.71(c)(4) Develop and maintain a plan to maximize recruitment and retention of direct care staff. §483.71(c)(5) Inform contingency planning for events that do not require activation of the facility's emergency plan, but do have the potential to affect resident care, such as, but not limited to, the availability of direct care nurse staffing or other resources needed for resident care. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to review and update the facility assessment to incorporate the minimal staff	F 838	1. A new facility assessment was completed to include an assessment of the resident population with a diagnosis of	

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F 838	Continued From page 41 requirements; and all resources and conditions to care for the resident populations. This had the potential to affect all 50 residents who resided in the facility. Findings include: The Facility Assessment dated 8/7/24, identified the need to determine what resources were necessary to care for its residents competently during both day-to-day operations and emergencies. The assessment listed resident count, activities of daily living (ADL) assistance needed, behavioral symptoms and active diagnoses. The facility utilized an interdisciplinary approach to meet the needs of residents across all shifts, including nights and weekends. The scheduler would check the schedule and divide staff based on the acuity of the facility assessment. The facility assessment failed to include information on the staffing levels needed for specific shifts, such as day, evening, and nights based on resident population and acuity. The facility assessment failed to identify residents who required oxygen supplementation and identify the minimal equipment and supplies needed to care for oxygen dependent residents. The facility assessment lacked evidence of assessment of resident population with diagnosis of PTSD. During interview on 11/25/24, at 2:10 p.m. the administrator stated the facility assessment had been completed by the previous administrator and he had not reviewed the assessment. Minimum staffing was based on the facility census. The bare minimum staffing would be one nurse and aide on each wing during the day and evening shift and one aide on each wing and a	F 838	PTSD, minimum staffing for specific shifts based on acuity, and the oxygen equipment and supplies needs of residents. 2. This has the potential to affect all residents. As a result, the administrator reviewed the Facility Assessment policy and procedure to audit information on the new assessment to verify it aligns with the requirements of our policy and current resident population. 3. To ensure systemic changes are sustained, the senior director reviewed our policy on facility assessments with the administrator and DNS to include but not limited to resident population with a diagnosis of PTSD, minimum staffing for specific shifts based on acuity, and the oxygen equipment and supplies need issues identified. 4. To ensure compliance, the facility assessment will be reviewed every month QAPI meeting for the committee to review and ensure it aligns with the current resident population and acuity. 5. Date of correction: 1/6/25	

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F 838	Continued From page 42 nurse float for the overnight shift. There should be something in the facility assessment that addressed minimum staffing needs. The administrator was unsure how detailed oxygen needs of residents would need to be documented in the facility assessment, but he was aware PTSD was required to be covered in the assessment. A policy on the facility assessment was required, however none was received.	F 838		
F 867 SS=F	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement. §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.71 and including how such information will be used to develop and monitor performance indicators.	F 867		1/6/25

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F 867	Continued From page 43 §483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation. §483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events. §483.75(d) Program systematic analysis and systemic action. §483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained. §483.75(d)(2) The facility will develop and implement policies addressing: (i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems; (ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and (iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained. §483.75(e) Program activities.	F 867		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 867	Continued From page 44 §483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care. §483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility. §483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.71. Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section. §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must:	F 867		

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F 867	Continued From page 45 (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to develop action plans for identified areas of monitoring and failed to identify and implement at least one process improvement project (PIP) This had the potential to affect all 50 residents who resided in the facility. Findings include: The Quality Assurance, Action Committee Meeting Minutes dated 7/11/24, identified the team had reviewed the following topics: -infection control. -emergency operation plan and facility assessment. -dietary concerns -therapy staffing changes -documentation of assessments and coding -resident council complaints -life style enrichment -human resources -life safety and environment The data failed to identify any facility developed and implemented action plans with measurable goals and/or identify actions taken. The Quality Assurance, Action Committee Meeting Minutes dated 8/22/24, identified the team had reviewed the following topics: -nursing services	F 867	1. The facility QAPI coordinator reviewed the results from the QAPI meetings, along with other data sources, to determine that antipsychotic medication use would be the priority of the PIP. 2. All residents have the potential to be affected by the deficient practice. As a result, a PIP committee was formed and is scheduled to meet monthly during the QAPI meetings to review and discuss antipsychotic medication use. The facility will conduct least one project annually that focuses on high risk or problem-prone areas identified through data collection and analysis. 3. To ensure systemic changes are sustained, The DNS or designee will continue to monitor PIP progress and completion. The QAPI coordinator will implement changes necessary to ensure action plans are in place with measurable goals and steps taken to improve the antipsychotic medication use for the duration of the antipsychotic PIP. 4. To ensure compliance, audits for PIP progress will be completed by the DNS or designee monthly for 3 months. Audit results will be presented to the monthly QAPI committee for input on whether to increase, decrease, or discontinue audits.	

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F 867	Continued From page 46 -resident council complaints -safety and emergency preparedness -employee action committee results -financial stewardship, -action plans from survey, Casper reports and/or corporate compliance. The data failed to identify any facility developed and implemented action plans with measurable goals and/or identify actions taken. The Quality Assurance, Action Committee Meeting Minutes dated 10/31/24, identified the team had reviewed the following topics: -incidents and safety -infection control -medication regimen review -QAPI plan priorities -staff quality concern trends -hand hygiene compliance -survey readiness -resident and family concerns -survey results The data failed to identify the facility developed and implemented action plans with measurable goals and/or identify actions taken. Although the facility listed out areas they were collecting data on there was a lack of information on whether the items were PIPS that required an action plan. Further, the facility could not provide evidence of any PIP project they were working on that focuses on high-risk or problem-prone areas, identified by the facility through data collection and analysis. When interviewed on 11/25/24, at 4:15 p.m. registered nurse (RN)-D stated she was responsible for the facility's QAPI program. RN-D received monthly audits from corporate and the	F 867	5. Date of correction: 1/6/25	

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F 867	Continued From page 47 facility was required to do them. Each month the audits would have a different focus. RN-D also gathered data for QAPI through focused chart reviews and track and analyzing incident reports. RN-D had social services report complaints and grievances to the QAPI committee as well. RN-D also collected data from review of resident council minutes and interactions with residents and families on a day-to-day basis. The facility did have significant issues with staffing in the beginning of the year and the main focus had been on staffing and staff retention. Now that had improved, and they could focus on other issues. Infection control and review of infections were addressed at every QAPI meeting; however, RN-D had not fully addressed the facility's response to their recent COVID-19 outbreak. That was on her agenda to discuss at the next meeting. RN-D stated performance improvement projects (PIPS) were new to her. She had just taken over QAPI and had not received much training on PIPS. RN-D was just trying to redirect everything in a format she could work with, and her next project was to figure out what type of PIP to work on. RN-D stated she needed to learn how to do the PIPS. During interview on 11/25/24, at 4:30 p.m. the director of nursing (DON) stated RN-D ran the QAPI program. The DON was not aware the facility did not have any developed PIPS in place. The DON stated there should be performance improvement projects in place and she would have helped identified areas to implement PIPS if she had been aware there were none. The facility's Quality Assurance and Performance Improvement policy dated 10/9/23, identified at a minimum one performance improvement project	F 867		

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F 867	Continued From page 48 would either be in development, ongoing or completed annually utilizing the improvement model adapted by the location. Performance improvement project activity would be monitored for progress and sustainability. Performance improvement activities would focus on high risk, high volume, or problem prone areas. Would consider incidence, prevalence, and severity of problems in that area and would lead to immediate correction of any identified problem that directly or potentially threatened the health and safety of residents. The QAPI committee was responsible for tracking and trending performance, systematically analyzing and prioritizing quality deficiencies, develop action plans, and monitor for effectiveness and sustainability.	F 867		
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	F 880		1/6/25

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F 880	Continued From page 49 providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 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.	F 880		

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F 880	Continued From page 50 Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to develop and implement an infection control surveillance plan for identifying, tracking, monitoring and/or reporting infections and communicable disease along with a monthly analysis; and failed to conduct COVID-19 testing of staff and residents per Centers for Disease Control (CDC) guidelines. In addition, the facility failed to implement enhanced barrier precautions (EBP) for 1 of 1 resident (R205) reviewed with pressure ulcers; and failed to wear a mask during a peripherally inserted central catheter (PIIC) line dressing change for 1 of 1 resident (R206) reviewed with a PIIC. These deficient practices had the potential to affect all 50 residents residing in the facility. Findings include: Surveillance and Analysis: The Monthly Report of Resident Infections in Location dated August 2024, identified unit, resident name, room number, admit date, infection type, body system, criteria met yes or no, onset C (community) or F (facility), symptoms, onset date, infection risk factors, precautions type and date resolved. The report identified two COVID-19 cases, one dental	F 880	1. Staff were immediately educated on EPB requirements for the care of R205 and the masking requirement during a PICC line change for R206. Education on the Infection and Antimicrobial Tracking Tool was provided to the infection preventionist immediately. 2. This deficient practice has the potential to affect all residents. As a result, all residents were audited to verify proper infection control practices were in place and that their care plans reflected any need of EBP, PICC line dressing changes, and that appropriate COVID-19 testing orders were put in place. 3. To ensure systemic changes are sustained, all staff received education from the DNS regarding COVID-19 surveillance and testing frequency, infection control, antibiotic use, and enhanced barrier precautions, and the requirement to wear a mask (and to have the resident either wear a mask or turn their head in the opposite direction of the dressing change) in order to prevent contamination to the PICC site and a potentially serious bloodstream infection. 4. To ensure compliance, infection control audits for COVID-19 testing, EBP, and masking to ensure proper techniques	

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F 880	Continued From page 51 abscess, one conjunctivitis (pink eye), one case of shingles, one pneumonia, three cellulitis, two osteomyelitis (bone infection), eight urinary tract infections (UTI) and one resident without an identified infection who demanded antibiotic drops. However, the report failed to identify if the infections were provided treatment, if any, nor did the report identify a resident with symptoms of a viral infection. The Monthly Infection Summary dated August 2024, identified all identified infections received treatment with an antimicrobial. The Monthly Infection Control Report dated August 2024, identified the total number of infections, the infection rate (infections/1000 resident days), antibiotic orders utlization (orders/1000 resident days) and antibiotic days of therapy (days of therapy/1000 resident days). For the month of August the following information was listed: - total number of nosocomial (healthcare acquired) infections 14 - infection rate: 8.85 percent (%) - antibiotic orders utlization: 13.28% - antibiotic days of therapy: 119.5 ordered, 114.5 actual The August 2024 Infection Control Reports identified the facility had 17 infections (14 facility acquired and 3 community acquired), 14 met McGreer's Criteria, 3 did not meet McGreer's Criteria and the facility antimicrobial usage rate was higher than the enterprise as a whole (13.28% versus 5.92%). The Monthly Report of Resident Infections in Location dated September 2024, identified unit,	F 880	during PICC line dressing changes will be completed by the infection preventionist or designee weekly for 4 weeks, and monthly for 2 months. Results will be presented to the monthly QAPI committee for input on whether to increase, decrease, or discontinue audits. 5. Date of correction: 1/6/25	

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F 880	Continued From page 52 resident name, room number, admit date, infection type, body system, criteria met yes or no, onset C (community) or F (facility), symptoms, onset date, infection risk factors, precautions type and date resolved. The report identified two eye infections, three cases of COVID-19, two cellulitis and one chronic obstructive pulmonary disease (COPD) exacerbation. However, the report failed to identify if the infections were provided treatment, if any nor did the report identify a resident with symptoms of a viral infection other than COVID-19. The Monthly Infection Summary dated September 2024, identified all but three cases of COVID-19 received antimicrobial treatment. The Monthly Infection Control Report dated September 2024, identified the total number of infections, the infection rate (infections/1000 resident days), antibiotic orders utlization (orders/1000 resident days) and antibiotic days of therapy (days of therapy/1000 resident days). For the month of August the following information was listed: - total number of nosocomial (healthcare acquired) infections: 7 - infection rate: 5.3% - antibiotic orders utlization: 3.3% - antibiotic days of therapy: 27.9 The September 2024 Infection Control Reports identified the facility had 17 infections (14 facility acquired and 3 community acquired), 14 met McGreer's Criteria, 3 did not meet McGreer's Criteria and the facility antimicrobial usage rate was higher than the enterprise as a whole (33.2% versus 17.6%).	F 880		

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F 880	Continued From page 53 The facility failed to provide a written summary of the analysis of actual/potential infections in the facility. The Monthly Report of Resident Infections in Location dated October 2024, identified unit, resident name, room number, admit date, infection type, body system, criteria met yes or no, onset C (community) or F (facility), symptoms, onset date, infection risk factors, precautions type and date resolved. The report identified nine cases of COVID-19, one cellulitis, one pneumonia, and four UTI. However, the report failed to identify if the infections were provided treatment, if any nor did the report identify a resident with symptoms of a viral infection other than COVID-19. The Monthly Infection Summary dated October 2024, identified all but the cases COVID-19 received antimicrobial treatment. The Monthly Infection Control Report dated October 2024, identified the total number of infections, the infection rate (infections/1000 resident days), antibiotic orders utlization (orders/1000 resident days) and antibiotic days of therapy (days of therapy/1000 resident days). For the month of August the following information was listed: - total number of nosocomial (healthcare acquired) infections: 17 - infection rate: 11.22% - antibiotic orders utlization: 6.6% - antibiotic days of therapy: 38.9 The September 2024 Infection Control Reports identified the facility had 17 infections (14 facility	F 880		

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F 880	Continued From page 54 acquired and 3 community acquired), 14 met McGreer's Criteria, 3 did not meet McGreer's Criteria and the facility antimicrobial usage rate was lower than the enterprise as a whole (5.4% versus 8.85%). The facility failed to provide a written summary of the analysis of actual/potential infections in the facility. The Monthly Report of Resident Infections in Location dated November 2024, identified unit, resident name, room number, admit date, infection type, body system, criteria met yes or no, onset C (community) or F (facility), symptoms, onset date, infection risk factors, precautions type and date resolved. The report identified two COVID-19 cases, three cellulitis, one osteomyelitis (bone infection), and three urinary tract infections (UTI). However, the report failed to identify if the infections were treated with an antimicrobial. No further information for November 2024 was provided. During an interview on 11/19/24 at 12:57 p.m., registered nurse (RN)-D stated she was responsible for the facility's Infection Prevention Program. RN-D reviewed antibiotics ordered and rounds/observation of what the staff were doing, including hand hygiene audits. RN-D updated the surveillance log everyday Monday through Friday. At the end of the month, RN-D completed all the reports that were needed for Quality Assurance. RN-D did not usually list residents with cold symptoms and/or "sniffles" on the surveillance log. "Now that you say that I should be tracking it."	F 880		

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F 880	Continued From page 55 During an interview on 11/21/24 at 3:06 p.m., the DON stated the facility needed to create a better tracking system to track staff and resident illness to prevent the transmission of illness. A facility policy related to infection surveillance, tracking and trending was requested but not received. STAFF TESTING The Centers for Disease Control (CDC) website Infection Control Guidance: SARS-CoV-2 (COVID-19) dated 6/24/24, identified a single new case of COVID-19 infection in any health care provider (HCP) or resident should be evaluated to determine if others in the facility could have been exposed. Perform testing for all residents and HCP identified as close contacts or on the affected unit. Testing was recommended at day 1, day 3 and day 5, where day of exposure is day 0. If additional cases were identified, testing should continue on affected units or facility-wide every 3 to 7 days until there were no new cases for 14 days. A facility untitled spreadsheet dated 6/18/24 through 11/14/24, identified employee name, positive test date, symptoms onset date, last day worked, unit(s) assigned/worked, precautions (return to work (RTW) dated and instructions) and symptoms. The spread sheet identified nine employees with onset positive dates which included: nursing assistant (NA)-C on 9/28/24, NA-D on 10/10/24, NA-E on 10/12/24, N A-L on 10/13/24, NA-F on 10/13/24, NA-G on 10/15/24, registered nurse (RN)-C on 10/15/24, NA-H on	F 880		

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F 880	Continued From page 56 10/18/24, NA-I on 10/23/24, NA-J on 11/2/24 and NA-K on 11/14/24. An undated facility COVID Testing Roster, identified staff name, test #1 results/date, test #2 results/date, test #3 results/date and symptoms. However, the roster failed to identify which staff were required to test or when. Review of the staff schedule 9/27/24 through 11/25/24, identified two registered nurses (RN), one trained medication aide (TMA), and 17 nursing assistants (NA) did not test according to CDC guidance during the breakout period. Additionally, one RN and 4 NAs were not listed on the COVID Testing Roster. During an interview with RN-D and the DON on 11/21/24 at 2:47 p.m., RN-D stated, if a staff member tested positive for COVID-19, RN-D sent an electronic communication to all staff working on the unit where the positive staff member last worked to notify them, they needed to test that day. RN-A spoke with dietary and activities staff, so they knew to test as well. RN-A then put a COVID-19 Testing Roster including all staff out on the unit. Staff were tested by the nurse working on the unit and marked off on the roster. However, RN-D did not identify any staff on the roster who were required to test. Review of the COVID-19 Testing Roster with the staff schedule, identified staff that did not test according to CDC guidance. The DON stated she believed the untested staff were casual staff that did not regularly work at the facility. Many tested while at home and called results into the facility, but there was no documentation of the result. RN-D stated the casual staff just didn't come into the facility to test. Additionally, the DON stated she believed the registered nurses also tested but forgot to document their results. The DON stated staff and	F 880		

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GOOD SAMARITAN SOCIETY - INTERNATIONAL FALLS	2201 KEENAN DRIVE INTERNATIONAL FALLS, MN 56649

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F 880	Continued From page 57	F 880		

residents were sick of COVID-19 and testing nonchalantly because they were not taking COVID-19 as seriously. It was frustrating. The facility needed to create a better tracking system to track staff and resident testing. Staff were expected to test before their shift and the facility needed to implement a system to do that. Additionally, the DON stated she needed to be informed of staff who refused to test so the DON can address it with the staff member. It was a system failure.

RESIDENT TESTING

A facility untitled spreadsheet dated 9/27/24 through 11/5/24, identified resident name, positive test date, symptom onset date, isolation period, out of isolation date, symptoms, and treatment (if any). The spread sheet identified 14 resident names with positive test results: R44 on 9/27/24, R39 on 9/30/24, R16 on 9/30/24, R42 on 10/2/24, R31 on 10/13/24, R4 on 10/13/24, R40 on 10/13/24, R1 on 10/13/24, R6 on 10/15/24, R33 on 10/15/24, R14 on 10/18/24, R26 on 10/21/24, R19 on 11/4/24 and R36 on 11/5/24.

A facility COVID Testing Roster for residents was requested but not received.

A facility list of residents tested due to symptoms was requested but not received.

R36's quarterly Minimum Data Set (MDS) dated 9/6/24, identified R36 was 91 years old and had diagnoses that included hypertension.

R36's nursing progress note dated 11/5/24 at 12:54 p.m., identified R36 was seen during rounds this morning by the nurse practitioner

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F 880	Continued From page 58 (NP). Discussed R36's complaints regarding moods, pain, and general complaints of not feeling well. The NP discussed with R36 and R36 was agreeable to increasing dosage of Abilify (an antipsychotic medication). Received order via fax to increase dose from 2 milligram (mg) per day to 3 mg per day for 2 weeks and then, if tolerating, increase to 4 mg daily at HS for mood stability. Order entered. However, the note failed to identify what R36's complaints of not feeling well were and/or if R36 was tested for COVID-19. R36's nursing progress note dated 11/5/24 at 8:53 p.m., identified R36 tested positive for COVID-19. R36 was increasingly confused and restless, R36 was walking in hallway to get something to drink. R36 was assisted into bed and 15-minute checks were initiated. During an interview on 11/21/24 at 9:02 a.m., TMA-A stated symptoms of COVID-19 included sore throat, runny nose, congestion, "all the symptoms a cold has" and fevers. Whenever a resident showed symptoms like that, they should be tested because often it's COVID-19. Usually, the nurse on the unit collected the test and, if negative, the resident was tested again in two days. If symptoms resolved and the original test was negative, the second test did not need to be collected. When the facility was in a COVID-19 "outbreak", staff needed to test every other day to make sure COVID-19 did not spread throughout staff, residents, and visitors. During an interview on 11/21/24 at 9:19 a.m., NA-W stated symptoms of COVID-19 included sore throat, cough, body aches, fever and then sometimes not a fever. Everyone was different, especially the elderly. During the facility's	F 880		

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F 880	Continued From page 59 COVID-19 outbreak, NA-W stated she noticed many residents became incontinent of bowel and that was the first sign something was wrong. R36 had a cough, fever and just really bad body aches. During an interview on 11/21/24 at 9:38 a.m., RN-A stated R36 was tested for COVID-19 on 11/4/24 due to facility outbreak testing and was negative. On 11/5/24, R36 complained of body aches and headache. That was kind of R36's initial complaints and later also complained of a sore throat. RN-A stated she did not test R36 for COVID-19 when R36 complained of symptoms nor placed R36 into isolation because RN-A was focused on R36's pain. RN-A stated she was unsure when a resident should be placed into isolation for exhibiting symptoms because RN-A relied on RN-D to tell her. During an interview on 11/21/24 at 9:58 a.m., RN-D stated she was told R36 was tested for COVID-19 due to exhibiting symptoms but was unaware R36 had complained of COVID-19 earlier in the day nor had reviewed R36's chart. During an interview on 11/20/24 at 6:55 p.m., RN-D stated an COVID-19 outbreak was one or more positive case. The facility's first outbreak started on 9/27/24 and ended 10/21/24. Then the facility had another COVID-19 outbreak that started 11/4/24 and ended 11/15/24. An outbreak ended when residents and staff made it passed their isolation period and the facility had done 3 rounds of testing with no more positives on days 1, 3 and 5. The facility only needed to test 3 times and if no more positives, the outbreak was over. If there was another positive, the outbreak testing restarted until the facility had 3 consecutive tests	F 880		

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F 880	Continued From page 60 without any further cases. RN-D did not keep any type of tracking of resident COVID-19 testing. The test was documented in the residents' electronic treatment administration record (ETAR). If a resident was positive, a nursing note would be documented as well. - On 9/27/24, R44 tested positive for COVID-19 at 10:30 a.m. RN-D stated that was day 1 and all residents and staff who had not had COVID-19 in the past 30 days on that unit were tested that day, then residents were tested again three days later. - On 9/30/24, two residents tested positive on another unit and this "threw off" the facility's testing plan. The facility added an extra two days of testing to ensure COVID-19 was not spreading more. COVID-19 outbreak testing was halted on 10/4/24. - On 10/10/24, NA-D worked a partial shift in two units. The first unit, NA-D wore a mask because there were positive cases but when she moved to the other unit removed her mask. RN-D stated she was unaware NA-D was working in two units because the facility did not typically do that. On 10/10/24, RN-D implemented masking on all units, however, outbreak testing did not begin until 10/13/24. RN-D stated she should have kept a paper record of all resident and staff testing to ensure she was able to track testing. Tracking of testing would ensure all staff and residents were tested according to CDC guidance. R36's medical record failed to identify when R36 was placed into transmission-based precautions. During an interview on 11/21/24 at 3:08 p.m., the DON stated the residents were tested on days one, three and five and stopped testing positive on 10/4/24. The facility halted COVID-19 outbreak testing. Any new resident testing positive would have restarted the cycle of every	F 880		

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F 880	Continued From page 61 two-day testing. The COVID-19 Confirmed Case Checklist updated 8/31/23, identified when a case of COVID-19 had been suspected/confirmed in the location: Isolate (suspected or confirmed case): The DON and Infection Preventionist determine isolation period: - The day of the positive test or symptom onset (whichever is sooner) is day zero. - Asymptomatic or mild to moderate illness: Isolate Day O through day 1 O - Severe to critical illness or residents with immunocompromising conditions: isolate up to 20 days. Test-based strategy may be used starting on Day 10, 2 negative tests 48 hours apart are needed to discontinue prior to day 20. - Confine resident to their room. Door should remain shut if safe. Pull privacy curtain. Isolate in a private room, if possible. - Initiate Airborne and contact transmission-based precautions. - Station with PPE including N95 respirator, eye protection, gowns and gloves available immediately outside of resident room. - Assign employees to care for the positive resident. - Implement source control masking in common spaces on affected units. - Look back two days from start of symptoms or positive test, whichever was sooner, to identify all residents, staff and visitors as able who had close contact or higher risk exposure with this resident. - Initiate outbreak testing via contact tracing or broad-based testing - Test all Employees and Residents determined to be close contacts/higher risk exposures on Day 1, Day 3, and Day 5 following the exposure.	F 880		

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F 880	Continued From page 62 - Contact trace any additional identified positives. - If unable to conduct contact tracing, move to broad based testing of all employees and residents on a unit/hall or facility on Day 1, Day 3, and Day 5 - If the outbreak becomes uncontained, move to testing of all employees and residents every 3-7 days until no new cases of COVI D-19 are identified for 14 days. Choosing a test - Either Antigen or NAAT can be used. Antigen testing is preferred for symptomatic people and for people who have recovered from COVID-19 infection in the prior 31-90 days. - People should not be included in outbreak testing through contact tracing or broad-based testing for 30 days following the onset of their COVID-19 illness unless new symptoms develop, in which case antigen test should be used. - Instruct symptomatic employees to get tested immediately, prior to working. - Instruct positive employees to stay home. Surveillance and Mitigation Plan for SNFs updated 4/26/23, identified if symptomatic residents test negative with an antigen test, they should be placed into transmission-based precautions, and in a single room, if possible, but not cohorted with a known positive resident until a confirmation test with a PCR is received or confirmation with another negative antigen test 48 hours later. EBP: R205's admission MDS dated 11/13/24, identified	F 880		

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F 880	Continued From page 63 R205 had moderate impaired cognition. R205 had one stage three pressure ulcer and one unstageable ulcer present on admission. In addition, the MDS identified R205 had infection of foot and required pressure ulcer care and application of dressings to his feet. Diagnoses included dementia, anxiety, and diabetes. R205's care plan dated 11/20/24, identified R205 had an unstageable pressure ulcer to his left second toe and stage three pressure injury to his right great toe. Staff were directed to monitor location, size and treatment of skin injury and report abnormalities to the provider, provide supplemental protein, vitamins, and minerals to support healing and notify nurse of any new skin breakdown or concerns. During observation on 11/20/24 9:55 a.m. licensed practical nurse (LPN)-A entered R205's room to change the dressing on his foot after applying alcohol-based hand sanitizer (ABHR). LPN-A gathered dressing supplies from R205's closet and put on gloves. LPN-A removed R205's sock on right foot. No dressings were visible and the wound on right great toe was left open to air. The wound was approximately three centimeters in diameter and was a stage two wound with a crater like appearance. LPN-A dabbed the wound with a 4x4 sponge. LPN-A changed gloves and applied iodosorb ointment with a cotton tipped swab into the wound bed. LPN-A covered the wound with a Band-Aid and put a sock and soft tennis shoe slipper onto R205's foot. LPN-A removed her gloves, put away supplies and washed her hands before exiting the room. There was no signage or personal protective equipment (PPE) cart outside of R205's room to indicate he was on enhanced barrier precautions.	F 880		

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F 880	Continued From page 64 During interview on 11/20/24, at 1:45 p.m. LPN-A stated the infection preventionist (IP) determined and setup enhanced barrier precautions (EBP) when it was needed for residents. Staff identified when they needed to implement enhanced barrier precautions to care for a resident when a PPE cart and signage was located outside a resident's door. R205 has never needed EBP since his admission and so she just used gloves for the dressing change to his foot. LPN-A knew EBP were needed for resident with catheters or wounds but not exactly sure when they were required. LPN-A just relied on the IP nurse to let staff know when EBP was needed to care for residents. When interviewed on 11/21/24, at 11:15 a.m. registered nurse (RN)-C stated she did not know why R205 was not on EBP. The IP nurse had told staff it was not needed because R205's wounds were not significant enough to need precautions. The IP nurse reviewed resident conditions even before they were admitted and determined what type, if any, precautions were needed for their care. The staff followed what they were told by the IP nurse. When interviewed on 11/21/24, at 11:50 a.m. the IP nurse stated R205 had a chronic wound and EBP was not required when the wound was chronic in nature. R205 was admitted with the wounds on his feet. The wounds were rapidly healing and R205 did not have a history of skin conditions, so she did not feel EBP was needed. During observation on 11/25/24, at 10:45 a.m. a PPE cart and EBP signage was noted posted outside of R205's room, with instruction for staff	F 880		

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F 880	Continued From page 65 to wear gown and gloves with any care or prolonged contact with R205. A facility policy on enhanced barrier precautions was requested, however none were received. The Centers for Disease Control and Prevention (CDC) Frequently Asked Questions (FAQs) about Enhanced Barrier Precautions in Nursing Homes, dated 6/28/24, indicated wound care was included as a high-contact resident care activity and was generally defined as the care of any skin opening requiring a dressing. This generally included residents with chronic wounds, and not those with only shorter-lasting wounds, such as skin breaks or skin tears covered with a Band-aid or similar dressing. Examples of chronic wounds include, but are not limited to, pressure ulcers, diabetic foot ulcers, and chronic venous stasis ulcers. Mask Use: R206's admission MDS dated 11/20/24, identified R206 had intact cognition. R206 was admitted with diabetic foot ulcer, open lesions on foot and application of dressings to feet. The MDS indicated antibiotics were administered daily. R206's care plan dated 11/25/24, identified R206 was on antibiotics for osteomyelitis with a peripherally inserted central catheter (PICC) in left arm. Antibiotics were ordered twice a day for six weeks. Staff were directed to monitor intravenous (IV) site in left arm every shift for symptoms of infection. The care plan also identified R206 was to be on enhanced barrier precautions due to her wounds and the presence of the PICC line. Staff were directed to don gown	F 880		

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F 880	Continued From page 66 and gloves when performing high contact activities such as dressing, grooming, repositioning, wound care, and device care and use. The PICC dressing was to be changed weekly. During observation on 11/19/24, at 2:55 p.m. RN-C and RN-E entered R206's room after applying alcohol-based hand sanitizer (ABHR) and gloving and gowning. RN-E, with clean gloves and gown on, proceeded to carefully remove the transparent adhesive dressing covering the PICC line insertion site. RN-E was not wearing a mask during the procedure. RN-E removed her gloves and washed her hands. RN-E opened the PICC line sterile dressing change packet , setup a sterile field barrier sheet and put on the sterile gloves. RN-E put on a sterile mask and began cleaning the PICC line insertion site with the enclosed chlorhexadine swab. RN-C put on a pair of sterile gloves to assist RN-E. RN-C took the sterile paper measuring tape and measured R206's upper arm, leaning over the PICC line insertion site to do so. RN-C then applied the sterile transparent adhesive dressing to cover the PICC line insertion site. Both nurses disposed of used supplies removed gloves and washed hands and exited room. During interview on 11/19/24, at 3:15 p.m. RN-C stated she was not wearing a face mask when assisting RN-E with the PICC line dressing change and she should have been. When interviewed on 11/21/24, at 8:40 a.m. RN-E stated she had never received training on PICC line dressing changes from the facility, except for the mentoring that was observed on 11/19/24,	F 880		

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F 880	Continued From page 67 while doing the procedure. RN-E verified she was not wearing a mask when removing the dressing covering the PICC line insertion site. RN-E stated she should have been wearing a face mask during the procedure. During on 11/21/24, at 11:55 p.m. the director of nursing (DON) stated it was the facility's expectation to perform PICC line dressing changes using sterile technique and procedures. The facility policy Peripherally Inserted Central Catheter dated 4/1/24, directed staff to perform hand hygiene and put on a face mask when performing a PICC line dressing change.	F 880		
F 881 SS=D	. Antibiotic Stewardship Program CFR(s): 483.80(a)(3) §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)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to establish a process for antibiotic review in order to determine appropriate	F 881	1. The identified resident R15's antibiotic usage was reviewed by DNS or designee and Consultant Pharmacist. Immediate	1/6/25

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F 881	Continued From page 68 indications for use of an antibiotic for 1 of 1 resident (R15) reviewed for antibiotic use. Findings include: R15's quarterly Minimum Data Set (MDS) dated 10/24/24, identified R15 had diagnoses that included renal insufficiency, diabetes, Alzheimer's disease, and dementia. R15 was always continent of bowel and bladder and required supervision or touching assistance with personal hygiene. The Monthly Report of Resident Infections in Location dated November 2024, identified R15 had a urinary tract infection with an onset date of 11/2/24. Symptoms included gross hematuria and flank pain related to kidney stones. However, the report failed to identify if R15 was treated with an antibiotic and/or if a urinalysis or urine culture were obtained. R15's Order Summary Report dated 11/2/24, identified R15's was prescribed cefdinir (an antibiotic) 300 mg capsules give 1 capsule by mouth two times a day for acute cystitis with hematuria for 10 days. R15's nursing progress note dated 11/2/24 at 8:58 a.m., identified R15 was transferred to the emergency department (ED) due to abdominal pain. - At 2:15 p.m., R15 returned from the ED with new orders for cefdinir 300 mg two times a day for 10 days. R15 had acute cystitis with hematuria (a conditions where a person develops cystitis (inflammation of the bladder) with the presence of blood in the urine) and ureterolithiasis (kidney stones).	F 881	education was provided to Infection Control nurse. 2. All residents have the potential to be affected by this deficient practice. All residents currently receiving antibiotics will be reviewed by Infection Preventionist or designee and Consultant Pharmacist to ensure appropriate indication and monitoring. 3. To ensure systemic changes are sustained, the Infection Preventionist or designee and Consultant Pharmacist will review and Follow Good Samaritan Society antibiotic stewardship program protocols, use Good Samaritan Society standardized tracking tool: The Infection and Antimicrobial Tracking Tool, establish criteria for antibiotic use review. Licensed nursing staff were educated by DNS on antibiotic stewardship plan, monitoring requirements, documentation expectations, and communication protocols. 4. To ensure compliance, the Infection Preventionist or designee will audit all new antibiotic orders weekly for 4 weeks, then monthly for 2 months. Consultant Pharmacist will review antibiotic usage patterns monthly. Audit results will be brought to the monthly QAPI committee for input on the need to increase, decrease, or discontinue audits. Date of correction: 1/6/25	

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F 881	Continued From page 69 R15's urine culture dated 11/24/24, identified mixed microflora (mixed microflora in urine culture typically indicates the culture yielded two or three different organisms, which may be considered colonization rather than infection.) During an interview with registered nurse (RN)-D on 11/19/24 at 1:35 p.m., RN-D stated she was responsible for the infection control program in the facility and tracked all antibiotic use. R15 was evaluated in the ED for kidney stones. R15 returned from the ED with an order for cefdinir to treat a UTI even though that wasn't a typical treatment for kidney stones. R15's urine culture identified mixed microflora and the culture was reviewed by the ED medical provider and determined it was a contaminated urine sample. However, by the time the culture returned, the antibiotic treatment was almost completed. - At 1:42 p.m., RN-D stated the facility used McGreer Criteria to determine if an antibiotic was warranted. However, RN-D stated McGreer Criteria was a "steep level" and residents had horrible infections by the time they reached the point of meeting criteria. The facility did review antibiotic orders during the morning meetings Monday through Friday, but RN-D stated she could not speak to what the nursing staff did at the unit level. RN-D stated the primary rounding providers were very involved in antibiotic stewardship and conducted 48-hour timeouts (an antibiotic "timeout" prompts a reassessment of the continuing need and choice of antibiotic when the clinical picture is clearer and more diagnostic information is available) on all UTI and generally did not order antibiotic treatment unless necessary. However, the ED providers ordered antibiotics for "everything". The ED had a "huge"	F 881		

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	245318	A. BUILDING _____ B. WING _____	C 11/25/2024

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F 881	Continued From page 70 rotating schedule of providers and that was why the facility received orders for kidney stones, chronic obstructive pulmonary disease (COPD) exacerbation and other illnesses not normally treated with antibiotics. RN-D had spoken with the medical director regarding concerns with orders prescribed by ED providers, but the topic had not gone past talking about it. RN-D stated she did not know who she would talk to at the hospital about antibiotic stewardship concerns and had not attempted. During an interview on 11/25/24 at 3:46 p.m., the director of nursing (DON) stated antibiotic stewardship was reviewed with each case because each case was different. When a resident returned from the ED with an order for an antibiotic, the provider was frequently no longer at the facility to review lab results with by the time the facility received results. The ED providers worked 7 days on and 7 days off and it was just difficult to speak with them. The DON stated she could not speak to any discussion that had been had with the hospital regarding antibiotic stewardship concerns or who to reach out to for concerns with lab results, but guessed the hospital would direct staff to reach out to the primary provider. The staff should be following McGreer Criteria to determine antibiotic treatment was appropriate and, for contaminated urine samples, another sample should have been collected with the intention to stop the antibiotic treatment. When R15 returned from the ED, there should have been follow up to determine if the antibiotic should have been stopped. The facility policy Definitions of Infection - For Surveillance Purposes Only, Infection Control, R/S LTC dated 11/1/23, identified the facility used	F 881		

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F 881	Continued From page 71 McGreer Criteria for UTI: Resident without indwelling catheter: At least one of the following signs or symptoms from these sub-criteria: - Acute dysuria or acute pain, swelling or tenderness of the testes, epididymis or prostrate. - Fever or leukocytosis and at least one of the following localizing urinary tract sub-criteria: - Acute costovertebral angle pain or tenderness - Supra-pubic pain - Gross hematuria - New or marked increase in incontinence. - New or marked increase in urgency. - New or marked increase in frequency. - In the absence of fever or leukocytosis, then two or more of the following localizing urinary tract sub-criteria must be present: - Supra-pubic pain - Gross hematuria - New or marked increase in incontinence. - New or marked increase in urgency. - New or marked increase in frequency. And One of the following: - At least 105 colony-forming units (cfu)/milliliter (ml) of no more than two species of microorganisms in a voided urine sample - At least 10^2 cfu/ml of any number of organisms in a specimen collected by an in-and-out catheter. Comments: UTIs should be diagnosed when there are localizing genitourinary signs and symptoms and a positive urine culture result. A diagnosis of UTI can be made without localizing symptoms if a blood culture isolate is the same as the organism isolated from the urine and there is no alternate site of infection. In the absence of a clear alternate source of infection, fever, or rigors with a positive urine culture result in the non-catheterized resident or acute confusion in	F 881		

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F 881	Continued From page 72 the catheterized resident will often be treated as a UTI. However, evidence suggests that most of these episodes are likely not due to infection of a urinary source. Urine specimens for culture should be processed as soon as possible, preferably within one or two hours. If urine specimens cannot be processed within 30 minutes of collection, they should be refrigerated. Refrigerated specimens should be cultured within 24 hours.	F 881		

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
December 12, 2024

Administrator
Good Samaritan Society - International Falls
2201 Keenan Drive
International Falls, MN 56649

Re: State Nursing Home Licensing Orders
Event ID: Z5V811

Dear Administrator:

The above facility was surveyed on November 19, 2024 through November 25, 2024 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

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

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

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

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

Jen Bahr, RN, Regional Operations Supervisor
Bemidji District Office
Health Regulation Division
Minnesota Department of Health
705 5th Street NW, Suite A
Bemidji, Minnesota 56601-2933
Email: Jennifer.bahr@state.mn.us
Office: (218) 308-2104

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

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 11/19/24 through 11/25/24, a licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you have reviewed these orders and	2 000		

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2 000	Continued From page 1 identify the date when they will be completed. The following complaint was reviewed: H53181372C (MN00099731) with no orders issued. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health.	2 000		

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2 000	Continued From page 2 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		
2 255	MN Rule 4658.0070 Quality Assessment and Assurance Committee A nursing home must maintain a quality assessment and assurance committee consisting of the administrator, the director of nursing services, the medical director or other physician designated by the medical director, and at least three other members of the nursing home's staff, representing disciplines directly involved in resident care. The quality assessment and assurance committee must identify issues with respect to which quality assurance activities are necessary and develop and implement appropriate plans of action to correct identified quality deficiencies. The committee must address, at a minimum, incident and accident reporting, infection control, and medications and pharmacy services. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to develop action plans for identified areas of monitoring and failed to identify and implement at least one process improvement project (PIP) This had the potential to affect all 50 residents who resided in the facility. Findings include:	2 255	corrected	1/6/25

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2 255	Continued From page 3 The Quality Assurance, Action Committee Meeting Minutes dated 7/11/24, identified the team had reviewed the following topics: -infection control. -emergency operation plan and facility assessment. -dietary concerns -therapy staffing changes -documentation of assessments and coding -resident council complaints -life style enrichment -human resources -life safety and environment The data failed to identify any facility developed and implemented action plans with measurable goals and/or identify actions taken. The Quality Assurance, Action Committee Meeting Minutes dated 8/22/24, identified the team had reviewed the following topics: -nursing services -resident council complaints -safety and emergency preparedness -employee action committee results -financial stewardship, -action plans from survey, Casper reports and/or corporate compliance. The data failed to identify any facility developed and implemented action plans with measurable goals and/or identify actions taken. The Quality Assurance, Action Committee Meeting Minutes dated 10/31/24, identified the team had reviewed the following topics: -incidents and safety -infection control -medication regimen review -QAPI plan priorities -staff quality concern trends	2 255		

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2 255	Continued From page 4 -hand hygiene compliance -survey readiness -resident and family concerns -survey results The data failed to identify the facility developed and implemented action plans with measurable goals and/or identify actions taken. Although the facility listed out areas they were collecting data on there was a lack of information on whether the items were PIPS that required an action plan. Further, the facility could not provide evidence of any PIP project they were working on that focuses on high-risk or problem-prone areas, identified by the facility through data collection and analysis. When interviewed on 11/25/24, at 4:15 p.m. registered nurse (RN)-D stated she was responsible for the facility's QAPI program. RN-D received monthly audits from corporate and the facility was required to do them. Each month the audits would have a different focus. RN-D also gathered data for QAPI through focused chart reviews and track and analyzing incident reports. RN-D had social services report complaints and grievances to the QAPI committee as well. RN-D also collected data from review of resident council minutes and interactions with residents and families on a day-to-day basis. The facility did have significant issues with staffing in the beginning of the year and the main focus had been on staffing and staff retention. Now that had improved, and they could focus on other issues. Infection control and review of infections were addressed at every QAPI meeting; however, RN-D had not fully addressed the facility's response to their recent COVID-19 outbreak. That was on her agenda to discuss at the next meeting. RN-D stated performance improvement	2 255		

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2 255	Continued From page 5 projects (PIPS) were new to her. She had just taken over QAPI and had not received much training on PIPS. RN-D was just trying to redirect everything in a format she could work with, and her next project was to figure out what type of PIP to work on. RN-D stated she needed to learn how to do the PIPS. During interview on 11/25/24, at 4:30 p.m. the director of nursing (DON) stated RN-D ran the QAPI program. The DON was not aware the facility did not have any developed PIPS in place. The DON stated there should be performance improvement projects in place and she would have helped identified areas to implement PIPS if she had been aware there were none. The facility's Quality Assurance and Performance Improvement policy dated 10/9/23, identified at a minimum one performance improvement project would either be in development, ongoing or completed annually utilizing the improvement model adapted by the location. Performance improvement project activity would be monitored for progress and sustainability. Performance improvement activities would focus on high risk, high volume, or problem prone areas. Would consider incidence, prevalence, and severity of problems in that area and would lead to immediate correction of any identified problem that directly or potentially threatened the health and safety of residents. The QAPI committee was responsible for tracking and trending performance, systematically analyzing and prioritizing quality deficiencies, develop action plans, and monitor for effectiveness and sustainability. SUGGESTED METHOD OF CORRECTION: The administrator or designee, could educate	2 255		

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2 255	Continued From page 6 staff on quality assurance performance improvement projects and identify one to two initial performance projects for review. The QAPI team could work on goals and interventions of the chose projects and analyze interventions for effectiveness with appropriate action plans. They could then audit to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	2 255		
2 550	MN Rule 4658.0400 Subp. 4 Comprehensive Resident Assessment; Review Subp. 4. Review of assessments. A nursing home must examine each resident at least quarterly and must revise the resident's comprehensive assessment to ensure the continued accuracy of the assessment. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure medications were coded correctly on the Minimum Data Set (MDS) for 1 of 5 residents (R27) reviewed for unnecessary medications. Findings include: R27's quarterly MDS dated 10/9/24, identified R27 had severe cognitive impairment. Diagnoses included Alzheimer's, non-Alzheimer's dementia, diabetes, and depression. The MDS identified R27 received an antianxiety medication. R27 medication administration report (MAR) for the month of October 2024, identified R27	2 550	corrected	1/6/25

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2 550	Continued From page 7 received Trazodone (an antidepressant) for generalized anxiety disorder, restlessness, and agitation. The MAR/orders did not identify R27 was receiving an antianxiety medication during the MDS lookback period. During an interview on 11/25/24 at 3:14 p.m., registered nurse (RN)-B identified she did the most recent MDS for R27. When RN-B went over the medications for R27, RN-B reviewed medications by what they were used for and not specifically the class of medication. R27's was receiving an antidepressant to help with anxiety, and it was entered on the MDS as an antianxiety medication and not an antidepressant. RN-B stated it was important to ensure the MDS was accurate, so staff had the accurate data to care for R27. During an interview on 11/25/24 at 4:00 p.m., the director of nursing (DON) stated she would expect the MDS for R27 would be complete and accurate to enable others working with R27 to get a complete picture of care required for them. The facility's MDS 3.0 Resident Assessment Instrument (RAI) dated 8/27/24, identified each team member would review the electronic medical record and determine if there is accurate documentation which supported coding for the MDS. SUGGESTED METHOD OF CORRECTION: The DON, or designee, could educate the nursing staff on completion of the Minimum Data Set (MDS) in accordance with the Resident Assessment Instrument (RAI) manual. They could then audit to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one	2 550		

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2 550	Continued From page 8 (21) days	2 550		
2 900	MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide timely repositioning for 1 of 1 resident (R203) reviewed for pressure ulcers. Findings include: R203's admission Minimum Data Set (MDS) dated 11/6/24, identified R203 had severe cognitive impairment and did not have identified behaviors. R203 required substantial to maximum assistance with rolling side to side and sitting up. R203 was dependent with toileting and transfers and was always incontinent of bowel and bladder.	2 900	corrected	1/6/25

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GOOD SAMARITAN SOCIETY - INTERNATIONA	2201 KEENAN DRIVE INTERNATIONAL FALLS, MN 56649

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2 900	Continued From page 9 R203 was at risk for pressure ulcer development and was admitted with a stage two unhealed pressure ulcer. A turn and reposition program was in place as well as a pressure reducing device for R203's bed. Diagnoses included malignant neoplasm of the sinus and brain, palliative care, moderate protein-calorie malnutrition, and pressure ulcer stage two of the sacral region. R203's care plan dated 10/31/24, identified R203 was dependent with most activities of daily living and was bedfast all or most of the time. R203 had actual impairment to skin integrity. Staff were directed to use extra caution with transfer and bed mobility to avoid injury to R203 skin, keep skin clean and dry and to turn and reposition R203 every two hours and as needed. R203's Braden Skin Assessment 10/31/24, scored 13 which identified a moderate risk for pressure ulcer development. During continuous observation on 11/20/24. 4;30 p.m. to 7:10 p.m. R203 was awake, lying on her back in bed, dressed in a hospital gown. A pillow was positioned under R203's right foot. No other positioning devices were in use. R203's head of the bed was raised at 25-degree angle. -at 4:50 p.m. there was no change in R203's position. -at 5:22 p.m. there was no change in R203's position. -at 5:37 p.m. homemaker (HMK)-A entered the room to record R203's supper meal choices. HMK-A raised R203's head of the bed to a 35-degree angle and exited the room. HMK-A made no attempt to move, shift R203's weight or reposition R203. -at 5:45 p.m. licensed practical nurse (LPN)-C	2 900		

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2 900	Continued From page 10 entered R203's room and raised the head of the bed to an upright sitting position of 45 degrees. LPN-C administered medications and exited the room. LPN-C did not turn, shift R203's weight or reposition R203 before exiting the room. -at 5:50 p.m. R203's call light was put on. LPN-C and unidentified NA entered room. R203 indicated the call light was on by accident and nothing was needed. Both staff exited the room after turning off call light. Neither staff attempted to turn, reposition or move R203. R203 remained seated fully upright in bed. - 5:57 p.m. R203 turned on her call light. R203 remained seated fully upright in bed. R203 had slid down in the bed and her head was hanging heavily to her right side with her chin in her chest. -at 6:11 p.m. R203 had not changed position. R203's head of the bed remained in full upright position. R203 was in slouched position in bed, leaning to her right side, with her chin in her chest. The call light remained on with steady green light over the door. -at 6:30 p.m. R203 had not changed position. The head of the bed remained in fully upright position. R203 has slouched further down in the bed with her head positioned halfway from top of bed to middle of bed. R203 leaning to her right side with her chin in her chest. The call light remains on. -At 6:45 p.m. there is no change in position. -At 6:56 p.m. R203's head of the bed remained fully elevated at 45-degree angle.R203 was leaning heavily to her right side with her chin touching her chest and slouched down to the middle of the bed. The call light remained on. -At 7:06 p.m. NA-M and NA-N entered R203's room and lowered R203's head of the bed and turned and repositioned R203. R203 was not incontinent of bowel or bladder. R203's peri area had dry, intact skin. Coccyx wound healed with no redness noted. NA-M stated she had been told	2 900		

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2 900	Continued From page 11 R203 had been turned and repositioned at 4:30 p.m. NA-M knew R203 was to be checked and/or changed and repositioned every two hours. NA-M and NA-N had been walking by and noticed R203 was leaning so far over to the right and nearly falling out of bed, so they went in to reposition her. NA-M had noticed R203's light was on, and she had wondered why, which is why she walked down the hall to check. When interviewed on 11/21/24, at 12:05 p.m. the director of nursing stated it was the facility's expectation staff were to check and change residents every two hours if the care plan directed them to do so. The long call wait time would need to be looked in to. The facility policy Activities of Daily Living dated 12/4/23, identified any resident who was unable to carry out activities of daily living would receive necessary services to maintain good nutrition, grooming, personal and oral hygiene. SUGGESTED METHOD OF CORRECTION: The DON, or designee, could educate audit staff on following the care plan for compliance. The DON or designeed could educate staff on the importance of following the care plan for turning and positioning to prevent pressure ulcers and then audit to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	2 900		
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	2 920		1/6/25

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2 920	Continued From page 12 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 assistance with toileting for 1 of 1 resident (R203) reviewed for activities of daily living and who were dependent on staff for their care. Findings include: R203's admission Minimum Data Set (MDS) dated 11/6/24, identified R203 had severe cognitive impairment and did not have behaviors. R203 required partial to moderate assistance with eating. R203 was dependent with toileting and transfers and was always incontinent of bowel and bladder. Diagnoses included malignant neoplasm of the sinus and brain, palliative care, moderate protein-calorie malnutrition, and pressure ulcer stage two of the sacral region. R203's care plan dated 10/31/24, identified R203 was dependent with most activities of daily living and was bedfast all or most of the time. R203 was incontinent of bowel and bladder. Staff were directed to check and change every two hours and as needed. During continuous observation on 11/20/24 from 4:30 p.m. to 7:10 p.m., R203 was awake, lying on her back in bed, dressed in a hospital gown. A pillow was positioned under R203's right foot. No other positioning devices were in use. R203's	2 920	corrected	

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2 920	Continued From page 13 head of the bed was raised at 25-degree angle. -at 4:50 p.m. there was no change in R203's position. -at 5:22 p.m. there was no change in R203's position. -at 5:37 p.m. nursing assistant (NA)-N entered the room to record R203's supper meal choices. NA-N raised R203's head of the bed to a 35-degree angle and asked R203 what she would like for supper. NA-N told R203 she would return with a couple of pudding choices for her supper and then exited the room. NA-N did not check R203 for incontinence. -at 5:45 p.m. licensed practical nurse (LPN)-C entered R203's room and raised the head of the bed to an upright sitting position of 45 degrees. LPN-C administered medications and exited the room. LPN-C did not check R203 for incontinence before exiting the room. -At 5:50 p.m. R203's call light was put on. LPN-C and an unidentified NA entered room. R203 identified the call light was on by accident and nothing was needed. Both staff exited the room after turning off call light. R203 was not checked for incontinence or need for toileting and remained seated fully seated upright in bed. - At 5:57 p.m. R203 turned on her call light. R203 was seated in bed. the head of the bed was in an upright position. R203 had slid down in the bed and her head was hanging heavily to her right side with her chin in her chest. -At 6:11 p.m. R203 had not changed position. R203's head of the bed remained in full upright position. R203 was in slouched position in bed, leaning to her right side, with her chin in her chest. The call light remained on with steady green light over the door. -At 6:30 p.m. R203 had not changed position, the head of the bed remained in fully upright position. R203 has slouched further down in the bed with	2 920		

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2 920	Continued From page 14 her head positioned halfway from top of bed to middle of bed. R203 leaning to her right side with her chin in her chest. The call light remained on. -At 6:45 p.m. there was no change in position. -At 6:56 p.m. R203's head of the bed remained fully elevated at 45-degree angle. R203 was leaning heavily to her right side with her chin touching her chest and slouched down to the middle of the bed. The call light remained on. -At 7:06 p.m. NA-M and NA-N entered R203's room and lowered R203's head of the bed and checked R203 for incontinence. R203 was dry and did not require a brief change. During interview on 11/20/24, at 7:10 p.m. NA-M stated they just checked R203 for incontinence and she was dry. NA-M stated she had been told R203 was checked at 4:30 p.m. NA-M knew R203 needed to be checked and/or changed and repositioned every two hours. NA-M and NA-N were walking by and noticed R203 was leaning so far over to the right and nearly falling out of bed so they went in to reposition her. NA-M noticed R203's light was on and wondered why, which is why she walked down the hall to check. During interview on 11/25/24, at 2:30 p.m. NA-N stated she remembered going into R203's room on 11/20/24 and offering her supper. R203 refused supper but then NA-N offered pudding and R203 had agreed. NA-N stated she had not checked or changed R203 for incontinence at that time. When interviewed on 11/21/24, at 12:05 p.m. the director of nursing stated it was the facility's expectation staff were to check and change residents every two hours if the care plan directed them to do so.	2 920		

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2 920	Continued From page 15 The facility policy Activities of Daily Living dated 12/4/23, identified any resident who was unable to carry out activities of daily living would receive necessary services to maintain good nutrition, grooming, personal and oral hygiene. SUGGESTED METHOD OF CORRECTION: The DON, or designee, could educate audit staff on following the care plan for compliance. The DON or designeed could educate staff on the importance of following the care plan for ADL's and then audit to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	2 920		
21390	MN Rule 4658.0800 Subp. 4 A-I Infection Control Subp. 4. Policies and procedures. The infection control program must include policies and procedures which provide for the following: A. surveillance based on systematic data collection to identify nosocomial infections in residents; B. a system for detection, investigation, and control of outbreaks of infectious diseases; C. isolation and precautions systems to reduce risk of transmission of infectious agents; D. in-service education in infection prevention and control; E. a resident health program including an immunization program, a tuberculosis program as defined in part 4658.0810, and policies and procedures of resident care practices to assist in the prevention and treatment of infections; F. the development and implementation of employee health policies and infection control practices, including a tuberculosis program as defined in part 4658.0815;	21390		1/6/25

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21390	Continued From page 16 G. a system for reviewing antibiotic use; H. a system for review and evaluation of products which affect infection control, such as disinfectants, antiseptics, gloves, and incontinence products; and I. methods for maintaining awareness of current standards of practice in infection control. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to develop and implement an infection control surveillance plan for identifying, tracking, monitoring and/or reporting infections and communicable disease along with a monthly analysis; and failed to conduct COVID-19 testing of staff and residents per Centers for Disease Control (CDC) guidelines. In addition, the facility failed to implement enhanced barrier precautions (EBP) for 1 of 1 resident (R205) reviewed with pressure ulcers; and failed to wear a mask during a peripherally inserted central catheter (PIIC) line dressing change for 1 of 1 resident (R206) reviewed with a PIIC. These deficient practices had the potential to affect all 50 residents residing in the facility. Findings include: Surveillance and Analysis: The Monthly Report of Resident Infections in Location dated August 2024, identified unit, resident name, room number, admit date, infection type, body system, criteria met yes or no, onset C (community) or F (facility), symptoms, onset date, infection risk factors, precautions type and date resolved. The report	21390	corrected	

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21390	Continued From page 17 identified two COVID-19 cases, one dental abscess, one conjunctivitis (pink eye), one case of shingles, one pneumonia, three cellulitis, two osteomyelitis (bone infection), eight urinary tract infections (UTI) and one resident without an identified infection who demanded antibiotic drops. However, the report failed to identify if the infections were provided treatment, if any, nor did the report identify a resident with symptoms of a viral infection. The Monthly Infection Summary dated August 2024, identified all identified infections received treatment with an antimicrobial. The Monthly Infection Control Report dated August 2024, identified the total number of infections, the infection rate (infections/1000 resident days), antibiotic orders utlization (orders/1000 resident days) and antibiotic days of therapy (days of therapy/1000 resident days). For the month of August the following information was listed: - total number of nosocomial (healthcare acquired) infections 14 - infection rate: 8.85 percent (%) - antibiotic orders utlization: 13.28% - antibiotic days of therapy: 119.5 ordered, 114.5 actual The August 2024 Infection Control Reports identified the facility had 17 infections (14 facility acquired and 3 community acquired), 14 met McGreer's Criteria, 3 did not meet McGreer's Criteria and the facility antimicrobial usage rate was higher than the enterprise as a whole (13.28% versus 5.92%). The Monthly Report of Resident Infections in Location dated September 2024, identified unit,	21390		

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21390	Continued From page 18 resident name, room number, admit date, infection type, body system, criteria met yes or no, onset C (community) or F (facility), symptoms, onset date, infection risk factors, precautions type and date resolved. The report identified two eye infections, three cases of COVID-19, two cellulitis and one chronic obstructive pulmonary disease (COPD) exacerbation. However, the report failed to identify if the infections were provided treatment, if any nor did the report identify a resident with symptoms of a viral infection other than COVID-19. The Monthly Infection Summary dated September 2024, identified all but three cases of COVID-19 received antimicrobial treatment. The Monthly Infection Control Report dated September 2024, identified the total number of infections, the infection rate (infections/1000 resident days), antibiotic orders utlization (orders/1000 resident days) and antibiotic days of therapy (days of therapy/1000 resident days). For the month of August the following information was listed: - total number of nosocomial (healthcare acquired) infections: 7 - infection rate: 5.3% - antibiotic orders utlization: 3.3% - antibiotic days of therapy: 27.9 The September 2024 Infection Control Reports identified the facility had 17 infections (14 facility acquired and 3 community acquired), 14 met McGreer's Criteria, 3 did not meet McGreer's Criteria and the facility antimicrobial usage rate was higher than the enterprise as a whole (33.2% versus 17.6%).	21390		

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21390	Continued From page 19 The facility failed to provide a written summary of the analysis of actual/potential infections in the facility. The Monthly Report of Resident Infections in Location dated October 2024, identified unit, resident name, room number, admit date, infection type, body system, criteria met yes or no, onset C (community) or F (facility), symptoms, onset date, infection risk factors, precautions type and date resolved. The report identified nine cases of COVID-19, one cellulitis, one pneumonia, and four UTI. However, the report failed to identify if the infections were provided treatment, if any nor did the report identify a resident with symptoms of a viral infection other than COVID-19. The Monthly Infection Summary dated October 2024, identified all but the cases COVID-19 received antimicrobial treatment. The Monthly Infection Control Report dated October 2024, identified the total number of infections, the infection rate (infections/1000 resident days), antibiotic orders utlization (orders/1000 resident days) and antibiotic days of therapy (days of therapy/1000 resident days). For the month of August the following information was listed: - total number of nosocomial (healthcare acquired) infections: 17 - infection rate: 11.22% - antibiotic orders utlization: 6.6% - antibiotic days of therapy: 38.9 The September 2024 Infection Control Reports identified the facility had 17 infections (14 facility acquired and 3 community acquired), 14 met McGreer's Criteria, 3 did not meet McGreer's	21390		

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21390	Continued From page 20 Criteria and the facility antimicrobial usage rate was lower than the enterprise as a whole (5.4% versus 8.85%). The facility failed to provide a written summary of the analysis of actual/potential infections in the facility. The Monthly Report of Resident Infections in Location dated November 2024, identified unit, resident name, room number, admit date, infection type, body system, criteria met yes or no, onset C (community) or F (facility), symptoms, onset date, infection risk factors, precautions type and date resolved. The report identified two COVID-19 cases, three cellulitis, one osteomyelitis (bone infection), and three urinary tract infections (UTI). However, the report failed to identify if the infections were treated with an antimicrobial. No further information for November 2024 was provided. During an interview on 11/19/24 at 12:57 p.m., registered nurse (RN)-D stated she was responsible for the facility's Infection Prevention Program. RN-D reviewed antibiotics ordered and rounds/observation of what the staff were doing, including hand hygiene audits. RN-D updated the surveillance log everyday Monday through Friday. At the end of the month, RN-D completed all the reports that were needed for Quality Assurance. RN-D did not usually list residents with cold symptoms and/or "sniffles" on the surveillance log. "Now that you say that I should be tracking it." During an interview on 11/21/24 at 3:06 p.m., the DON stated the facility needed to create a better	21390		

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21390	Continued From page 21 tracking system to track staff and resident illness to prevent the transmission of illness. A facility policy related to infection surveillance, tracking and trending was requested but not received. STAFF TESTING The Centers for Disease Control (CDC) website Infection Control Guidance: SARS-CoV-2 (COVID-19) dated 6/24/24, identified a single new case of COVID-19 infection in any health care provider (HCP) or resident should be evaluated to determine if others in the facility could have been exposed. Perform testing for all residents and HCP identified as close contacts or on the affected unit. Testing was recommended at day 1, day 3 and day 5, where day of exposure is day 0. If additional cases were identified, testing should continue on affected units or facility-wide every 3 to 7 days until there were no new cases for 14 days. A facility untitled spreadsheet dated 6/18/24 through 11/14/24, identified employee name, positive test date, symptoms onset date, last day worked, unit(s) assigned/worked, precautions (return to work (RTW) dated and instructions) and symptoms. The spread sheet identified nine employees with onset positive dates which included: nursing assistant (NA)-C on 9/28/24, NA-D on 10/10/24, NA-E on 10/12/24, N A-L on 10/13/24, NA-F on 10/13/24, NA-G on 10/15/24, registered nurse (RN)-C on 10/15/24, NA-H on 10/18/24, NA-I on 10/23/24, NA-J on 11/2/24 and NA-K on 11/14/24. An undated facility COVID Testing Roster,	21390		

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	00322	A. BUILDING: _____ B. WING _____	C 11/25/2024

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21390	Continued From page 22 identified staff name, test #1 results/date, test #2 results/date, test #3 results/date and symptoms. However, the roster failed to identify which staff were required to test or when. Review of the staff schedule 9/27/24 through 11/25/24, identified two registered nurses (RN), one trained medication aide (TMA), and 17 nursing assistants (NA) did not test according to CDC guidance during the breakout period. Additionally, one RN and 4 NAs were not listed on the COVID Testing Roster. During an interview with RN-D and the DON on 11/21/24 at 2:47 p.m., RN-D stated, if a staff member tested positive for COVID-19, RN-D sent an electronic communication to all staff working on the unit where the positive staff member last worked to notify them, they needed to test that day. RN-A spoke with dietary and activities staff, so they knew to test as well. RN-A then put a COVID-19 Testing Roster including all staff out on the unit. Staff were tested by the nurse working on the unit and marked off on the roster. However, RN-D did not identify any staff on the roster who were required to test. Review of the COVID-19 Testing Roster with the staff schedule, identified staff that did not test according to CDC guidance. The DON stated she believed the untested staff were casual staff that did not regularly work at the facility. Many tested while at home and called results into the facility, but there was no documentation of the result. RN-D stated the casual staff just didn't come into the facility to test. Additionally, the DON stated she believed the registered nurses also tested but forgot to document their results. The DON stated staff and residents were sick of COVID-19 and testing nonchalantly because they were not taking COVID-19 as seriously. It was frustrating. The facility needed to create a better tracking system to track staff and resident testing. Staff were	21390		

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21390	Continued From page 23 expected to test before their shift and the facility needed to implement a system to do that. Additionally, the DON stated she needed to be informed of staff who refused to test so the DON can address it with the staff member. It was a system failure. RESIDENT TESTING A facility untitled spreadsheet dated 9/27/24 through 11/5/24, identified resident name, positive test date, symptom onset date, isolation period, out of isolation date, symptoms, and treatment (if any). The spread sheet identified 14 resident names with positive test results: R44 on 9/27/24, R39 on 9/30/24, R16 on 9/30/24, R42 on 10/2/24, R31 on 10/13/24, R4 on 10/13/24, R40 on 10/13/24, R1 on 10/13/24, R6 on 10/15/24, R33 on 10/15/24, R14 on 10/18/24, R26 on 10/21/24, R19 on 11/4/24 and R36 on 11/5/24. A facility COVID Testing Roster for residents was requested but not received. A facility list of residents tested due to symptoms was requested but not received. R36's quarterly Minimum Data Set (MDS) dated 9/6/24, identified R36 was 91 years old and had diagnoses that included hypertension. R36's nursing progress note dated 11/5/24 at 12:54 p.m., identified R36 was seen during rounds this morning by the nurse practitioner (NP). Discussed R36's complaints regarding moods, pain, and general complaints of not feeling well. The NP discussed with R36 and R36 was agreeable to increasing dosage of Abilify (an antipsychotic medication). Received order via fax to increase dose from 2 milligram (mg) per day to	21390		

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21390	Continued From page 24 3 mg per day for 2 weeks and then, if tolerating, increase to 4 mg daily at HS for mood stability. Order entered. However, the note failed to identify what R36's complaints of not feeling well were and/or if R36 was tested for COVID-19. R36's nursing progress note dated 11/5/24 at 8:53 p.m., identified R36 tested positive for COVID-19. R36 was increasingly confused and restless, R36 was walking in hallway to get something to drink. R36 was assisted into bed and 15-minute checks were initiated. During an interview on 11/21/24 at 9:02 a.m., TMA-A stated symptoms of COVID-19 included sore throat, runny nose, congestion, "all the symptoms a cold has" and fevers. Whenever a resident showed symptoms like that, they should be tested because often it's COVID-19. Usually, the nurse on the unit collected the test and, if negative, the resident was tested again in two days. If symptoms resolved and the original test was negative, the second test did not need to be collected. When the facility was in a COVID-19 "outbreak", staff needed to test every other day to make sure COVID-19 did not spread throughout staff, residents, and visitors. During an interview on 11/21/24 at 9:19 a.m., NA-W stated symptoms of COVID-19 included sore throat, cough, body aches, fever and then sometimes not a fever. Everyone was different, especially the elderly. During the facility's COVID-19 outbreak, NA-W stated she noticed many residents became incontinent of bowel and that was the first sign something was wrong. R36 had a cough, fever and just really bad body aches. During an interview on 11/21/24 at 9:38 a.m.,	21390		

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21390	Continued From page 25 RN-A stated R36 was tested for COVID-19 on 11/4/24 due to facility outbreak testing and was negative. On 11/5/24, R36 complained of body aches and headache. That was kind of R36's initial complaints and later also complained of a sore throat. RN-A stated she did not test R36 for COVID-19 when R36 complained of symptoms nor placed R36 into isolation because RN-A was focused on R36's pain. RN-A stated she was unsure when a resident should be placed into isolation for exhibiting symptoms because RN-A relied on RN-D to tell her. During an interview on 11/21/24 at 9:58 a.m., RN-D stated she was told R36 was tested for COVID-19 due to exhibiting symptoms but was unaware R36 had complained of COVID-19 earlier in the day nor had reviewed R36's chart. During an interview on 11/20/24 at 6:55 p.m., RN-D stated an COVID-19 outbreak was one or more positive case. The facility's first outbreak started on 9/27/24 and ended 10/21/24. Then the facility had another COVID-19 outbreak that started 11/4/24 and ended 11/15/24. An outbreak ended when residents and staff made it passed their isolation period and the facility had done 3 rounds of testing with no more positives on days 1, 3 and 5. The facility only needed to test 3 times and if no more positives, the outbreak was over. If there was another positive, the outbreak testing restarted until the facility had 3 consecutive tests without any further cases. RN-D did not keep any type of tracking of resident COVID-19 testing. The test was documented in the residents' electronic treatment administration record (ETAR). If a resident was positive, a nursing note would be documented as well. - On 9/27/24, R44 tested positive for COVID-19 at 10:30 a.m. RN-D stated that was day 1 and all	21390		

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21390	Continued From page 26 residents and staff who had not had COVID-19 in the past 30 days on that unit were tested that day, then residents were tested again three days later. - On 9/30/24, two residents tested positive on another unit and this "threw off" the facility's testing plan. The facility added an extra two days of testing to ensure COVID-19 was not spreading more. COVID-19 outbreak testing was halted on 10/4/24. - On 10/10/24, NA-D worked a partial shift in two units. The first unit, NA-D wore a mask because there were positive cases but when she moved to the other unit removed her mask. RN-D stated she was unaware NA-D was working in two units because the facility did not typically do that. On 10/10/24, RN-D implemented masking on all units, however, outbreak testing did not begin until 10/13/24. RN-D stated she should have kept a paper record of all resident and staff testing to ensure she was able to track testing. Tracking of testing would ensure all staff and residents were tested according to CDC guidance. R36's medical record failed to identify when R36 was placed into transmission-based precautions. During an interview on 11/21/24 at 3:08 p.m., the DON stated the residents were tested on days one, three and five and stopped testing positive on 10/4/24. The facility halted COVID-19 outbreak testing. Any new resident testing positive would have restarted the cycle of every two-day testing. The COVID-19 Confirmed Case Checklist updated 8/31/23, identified when a case of COVID-19 had been suspected/confirmed in the location: Isolate (suspected or confirmed case): The DON and Infection Preventionist determine isolation period:	21390		

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21390	Continued From page 27 - The day of the positive test or symptom onset (whichever is sooner) is day zero. - Asymptomatic or mild to moderate illness: Isolate Day O through day 1 O - Severe to critical illness or residents with immunocompromising conditions: isolate up to 20 days. Test-based strategy may be used starting on Day 10, 2 negative tests 48 hours apart are needed to discontinue prior to day 20. - Confine resident to their room. Door should remain shut if safe. Pull privacy curtain. Isolate in a private room, if possible. - Initiate Airborne and contact transmission-based precautions. - Station with PPE including N95 respirator, eye protection, gowns and gloves available immediately outside of resident room. - Assign employees to care for the positive resident. - Implement source control masking in common spaces on affected units. - Look back two days from start of symptoms or positive test, whichever was sooner, to identify all residents, staff and visitors as able who had close contact or higher risk exposure with this resident. - Initiate outbreak testing via contact tracing or broad-based testing - Test all Employees and Residents determined to be close contacts/higher risk exposures on Day 1, Day 3, and Day 5 following the exposure. - Contact trace any additional identified positives. - If unable to conduct contact tracing, move to broad based testing of all employees and residents on a unit/hall or facility on Day 1, Day 3, and Day 5 - If the outbreak becomes uncontained, move to testing of all employees and residents every 3-7 days until no new cases of COVI D-19 are identified for 14 days. Choosing a test	21390		

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21390	Continued From page 28 - Either Antigen or NAAT can be used. Antigen testing is preferred for symptomatic people and for people who have recovered from COVID-19 infection in the prior 31-90 days. - People should not be included in outbreak testing through contact tracing or broad-based testing for 30 days following the onset of their COVID-19 illness unless new symptoms develop, in which case antigen test should be used. - Instruct symptomatic employees to get tested immediately, prior to working. - Instruct positive employees to stay home. Surveillance and Mitigation Plan for SNFs updated 4/26/23, identified if symptomatic residents test negative with an antigen test, they should be placed into transmission-based precautions, and in a single room, if possible, but not cohorted with a known positive resident until a confirmation test with a PCR is received or confirmation with another negative antigen test 48 hours later. EBP: R205's admission MDS dated 11/13/24, identified R205 had moderate impaired cognition. R205 had one stage three pressure ulcer and one unstageable ulcer present on admission. In addition, the MDS identified R205 had infection of foot and required pressure ulcer care and application of dressings to his feet. Diagnoses included dementia, anxiety, and diabetes. R205's care plan dated 11/20/24, identified R205 had an unstageable pressure ulcer to his left second toe and stage three pressure injury to his right great toe. Staff were directed to monitor location, size and treatment of skin injury and report abnormalities to the provider, provide	21390		

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21390	Continued From page 29 supplemental protein, vitamins, and minerals to support healing and notify nurse of any new skin breakdown or concerns. During observation on 11/20/24 9:55 a.m. licensed practical nurse (LPN)-A entered R205's room to change the dressing on his foot after applying alcohol-based hand sanitizer (ABHR). LPN-A gathered dressing supplies from R205's closet and put on gloves. LPN-A removed R205's sock on right foot. No dressings were visible and the wound on right great toe was left open to air. The wound was approximately three centimeters in diameter and was a stage two wound with a crater like appearance. LPN-A dabbed the wound with a 4x4 sponge. LPN-A changed gloves and applied iodosorb ointment with a cotton tipped swab into the wound bed. LPN-A covered the wound with a Band-Aid and put a sock and soft tennis shoe slipper onto R205's foot. LPN-A removed her gloves, put away supplies and washed her hands before exiting the room. There was no signage or personal protective equipment (PPE) cart outside of R205's room to indicate he was on enhanced barrier precautions. During interview on 11/20/24, at 1:45 p.m. LPN-A stated the infection preventionist (IP) determined and setup enhanced barrier precautions (EBP) when it was needed for residents. Staff identified when they needed to implement enhanced barrier precautions to care for a resident when a PPE cart and signage was located outside a resident's door. R205 has never needed EBP since his admission and so she just used gloves for the dressing change to his foot. LPN-A knew EBP were needed for resident with catheters or wounds but not exactly sure when they were required. LPN-A just relied on the IP nurse to let staff know when EBP was needed to care for	21390		

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21390	Continued From page 30 residents. When interviewed on 11/21/24, at 11:15 a.m. registered nurse (RN)-C stated she did not know why R205 was not on EBP. The IP nurse had told staff it was not needed because R205's wounds were not significant enough to need precautions. The IP nurse reviewed resident conditions even before they were admitted and determined what type, if any, precautions were needed for their care. The staff followed what they were told by the IP nurse. When interviewed on 11/21/24, at 11:50 a.m. the IP nurse stated R205 had a chronic wound and EBP was not required when the wound was chronic in nature. R205 was admitted with the wounds on his feet. The wounds were rapidly healing and R205 did not have a history of skin conditions, so she did not feel EBP was needed. During observation on 11/25/24, at 10:45 a.m. a PPE cart and EBP signage was noted posted outside of R205's room, with instruction for staff to wear gown and gloves with any care or prolonged contact with R205. A facility policy on enhanced barrier precautions was requested, however none were received. The Centers for Disease Control and Prevention (CDC) Frequently Asked Questions (FAQs) about Enhanced Barrier Precautions in Nursing Homes, dated 6/28/24, indicated wound care was included as a high-contact resident care activity and was generally defined as the care of any skin opening requiring a dressing. This generally included residents with chronic wounds, and not those with only shorter-lasting wounds, such as skin breaks or skin tears covered with a Band-aid	21390		

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21390	Continued From page 31 or similar dressing. Examples of chronic wounds include, but are not limited to, pressure ulcers, diabetic foot ulcers, and chronic venous stasis ulcers. Mask Use: R206's admission MDS dated 11/20/24, identified R206 had intact cognition. R206 was admitted with diabetic foot ulcer, open lesions on foot and application of dressings to feet. The MDS indicated antibiotics were administered daily. R206's care plan dated 11/25/24, identified R206 was on antibiotics for osteomyelitis with a peripherally inserted central catheter (PICC) in left arm. Antibiotics were ordered twice a day for six weeks. Staff were directed to monitor intravenous (IV) site in left arm every shift for symptoms of infection. The care plan also identified R206 was to be on enhanced barrier precautions due to her wounds and the presence of the PICC line. Staff were directed to don gown and gloves when performing high contact activities such as dressing, grooming, repositioning, wound care, and device care and use. The PICC dressing was to be changed weekly. During observation on 11/19/24, at 2:55 p.m. RN-C and RN-E entered R206's room after applying alcohol-based hand sanitizer (ABHR) and gloving and gowning. RN-E, with clean gloves and gown on, proceeded to carefully remove the transparent adhesive dressing covering the PICC line insertion site. RN-E was not wearing a mask during the procedure. RN-E removed her gloves and washed her hands. RN-E opened the PICC line sterile dressing change packet , setup a sterile field barrier sheet	21390		

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21390	Continued From page 32 and put on the sterile gloves. RN-E put on a sterile mask and began cleaning the PICC line insertion site with the enclosed chlorhexadine swab. RN-C put on a pair of sterile gloves to assist RN-E. RN-C took the sterile paper measuring tape and measured R206's upper arm, leaning over the PICC line insertion site to do so. RN-C then applied the sterile transparent adhesive dressing to cover the PICC line insertion site. Both nurses disposed of used supplies removed gloves and washed hands and exited room. During interview on 11/19/24, at 3:15 p.m. RN-C stated she was not wearing a face mask when assisting RN-E with the PICC line dressing change and she should have been. When interviewed on 11/21/24, at 8:40 a.m. RN-E stated she had never received training on PICC line dressing changes from the facility, except for the mentoring that was observed on 11/19/24, while doing the procedure. RN-E verified she was not wearing a mask when removing the dressing covering the PICC line insertion site. RN-E stated she should have been wearing a face mask during the procedure. During on 11/21/24, at 11:55 p.m. the director of nursing (DON) stated it was the facility's expectation to perform PICC line dressing changes using sterile technique and procedures. The facility policy Peripherally Inserted Central Catheter dated 4/1/24, directed staff to perform hand hygiene and put on a face mask when performing a PICC line dressing change. Suggested Method of Correction: The DON or designee could review policies and procedures to	21390		

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21390	Continued From page 33 ensure, proper data collection, moitoring and analysis of infections, precautions are followed per CDC guidelines and then educate staff on the requirements. They could audit the program along with observations to ensure compliance. Time Period for Correction: Twenty one (21) days.	21390		
21525	MN Rule 4658.1305 A.B.C Pharmacist Service Consultation A nursing home must employ or obtain the services of a pharmacist currently licensed by the Board of Pharmacy who: A. provides consultation on all aspects of the provision of pharmacy services in the nursing home; B. establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and C. determines that drug records are accurately maintained and that an account of all controlled drugs is maintained. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure the consulting pharmacist (CP) identified and communicated to the facility the need for monitoring for potential adverse events for high- risk medications for 2 of 5 residents (R22, R37); and failed to identify the need to monitor for adverse behaviors for psychotropic medications for 1 of 5 residents (R37) reviewed for unnecessary medications. Findings include:	21525	corrected	1/6/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00322	A. BUILDING: _____ B. WING _____	C 11/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - INTERNATIONA	2201 KEENAN DRIVE INTERNATIONAL FALLS, MN 56649

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21525	Continued From page 34 R22's quarterly Minimum Data Set (MDS) dated 9/17/24, identified R22 had moderate cognitive impairment and exhibited behavior of verbal abuse to others four to six times per week and physical behaviors of hitting, scratching, pacing, and wandering, one to three times per week. R22 also rejected care four to six times weekly. The MDS identified R22 had received antidepressant medications daily. Diagnoses included chronic myeloid leukemia, anxiety, post-traumatic stress disorder (PTSD) and dementia. R22's signed Order Summary Report, dated 11/21/24, identified R22's current ordered medications and treatments at the nursing home. These included orders for: Gleevec (to treat myeloid leukemia) 400 milligrams (mg) daily, nurse to monitor for side effects and MD as needed, and venlafaxine (to treat depression) 75 mg daily. The summary listed an order which directed "Nurse to monitor for the following symptoms: weakness, dizziness, sudden changes in strength or mobility, nausea or vomiting, unusual bleeding, bruising, black or tarry stools, extreme fatigue. Swelling, redness and/or pain in upper or lower extremities, yellowing of the skin or eyes, swelling of the face, mouth, tongue, legs, ankles or feet, or sudden weight gain." R22's medical record lacked evidence R22 was being assessed or evaluated for adverse effects as ordered by the physician. R22's PharMerica Physician Recommendations dated 8/23/24, identified R22 was receiving venlafaxine and donepezil daily. The consultant pharmacist (CP) identified donepezil could cause side effects for aggression and agitation. A	21525		

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21525	Continued From page 35 recommendation was made to increase venlafaxine and consider reducing R22's donepezil. During interview on 11/21/24, at 11:11 a.m. registered nurse (RN)-C stated R22 did have an active order to monitor for side effects to his chemotherapy medication and so the order should be on his MAR to monitor. The MAR usually pulled from the resident orders but in R22's case, it had been entered incorrectly and did not get pulled over. It was the facility policy to monitor high risk medication and psychotropic medications for side effects every shift and document it was completed on the MAR or the TAR. RN-C had just discussed the need to monitor labs with residents on certain medications. Lab work was not part of the standing orders, and they relied on the primary physician to order labs as needed and so it frequently was missed. Pharmacy reviews were conducted monthly and review of recommendations January 2024 through November 2024, identified no further concerns or recommendations. The pharmacy reviews lacked evidence the CP identified the need and made the recommendation to the facility to monitor for psychotropic medication adverse effects as ordered. R37's quarterly MDS dated 8/9/24, identified R37 had intact cognition and no behavioral symptoms were identified. The MDS indicated R37 had consumed antidepressant, anticoagulant and diuretic medications daily. Diagnoses included chronic obstructive pulmonary disease (COPD), anxiety, atrial fibrillation (irregular heartbeat), and kidney disease.	21525		

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21525	Continued From page 36 R37's signed Order Summary Report, dated 11/25/24, identified R37's current physician ordered medications and treatments at the nursing home. These included orders for furosemide (a diuretic) 40 mg daily, lorazepam (an antianxiety) 0.5 mg at bedtime, methimazole (to treat hyperthyroid) 2.5 mg daily and Lexapro (an antidepressant) 10 mg daily. A hospital discharge summary dated 11/28/23, identified R37 had been hospitalized and treated for anemia with a hemoglobin of 6.4. R37's hemoglobin on discharge was 10.3 and medications changes were made to discontinue coumadin and to start aspirin 325 mg instead. R37's medical record lacked evidence R22 had annual blood work to assess, or evaluate for adverse effects, effectiveness of hyperthyroid treatment and monitoring for therapeutic dosages. R37's PharMerica Physician Recommendations dated 7/29/24, identified R37 received Lexapro and lorazepam daily with a recommendation to the physician to review the medications and consider a gradual dose reduction (GDR). The physician refused the recommendation due to R37 was stable with current dose. Pharmacy reviews were conducted monthly and review of recommendations January 2024 through November 2024, identified no further concerns or recommendations. The pharmacy reviews lacked evidence the CP identified the need and made the recommendation to the facility to monitor for psychotropic medication side effects as ordered or to track and monitor adverse behaviors for which the medications were ordered.	21525		

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21525	Continued From page 37 During interview on 11/21/24, at 11:11 a.m. RN-C stated R37 should have had lab work done to monitor for dehydration related to her diuretic medications as well as potassium level and hemoglobin to check for the need for supplementation related to the diuretic medications. RN-C had just discussed this with the director of nursing (DON) that some residents should have routine lab work done every six months to a year. Some of the physicians were on top of their residents to order labs and others were not. A joint interview was conducted with the DON and RN-D on 11/21/24, at 11:59 a.m. RN-D stated it was the facility's practice to monitor high risk and psychotropic medications every shift and staff were to document it was completed on the resident's TAR. The DON stated R37 should have symptoms of anxiety and depression monitored every shift. RN-D stated they never received recommendations from the pharmacist regarding need for lab work related to a resident's medications. RN-D commented it would be another check to ensure things were not missed and a good resource for the facility. During telephone interview on 11/25/24, at 3:49 p.m. the CP stated when charts were reviewed monthly the CP did check to ensure the facility was monitoring for side effects as well as adverse behaviors. The facility had been short staffed and had just resumed monthly behavior meetings, which the CP attended. The CP had been looking at each residents' charts for side effects and behavior monitoring and had told the facility to be sure to have specific behaviors to monitor on residents receiving psychotropic medications. The CP had made recommendations to try to	21525		

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21525	Continued From page 38 reduce medications but felt the recommendations were not considered because the psychiatric clinic would keep adding on more medications. The CP felt R37 should have some lab work drawn. Sometimes the resident or family would refuse but the CP was unsure why a recommendation to check lab work was not made for R37. The facility policy Consultant Pharmacist Services Provider Requirements dated 1/2023, identified regular and reliable pharmacist services were to be provided to residents of the facility. The consultant pharmacist would provide pharmaceutical care services. Suggested Method of Correction: The DON with the Consulting Pharmacist could establish a system to ensure monitoring for adverse events and behaviors was completed every shift as well as therapuetic drug levels, and labs obtained. Then could randomly audit the system to ensure interventions are being addressed and report to the quality assurance committee. Time Period For Correction: Twenty one- (21) days.	21525		
21530	MN Rule 4658.1310 A.B.C Drug Regimen Review A. The drug regimen of each resident must be reviewed at least monthly by a pharmacist currently licensed by the Board of Pharmacy. This review must be done in accordance with Appendix N of the State Operations Manual, Surveyor Procedures for Pharmaceutical Service Requirements in Long-Term Care, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992.	21530		1/6/25

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21530	Continued From page 39 This standard is incorporated by reference. It is available through the Minitex interlibrary loan system. It is not subject to frequent change. B. The pharmacist must report any irregularities to the director of nursing services and the attending physician, and these reports must be acted upon by the time of the next physician visit, or sooner, if indicated by the pharmacist. For purposes of this part, "acted upon" means the acceptance or rejection of the report and the signing or initialing by the director of nursing services and the attending physician. C. If the attending physician does not concur with the pharmacist's recommendation, or does not provide adequate justification, and the pharmacist believes the resident's quality of life is being adversely affected, the pharmacist must refer the matter to the medical director for review if the medical director is not the attending physician. If the medical director determines that the attending physician does not have adequate justification for the order and if the attending physician does not change the order, the matter must be referred for review to the quality assessment and assurance committee required by part 4658.0070. If the attending physician is the medical director, the consulting pharmacist must refer the matter directly to the quality assessment and assurance committee. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure the consulting pharmacist (CP) identified and communicated to the facility the need for monitoring for potential adverse events for high- risk medications for 2 of 5 residents (R22, R37); and failed to identify the need to monitor for adverse behaviors for	21530	corrected	

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21530	Continued From page 40 psychotropic medications for 1 of 5 residents (R37) reviewed for unnecessary medications. Findings include: R22's quarterly Minimum Data Set (MDS) dated 9/17/24, identified R22 had moderate cognitive impairment and exhibited behavior of verbal abuse to others four to six times per week and physical behaviors of hitting, scratching, pacing, and wandering, one to three times per week. R22 also rejected care four to six times weekly. The MDS identified R22 had received antidepressant medications daily. Diagnoses included chronic myeloid leukemia, anxiety, post-traumatic stress disorder (PTSD) and dementia. R22's signed Order Summary Report, dated 11/21/24, identified R22's current ordered medications and treatments at the nursing home. These included orders for: Gleevec (to treat myeloid leukemia) 400 milligrams (mg) daily, nurse to monitor for side effects and MD as needed, and venlafaxine (to treat depression) 75 mg daily. The summary listed an order which directed "Nurse to monitor for the following symptoms: weakness, dizziness, sudden changes in strength or mobility, nausea or vomiting, unusual bleeding, bruising, black or tarry stools, extreme fatigue. Swelling, redness and/or pain in upper or lower extremities, yellowing of the skin or eyes, swelling of the face, mouth, tongue, legs, ankles or feet, or sudden weight gain." R22's medical record lacked evidence R22 was being assessed or evaluated for adverse effects as ordered by the physician. R22's PharMerica Physician Recommendations	21530		

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21530	Continued From page 41 dated 8/23/24, identified R22 was receiving venlafaxine and donepezil daily. The consultant pharmacist (CP) identified donepezil could cause side effects for aggression and agitation. A recommendation was made to increase venlafaxine and consider reducing R22's donepezil. During interview on 11/21/24, at 11:11 a.m. registered nurse (RN)-C stated R22 did have an active order to monitor for side effects to his chemotherapy medication and so the order should be on his MAR to monitor. The MAR usually pulled from the resident orders but in R22's case, it had been entered incorrectly and did not get pulled over. It was the facility policy to monitor high risk medication and psychotropic medications for side effects every shift and document it was completed on the MAR or the TAR. RN-C had just discussed the need to monitor labs with residents on certain medications. Lab work was not part of the standing orders, and they relied on the primary physician to order labs as needed and so it frequently was missed. Pharmacy reviews were conducted monthly and review of recommendations January 2024 through November 2024, identified no further concerns or recommendations. The pharmacy reviews lacked evidence the CP identified the need and made the recommendation to the facility to monitor for psychotropic medication adverse effects as ordered. R37's quarterly MDS dated 8/9/24, identified R37 had intact cognition and no behavioral symptoms were identified. The MDS indicated R37 had consumed antidepressant, anticoagulant and diuretic medications daily. Diagnoses included	21530		

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21530	Continued From page 42 chronic obstructive pulmonary disease (COPD), anxiety, atrial fibrillation (irregular heartbeat), and kidney disease. R37's signed Order Summary Report, dated 11/25/24, identified R37's current physician ordered medications and treatments at the nursing home. These included orders for furosemide (a diuretic) 40 mg daily, lorazepam (an antianxiety) 0.5 mg at bedtime, methimazole (to treat hyperthyroid) 2.5 mg daily and Lexapro (an antidepressant) 10 mg daily. A hospital discharge summary dated 11/28/23, identified R37 had been hospitalized and treated for anemia with a hemoglobin of 6.4. R37's hemoglobin on discharge was 10.3 and medications changes were made to discontinue coumadin and to start aspirin 325 mg instead. R37's medical record lacked evidence R22 had annual blood work to assess, or evaluate for adverse effects, effectiveness of hyperthyroid treatment and monitoring for therapeutic dosages. R37's PharMerica Physician Recommendations dated 7/29/24, identified R37 received Lexapro and lorazepam daily with a recommendation to the physician to review the medications and consider a gradual dose reduction (GDR). The physician refused the recommendation due to R37 was stable with current dose. Pharmacy reviews were conducted monthly and review of recommendations January 2024 through November 2024, identified no further concerns or recommendations. The pharmacy reviews lacked evidence the CP identified the need and made the recommendation to the	21530		

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21530	Continued From page 43 facility to monitor for psychotropic medication side effects as ordered or to track and monitor adverse behaviors for which the medications were ordered. During interview on 11/21/24, at 11:11 a.m. RN-C stated R37 should have had lab work done to monitor for dehydration related to her diuretic medications as well as potassium level and hemoglobin to check for the need for supplementation related to the diuretic medications. RN-C had just discussed this with the director of nursing (DON) that some residents should have routine lab work done every six months to a year. Some of the physicians were on top of their residents to order labs and others were not. A joint interview was conducted with the DON and RN-D on 11/21/24, at 11:59 a.m. RN-D stated it was the facility's practice to monitor high risk and psychotropic medications every shift and staff were to document it was completed on the resident's TAR. The DON stated R37 should have symptoms of anxiety and depression monitored every shift. RN-D stated they never received recommendations from the pharmacist regarding need for lab work related to a resident's medications. RN-D commented it would be another check to ensure things were not missed and a good resource for the facility. During telephone interview on 11/25/24, at 3:49 p.m. the CP stated when charts were reviewed monthly the CP did check to ensure the facility was monitoring for side effects as well as adverse behaviors. The facility had been short staffed and had just resumed monthly behavior meetings, which the CP attended. The CP had been looking at each residents' charts for side effects and	21530		

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21530	Continued From page 44 behavior monitoring and had told the facility to be sure to have specific behaviors to monitor on residents receiving psychotropic medications. The CP had made recommendations to try to reduce medications but felt the recommendations were not considered because the psychiatric clinic would keep adding on more medications. The CP felt R37 should have some lab work drawn. Sometimes the resident or family would refuse but the CP was unsure why a recommendation to check lab work was not made for R37. The facility policy Consultant Pharmacist Services Provider Requirements dated 1/2023, identified regular and reliable pharmacist services were to be provided to residents of the facility. The consultant pharmacist would provide pharmaceutical care services to include assist in the SUGGESTED METHOD FOR CORRECTION: The DON or designee could review with the consulting pharmacist the process to identfy irregularities specifically realted to adverse events and behavior monitory. Then the facility could audit charts to ensure they have adverse medication monitoring and behavior monitoring in plance. The Quality Assurance Committee could randomly audit records to assure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21530		
21540	MN Rule 4658.1315 Subp. 2 Unnecessary Drug Usage; Monitoring Subp. 2. Monitoring. A nursing home must monitor each resident's drug regimen for	21540		1/6/25

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21540	Continued From page 45 unnecessary drug usage, based on the nursing home's policies and procedures, and the pharmacist must report any irregularity to the resident's attending physician. If the attending physician does not concur with the nursing home's recommendation, or does not provide adequate justification, and the pharmacist believes the resident's quality of life is being adversely affected, the pharmacist must refer the matter to the medical director for review if the medical director is not the attending physician. If the medical director determines that the attending physician does not have adequate justification for the order and if the attending physician does not change the order, the matter must be referred for review to the Quality Assurance and Assessment (QAA) committee required by part 4658.0070. If the attending physician is the medical director, the consulting pharmacist shall refer the matter directly to the QAA. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure adverse event monitoring was completed for high-risk medications 2 of 5 residents (R22, R37) reviewed for unnecessary medications. Findings include: R22's quarterly Minimum Data Set (MDS) dated 9/17/24, identified R22 had moderate cognitive impairment. Diagnoses included chronic myeloid leukemia and dementia. R22's signed Order Summary Report, dated 11/21/24, identified R22's current ordered medications and treatments at the nursing home.	21540	corrected	

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21540	Continued From page 46 These included orders for: Gleevec (to treat myeloid leukemia) 400 milligrams (mg) daily, nurse to monitor for side effects and notify MD as needed. The summary listed an order which directed "Nurse to monitor for the following symptoms: weakness, dizziness, sudden changes in strength or mobility, nausea or vomiting, unusual bleeding, bruising, black or tarry stools, extreme fatigue. Swelling, redness and/or pain in upper or lower extremities, yellowing of the skin or eyes, swelling of the face, mouth, tongue, legs, ankles or feet, or sudden weight gain." R22's care plan dated 10/11/24, identified R22 consumed a non-cytotoxic oral chemotherapy with a goal to remain free of complications related to chemo therapy side effects. Interventions included drawing blood work as ordered, administering the medication as ordered, and monitor for chemotherapy complications and side effects. R22's Medication Administration Record (MAR), dated 11/2023, identified the order for Gleevec and recorded R22 received the medication, as ordered, on a daily basis. However, the MAR and Treatment Administration Record (TAR) both lacked evidence of monitoring for adverse effects of the medications. Further, R22's medical record was reviewed and lacked evidence R22 was being assessed, or evaluated for adverse effects as ordered by the physician. During interview on 11/21/24, at 11:11 a.m. registered nurse (RN)-C stated R22 did have an active order to monitor for side effects to his chemotherapy medication and so the order should be on his MAR or TAR to monitor. The MAR usually pulled from the resident orders but	21540		

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	00322	A. BUILDING: _____ B. WING _____	C 11/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - INTERNATIONA	2201 KEENAN DRIVE INTERNATIONAL FALLS, MN 56649

(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
21540	Continued From page 47 in R22's case, it had been entered incorrectly and did not get pulled over. It was the facility policy to monitor high risk medication for side effects every shift and document it was completed on the TAR. RN-C had just discussed the need to monitor labs with residents on certain medications. Lab work was not part of the standing orders and they relied the primary physician to order labs as needed and so it frequently was missed. R37's quarterly MDS dated 8/9/24, identified R37 had intact cognition and no behavioral symptoms were identified. The MDS indicated R37 had consumed anticoagulant and diuretic medications daily. Diagnoses included chronic obstructive pulmonary disease (COPD), atrial fibrillation (irregular heartbeat), and kidney disease. R37's signed Order Summary Report, dated 11/25/24, identified R37's current physician ordered medications and treatments at the nursing home. These included orders for furosemide (a diuretic) 40 mg daily, potassium (a supplement) 10 milliequivalents daily, and methimazole (to treat hyperthyroid) 2.5 mg daily. R37's care plan with last revision date 8/13/24, identified R37 received diuretic therapy. Interventions included monitor for side effects based on clinical standards of practice and to monitor for symptoms of dehydration and encourage adequate fluid intake. R37's medical record lacked evidence annual lab work was completed to monitor for adverse effects and/or therapuetic drug levels of the high risk medications. R37's MAR, dated 11/2023, identified the orders	21540		

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21540	Continued From page 48 for furosemide, methimazole and potassium and recorded R37 received the medications, as ordered, on a daily basis. However, the MAR and TAR both lacked evidence staff were monitoring for adverse effects of the medications. Further, R37's medical record was reviewed and lacked evidence R22 had annual blood work to assess, or evaluate for adverse effects, effectiveness of hyperthyroid treatment and monitoring for therapeutic dosages. During interview on 11/21/24, at 11:11 a.m. registered nurse RN-C stated R37 should have had lab work done to monitor for dehydration related to her diuretic medications as well as potassium level and hemoglobin to check for the need for supplementation related to the diuretic medications and history of anemia. RN-C had just discussed this with the DON that some residents should have routine lab work done every six months to a year. Some of the physicians were on top of their residents to order labs and others were not. During joint interview on 11/21/24, at 11:59 a.m. with the director of nursing and RN-D, RN-D stated it was the facility's practice to monitor for adverse events with high risk medications every shift and staff were to document it was completed on the resident's TAR. During telephone interview on 11/25/24, at 3:49 p.m. the consultant pharmacist (CP) stated when charts were reviewed monthly the CP did check to ensure the facility was monitoring for side effects. The CP reviewed each resident charts individually for side effects. When a resident was receiving diuretic or thyroid medications, lab work was something the facility would want to look at. R37 should have lab work drawn and the CP was	21540		

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GOOD SAMARITAN SOCIETY - INTERNATIONA	2201 KEENAN DRIVE INTERNATIONAL FALLS, MN 56649

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21540	Continued From page 49 not sure why there had not been a recommendation to do so in the past year. The facility policy Medication Drug Regimen Review dated 2/28/24, identified the drug regimen review was a process that included medication reconciliation and review of all medications a resident was taking to identify and prevent potentially significant medication issues. _____ _____ ___ Based on interview and document review, the facility failed to ensure adverse event monitoring was completed for 2 of 5 residents (R22, R37); and failed to monitor adverse behaviors for 1 of 5 residents (R37) reviewed for unnecessary medication use and were taking a psychotropic medication. Findings include: R22's quarterly Minimum Data Set (MDS) dated 9/17/24, identified R22 had moderate cognitive impairment and exhibited behaviors of verbal abuse to others four to six times per week and physical behaviors of hitting, scratching, pacing and wandering, one to three times per week. R22 also rejected care four to six times weekly. The MDS identified R22 had received antidepressant medications daily. Diagnoses included chronic myeloid leukemia, anxiety, post-traumatic stress disorder (PTSD) and dementia. R22's signed Order Summary Report, dated 11/21/24, identified R22's current ordered medications and treatments at the nursing home. These included orders for: venlafaxine (to treat	21540		

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21540	Continued From page 50 depression) 75 mg daily. The summary listed an order which directed "Nurse to monitor for the following symptoms: weakness, dizziness, sudden changes in strength or mobility, nausea or vomiting, unusual bleeding, bruising, black or tarry stools, extreme fatigue. Swelling, redness and/or pain in upper or lower extremities, yellowing of the skin or eyes, swelling of the face, mouth, tongue, legs, ankles or feet, or sudden weight gain." R22's care plan dated 10/11/24, included interventions of report to nurse signs and symptoms of confusion, mood change, change in behavior, or ability to help with activities of daily living, suicidal ideation, constipation, shuffle gait, rigid muscles, diarrhea, appetite loss, weight loss, nausea and vomiting and fatigue. R22's Medication Administration Record (MAR), dated 11/2023, included the order for venlafaxine and identified R22 received the medication, as ordered, on a daily basis. However, the MAR and Treatment Administration Record (TAR) lacked evidence of an order to monitor for adverse effects of the medications. R22's medical record lacked evidence R22 was being assessed or evaluated for adverse effects as ordered by the physician. During interview on 11/21/24, at 11:11 a.m. registered nurse (RN)-C stated R22 did have an active order to monitor for side effects and so the order should be on the resident's MAR or TAR to monitor. The MAR and TAR usually pulled from the resident orders but in R22's case, it had been entered incorrectly and did not get pulled over. It was the facility policy to monitor high risk psychotropic medications for side effects every	21540		

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21540	Continued From page 51 shift and document it was completed on the TAR. R37's quarterly MDS dated 8/9/24, identified R37 had intact cognition and no behavioral symptoms were identified. The MDS indicated R37 received antidepressant, and antianxiety medications daily. Diagnoses included chronic obstructive pulmonary disease (COPD), anxiety, atrial fibrillation (irregular heartbeat), and kidney disease. R37's signed Order Summary Report, dated 11/25/24, identified R37's current physician ordered medications and treatments at the nursing home. These included orders for lorazepam (an antianxiety) 0.5 mg at bedtime, and Lexapro (an antidepressant) 10 mg daily. R37's care plan with last revision date 8/13/24,identified R37 had depression and included interventions to help R37 meet this goal including consult with pharmacist, administer the medication as ordered, and monitor for complications and side effects such as confusion, mood change, change in behavior, or ability to help with activities of daily living, suicidal ideation, constipation. Staff were also directed to monitor and report if noted increased anger, labile mood or agitation, feeling threatened or thoughts of harming others, and possession of objects that could be used for weapons. R37's MAR dated 11/2023, identified the orders for lorazepam and Lexapro and recorded R37 received the medications, as ordered, on a daily basis. However, the MAR and TAR lacked evidence staff monitored for adverse effects of the medications. The MAR and TAR failed to identify behavioral symptoms to monitor, and track.	21540		

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21540	Continued From page 52 R37's medical record lacked evidence R37's behaviors were monitored, assessed, and reviewed to justify the daily medication administration. During joint interview on 11/21/24, at 11:59 a.m. with the director of nursing (DON) and RN-D, RN-D stated it was the facility's practice to monitor psychotropic medications every shift and staff were to document it was completed on the resident's TAR. The DON stated R37 should have symptoms of anxiety and depression monitored every shift. During telephone interview on 11/25/24, at 3:49 p.m. the consultant pharmacist (CP) stated when charts were reviewed monthly the CP did check to ensure the facility was monitoring for side effects as well as adverse behaviors. The facility had been short staffed and had just resumed monthly behavior monitoring meetings. During the meetings the facility staff and CP reviewed each residents' psychotropic medications and behavior monitoring. The CP also looked at each resident's chart individually and had made the recommendation to be sure to have specific individualized targeted behaviors for each resident and not just general. The CP was working on reviewing psychotropic medications and behavior monitoring and had planned to review the wing where R37 and R22 resided later in the week. She was not sure why she had not made recommendations to monitor side effects for the two residents or adverse behaviors for R37. Those were things the CP reviewed when she reviewed the resident charts monthly. The facility policy Psychotropic Medications dated 12/6/23, identified throughout the administration	21540		

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21540	Continued From page 53 of psychotropic medications, mood and behavior documentation must continue in order to monitor the effect the medication has on the behaviors, as well as monitoring for side effects. Staff were directed to monitor for effectiveness and potential adverse consequences of the medications. SUGGESTED METHOD OF CORRECTION: The DON and/or designee can inservice staff regarding appropriate psychotropic and high risk monitoring for adverse and behaviorss. The DON or designee could audit residents charts, review policies and procedures and educate staff responsible and then audit for compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21540		
21620	MN Rule 4658.1345 Labeling of Drugs Drugs used in the nursing home must be labeled in accordance with part 6800.6300. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure two insulin pens were labeled with the resident name for 1 of 1 resident (R154) observed during medication pass and who's medication was not labeled. Findings include: R154's Admission Record dated 11/25/24, identified R154 was admitted to the facility on 11/13/24. R154's Diagnosis Report dated 11/25/24,	21620	corrected	1/6/25

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21620	Continued From page 54 identified R154 was a Type 2 diabetic. R154's Order Summary Report dated 11/25/24, identified the following: 11/13/24, R154 was prescribed insulin lispro (Humalog) (a short acting insulin) with the following instructions: - insulin lispro (1 Unit Dial) Subcutaneous Solution Pen-injector 100 unit/milliliter (ml) Inject as per sliding scale: if 0 - 160 = 0 UNITS; 161 - 190 = 1 UNIT; 191 - 220 = 2 UNITS; 221 - 250 = 3 UNITS; 251 - 280 = 4 UNITS; 281 - 310 = 5 UNITS; 311 - 340 = 6 UNITS; 341 - 370 = 7 UNITS; 371 - 400 = 8 UNITS; 401 - 999 = 9 UNITS, subcutaneously three times a day for Type 2 diabetes. Give sliding scale dose in addition to scheduled dose. - Insulin Lispro (1 Unit Dial) Subcutaneous Solution Pen-injector 100 UNIT/ML give 25 Units before breakfast daily plus sliding scale; give 22 Units before lunch daily plus sliding scale; and give 21 Units before supper daily plus sliding scale. - 11/13/24, R154 was prescribed Toujeo Max SoloStar Subcutaneous Solution Pen-injector 300 unit/ml (insulin glargine) (a long acting insulin) inject 84 unit subcutaneously one time a day for Type 2 diabetes. During an observation on 11/19/24 at 8:59 a.m., licensed practical nurse (LPN)-A administered Humalog insulin and Toujeo to R154. Neither the Humalog kwik pen or the Toujeo pen had a label identifying the pens belonged to R154. During an interview on 11/19/24 at 9:02 a.m., LPN-A stated the medication pens did not come with a label from the pharmacy but the boxes did. The boxes of medication were kept in the fridge in the medication room. When asked how she knew the pens belonged to R154, LPN-A stated R154 was the only diabetic resident on the unit	21620		

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21620	Continued From page 55 who received injectable medication. The medication pens were stored in the top drawer of the medication cart and everyone just knew they belonged to R154. "I guess I could put her [R154] initials and room number on it." During an interview on 11/19/24 at 9:22 a.m., registered nurse (RN)-A stated all medication pens should be labeled when they come from the pharmacy. If not, staff should put a sticker with the resident's information on it. RN-A stated she was unaware R154's medication pens were unlabeled but would put a sticker on them. There was only one diabetic resident on the unit and R154 was just admitted to the facility on 11/13/24. RN-A stated a medication pen without a label was an infection control issue because staff shouldn't use a medication pen on the wrong resident. Also, R154 paid for that mediation, and it should be labeled with R154's name. During an interview on 11/25/24 at 3:44 p.m. the director of nursing (DON) stated she expected all medication pens to come from the pharmacy labeled or staff should place a resident sticker on the pen identifying who the pen belonged to. The facility policy Medication Ordering and Receiving from Pharmacy Provider Medications and Medication Labels dated 1/2023, identified each prescription medication would be labeled to include: a. Resident's name b. Specific directions for use, including route of administration c. Medication name d. Strength of medication e. Prescriber's name f. Date medication is dispensed g. Quantity dispensed	21620		

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21620	Continued From page 56 h. Expiration or end-of-use date, if not dispensed in original manufacturer packaging i. Name, address, and telephone number of dispensing pharmacy J. Prescription number k. Accessory/precautionary labels indicating storage requirements and special procedures. Example: "Shake well", "Take on empty stomach, one hour before or 2 hours after meals," "Do not crush". l. Dispensing pharmacist's initials m. Lot number of medication dispensed, if not dispensed in original manufacturer packaging, where required by state law n. Any other information required by state and federal Medication containers having soiled, damaged, incomplete, illegible, or makeshift labels are returned to the dispensing pharmacy for re-labeling or destroyed in accordance with the medication destruction policy. SUGGESTED METHOD OF CORRECTION: The DON and or designeed, in conjunction with the consulting pharmacist, could review and revise policies and procedures for proper storage and labeling of medications. Nursing staff could be educated as necessary, on the importance of labeling medications properly. The DON or designee, along with the pharmacist, could audit medications on a regular basis to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21620		

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	245318	A. BUILDING **03 - 2013 BUILDING** B. WING _____	**11/19/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - INTERNATIONAL FALLS	**2201 KEENAN DRIVE INTERNATIONAL FALLS, MN 56649**

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 11/19/2024. At the time of this survey, Good Samaritan Society-International Falls 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 | 12/20/2024

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

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	245318	A. BUILDING **03 - 2013 BUILDING** B. WING _____	**11/19/2024**

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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. The Good Samaritan Society International Falls is a new 1-story building, no basement, and was determined to be Type V (111) construction. The building is separated from the new assisted living building with a 2-hour fire barrier. The building is fully fire sprinkler protected in accordance with NFPA 13 Standard for the Installation of Sprinkler Systems (2010 edition) with quick response sprinkler heads. The facility is also protected by a complete automatic fire	K 000		

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	245318	A. BUILDING **03 - 2013 BUILDING** B. WING _____	**11/19/2024**

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K 000	Continued From page 2 alarm system with smoke detectors throughout the corridors and areas open to the corridor and in all sleeping rooms that is monitored that is installed in accordance with NFPA 72 "The National Fire Alarm Code" (2010 edition). The building is divided into 3 smoke compartments by 1-hour smoke barriers and 2-hour fire barriers. The facility has a capacity of 54 beds and had a census of 50 at the time of the survey.	K 000		
K 211 SS=D	The requirements at 42 CFR, Subpart 483.70(a), are NOT MET as evidenced by: 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 a clear path of egress system per NFPA 101 (2012 edition), Life Safety Code, sections 19.2.1 and 7.1.10.1. This deficient finding could have an isolated impact on the residents within the facility. Findings include:	K 211	Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. For	1/6/25

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K 211	Continued From page 3 On 11/19/2024, between 9:30am and 12:30pm, it was revealed by observation that there was medical equipment in the egress corridor reducing the egress corridor to less than 8' required minimum. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 211	the purposes of any allegation that the center is not in substantial compliance with federal requirements of participation, this response and plan of correction constitutes the center□s allegation of compliance in accordance with section 7305 of the State Operations Manual 1. Beds and equipment were moved out of the hallway 11/19/24. 2. All residents have the potential to be affected by this deficient practice. As a result, immediate education was provided to the maintenance director. 3. Audits will be completed weekly x4, monthly x 2 and quarterly x 1. 4. The maintenance director or designee will be responsible for ensuring audit completion. 5. Date of correction: 1/6/25	
K 353 SS=F	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 _____	K 353		1/6/25

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K 353	Continued From page 4 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 a review of available documentation and staff interview, the facility failed to maintain the automatic sprinkler system per NFPA 101 (2012 edition), Life Safety Code Section 19.7.6, and 4.6.12, NFPA 25 (2011 edition), Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, section 5.1.1.2. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 11/19/2024, between 9:30am and 12:30pm, it was revealed by a review of available documentation the facility failed to perform the quarter sprinkler system testing. An interview with Maintenance Director verified these deficient findings at the time of discovery.	K 353	1. On 11/29/24 Northern Horizon conducted a quarterly sprinkler testing test. 2. All residents have the potential to be affected by this deficient practice. 3. Quarterly sprinkler system testing will be added into TELS and audited quarterly. 4. The administrator or designee will be responsible for ensuring TELS completion. 5. Date of correction: 1/6/25	
K 363 SS=D	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors	K 363		1/6/25

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K 363	Continued From page 5 to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain corridor doors per NFPA 101 (2012 edition), Life Safety Code, section 19.3.6.3.5. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 11/19/2024, between 9:30am and 12:30pm, it	K 363	1. Single door closure was fixed on 12/3/24. 2. All residents have the potential to be affected by this deficient practice. As a result, extra door closures have been added to our stock in case this event happening again. 3. Door inspections have been added into TELS as a quarterly task.	

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K 363	Continued From page 6 was revealed by observation that soiled utility door located on Compton wing does not latch. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 363	4. The maintenance director or designee will audit door closures weekly. 5. Date of correction: 1/6/24	
K 372 SS=F	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain their smoke barrier per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.7.1, 19.3.7.3, 8.5.2.2, and 8.5.6.5. These deficient findings could have a widespread impact on the residents within the facility. Findings include: On 11/19/2024, between 9:30am and 12:30pm, it was revealed by observation that there was a penetration running from one smoke compartment to another above doors leading to	K 372	1. Fire caulking was added to fix open barrier in ceiling on 11/20/24. 2. All residents have the potential to be affected by this deficient practice. 3. A checklist was created for maintenance to ensure we always have the correct barrier twice a year. 4. The maintenance director or designee will audit quarterly that the checklist was completed and within compliance. 5. Date of correction: 1/6/25	1/6/25

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K 372	Continued From page 7 Voyagers Wing. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 372		
K 712 SS=F	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to conduct fire drills under varied times and conditions per NFPA 101 (2012 edition), Life Safety Code, sections 19.7.1.6, 4.7.4, and 4.6.1.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 11/19/2024, between 9:30am and 12:30pm, it was revealed by a review of available documentation that fire drills were not completed: 1) September 2024 - Drill missing 2) July 2024 - Drill missing	K 712	1. On 11/28/24 information from missing monthly fire drills was pulled from our fire panel. 2. All residents have the potential to be affected by this deficient practice. As a result, the maintenance director was given immediate education on the need for proper documentation on monthly drills. 3. A paper log was placed by the fire panel to ensure there is a paper form when the fire panel is triggered. 4. The administrator or designee will audit monthly that fire drills are being completed. 5. Date of correction: 1/6/25	1/6/25

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K 712	Continued From page 8 3) May 2024 - Drill missing 4) March 2024 - Drill missing An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 712		
K 761 SS=F	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to inspect fire doors per NFPA 101 (2012 edition), Life Safety Code section 8.3.3.1, and NFPA 80 (2010 edition), Standard for Fire Doors and Other Opening Protectives, section 5.2.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 11/19/2024, between 9:30am and 12:30pm, it	K 761	1. All fire doors were inspected on 11/27/24. 2. All residents have the potential to be affected by this deficient practice. As a result, a folder was created to track door inspections. 3. All fire doors were entered in TELS to be completed every year in May. 4. The administrator or designee will audit weekly times 4, monthly x 2, quarterly times 1 to ensure the yearly task is completed each May.	1/6/25

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K 761	Continued From page 9 was revealed by review of available documentation the required annual door inspection documentation was not available at the time of the survey. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 761	5. Date of correction: 1/6/25	
K 914 SS=F	Electrical Systems - Maintenance and Testing CFR(s): NFPA 101 Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to conduct the electrical testing and maintenance per NFPA	K 914	1. Annual receptacle inspections were completed 11/30/24. 2. All residents have the potential to be	1/6/25

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K 914	Continued From page 10 99 Standards for Health Care Facilities 2012 edition, section 6.3.3.2, 6.3.4.1.3, and 6.3.4.2.1.2. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 11/19/2024, between 9:30am and 12:30pm, it was revealed by review of available documentation the required annual receptacle inspection documentation was not available at the time of the survey. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 914	affected by this deficient practice. As a result, there is an additional folder created for all inspection paperwork to be stored. 3. Annual receptacle testing has been added into TELS to be completed every month. 4. The administrator or designee will audit to ensure yearly completion and compliance. 5. Date of correction: 1/6/25	
K 923 SS=F	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than	K 923		1/6/25

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K 923	Continued From page 11 or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to store oxygen cylinders per Health Care Facilities Code NFPA 99 (2012 Edition), sections 11.3.2.3, 11.6.5.2 and 11.6.5.3. These deficient findings could have a widespread impact on the residents within the facility. Findings include: On 11/19/2024, between 9:30am and 12:30pm, it was revealed by observation that full and empty oxygen cylinders were stored intermixed. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 923	1. On 12/2/24 all oxygen cylinders were rearranged to be stored in proper empty/full designated spots. 2. All residents have the potential to be affected by this deficient practice. As a result, extra signage has been placed to ensure cylinders are stored in the correct holders. 3. Audits will be completed weekly x4, monthly x 2 and quarterly x 1. 4. The maintenance director or designee will be responsible for the completion of audits and continued compliance. 5. Date of correction: 1/6/25	