Electronically delivered

October 12, 2021

Administrator
Texas Terrace A Villa Center
7900 West 28th Street
Saint Louis Park, MN 55426

RE: CCN: 245187
Cycle Start Date: September 10, 2021

Dear Administrator:

On September 26, 2021, we informed you that we may impose enforcement remedies.

On September 17, 2021, the Minnesota Department(s) of Health and Public Safety completed a survey and it has been determined that your facility is not in substantial compliance. The most serious deficiencies in your facility were found to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

REMEDIES

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

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

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective October 27, 2021.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective October 27, 2021. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective October 27, 2021.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for

new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

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

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

NURSE AIDE TRAINING PROHIBITION

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

If you have not achieved substantial compliance by October 27, 2021, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Texas Terrace A Villa Center will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from October 27, 2021. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

ELECTRONIC PLAN OF CORRECTION (ePOC)

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

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

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient

practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

DEPARTMENT CONTACT

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

Jamie Perell, Unit Supervisor
Metro B District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: jamie.perell@state.mn.us
Office: (651) 245-8094

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by March 10, 2022 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 488.412 and § 488.456.

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

APPEAL RIGHTS

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

Tamika.Brown@cms.hhs.gov

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

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

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you

have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

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

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

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

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

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

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

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	245187	A. BUILDING _____ B. WING _____	C 09/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TEXAS TERRACE A VILLA CENTER	**7900 WEST 28TH STREET SAINT LOUIS PARK, MN 55426**

(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 9/13/21, through 9/17/21, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On 9/13/21, through 9/17/21, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaint was found to be SUBSTANTIATED: H5187170C (MN00048606), however, NO deficiencies were cited due to actions implemented by the facility prior to survey: The following complaints were found to be UNSUBSTANTIATED: H5187165C (MN00074615, MN00073085, MN00070319, and MN00069280) H5187166C (MN00073954) H5187167C (MN00052544) H5187168C (MN00049147) H5187169C (MN00049815) H5187173C (MN00074171) H5187175C (MN00076604)	F 000		

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

Electronically Signed | 10/22/2021

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F 000	Continued From page 1 The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F 000		
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure a self-administration of medication assessment was completed for 1 of 1 resident (R10) who was observed with medications at her bedside. Findings include: R10's quarterly Minimum Data Set (MDS) dated 6/10/21, indicated R10 had intact cognition and diagnoses which included type II diabetes and visual disturbances. A Physician Order dated 3/26/20, indicated levothyroxine sodium (thyroid medication) tablet 88 micrograms (mcg), give 1 tablet by mouth one time daily	F 554	R10's provider was notified. R10 experienced no adverse outcomes from the deficient practice. R10 had a self-administration of medication evaluation completed. Staff to supervise R10 taking oral medications. Residents who self-administer medications have received evaluations, order reviews, and care plans updates as needed to ensure appropriateness of self-administration of medications. The facility has reviewed policies and procedures relating to self-administration of medications, and the policies remain current. Nurses and TMA's will be educated on policies and procedures related to	10/26/21

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F 554	Continued From page 2 During an observation on 9/13/21, at 3:23 p.m. R10 had a plastic medication cup which contained 10 pills. R10 stated the medications were, "from the day before." R10 stated she did not take the medications because she was legally blind and was not sure what medications were in the cup. During an observation on 9/15/21, at 7:51 a.m. trained medication assistant (TMA)-B entered R10's room to administer medications and R10 pointed to a medication cup which contained a single pill. In addition to R10's thyroid medication, another medication cup contained 10 pills was also observed. R10 stated, earlier in the day staff entered her room and she held out her hand so the nurse could hand her the medication, but no one was there. R10 stated the pill was her thyroid medication and she did not take the medication because it appeared different than the medication she had taken previously. TMA-B exited the room and reviewed R10's orders. TMA-B went back to R10's room and explained the doctor had reduced the dose of the medication, which is why it was different. TMA-B asked R10 if she was going to take the thyroid medication and she stated, "yes." TMA-B exited R10's room prior to her taking the medication. During an interview on 9/15/21, at 8:27 a.m. TMA-B verified R10 had a medication cup with 10 pills in her room. R10 stated the pills were from the previous day. During an interview on 9/16/21, at 9:56 a.m. registered nurse (RN)-B verified R10 was unable to self-administer medications and staff should ensure R10 had taken them.	F 554	allowing self-administration of medications. DON/designee will audit 5 random residents per week to ensure self-administration of medication evaluations are complete and being followed. Results of the audits will be shared at QAPI. Audits will continue until discontinued by QAPI.	

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F 554	Continued From page 3 During an interview on 9/16/21, at 11:19 a.m. the director of nursing (DON) stated staff were expected to ensure residents had taken their medication prior to leaving the room. Review of R10's medical record lacked indication a self administration of medication assessment was completed. A medication administration policy was requested, but not provided.	F 554		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2)	F 580		10/26/21

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F 580	Continued From page 4 is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the physician was notified of a pattern of increased blood glucose levels for 1 of 1 resident (R10) reviewed who received insulin. Findings include: According to the American Diabetes Association (ADA), the recommended blood glucose range (before meals) was 80 - 130 milligrams (mg) per deciliter (dL).	F 580	R10's provider was notified of resident's pattern of increased blood glucose levels. Residents who have a diagnosis of diabetes blood glucose levels have been audited and providers have been notified of blood glucose level patterns if indicated. The facility has reviewed policies and procedures related to medication administration, and the policies remain current. Nurses and TMA's will be educated on identifying blood sugar patterns and if/when to notify the provider.	

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F 580	Continued From page 5 R10's quarterly Minimum Data Set (MDS) dated 6/10/21, indicated R10 had intact cognition and diagnoses of type 2 diabetes mellitus and visual disturbances. R10's Order Summary Report dated 9/16/21, indicated R10 was ordered the following: - Blood glucose check three times daily before meals for diabetes mellitus dated 4/29/21. - R10 was okay to check her own blood glucose and administer Humalog and Lantus insulin under nursing supervision dated 1/10/21. - Humalog 100 units (u)/milliliter (mL). Inject 5 units subcutaneously (injection in fat tissue) with meals for diabetes mellitus unsupervised self-administration. Lantus 100 u/mL. Inject 10 units subcutaneously in the evening for diabetes mellitus. Review of R10 Weights and Vitals Summary report dated 9/16/21, indicated 44 blood glucose levels were documented for R10 in the month of September which were all above recommended ranges by the ADA. Results included: - 156 - 199 mg/dl: 3 - 200 - 299 mg/dl: 24 - 300 - 399 mg/dl: 14 - 400 and greater mg/dl: 3 During an interview on 9/16/21, at 8:53 a.m. R10 she was not ordered sliding scale insulin (insulin dosing dependent upon blood glucose result) and always took the same dose. R10 stated staff did not monitor her blood glucose levels or ask her if she had symptoms when her blood glucose level was high. R10 stated staff did not supervise her when taking her blood glucose and she handed a nurse or trained medication assistant (TMA) a piece of paper with the result.	F 580	DON/designee will audit 5 random residents on insulin per week to ensure that blood glucose patterns are being reported to provider as needed. Results of the audits will be shared at QAPI. Audits will continue until discontinued by QAPI.	

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F 580	Continued From page 6	F 580		

During an interview on 9/16/21, at 9:14 a.m. TMA-B stated she would inform the nurse if R10's blood glucose was high and the nurse would call the doctor.

During an interview on 9/16/21, at 9:19 a.m. licensed practical nurse (LPN)-B stated, "We should be monitoring R10's blood sugar and notify the provider [if blood glucose levels were out of range]."

During an interview on 9/16/21, at 9:56 a.m. registered nurse (RN)-B stated nurses should had monitored R10's blood glucose levels and alerted the physician when her results were high/low. RN-B stated when R10 had a high blood sugar level, staff should had asked R10 if she had any symptoms. RN-B confirmed nurses did not notify R10's physician and stated it was because R10 had fired the facility provided and would not provide the facility the name of a new physician.

During an interview on 9/16/21, at 11:19 a.m. the director of nursing (DON) stated she expected R10's blood glucose levels to be monitored and to notify the provider of high blood glucose levels.

During an interview on 9/16/21, at 1:20 p.m. LPN-D stated R10's blood glucose was 433 mg/dL on 9/15/21 at 6:00 p.m., however, did not call the doctor because, "It isn't new for her and she didn't have time."

During an interview on 9/16/21, at 9:39 a.m. nurse practitioner (NP)-B stated she facility should had monitored R10's blood glucose levels and notified the provider.

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F 580	Continued From page 7 A medication administration policy was requested but not provided.	F 580		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document	F 656		10/26/21

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TEXAS TERRACE A VILLA CENTER	**7900 WEST 28TH STREET SAINT LOUIS PARK, MN 55426**

(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 656	Continued From page 8 whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to develop a comprehensive person-centered care plan to reflect individualized goals for 1 of 4 residents (R38) reviewed for care planning. Findings include: R38's admission Minimum Data Set (MDS) dated 7/26/21, indicated R38 had a mild cognitive impairment and required one to two person physical assistance with most activities of daily living (ADLs). R38's MDS further indicated R38's diagnoses included dysphagia (difficulty swallowing), right sided hemiplegia/hemiparesis (paralysis/weakness affecting half of the body), and major depressive disorder. The MDS further indicated R38 received occupational and physical therapy. R38's care plan dated 7/21/21, indicated R38, "has (SPECIFY) actual/potential for an ADL self-care performance deficit r/t [related to]." 38's goal was documented as, "The resident will maintain current level of function in (SPECIFY) through the review date." Interventions included, "Monitor/document/report PRN [as needed] any changes, any potential for improvement, reasons, for self-care deficit, expected course, declines in	F 656	R38's care plan has been updated to reflect individualized goals. All care plans of residents who reside at Texas Terrace a Villa Center will be audited to ensure individualized goals are reflected. The facility has reviewed policies and procedures relating to care planning, and the policies remain current. Nursing staff will be educated on developing comprehensive person-centered care plans to reflect individualized goals. DON/designee will audit 5 random care plans to ensure care plans are comprehensive, person-centered, and reflect individualized goals. Results of the audits will be shared at QAPI. Audits will continue until discontinued by QAPI.	

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F 656	Continued From page 9	F 656		

function" and "Encourage to use bell to call for assistance." Further, R38's care plan indicated, "The resident has (SPECIFY: URGE, STRESS, FUNCTIONAL, MIXED) bladder incontinence r/t" and "Has a psychosocial well-being problem (actual or potential) r/t Illness/Disease process (SPECIFY:), Recent admission" with no associated goal or interventions.

R69's admission MDS dated 8/9/21, indicated R69 had moderately impaired cognition and required two person assistance with most ADLs. R69's MDS further indicated R69's diagnoses included hemiplegia/hemiparesis, dysphagia, aphasia (difficulty speaking), type 2 diabetes, and cerebral infarction (stroke).

During an interview on 9/16/21, at 10:16 a.m. registered nurse (RN)-C stated care plans identify areas of concern, goals, and interventions. RN-C stated the comprehensive care plan should accurately reflect a residents current plan of care.

During an interview on 9/16/21, at 10:52 a.m. the director of nursing (DON) stated the expectation was a comprehensive care plan would be person-centered and individualized for each resident. The DON stated R38's care plan was overdue for review and including "SPECIFY" in brackets was not individualized and would not be considered comprehensive.

During an interview on 9/16/21, at 12:12 p.m. social services designee (SSD)-B stated a comprehensive care plan should be person centered and individualized. SSD-B stated documenting "SPECIFY" in brackets was not individualized.

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F 656	Continued From page 10 Facility policy titled Care Plan Guidelines dated 11/28/17, indicated the facility must develop and implement a comprehensive person-centered care plan for each resident. The care plan must include measurable objectives and timeframes to meet a resident's needs.	F 656		
F 676 SS=D	Activities Daily Living (ADLs)/Mntn Abilities CFR(s): 483.24(a)(1)(b)(1)-(5)(i)-(iii) §483.24(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that: §483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section ... §483.24(b) Activities of daily living. The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living: §483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care, §483.24(b)(2) Mobility-transfer and ambulation, including walking, §483.24(b)(3) Elimination-toileting,	F 676		10/26/21

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F 676	Continued From page 11 §483.24(b)(4) Dining-eating, including meals and snacks, §483.24(b)(5) Communication, including (i) Speech, (ii) Language, (iii) Other functional communication systems. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure assistance was provided with removing facial hair and dressing and/or bathing was for 2 of 4 residents (R58, R3) reviewed who required staff assistance with activities of daily living (ADL). R58's quarterly Minimum Data Set (MDS) dated 8/11/21, identified R58 had diagnoses of chronic kidney failure, heart failure, and diabetes. R58 had intact cognition, used a walker for mobility, and required set up assistance with bathing. R58's Active Order Summary dated 9/16/21, indicated R58 received dialysis on Tuesday, Thursday, and Saturday. R58's dialysis dressing was to be removed the day after dialysis. R58's care plan dated 3/25/21, indicated R58 would continue to make daily preferences/choices which were important to him. R58's care plan lacked evidence of bathing preferences. R58's Nursing Assistant task sheet (undated) indicated R58 was scheduled for showers on Saturday evenings and required assistance with bathing. R58's Nursing Assistant Task documentation dated 9/15/21, indicated R58's bathing schedule	F 676	R58 has been provided assistance with bathing. R58's care plan has been updated to reflect shower day preferences. R3 has been provided with a pair of tweezers for removal of facial hair per resident's preference. R3 has been assessed for safety and ability to use tweezers. All residents that require staff assistance with ADL's have the potential to be affected. Residents who require assistance with ADL's will be audited to ensure that assistance is being provided to remove facial hair and with dressing and bathing. The facility has reviewed policies and procedures relating to activities of daily living, and the policies remain current. Nursing staff will be educated on activities of daily living pertaining to residents' preferences and ability to perform activities of daily living. DON/designee will audit 5 random residents per week to ensure residents are receiving assistance with removal of unwanted facial hair and bathing/dressing. Results of the audits will be shared at QAPI. Audits will continue until discontinued by QAPI.	

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F 676	Continued From page 12	F 676		

was Friday afternoons. The bathing schedule lacked documentation R58 had a shower and/or refused in the past 30 days.

During an observation on 9/13/21, at 5:50 p.m. R58 had on a soiled tee-shirt and a pair of gray shorts. R58 appeared unkempt. R58 stated they were frustrated with staff wanting to provide them showers on Saturday. R58 stated their dialysis dressing was on until the next day and should not come off. R58 stated, "They just don't get it." R58 stated they wanted a shower on Sundays, but that does not get to.

During an interview on 9/15/21, at 9:32 a.m. nursing assistant (NA)-E stated they were unaware of R58's shower day. NA-E stated R58 should have a shower on a day he does not go to dialysis. R58 can ask any time and would be helped with a shower.

During an interview on 9/15/21, at 9:45 a.m. licensed practical nurse (LPN)-B stated there was a shower schedule at the main desk which was how nursing assistant knew when to shower residents. LPN-B stated if R58 asked for a shower on a different day, R58 would get one.

During an interview on 9/16/21, at 9:30 a.m. R58 stated it had been three weeks since he had a shower. R58 stated, "I want a shower on Sunday, and I will ask for a shower on Sunday. They say there were too busy and never come back." R58 stated staff offered to give him a shower on Saturday, but the dialysis dressing was still on. R58 stated a shower was not offered any other time during the week. R58 had on the same soiled tee-shirt and gray shorts as 9/13/21.

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F 676	Continued From page 13	F 676		

During an interview on 9/16/21, at 1:06 p.m. registered nurse (RN)-B stated she shower schedule was based on room numbers. RN-B verified the shower scheduled showed R58's shower was listed on Saturday evening. RN-B stated the list was a system to help organize the work and if residents requested a shower, it was provided. RN-B stated if a shower was missed or refused, the nursing assistant needed to tell the nurse, document, and try again later. RN-B was not aware of R58's shower preference. RN-B believed R58 came from another floor and stated R58 was not asked about his shower preference since he arrived to the unit.

During an interview on 9/16/21, at 3:38 p.m. the director of nursing (DON) stated residents had a scheduled shower day, but could ask outside of that time. If a resident asked, they should receive a shower. If staff were to find out a resident's preference for a shower day or time, it needed to be communicated. The nurse can update the care plan and care guides.
R3's Face Sheet dated 5/27/21, indicated R3's diagnoses included Alzheimer's disease, urinary incontinence, and altered mental status.

R3's admission Minimum Data Set (MDS) dated 6/3/21, indicated R3 had a severe cognitive impairment.

R3's quarterly MDS dated 9/3/21, indicated R3 required supervision with bed mobility and dressing. Further, R3 required extensive assistance toileting and personal hygiene was not assessed.

R3's care plan dated 5/27/21, indicated R3 had an actual ADL deficit self-care performance

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F 676	Continued From page 14	F 676		

related to dementia and impaired balance. The care plan further indicated R3 did not like her facial hair shaved and preferred tweezers. An intervention was added on 9/16/21, which indicated offering R3 tweezers and assistance with facial hair. R3 required supervision of one staff with personal hygiene. Staff were to ensure R3's clothing was changed at least every two days.

During an observation on 9/13/21, at 5:36 p.m. R3 was seated on a rolling walker near the nurses station and talking. R3 was noted to have hair on her lower chin which was several inches long. R3 was wearing a gray long-sleeved shirt and pajama pants.

During an observation on 9/15/21, at 12:20 p.m. R3 was seated on a rolling walker. R3 was wearing a gray long-sleeved shirt and pajama pants. The hair remained on R3's lower chin.

During an observation on 9/16/21, at 9:04 a.m. R3 was in her room and seated on her bed. R3's room smelled of urine and R3 stated, "I am soaked. I have been sitting her in wet clothing and no one was helping." R3 was on a cellular phone and stated she was trying to reach her niece as no one was available to assist her getting changed. R3 was wearing the same long sleeved gray shirt and pajama pants seen on 9/13/21. The hair remained on R3's lower chin.

During an interview on 9/15/21, at 12:47 p.m. nursing assistant (NA)-A stated no "one" nursing assistant was assigned to R3 and the nursing assistants worked as a team. NA-A stated they sometimes provide R3 assistance with cares and R3 was able to toilet herself. NA-A stated R3

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F 676	Continued From page 15 sometimes soaked the bed and staff assisted providing care. NA-A stated he had not went into R3's room during his shift. During an interview on 9/15/21, at 2:46 p.m. NA-J stated nursing assistants worked in a group together and no one was assigned to R3. NA-J stated nursing assistants worked as a team. NA-J stated R3 turned on her call light when she needed assistance with dressing, grooming, and toileting. R3 was confused, able to ambulate independently, and was sometimes incontinent of urine. During an interview on 9/15/21, at 12:29 p.m. R3 stated she did not like hairs to her lower chin, but did not like the hairs shaved and preferred tweezers to be used. R3 stated a tweezer was better for getting hair out at the roots. R3 stated if she had tweezers she would be able to remove the hairs, however, one was not provided. During an interview on 9/16/21, at 3:00 p.m. the director of nursing (DON) stated it was expected staff provide assistance removing facial hair on bath days and as needed. Further, staff were to provide hygiene assistance as indicated on the care plan. Facility policy titled Activities of Daily Living dated 5/7/20, directed the collaborative professional team, together with the resident and resident representative would recognize and evaluate the inability to perform ADLs or the risk for decline in any ability to perform ADLs.	F 676		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2)	F 677		10/26/21

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F 677	Continued From page 16 §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide assistance removing facial hair for 2 of 2 residents reviewed who were dependent upon staff for hygiene assistance. Findings include: R32's quarterly Minimum Data Set (MDS) dated 7/8/21, indicated R32 had a moderate cognitive impairment and required extensive assistance with personal hygiene. R32's diagnoses included dementia with behavioral disturbance. R32's care plan revised 9/28/20, indicated, "Grooming: limited assist of 1." On 9/13/21, at 1:30 p.m. R32 was observed to have 1/4 inch long hairs across her chin. R32 stated she did not want hair on her chin and needed staff's help to remove it. R32 stated she would like her chin hairs removed daily. R32 was unsure when staff last assisted her with shaving. On 9/14/21, at 1:52 p.m. R32's chin hair remained unchanged. R32 stated staff had not offered to assist her removing the hair. On 9/15/21, at 10:08 a.m. R32's chin hair remained unchanged. During an interview on 9/15/21, at 7:47 a.m. nursing assistant (NA)-B stated R32 does not get	F 677	R32 and R42 have been provided assistance with removing facial hair. Dependent residents who resided at Texas Terrace a Villa Center have the potential to be affected by these practices. Dependent residents' will be assessed and facial hair will be removed per resident preference as indicated. The facility has reviewed policies and procedures relating to activities of daily living, and the policies remain current. Nursing staff will be educated on ensuring residents are receiving assistance with removal of unwanted facial hair. DON/designee will audit 5 random residents per week to ensure residents are receiving assistance with removal of unwanted facial hair. Results of the audits will be shared at QAPI. Audits will continue until discontinued by QAPI.	

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F 677	Continued From page 17 facial hair often, but needed assistance removing it when it appeared. During an interview on 9/15/21, at 12:08 p.m. clinical manager (CM)-A observed R32's facial hair and stated staff should had removed the hair. R42's quarterly MDS dated 7/27/21, indicated R42 had a severe cognitive impairment and required extensive assistance with personal hygiene. R42's diagnoses included dementia with behavioral disturbance and multiple sclerosis. R42's care plan dated 2/13/18, indicated, "Requires 1 staff participation with personal hygiene." On 9/13/21, at 1:38 p.m. R42 had numerous approximately 1/2 inch long hairs on her chin. R42 was unable to express her preference regarding facial hair. On 9/16/21, at 11:15 a.m. R42 was observed and her chin hair remained unchanged. During an interview on 9/15/21, at 7:24 a.m. NA-A stated R42 needed help removing her facial hair. NA-A stated he checked R42 for facial hair every day and removed it every other day; however, was unable to recall the last time he offered R42 assistance. During an interview on 9/15/21, at 9:45 a.m. clinical manager (CM)-A stated both nurses and nursing assistants were responsible for ensuring residents were groomed, including removing unwanted facial hair. During an interview on 9/15/21, at 10:10 a.m. the	F 677		

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F 677	Continued From page 18 director of nursing (DON) stated nursing assistants should check female residents for facial hair daily and help remove it as needed. During an interview on 9/15/21, at 11:54 a.m. NA-C stated he got R42 out of bed in the morning. NA-C confirmed he did not offer R42 assistance removing her facial hair. On 9/15/21, at 1:27 p.m. CM-A was observed removing R42's facial hair. Facility policy titled Activities of Daily Living dated 5/7/21, directed, "In accordance with the comprehensive assessment, together with respect for individual resident needs and choices our facility proves care and services for the following activities: hygiene: Bathing, dressing, grooming, and oral care."	F 677		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure daily weights were obtained for 2 of 2 residents (R85, R443) reviewed whom had daily weights ordered.	F 684	R85 and R443 no longer reside at this facility. Residents with orders for daily weights have the potential to be affected. Residents with orders for daily weights are	10/26/21

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F 684	Continued From page 19 Findings include: R85's Face Sheet dated 9/16/21, indicated R85's diagnoses included cerebral infarction (stroke), essential hypertension (high blood pressure), and chronic obstructive pulmonary disease (airflow blockage which causes breathing related issues). R85's admission Minimum Data Set dated 8/25/21, indicated R85 was cognitively intact and required extensive assistance with transfers, toileting, and personal hygiene. R85's care plan dated 8/25/21, indicated R85 had congestive heart failure with interventions which included monitoring for edema (swelling) of the legs and feet, periorbital (area around eyes), shortness of breath upon exertion, and weight gain. A Physician Progress Note dated 8/26/21, indicated R85 was admitted to the facility related to bilateral pneumonia and newly diagnosed with congestive heart failure. R85 was started on Lasix (water pill). R85 was to follow-up with cardiology and was to receive rehabilitation. R85's Physician Order Summary Report indicated R85 was ordered daily weights on 8/31/21. Review of R85's Weights and Vitals Summary from 8/31/21, to 9/16/21, revealed no weights were documented 8/31/21, through 9/6/21. Further, no weights were documented from 9/10/21, through 9/16/21. During an interview on on 9/16/21, at 10:50 a.m. licensed practical nurse (LPN)-C stated weights were not getting done per physician orders due to	F 684	being weighed daily according to orders. Daily weights are reviewed in clinical start up meeting. Policies and procedures related to obtaining weights have been reviewed and remain current. Nursing staff will be educated on ensuring weights are being obtained according to orders. DON/designee will audit 5 random residents per week to ensure residents are getting weighed according to their orders. Results of the audits will be shared at QAPI. Audits will continue until discontinued by QAPI.	

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F 684	Continued From page 20	F 684		

staffing issues at the facility. LPN-C herself and nursing assistant (NA)-G were working alone during the morning and it made it difficult to perform certain tasks including obtaining R85's weight. LPN-C stated they were usually busy when working short.

During an interview on 9/16/21, at 11:47 a.m. nursing assistant (NA)-G stated due to staffing issues, and having to work alone on the unit often, it was difficult to complete weights daily.

During a telephone interview on 9/16/21, at 12:47 p.m. nurse practitioner (NP)-B stated R85 was recently diagnosed with congestive heart failure and staff were expected to check weight daily, per physician orders.

During an interview on 9/17/21, at 8:37 a.m. the director of nursing (DON) stated weight were to be completed by staff according to physician orders.

R85's weight documentation was requested, but not provided by the facility.

Facility Weight Monitoring Guideline revised 7/1/19, directed residents would be weighted, and documentation would be recorded in Point Click Care (EMR) as specified by the physician or mid-level practitioner.
Findings include:

R443's admission Minimum Data Set (MDS) dated 9/2/21, indicated R443 was cognitively intact with diagnoses which included congestive heart failure (CHF), localized edema, and difficulty walking. R443's MDS further indicated R443 required extensive assistance with

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F 684	Continued From page 21 transfers. R443's care plan dated 8/26/21, indicated R443 had CHF and staff were directed to monitor and report and signs and symptoms of CHF which included weight gain unrelated to intake. R443's Physician Order Summary dated 8/27/21, included an order, "Daily weights in the AM [morning]." Further, staff were to update the nurse practitioner if R443's weight increased two pounds in 24 hours or five pounds in one week. Review of R443's Weights and Vitals Summary printed 9/16/21 revealed: - There was no documentation of weights for 5 of 5 opportunities in August 2021. - There was no documentation of weights for 13 of 16 opportunities in September 2021. During an interview on 9/13/21, at 1:59 p.m. R443 stated she was supposed to be weight daily, but was only weighed once since admission. During an observation on 9/15/21, at 8:22 a.m. nursing assistant (NA)-G wheeled R443 to the shower room. R443 stood on a scale and her weight was 136.15 pounds. During an interview on 9/15/21, at 8:27 a.m. NA-G stated she was just told by the nurse to obtain a weight for R443. NA-G stated she was not aware R443 required a daily weight. During an interview on 9/15/21, at 9:37 a.m. licensed practical nurse (LPN)-C stated R433 required daily weights. LPN-C stated normally a nursing assistant would obtain a weight and report it to the nurse who was responsible for a	F 684		

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F 684	Continued From page 22 resident. During an interview on 9/16/21, at 9:53 a.m. nurse practitioner (NP)-A stated daily weights were ordered for R443 and were expected to be completed and accurately documented in the electronic health record (EHR). NP-A stated a two pound difference in 24 hours would be significant. During an interview on 9/16/21, at 11:08 a.m. the director of nursing (DON) stated daily weights were expected to be done daily and accurately.	F 684		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder	F 690		10/26/21

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F 690	Continued From page 23 receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure a urinary drainage bag and catheter tubing was kept off the floor to prevent cross contamination and potential infection for 1 of 1 residents (R42) reviewed for catheters. Findings include: R42's quarterly Minimum Data Set (MDS) dated 7/27/21, indicated R42 had a severe cognitive impairment, an indwelling catheter, and required extensive assistance with toilet use. R42's diagnoses included neuromuscular dysfunction of the bladder, dementia, and multiple sclerosis. R42's care plan dated 2/13/18 indicated, "Alteration in urinary elimination r/t [related to] suprapubic catheter." On 9/14/21, at 1:57 p.m. R42 was observed lying in bed. R42's urinary drainage bag was placed on a fall mat next to R42's bed. The fall mat was visibly soiled with three quarter-sized brown spots and gray and brown smudges. At 2:25 p.m. registered nurse (RN)-A observed the urinary	F 690	R42's urinary drainage bag and catheter tubing are being stored in a basin to prevent them from touching the floor. Residents who have urinary catheters who resided at Texas Terrace a Villa Center have the potential to be affected by these practices. Residents' urinary catheter drainage bags and tubing are being kept off the floor. The facility has reviewed policies and procedures relating to indwelling catheter management, and the policies remain current. Nursing staff will be educated on keeping catheter drainage bags and tubing off the floor to prevent cross contamination and potential infection by 10/26/2021. DON/designee will audit 5 random residents per week to ensure residents are receiving assistance with removal of unwanted facial hair. Results of the audits will be shared at QAPI. Audits will continue until discontinued by QAPI.	

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F 690	Continued From page 24 drainage bag lying on the fall matt, next to R42's bed, and stated there was no concern. On 9/15/21, at 7:20 a.m. R42 was lying in bed. R42's urinary drainage bag was placed on the visibly soiled fall matt next to the bed. On 9/15/21, at 7:55 a.m. clinical manager (CM)-A stated when R42 was in bed the urinary drainage bag should be hung from the side rail or bed frame. The urinary drainage bag should not be placed on the floor or fall matt. CM-A stated R42 needed her bed in the lowest position as a fall intervention and if the urinary drainage bag has hung from the bed it would still touch the floor. CM-A stated there was "no change of infection) as it was a "closed system." On 9/15/21, at 10:13 a.m. the director of nursing (DON) stated catheters needed to be hooked on a bed whenever a resident was in bed. The DON added if a resident's bed needed to be in the lowest position, the urinary drainage bag should not be touching the floor or fall mat. The DON stated the urinary drainage bag should be kept in a basin to prevent it from touching the floor for infection control purposes. Facility policy titled Urinary Indwelling Catheter Management Guideline effective 11/28/17, directed, "Drainage collection devices will remain off all floor surfaces at all times to eliminate the exposure of microorganisms.	F 690		
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	F 732		10/26/21

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F 732	Continued From page 25 must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (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 interview and document review, the facility failed to ensure the posted nurse staffing hours accurately reflected the hours worked each	F 732	The daily facility staffing postings from 09/01/2021 through 09/14/2021 have been updated to accurately reflect the	

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F 732	Continued From page 26 day. This had the potential to affect all 92 residents who resided at the facility. Findings include: During a comparison review of daily schedules and daily facility postings of staffed hours from 9/1/21, through 9/14/21, the posted hours did not accurately reflect the number of nursing hours worked in the facility. The comparisons reflected the for 7 of the 14 days reviewed, the nursing hours posted were higher than the actual nursing hours worked reflected on the schedule. During an interview on 9/16/21, at 2:28 p.m. the director of nursing (DON) stated the scheduler posted schedules and was responsible to update the posted nursing hours worked. The DON stated the posted nurse staffing hours needed to be updated for sick calls and partial shifts. The DON stated her expectation was for the postings to be updated by the scheduler or night supervisor. During an interview on 9/16/21, at 2:49 p.m. the administrator stated they expected the posted nursing hours to be adjusted in real time. The administrator confirmed the nurse staff postings were not updated, but it was her expectation. A facility policy for staffing and scheduling was requested but was not received.	F 732	number of hours worked in the facility. Daily facility staffing postings are being posted daily and updated in real time. Nursing staff and management team to be educated on daily staffing postings and updating postings in real time to accurately reflect the number of hours worked in the facility. Administrator/designee will audit daily facility staffing postings once per week to ensure they accurately reflect the number of hours worked in the facility. Results of the audits will be shared at QAPI. Audits will continue until discontinued by QAPI.	
F 880 SS=E	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	F 880		10/26/21

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F 880	Continued From page 27 designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (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	F 880		

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F 880	Continued From page 28 least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to follow the Centers for Disease Control (CDC) guidelines to prevent and/or minimize the transmission of COVID-19 related to the proper utilization of personal protective equipment (PPE) including facemasks and eye protection. This had the potential to affect 22 residents who resided on the Willows neighborhood. Findings include: R8's admission Minimum Data Set (MDS) dated 5/24/21, indicated R8 had intact cognition and ate independently.	F 880	No residents were affected by the deficient practice. Residents who reside on the Willows unit have the potential be affected. All staff who work on the Willows unit are wearing PPE appropriately. Policies and procedures related to PPE including masks, gowns, and transmission-based precautions were reviewed, and the policies remain current. The DON will educate staff from all departments on standard infection control practices including transmission-based precautions, appropriate PPE use, and donning and doffing of PPE. Documented	

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F 880	Continued From page 29 R35's quarterly MDS dated 7/15/21, indicated R35 had intact cognition and ate independently. R91's significant change MDS dated 8/25/21, indicated R91 had severely impaired cognition and needed extensive assistance with locomotion. On 9/13/21, at 6:21 p.m. dietary aide (DA)-A was observed dishing meals in a satellite kitchen located in the Willows neighborhood dining room. A facemask was pulled below DA-A's nose. DA-A delivered soup to R8 who was seated in the dining room. DA-A was within two feet from R8 for approximately one minute. DA-A remained in the dining room with her mask pulled below her nose throughout the meal service and clean-up which was approximately 20 minutes. 14 residents were noted in the Willows neighborhood dining room. On 9/14/21, at 12:21 p.m. DA-A was observed scooping ice from an ice machine with her mask below her nose. On 9/15/21, at 9:05 a.m. DA-A dished up meals in a satellite kitchen in the Willows neighborhood dining room. No staff or resident's were near DA-A at this time. A facemask was pulled below DA-A's nose. DA-A stood next to R35 with her mask below her nose while she assisted the resident peeling a banana. DA-A was within one foot of R35 for approximately one minute. DA-A remained in the dining room with her mask below her nose throughout the meal service which was approximately 30 minutes. 16 residents were noted in the Willow neighborhood dining room. On 9/15/21, at 9:24 a.m. trained medication	F 880	competency testing of staff will be completed. Residents and their representatives will receive education on the facility's infection control program. DON/designee will audit aerosolizing generating procedures to ensure PPE is in use; donning and doffing of PPE with transmission-based precautions; and proper use of gowns, eyewear, and masks. Audits will be conducted audited on all shifts 4 times a week for 1 week, then 2 times per week for 1 week until 100% compliance is met. Results of the audits will be shared at QAPI. Audits will continue until discontinued by QAPI.	

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F 880	Continued From page 30 assistant (TMA)-A brought an unidentified resident medication in the Willows neighborhood dining room. TMA-A sat next to the resident for approximately two minutes and their face shield was pulled above their eyes. On 9/15/21, at 12:18 p.m. DA-A placed trays of food in a steam table in the satellite kitchen located in the Willows neighborhood dining room. DA-A adjusted her facemask two times by pulling on the outside of the mask. DA-A facemask was below her nose. DA-A did not perform hand hygiene and proceeded to dish up meals. 15 residents were noted in the Willows neighborhood dining room. On 9/15/21, at 12:21 p.m. TMA-A entered the Willows neighborhood dining room with a face shield on top of her head and mask below her nose. On 9/15/21, at 1:48 p.m. TMA-A was observed seated at the nurses' station with her face shield on top of her head and mask below her nose. R8 was within three feet of TMA-A and visited for five minutes. On 9/15/21, at 1:53 p.m. TMA-A assisted R91 put on a facemask and transported her off the unit for a family visit. TMA-A's face shield was on the top of her head and her mask was below her nose. On 9/16/21, at 9:00 a.m. the director of nursing (DON) stated all staff were expected to wear a surgical face mask which covered both their mouth and nose. Further, staff were expected to wear goggles or a face shield which covers the eyes. The DON stated all staff completed training on the appropriate use of PPE on 7/13/21.	F 880		

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F 880	Continued From page 31 Facility policy titled Guideline for Standard and Transmission-based Precautions revised 11/9/20, directed, ""Standard [transmission-based] precautions are used for all resident care. As noted by the CDC [Centers for Disease Control and Prevention], these precautions make use of common-sense practice and personal protective equipment use that protect healthcare providers from infection and prevent the spread of infection from patient to patient. These precautions include: Perform hand hygiene, Use personal protective equipment (PPE) whenever there is an expectation of possible exposure to infectious materials."	F 880		
F 921 SS=E	Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i) §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure privacy curtains, resident walls, and fall mats were clean and/or in good repair for 4 of 4 residents (R42, R33, R28, R10) reviewed for environment. Findings include: R42's quarterly Minimum Data Set (MDS) dated 7/27/21, indicated R42 had a severe cognitive impairment. R42's diagnoses included dementia with behavioral disturbance. On 9/13/21, at 1:36 p.m. R42's privacy curtain	F 921	R42, R33, R28 and R10 all received clean privacy curtains. R42's fall mat was replaced and wall was cleaned. All residents have the potential to be affected by this deficient practice. All resident rooms will be audited to ensure privacy curtains, fall mats, and walls are clean and in good repair. The facility has reviewed policies and procedures relating to Environmental Services Cleaning Guidelines, and the policies remain current. Staff from all departments will be educated on cleanliness and repair of	10/26/21

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F 921	Continued From page 32 was observed to have three circular one inch sized dark brown spots of dried material. Additionally, 20 various sized light brown spots, which were dry, were noted on the privacy curtain. Four areas on the wall, above R42 bed, contained a dried light brown substance. Further, a fall matt which was placed next to R42's bed had a four inch tear which exposed the interior foam. R33's annual MDS dated 7/13/21, indicated R33 had a severe cognitive impairment. R33's diagnoses included dementia. On 9/13/21, at 3:07 p.m. R33's privacy curtain was observed to have multiple light brown spots and a finger-tip sized brown spot near the bottom of the curtain. R28's quarterly MDS dated 7/1/21, indicated R28 had a moderate cognitive impairment. R33's diagnoses included dementia. On 9/13/21, at 4:57 p.m. R28's privacy curtain was observed to have three reddish/brown finger-tipped sized spots of dried material. R10's quarterly MDS dated 6/10/21, indicated R28 had intact cognition. R10's diagnoses included diabetes. On 9/15/21, at 8:22 a.m. R10's privacy curtain was observed to have a large brown stain across the bottom of the curtain. R10 stated the stains were there since he was admitted in March 2020. On 9/14/21, at 2:02 p.m. nursing assistant (NA)-D stated all staff were responsible to maintain a clean environment and ensuring items used for	F 921	privacy curtains, walls, and floor mats. Administrator/designee will audit 5 random resident rooms per week to ensure privacy curtains are clean, walls are clean, and fall mats are clean and in good repair. Results of the audits will be shared at QAPI. Audits will continue until discontinued by QAPI.	

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	245187	A. BUILDING _____ B. WING _____	C 09/17/2021

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F 921	Continued From page 33	F 921		

resident care were in good repair. If privacy curtains were soiled, staff needed to report it to housekeeping who will remove it. NA-D stated housekeeping cleaned rooms daily.

On 9/14/21, at 2:06 p.m. the director of housekeeping stated to ensure a clean environment he checked all resident rooms weekly. This included checking the cleanliness of privacy curtains, furniture in the room, medical equipment, and walls. The director of housekeeping stated he planned to remove R32's privacy curtain so it could be cleaned and he was not aware of soiling in R33's room.

On 9/14/21, at 2:25 p.m. registered nurse (RN)-A observed R42's fall mat and stated it was the nurses responsibility to ensure the fall mat was placed for safety, but housekeeping's responsibility to ensure it was clean. RN-A confirmed the fall mat was ripped in multiple locations and foam was exposed.

On 9/14/21, at 2:28 p.m. clinical manager (CM)-A observed the floor mat in R42's room and stated it was concerning due to its overall condition. CM-A stated if a fall mat needed to be repaired or replaced the staff who observed the concern should report it to the director of nursing (DON). CM-A stated if privacy curtains were soiled any staff could report it to housekeeping for it to be changed. CM-A stated privacy curtains were changed as needed and was unaware of a schedule for routine checks.

On 9/15/21, at 7:31 a.m. housekeeper (HSK)-A stated housekeeping should wipe down walls and furniture in resident rooms daily. HSK-A stated each housekeeper has a daily checklist which is

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F 921	Continued From page 34 completed and turned in at the end of their shift. On 9/15/21, at 10:09 a.m. the director of nursing (DON) stated all staff needed to report items that needed to be repaired. R42's fall mat was removed at this time. Facility policy titled Environmental Services Cleaning Guidelines (2017) directed, "It is important that a clean, safe and sanitary environment is maintained for our residents."	F 921		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

October 12, 2021

Administrator
Texas Terrace A Villa Center
7900 West 28th Street
Saint Louis Park, MN 55426

Re: State Nursing Home Licensing Orders
Event ID: ZFW011

Dear Administrator:

The above facility was surveyed on September 13, 2021 through September 17, 2021 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

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

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

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

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

Jamie Perell, Unit Supervisor
Metro B District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: jamie.perell@state.mn.us
Office: (651) 245-8094

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

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

Please feel free to call me with any questions.

Sincerely,

Kamala Ritke-Downing

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

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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 9/13/21, through 9/17/21, a licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found NOT in compliance with the MN State Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you have reviewed	2 000		

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2 000	Continued From page 1 these orders, and identify the date when they will be completed. The following complaint was found to be SUBSTANTIATED, however, no licensing orders were issued: H5187170C (MN00048606) The following complaints were found to be UNSUBSTANTIATED: H5187165C (MN00074615, MN00073085, MN00070319, MN00069280) H5187166C (MN00073954) H5187167C (MN00052544) H5187168C (MN00049147) H5187169C (MN00049815) H5187173C (MN00074171) H5187175C (MN00076604) 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 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/inf	2 000		

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2 000	Continued From page 2 obul.htm The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 265	MN Rule 4658.0085 Notification of Chg in Resident Health Status A nursing home must develop and implement policies to guide staff decisions to consult physicians, physician assistants, and nurse practitioners, and if known, notify the resident's legal representative or an interested family member of a resident's acute illness, serious accident, or death. At a minimum, the director of nursing services, and the medical director or an attending physician must be involved in the development of these policies. The policies must have criteria which address at least the appropriate notification times for: A. an accident involving the resident which results in injury and has the potential for requiring	2 265		10/26/21

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2 265	Continued From page 3 physician intervention; B. a significant change in the resident's physical, mental, or psychosocial status, for example, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications; C. a need to alter treatment significantly, for example, a need to discontinue an existing form of treatment due to adverse consequences, or to begin a new form of treatment; D. a decision to transfer or discharge the resident from the nursing home; or E. expected and unexpected resident deaths. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure the physician was notified of a pattern of increased blood glucose levels for 1 of 1 resident (R10) who received insulin. Findings include: According to the American Diabetes Association (ADA), the recommended blood glucose range (before meals) was 80 - 130 milligrams (mg) per deciliter (dL). R10's quarterly Minimum Data Set (MDS) dated 6/10/21, indicated R10 had intact cognition and diagnoses of type 2 diabetes mellitus and visual disturbances. R10's Order Summary Report dated 9/16/21, indicated R10 was ordered the following:	2 265	Corrected	

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2 265	Continued From page 4 - Blood glucose check three times daily before meals for diabetes mellitus dated 4/29/21. - R10 was okay to check her own blood glucose and administer Humalog and Lantus insulin under nursing supervision dated 1/10/21. - Humalog 100 units (u)/milliliter (mL). Inject 5 units subcutaneously (injection in fat tissue) with meals for diabetes mellitus unsupervised self-administration. Lantus 100 u/mL. Inject 10 units subcutaneously in the evening for diabetes mellitus. Review of R10 Weights and Vitals Summary report dated 9/16/21, indicated 44 blood glucose levels were documented for R10 in the month of September which were all above recommended ranges by the ADA. Results included: - 156 - 199 mg/dl: 3 - 200 - 299 mg/dl: 24 - 300 - 399 mg/dl: 14 - 400 and greater mg/dl: 3 During an interview on 9/16/21, at 8:53 a.m. R10 she was not ordered sliding scale insulin (insulin dosing dependent upon blood glucose result) and always took the same dose. R10 stated staff did not monitor her blood glucose levels or ask her if she had symptoms when her blood glucose level was high. R10 stated staff did not supervise her when taking her blood glucose and she handed a nurse or trained medication assistant (TMA) a piece of paper with the result. During an interview on 9/16/21, at 9:14 a.m. TMA-B stated she would inform the nurse if R10's blood glucose was high and the nurse would call the doctor. During an interview on 9/16/21, at 9:19 a.m. licensed practical nurse (LPN)-B stated, "We	2 265		

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2 265	Continued From page 5 should be monitoring R10's blood sugar and notify the provider [if blood glucose levels were out of range]." During an interview on 9/16/21, at 9:56 a.m. registered nurse (RN)-B stated nurses should had monitored R10's blood glucose levels and alerted the physician when her results were high/low. RN-B stated when R10 had a high blood sugar level, staff should had asked R10 if she had any symptoms. RN-B confirmed nurses did not notify R10's physician and stated it was because R10 had fired the facility provided and would not provide the facility the name of a new physician. During an interview on 9/16/21, at 11:19 a.m. the director of nursing (DON) stated she expected R10's blood glucose levels to be monitored and to notify the provider of high blood glucose levels. During an interview on 9/16/21, at 1:20 p.m. LPN-D stated R10's blood glucose was 433 mg/dL on 9/15/21 at 6:00 p.m., however, did not call the doctor because, "It isn't new for her and she didn't have time." During an interview on 9/16/21, at 9:39 a.m. nurse practitioner (NP)-B stated she facility should had monitored R10's blood glucose levels and notified the provider. A medication administration policy was requested but not provided. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON), or designee, could work with the medical director and update applicable policies and procedures regarding notifying the physician.	2 265		

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2 265	Continued From page 6 The DON, or designee, could provide education to staff regarding applicable policies and procedures. The DON, or designee, could perform audits to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 265		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to develop a comprehensive person-centered care plan to reflect individualized goals for 1 of 4 residents (R38) reviewed for care planning. Findings include: R38's admission Minimum Data Set (MDS) dated 7/26/21, indicated R38 had a mild cognitive impairment and required one to two person physical assistance with most activities of daily living (ADLs). R38's MDS further indicated R38's diagnoses included dysphagia (difficulty swallowing), right sided hemiplegia/hemiparesis (paralysis/weakness affecting half of the body), and major depressive disorder. The MDS further indicated R38 received occupational and physical	2 565	Corrected	10/26/21

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2 565	Continued From page 7 therapy. R38's care plan dated 7/21/21, indicated R38, "has (SPECIFY) actual/potential for an ADL self-care performance deficit r/t [related to]." 38's goal was documented as, "The resident will maintain current level of function in (SPECIFY) through the review date." Interventions included, "Monitor/document/report PRN [as needed] any changes, any potential for improvement, reasons, for self-care deficit, expected course, declines in function" and "Encourage to use bell to call for assistance." Further, R38's care plan indicated, "The resident has (SPECIFY: URGE, STRESS, FUNCTIONAL, MIXED) bladder incontinence r/t" and "Has a psychosocial well-being problem (actual or potential) r/t Illness/Disease process (SPECIFY:), Recent admission" with no associated goal or interventions. R69's admission MDS dated 8/9/21, indicated R69 had moderately impaired cognition and required two person assistance with most ADLs. R69's MDS further indicated R69's diagnoses included hemiplegia/hemiparesis, dysphagia, aphasia (difficulty speaking), type 2 diabetes, and cerebral infarction (stroke). During an interview on 9/16/21, at 10:16 a.m. registered nurse (RN)-C stated care plans identify areas of concern, goals, and interventions. RN-C stated the comprehensive care plan should accurately reflect a residents current plan of care. During an interview on 9/16/21, at 10:52 a.m. the director of nursing (DON) stated the expectation was a comprehensive care plan would be person-centered and individualized for each resident. The DON stated R38's care plan was overdue for review and including "SPECIFY" in	2 565		

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2 565	Continued From page 8 brackets was not individualized and would not be considered comprehensive. During an interview on 9/16/21, at 12:12 p.m. social services designee (SSD)-B stated a comprehensive care plan should be person centered and individualized. SSD-B stated documenting "SPECIFY" in brackets was not individualized. Facility policy titled Care Plan Guidelines dated 11/28/17, indicated the facility must develop and implement a comprehensive person-centered care plan for each resident. The care plan must include measurable objectives and timeframes to meet a resident's needs. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON), or designee, review and/or revise applicable policies and procedures to ensure resident care plans are individualized. The DON, or designee, could educate staff to ensure each residents care plan is individualized. The DON, or designee, could then perform audits to ensure each residents care plan is individualized TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 565		
2 915	MN Rule 4658.0525 Subp. 6 A Rehab - ADLs Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that: A. a resident is given the appropriate treatments and services to maintain or improve abilities in activities of daily living unless	2 915		10/26/21

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 915	Continued From page 9 deterioration is a normal or characteristic part of the resident's condition. For purposes of this part, activities of daily living includes the resident's ability to: (1) bathe, dress, and groom; (2) transfer and ambulate; (3) use the toilet; (4) eat; and (5) use speech, language, or other functional communication systems; and This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure assistance was provided with removing facial hair and dressing and/or bathing was for 2 of 4 residents (R58, R3) who required staff assistance with activities of daily living (ADL). R58's quarterly Minimum Data Set (MDS) dated 8/11/21, identified R58 had diagnoses of chronic kidney failure, heart failure, and diabetes. R58 had intact cognition, used a walker for mobility, and required set up assistance with bathing. R58's Active Order Summary dated 9/16/21, indicated R58 received dialysis on Tuesday, Thursday, and Saturday. R58's dialysis dressing was to be removed the day after dialysis. R58's care plan dated 3/25/21, indicated R58 would continue to make daily preferences/choices which were important to him. R58's care plan lacked evidence of bathing preferences.	2 915	Corrected	

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2 915	Continued From page 10 R58's Nursing Assistant task sheet (undated) indicated R58 was scheduled for showers on Saturday evenings and required assistance with bathing. R58's Nursing Assistant Task documentation dated 9/15/21, indicated R58's bathing schedule was Friday afternoons. The bathing schedule lacked documentation R58 had a shower and/or refused in the past 30 days. During an observation on 9/13/21, at 5:50 p.m. R58 had on a soiled tee-shirt and a pair of gray shorts. R58 appeared unkempt. R58 stated they were frustrated with staff wanting to provide them showers on Saturday. R58 stated their dialysis dressing was on until the next day and should not come off. R58 stated, "They just don't get it." R58 stated they wanted a shower on Sundays, but that does not get to. During an interview on 9/15/21, at 9:32 a.m. nursing assistant (NA)-E stated they were unaware of R58's shower day. NA-E stated R58 should have a shower on a day he does not go to dialysis. R58 can ask any time and would be helped with a shower. During an interview on 9/15/21, at 9:45 a.m. licensed practical nurse (LPN)-B stated there was a shower schedule at the main desk which was how nursing assistant knew when to shower residents. LPN-B stated if R58 asked for a shower on a different day, R58 would get one. During an interview on 9/16/21, at 9:30 a.m. R58 stated it had been three weeks since he had a shower. R58 stated, "I want a shower on Sunday, and I will ask for a shower on Sunday. They say there were too busy and never come back." R58	2 915		

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2 915	Continued From page 11	2 915		

stated staff offered to give him a shower on Saturday, but the dialysis dressing was still on. R58 stated a shower was not offered any other time during the week. R58 had on the same soiled tee-shirt and gray shorts as 9/13/21.

During an interview on 9/16/21, at 1:06 p.m. registered nurse (RN)-B stated she shower schedule was based on room numbers. RN-B verified the shower scheduled showed R58's shower was listed on Saturday evening. RN-B stated the list was a system to help organize the work and if residents requested a shower, it was provided. RN-B stated if a shower was missed or refused, the nursing assistant needed to tell the nurse, document, and try again later. RN-B was not aware of R58's shower preference. RN-B believed R58 came from another floor and stated R58 was not asked about his shower preference since he arrived to the unit.

During an interview on 9/16/21, at 3:38 p.m. the director of nursing (DON) stated residents had a scheduled shower day, but could ask outside of that time. If a resident asked, they should receive a shower. If staff were to find out a resident's preference for a shower day or time, it needed to be communicated. The nurse can update the care plan and care guides.

R3's Face Sheet dated 5/27/21, indicated R3's diagnoses included Alzheimer's disease, urinary incontinence, and altered mental status.

R3's admission Minimum Data Set (MDS) dated 6/3/21, indicated R3 had a severe cognitive impairment.

R3's quarterly MDS dated 9/3/21, indicated R3 required supervision with bed mobility and

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2 915	Continued From page 12 dressing. Further, R3 required extensive assistance toileting and personal hygiene was not assessed. R3's care plan dated 5/27/21, indicated R3 had an actual ADL deficit self-care performance related to dementia and impaired balance. The care plan further indicated R3 did not like her facial hair shaved and preferred tweezers. An intervention was added on 9/16/21, which indicated offering R3 tweezers and assistance with facial hair. R3 required supervision of one staff with personal hygiene. Staff were to ensure R3's clothing was changed at least every two days. During an observation on 9/13/21, at 5:36 p.m. R3 was seated on a rolling walker near the nurses station and talking. R3 was noted to have hair on her lower chin which was several inches long. R3 was wearing a gray long-sleeved shirt and pajama pants. During an observation on 9/15/21, at 12:20 p.m. R3 was seated on a rolling walker. R3 was wearing a gray long-sleeved shirt and pajama pants. The hair remained on R3's lower chin. During an observation on 9/16/21, at 9:04 a.m. R3 was in her room and seated on her bed. R3's room smelled of urine and R3 stated, "I am soaked. I have been sitting her in wet clothing and no one was helping." R3 was on a cellular phone and stated she was trying to reach her niece as no one was available to assist her getting changed. R3 was wearing the same long sleeved gray shirt and pajama pants seen on 9/13/21. The hair remained on R3's lower chin. During an interview on 9/15/21, at 12:47 p.m.	2 915		

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2 915	Continued From page 13 nursing assistant (NA)-A stated no "one" nursing assistant was assigned to R3 and the nursing assistants worked as a team. NA-A stated they sometimes provide R3 assistance with cares and R3 was able to toilet herself. NA-A stated R3 sometimes soaked the bed and staff assisted providing care. NA-A stated he had not went into R3's room during his shift. During an interview on 9/15/21, at 2:46 p.m. NA-J stated nursing assistants worked in a group together and no one was assigned to R3. NA-J stated nursing assistants worked as a team. NA-J stated R3 turned on her call light when she needed assistance with dressing, grooming, and toileting. R3 was confused, able to ambulate independently, and was sometimes incontinent of urine. During an interview on 9/15/21, at 12:29 p.m. R3 stated she did not like hairs to her lower chin, but did not like the hairs shaved and preferred tweezers to be used. R3 stated a tweezer was better for getting hair out at the roots. R3 stated if she had tweezers she would be able to remove the hairs, however, one was not provided. During an interview on 9/16/21, at 3:00 p.m. the director of nursing (DON) stated it was expected staff provide assistance removing facial hair on bath days and as needed. Further, staff were to provide hygiene assistance as indicated on the care plan. Facility policy titled Activities of Daily Living dated 5/7/20, directed the collaborative professional team, together with the resident and resident representative would recognize and evaluate the inability to perform ADLs or the risk for decline in any ability to perform ADLs.	2 915		

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2 915	Continued From page 14 SUGGESTED METHOD FOR CORRECTION: The director of nursing (DON), or designee, could review and/or revise policies and procedures regarding activities of daily living. The DON, or designee, could provide education for all staff on these policies and procedures. The DON, or designee, could conduct audits to ensure all residents are receiving assistance with grooming. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 915		
2 920	MN Rule 4658.0525 Subp. 6 B Rehab - ADLs Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that: B. a resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide assistance removing facial hair for 2 of 2 residents who were dependent upon staff for hygiene assistance. Findings include: R32's quarterly Minimum Data Set (MDS) dated 7/8/21, indicated R32 had a moderate cognitive impairment and required extensive assistance with personal hygiene. R32's diagnoses included dementia with behavioral disturbance.	2 920	Corrected	10/26/21

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2 920	Continued From page 15 R32's care plan revised 9/28/20, indicated, "Grooming: limited assist of 1." On 9/13/21, at 1:30 p.m. R32 was observed to have 1/4 inch long hairs across her chin. R32 stated she did not want hair on her chin and needed staff's help to remove it. R32 stated she would like her chin hairs removed daily. R32 was unsure when staff last assisted her with shaving. On 9/14/21, at 1:52 p.m. R32's chin hair remained unchanged. R32 stated staff had not offered to assist her removing the hair. On 9/15/21, at 10:08 a.m. R32's chin hair remained unchanged. During an interview on 9/15/21, at 7:47 a.m. nursing assistant (NA)-B stated R32 does not get facial hair often, but needed assistance removing it when it appeared. During an interview on 9/15/21, at 12:08 p.m. clinical manager (CM)-A observed R32's facial hair and stated staff should had removed the hair. R42's quarterly MDS dated 7/27/21, indicated R42 had a severe cognitive impairment and required extensive assistance with personal hygiene. R42's diagnoses included dementia with behavioral disturbance and multiple sclerosis. R42's care plan dated 2/13/18, indicated, "Requires 1 staff participation with personal hygiene." On 9/13/21, at 1:38 p.m. R42 had numerous approximately 1/2 inch long hairs on her chin. R42 was unable to express her preference	2 920		

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2 920	Continued From page 16 regarding facial hair. On 9/16/21, at 11:15 a.m. R42 was observed and her chin hair remained unchanged. During an interview on 9/15/21, at 7:24 a.m. NA-A stated R42 needed help removing her facial hair. NA-A stated he checked R42 for facial hair every day and removed it every other day; however, was unable to recall the last time he offered R42 assistance. During an interview on 9/15/21, at 9:45 a.m. clinical manager (CM)-A stated both nurses and nursing assistants were responsible for ensuring residents were groomed, including removing unwanted facial hair. During an interview on 9/15/21, at 10:10 a.m. the director of nursing (DON) stated nursing assistants should check female residents for facial hair daily and help remove it as needed. During an interview on 9/15/21, at 11:54 a.m. NA-C stated he got R42 out of bed in the morning. NA-C confirmed he did not offer R42 assistance removing her facial hair. On 9/15/21, at 1:27 p.m. CM-A was observed removing R42's facial hair. Facility policy titled Activities of Daily Living dated 5/7/21, directed, "In accordance with the comprehensive assessment, together with respect for individual resident needs and choices our facility proves care and services for the following activities: hygiene: Bathing, dressing, grooming, and oral care." SUGGESTED METHOD OF CORRECTION:	2 920		

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2 920	Continued From page 17 The director of nursing (DON), or designee, could educate staff to provide activity of daily living assistance to dependent residents. The DON, or designee, could conduct audits of resident cares to ensure their personal hygiene needs are met. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 920		
21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to follow the Centers for Disease Control (CDC) guidelines to prevent and/or minimize the transmission of COVID-19 related to the proper utilization of personal protective equipment (PPE) including facemasks and eye protection. This had the potential to affect 22 residents who resided on the Willows neighborhood. Findings include: R8's admission Minimum Data Set (MDS) dated 5/24/21, indicated R8 had intact cognition and ate independently. R35's quarterly MDS dated 7/15/21, indicated R35 had intact cognition and ate independently.	21375	Corrected	10/26/21

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21375	Continued From page 18 R91's significant change MDS dated 8/25/21, indicated R91 had severely impaired cognition and needed extensive assistance with locomotion. On 9/13/21, at 6:21 p.m. dietary aide (DA)-A was observed dishing meals in a satellite kitchen located in the Willows neighborhood dining room. A facemask was pulled below DA-A's nose. DA-A delivered soup to R8 who was seated in the dining room. DA-A was within two feet from R8 for approximately one minute. DA-A remained in the dining room with her mask pulled below her nose throughout the meal service and clean-up which was approximately 20 minutes. 14 residents were noted in the Willows neighborhood dining room. On 9/14/21, at 12:21 p.m. DA-A was observed scooping ice from an ice machine with her mask below her nose. On 9/15/21, at 9:05 a.m. DA-A dished up meals in a satellite kitchen in the Willows neighborhood dining room. No staff or resident's were near DA-A at this time. A facemask was pulled below DA-A's nose. DA-A stood next to R35 with her mask below her nose while she assisted the resident peeling a banana. DA-A was within one foot of R35 for approximately one minute. DA-A remained in the dining room with her mask below her nose throughout the meal service which was approximately 30 minutes. 16 residents were noted in the Willow neighborhood dining room. On 9/15/21, at 9:24 a.m. trained medication assistant (TMA)-A brought an unidentified resident medication in the Willows neighborhood dining room. TMA-A sat next to the resident for approximately two minutes and their face shield	21375		

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21375	Continued From page 19 was pulled above their eyes. On 9/15/21, at 12:18 p.m. DA-A placed trays of food in a steam table in the satellite kitchen located in the Willows neighborhood dining room. DA-A adjusted her facemask two times by pulling on the outside of the mask. DA-A facemask was below her nose. DA-A did not perform hand hygiene and proceeded to dish up meals. 15 residents were noted in the Willows neighborhood dining room. On 9/15/21, at 12:21 p.m. TMA-A entered the Willows neighborhood dining room with a face shield on top of her head and mask below her nose. On 9/15/21, at 1:48 p.m. TMA-A was observed seated at the nurses' station with her face shield on top of her head and mask below her nose. R8 was within three feet of TMA-A and visited for five minutes. On 9/15/21, at 1:53 p.m. TMA-A assisted R91 put on a facemask and transported her off the unit for a family visit. TMA-A's face shield was on the top of her head and her mask was below her nose. On 9/16/21, at 9:00 a.m. the director of nursing (DON) stated all staff were expected to wear a surgical face mask which covered both their mouth and nose. Further, staff were expected to wear goggles or a face shield which covers the eyes. The DON stated all staff completed training on the appropriate use of PPE on 7/13/21. Facility policy titled Guideline for Standard and Transmission-based Precautions revised 11/9/20, directed, ""Standard [transmission-based] precautions are used for all resident care. As	21375		

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21375	Continued From page 20 noted by the CDC [Centers for Disease Control and Prevention], these precautions make use of common-sense practice and personal protective equipment use that protect healthcare providers from infection and prevent the spread of infection from patient to patient. These precautions include: Perform hand hygiene, Use personal protective equipment (PPE) whenever there is an expectation of possible exposure to infectious materials." SUGGESTED METHOD OF CORRECTION: The director of nursing (DON), or designee, could review and/or revise facility policies to related to personal protective equipment (PPE). The DON, or designee, could educate staff on the proper use of PPE. The DON, or designee, could perform audits to ensure policies and procedures were being followed. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21375		
21426	MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of	21426		10/26/21

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21426	Continued From page 21 Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure the completion of tuberculosis (TB) testing for 4 of 5 staff (E2, E3, E4, E5) who were employed by the facility and reviewed for TB testing. This had the potential to affect all 90 residents who resided at the facility. Further, the facility failed to ensure the completion of tuberculosis (TB) testing for 4 of 5 residents (R25, R64, R85, R443) reviewed for TB testing. Findings include: E2's hire date was 7/21/21 and a Baseline TB Screening Tool for Health Care Workers was undated and indicated E2 had a negative Tuberculin skin test (TST) March 2021 but failed to indicate any documentation of a step 2 TST. E3's hire date was 7/19/21 and a Baseline TB Screening Tool for Health Care Workers was undated failed to show any documentation of step 1 or step 2 TST. E4's hire date was 7/21/21 and a Baseline TB Screening Tool for Health Care Workers was dated 9/16/21 failed to show any documentation	21426	Corrected	

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21426	Continued From page 22 of a step 1 or step 2 TST. E5's hire date was 8/18/21 and a Baseline TB Screening Tool for Health Care Workers was dated 9/16/21 and failed to show any documentation of a step 1 or step 2 TST. R25's TB screening assessment was requested but not provided. R25's electronic health record (EHR) indicated a TB step 1 TST was completed on 6/23/21 with a negative result with no indication of a TB step 2 TST. R64's TB screening assessment was requested but not provided. R64's EHR indicated a TB step 1 TST was completed on 1/3/21 with results pending. R85's TB screening assessment was requested but not provided. R443's TB screening assessment was requested but not provided. When interviewed on 9/16/21 at 2:41 p.m. director of nursing (DON) stated she did not have the TB skin test results for the staff. DON further stated having a binder with such items in it that she recently started organizing but could not find the requested results. DON stated, "I just don't have them." The facility policy Mycobacterium Tuberculosis - Interim Guidance dated 11/6/19, indicated, "Health care personnel should receive a baseline individual TB risk assessment, symptom screening, and TB testing (e.g., TB blood test or TB skin test) upon hire." SUGGESTED METHOD OF CORRECTION:	21426		

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	00144	A. BUILDING: _____ B. WING _____	C 09/17/2021

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21426	Continued From page 23 The director of nursing (DON), or designee, could monitor to assure tuberculin testing procedures were developed and implemented to ensure staff was free of tuberculosis prior to working with residents. The DON, or designee, could conduct audits to ensure TB testing was conducted. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21426		
21565	MN Rule 4658.1325 Subp. 4 Administration of Medications Self Admin Subp. 4. Self-administration. A resident may self-administer medications if the comprehensive resident assessment and comprehensive plan of care as required in parts 4658.0400 and 4658.0405 indicate this practice is safe and there is a written order from the attending physician. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure a self-administration of medication assessment was completed for 1 of 1 resident (R10) who was observed with medications at her bedside. Findings include: R10's quarterly Minimum Data Set (MDS) dated 6/10/21, indicated R10 had intact cognition and diagnoses which included type II diabetes and visual disturbances. A Physician Order dated 3/26/20, indicated levothyroxine sodium (thyroid medication) tablet 88 micrograms (mcg), give 1 tablet by mouth one	21565	Corrected	10/26/21

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21565	Continued From page 24 time daily During an observation on 9/13/21, at 3:23 p.m. R10 had a plastic medication cup which contained 10 pills. R10 stated the medications were, "from the day before." R10 stated she did not take the medications because she was legally blind and was not sure what medications were in the cup. During an observation on 9/15/21, at 7:51 a.m. trained medication assistant (TMA)-B entered R10's room to administer medications and R10 pointed to a medication cup which contained a single pill. In addition to R10's thyroid medication, another medication cup contained 10 pills was also observed. R10 stated, earlier in the day staff entered her room and she held out her hand so the nurse could hand her the medication, but no one was there. R10 stated the pill was her thyroid medication and she did not take the medication because it appeared different than the medication she had taken previously. TMA-B exited the room and reviewed R10's orders. TMA-B went back to R10's room and explained the doctor had reduced the dose of the medication, which is why it was different. TMA-B asked R10 if she was going to take the thyroid medication and she stated, "yes." TMA-B exited R10's room prior to her taking the medication. During an interview on 9/15/21, at 8:27 a.m. TMA-B verified R10 had a medication cup with 10 pills in her room. R10 stated the pills were from the previous day. During an interview on 9/16/21, at 9:56 a.m. registered nurse (RN)-B verified R10 was unable to self-administer medications and staff should ensure R10 had taken them.	21565		

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21565	Continued From page 25 During an interview on 9/16/21, at 11:19 a.m. the director of nursing (DON) stated staff were expected to ensure residents had taken their medication prior to leaving the room. Review of R10's September 2021 Medication Administration Record (MAR) revealed the following: - On 9/12/21, R10 was administered all her medications. - Contrary to observation, on 9/15/21, at 6:00 a.m. levothyroxine was documented as administered. Review of R10's medical record lacked indication a self administration of medication assessment was completed. A medication administration policy was requested, but not provided. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON), or designee, could review applicable policies and procedures to ensure residents' are assessed to determine if self administering medications was appropriate. The DON, or designee, could provide staff education regarding self-administration of medications. The quality assurance committee could monitor for compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21565		
21665	MN Rule 4658.1400 Physical Environment A nursing home must provide a safe, clean,	21665		10/26/21

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21665	Continued From page 26 functional, comfortable, and homelike physical environment, allowing the resident to use personal belongings to the extent possible. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure privacy curtains, resident walls, and fall mats were clean and/or in good repair for 4 of 4 residents (R42, R33, R28, R10) reviewed for environment. Findings include: R42's quarterly Minimum Data Set (MDS) dated 7/27/21, indicated R42 had a severe cognitive impairment. R42's diagnoses included dementia with behavioral disturbance. On 9/13/21, at 1:36 p.m. R42's privacy curtain was observed to have three circular one inch sized dark brown spots of dried material. Additionally, 20 various sized light brown spots, which were dry, were noted on the privacy curtain. Four areas on the wall, above R42 bed, contained a dried light brown substance. Further, a fall matt which was placed next to R42's bed had a four inch tear which exposed the interior foam. R33's annual MDS dated 7/13/21, indicated R33 had a severe cognitive impairment. R33's diagnoses included dementia. On 9/13/21, at 3:07 p.m. R33's privacy curtain was observed to have multiple light brown spots and a finger-tip sized brown spot near the bottom of the curtain.	21665	Corrected	

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21665	Continued From page 27 R28's quarterly MDS dated 7/1/21, indicated R28 had a moderate cognitive impairment. R33's diagnoses included dementia. On 9/13/21, at 4:57 p.m. R28's privacy curtain was observed to have three reddish/brown finger-tipped sized spots of dried material. R10's quarterly MDS dated 6/10/21, indicated R28 had intact cognition. R10's diagnoses included diabetes. On 9/15/21, at 8:22 a.m. R10's privacy curtain was observed to have a large brown stain across the bottom of the curtain. R10 stated the stains were there since he was admitted in March 2020. On 9/14/21, at 2:02 p.m. nursing assistant (NA)-D stated all staff were responsible to maintain a clean environment and ensuring items used for resident care were in good repair. If privacy curtains were soiled, staff needed to report it to housekeeping who will remove it. NA-D stated housekeeping cleaned rooms daily. On 9/14/21, at 2:06 p.m. the director of housekeeping stated to ensure a clean environment he checked all resident rooms weekly. This included checking the cleanliness of privacy curtains, furniture in the room, medical equipment, and walls. The director of housekeeping stated he planned to remove R32's privacy curtain so it could be cleaned and he was not aware of soiling in R33's room. On 9/14/21, at 2:25 p.m. registered nurse (RN)-A observed R42's fall mat and stated it was the nurses responsibility to ensure the fall mat was placed for safety, but housekeeping's responsibility to ensure it was clean. RN-A	21665		

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21665	Continued From page 28 confirmed the fall mat was ripped in multiple locations and foam was exposed. On 9/14/21, at 2:28 p.m. clinical manager (CM)-A observed the floor mat in R42's room and stated it was concerning due to its overall condition. CM-A stated if a fall mat needed to be repaired or replaced the staff who observed the concern should report it to the director of nursing (DON). CM-A stated if privacy curtains were soiled any staff could report it to housekeeping for it to be changed. CM-A stated privacy curtains were changed as needed and was unaware of a schedule for routine checks. On 9/15/21, at 7:31 a.m. housekeeper (HSK)-A stated housekeeping should wipe down walls and furniture in resident rooms daily. HSK-A stated each housekeeper has a daily checklist which is completed and turned in at the end of their shift. On 9/15/21, at 10:09 a.m. the director of nursing (DON) stated all staff needed to report items that needed to be repaired. R42's fall mat was removed at this time. Facility policy titled Environmental Services Cleaning Guidelines (2017) directed, "It is important that a clean, safe and sanitary environment is maintained for our residents." SUGGESTED METHOD OF CORRECTION: The administrator, or designee, could educate staff regarding the importance of a safe, clean, functional and homelike environment. The administrator, or designee, could coordinate with maintenance and housekeeping staff to conduct periodic audits of areas residents frequent to ensure a safe, clean, functional and homelike environment is maintained to the extent	21665		

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21665	Continued From page 29 possible. The administrator, or designee, could conduct audits to ensure ongoing compliance.	21665		

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	245187	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**09/15/2021**

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Texas Terrace A Villa Center 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) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, the 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 | 10/20/2021

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

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K 000	Continued From page 1	K 000		

Healthcare Fire Inspections
State Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101-5145, OR

By email to:
FM.HC.Inspections@state.mn.us

THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION:

1. A detailed description of the corrective action taken or planned to correct the deficiency.

2. Address the measures that will be put in place to ensure the deficiency does not reoccur.

3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained.

4. Identify who is responsible for the corrective actions and monitoring of compliance.

5. The actual or proposed date for completion of the remedy.

Texas Terrace Care Center is a 3-story building with no basement. The original building was constructed in 1972 and was determined to be of Type I(332) Construction. In 1995 an addition was constructed to the west, and it was determined to be of TYPE I(332) Construction. This facility is fully protected throughout by an automatic fire sprinkler system and has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for

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K 000	Continued From page 2 automatic fire department notification. The facility has a capacity of 112 beds and had a census of 89 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a), is NOT MET as evidenced by:	K 000		
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 _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the sprinkler system in accordance with the 2012 Life Safety Code (NFPA 101) and NFPA 25, 2011 edition Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems sections 4.1.4.1, 4.1.4.2, 4.7, 5.2.1.1.1. The Standard for	K 353	The sprinkler head in the dietary office was replaced and a escutcheon plate was installed around it. The sprinkler head in the walk in cooler was replaced. The sprinkler heads were tested and are in working order. The sprinkler system will continue to be	10/26/21

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K 353	Continued From page 3 Testing and Maintenance of Sprinkler Systems. This deficient condition could have a widespread impact on the residents within the facility. Findings include: 1) On 09/15/2021, between 9:30 AM to 1:30 PM, it was revealed in the dietary office there is a sprinkler head that has paint on it and no escutcheon plate around it. 2) On 09/15/2021 between 9:30 AM to 1:30 PM, it was revealed the documentation from 2019 from the vendor stated several deficiencies. During the Annual inspection on 3/9/2021, the deficiencies were still noted on the report. The facility has addressed the issue as of 09/13/2021. These deficient conditions were verified by Maintenance Director and Regional Maintenance Director.	K 353	audited quarterly, annually, and as needed by Summit Sprinkler System. Maintenance director or designee will audit 5 random sprinkler heads per week to ensure that they are free from paint and have escutcheon plates around them. Results of the audits will be shared at QAPI. Audits will continue until discontinued by QAPI.	