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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: ZR77
Facility ID: 00299

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245495**

2.STATE VENDOR OR MEDICAID NO.
(L2) **606318700**

3. NAME AND ADDRESS OF FACILITY
(L3) **THE EMERALDS AT GRAND RAPIDS LLC**
(L4) **2801 SOUTH HIGHWAY 169**
(L5) **GRAND RAPIDS, MN** (L6) **55744**

4. TYPE OF ACTION: **7** (L8)

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **02/01/2019**

6. DATE OF SURVEY **10/08/2020** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **93** (L18)
13.Total Certified Beds **93** (L17)

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

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

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	93			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Teresa Ament, Unit Supervisor 11/12/2020 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Joanne Simon, Enforcement Specialist 11/12/2020 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
08/01/1987
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
06201
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
10/29/2020
(L33)

DETERMINATION APPROVAL

P r o t e c t i n g , M a i n t a i n i n g a n d I m p r o v i n g t h e H e a l t h o f A l l M i n n e s o t a n s

Electronically delivered
November 12, 2020

CMS Certification Number (CCN): 245495

Administrator
The Emeralds At Grand Rapids Llc
2801 South Highway 169
Grand Rapids, MN 55744

Dear Administrator:

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

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

Effective October 30, 2020 the above facility is certified for:

93 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 93 skilled nursing facility beds.

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

Please contact me if you have any questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
November 12, 2020

Administrator
The Emeralds At Grand Rapids Llc
2801 South Highway 169
Grand Rapids, MN 55744

RE: CCN: 245495
Cycle Start Date: September 4, 2020

Dear Administrator:

On September 24, 2020, we notified you a remedy was imposed. On October 8, 2020 the Minnesota Department(s) of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of October 30, 2020.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective October 24, 2020 be discontinued as of October 30, 2020. (42 CFR 488.417 (b))

However, as we notified you in our letter of September 24, 2020, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from October 24, 2020. This does not apply to or affect any previously imposed NATCEP loss.

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

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: ZR77

Facility ID: 00299

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(L4) **2801 SOUTH HIGHWAY 169**
(L5) **GRAND RAPIDS, MN** (L6) **55744**

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

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6. DATE OF SURVEY **09/04/2020** (L34)

8. ACCREDITATION STATUS: ___ (L10)
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04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	

FISCAL YEAR ENDING DATE: (L35) **12/31**

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To (b) :

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A. In Compliance With Program Requirements Compliance Based On:
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X B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	93			
(L37)	(L38)	(L39)	(L42)	(L43)

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1861 (e) (1) or 1861 (j) (1): (L15)

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

17. SURVEYOR SIGNATURE — Date :
Sativa Bushey, HFE - NE II — 10/12/2020 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Joanne Simon, Enforcement Specialist — 10/26/2020 (L20)

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

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

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2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION **08/01/1987** (L24)

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
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03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. **06201** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

Electronically delivered
September 24, 2020

Administrator
The Emeralds At Grand Rapids Llc
2801 South Highway 169
Grand Rapids, MN 55744

RE: CCN: 245495
Cycle Start Date: September 4, 2020

Dear Administrator:

On September 4, 2020, a survey was completed at your facility by the Minnesota Department(s) of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

REMEDIES

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

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective October 24, 2020.

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

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective October 24, 2020 They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective October 24, 2020.

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

This Department is also recommending that CMS impose:

• Civil money penalty (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

NURSE AIDE TRAINING PROHIBITION

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

If you have not achieved substantial compliance by October 24, 2020, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, The Emeralds At Grand Rapids Llc will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from October 24, 2020. 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:

Teresa Ament, Unit Supervisor
Duluth Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Duluth Technology Village
11 East Superior Street, Suite 290
Duluth, Minnesota 55802-2007
Email: teresa.ament@state.mn.us
Phone: (218) 302-6151

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 4, 2021 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:

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145
Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245495	A. BUILDING ______ B. WING ______	C 09/04/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE EMERALDS AT GRAND RAPIDS LLC	**2801 SOUTH HIGHWAY 169 GRAND RAPIDS, MN 55744**

(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 A survey with CMS Appendix Z Emergency Preparedness Requirements, was conducted on 8/31/20, through 9/4/20, during a recertification survey. The facility is in compliance with the Appendix Z Emergency Preparedness Requirements.	E 000		
F 000	INITIAL COMMENTS On 8/31/20, through 9/4/20, a recertification survey and a complaint survey was conducted at your facility. Complaint investigations were also conducted. Your facility was found not to be in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were found unsubstantiated: H5595078C H5595079C H5595080C H5595081C The following complaint was found to be substantiated with no deficiencies: H5595082C The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		09/25/2020

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245495	A. BUILDING ______ B. WING ______	C 09/04/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE EMERALDS AT GRAND RAPIDS LLC	2801 SOUTH HIGHWAY 169 GRAND RAPIDS, MN 55744

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	Continued From page 1 validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
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) 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	F 580		10/7/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245495	A. BUILDING ______ B. WING ______	C 09/04/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE EMERALDS AT GRAND RAPIDS LLC	2801 SOUTH HIGHWAY 169 GRAND RAPIDS, MN 55744

(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 580	Continued From page 2 (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 observation, interview, and document review, the facility failed to ensure the primary care provider was notified timely when weight gained and edema occurred for 1 of 3 residents (R18) reviewed for edema. R18's Admission Record printed 9/4/20, indicated R18's diagnoses included hypertension, and acute respiratory failure. R18's Minimum Data Set (MDS) dated 8/19/20, indicated R18 was cognitively intact, required limited assistance with bed mobility, transfers, dressing, personal hygiene, and required extensive assistance with toileting. R18's medical record indicated the following weights: On 8/12/20, weight was 117 pounds (lbs) On 8/17/20, weight was 116 lbs On 8/24/20, weight was 123.4 lbs (7.4 lbs. weight increase in seven days)	F 580	F580: Notification of Change Immediate Corrective Action: R18 physician was notified of weight gain and edema on 9/4/20. Action as it Applies to Others: Change in a Resident's Condition or Status policy was reviewed and remains current. All residents were reviewed for weight gain/edema to ensure that MD has been notified. All nurses were re-educated on Resident's Condition or Status policy to include timely MD notification of a resident change in weight of +/- 5 lbs or per MD order. Date of Compliance: 10/7/2020 Reoccurrence will be prevented by: Audit of 5 residents with a change in condition will be conducted weekly x 4 weeks then monthly x2 months to assure physician is notified of resident changes in condition.	

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	245495	A. BUILDING ______ B. WING ______	C 09/04/2020

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On 9/3/20, weight was 125.5 lbs

R18's medical record lacked indication the physician or nurse practitioner (NP) was notified on 8/24/20, at the time of R18's 7.4 lbs weight gain.

On 8/27/20, a progress note indicated R18 had no edema.

On 8/29/20, two separate progress notes indicated R18 had edema to the left foot and lower leg.

On 8/30/20, a progress note indicated R18 had edema to the left foot and lower leg.

On 8/31/20, a progress note indicated R18 had edema to the foot.

On 9/1/20, a progress note indicated R18 had edema in left foot.

R18's progress notes lacked indication the MD was notified of R18's edema.

On 9/1/20, at 9:45 a.m. the top of R18's left foot and toes were observed to be swollen. R18 stated she told licensed practical nurse (LPN)-C her left foot was swollen, she was gaining weight, and requested to have a diuretic (medication that removes excess fluid) ordered. R18 stated she had gained over 7 lbs in a week, and was concerned her left foot and toes were swollen.

On 9/2/20, at 7:30 a.m. R18's was observed propelling herself in the hallway in her wheelchair and R18's left lower leg was observed to be swollen.

Provider's Plan of Correction (F 580):

The results of these audits will be shared with the facility QAPI committee for input on the need to increase, decrease, or discontinue the audits.
Corrections will be monitored by:
DON/Nurse Managers/Designee

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On 9/3/20, at 10:55 a.m. LPN-F stated she was unaware R18 had a weight gain of 7.4 lbs in a week prior to that day. LPN-F verified R18's medical record lacked indication R18's physician was notified of R18's 7.4 lbs weight gain, and edema prior to 9/2/20. LPN-F stated a physician should be notified of a weight gain of five lbs or greater in a week.

On 9/3/20, at 11:35 a.m. LPN-C stated she reviewed resident weights weekly. LPN-C stated she was aware of R18's weight gain the week of 8/24/20. LPN-C stated she did not notify the NP of R18's weight gain and edema because R18 was already on the NP's schedule to bee seen on 8/24/20. LPN-C stated was unsure why R18 was not seen by the NP on 8/24/20, or 8/26/20. LPN-C stated she added R18 to the NP's schedule on 9/2/20, because of her weight gain. LPN-C stated the NP should have been notified immediately of R18's weight gain and edema, and further stated LPN-C should have followed up with the NP prior to 9/2/20.

On 9/3/20, at 3:01 p.m. LPN-I stated she was responsible for keeping the NP rounding schedule. LPN-I stated the nurses would request a resident to be seen by the NP, and LPN-I would add the resident to the NP's schedule and the reason for the visit. LPN-I stated R18 was scheduled to be seen on 8/24/20, for an initial NP visit after her admission to the facility. LPN-I stated the NP was running out of time that day, and R18 was rescheduled to be seen on 8/26/20. LPN-I stated R18 was not seen by the NP on 8/26/20. LPN-I verified according the NP's schedule, the reason listed R18's was to be seen on 8/24/20, and 8/26/20, was for an initial visit,

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F 580	Continued From page 5 and weight gain was also listed. LPN-I verified the NP did not see R18 until 9/2/20. On 9/4/20, at 3:51 p.m. the director of nursing (DON) stated she expected the physician or NP to be notified of any weight gain over five lbs either by fax or phone the day the weight increase was discovered. The DON further stated a weight gain of 7.4 lbs would be a concern of changes in underlying medical conditions. The facility policy Change in Resident's Condition or Status revised 5/17, directed to promptly notify the resident's physician of changes in the resident's medical/mental condition and/or status.	F 580		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance	F 584		10/7/20

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F 584	Continued From page 6 services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure a wheelchair was cleaned and in sanitary condition for 1 of 8 residents (R45) reviewed for environment. Findings include: R45's Admission Record dated 9/3/20, indicated R45's diagnoses included visual loss, cataract, and muscle weakness. R45's annual Minimum Data Set (MDS) dated 7/30/20, indicated R45 was cognitively intact. R45's MDS further indicated he had severely impaired vision, used a wheelchair, and required extensive assistance with transfers. R45's care plan dated 7/29/20, directed staff to	F 584	F584: Safe/Clean/Comfortable/Homelike Environment Immediate Corrective Action: R45s wheelchair was cleaned on 9/4/20 Action as it Applies to Others: All resident wheelchairs and cushions were cleaned. Nursing and maintenance staff educated on importance of cleaning wheelchairs monthly per schedule and when soiled. Date of Compliance: 10/7/2020 Reoccurrence will be prevented by: Audit of 5 resident wheelchairs/cushions for cleanliness will be conducted weekly x 4 weeks then monthly x2 months to assure resident wheelchairs/cushions are clean. The results of these audits will be shared with the facility QAPI committee for input	

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F 584	Continued From page 7 clean equipment when visibly soiled and at least weekly. On 9/2/20, at 8:22 a.m. R45's wheelchair cushion was observed to have dried, yellow, and white crusted food debris on it. The food debris was approximately four inches (in.) by two in. Nursing assistant (NA)-G and NA-F were in R45's room. NA-G was observed to stand over R45's wheelchair and looked at the wheelchair cushion. NA-G then walked to R45's bathroom and NA-F was observed to also look at R45's wheelchair. NA-G and NA-F then transferred R45 to his wheelchair. R45 was seated directly on top of the soiled wheelchair cushion. On 9/2/20, at 10:25 a.m., R45 was observed being transferred, by NA-H, from his wheelchair to the bed. R45's wheelchair cushion remained soiled. On 9/2/20, at 10:30 a.m., NA-H was interviewed and confirmed R45's wheelchair cushion was soiled. NA-H stated, he believed it was egg residue on R45's wheelchair. NA-H stated he did not notice the residue when he got R45 up. NA-H stated wheelchair cleaning was completed weekly and when spills occurred. On 9/3/20, at 2:22 p.m., the director of nursing (DON) stated she expected staff to clean a wheelchair cushion when it was dirty. A wheelchair cleaning schedule was requested but not provided by the facility A policy on wheelchair cleaning was requested but not provided by the facility.	F 584	on the need to increase, decrease, or discontinue the audits. Corrections will be monitored by: Maintenance Supervisor/Designee	

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F 609	Continued From page 8	F 609		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to immediately report an allegation of abuse to the stated agency (SA) for 1 of 2 residents (R7) reviewed for abuse. Findings include:	F 609	F609: Reporting of Alleged Violations Immediate Corrective Action: R7 discharged from facility on 9/19/20 Action as it Applies to Others: Abuse Prohibition/Vulnerable Adult Plan policy was reviewed and remained	10/7/20

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F 609

Continued From page 9

R7's quarterly Minimum Data Set (MDS) dated 8/16/20, indicated she was severely cognitively impaired, and required extensive assistance for bed mobility, and total assistance for transfers.

On 8/6/20, an untitled facility document indicated around 6:40 p.m., a nursing assistant (NA) went to the unit, and as she approached the doors she heard a nurse in front of the medication cart facing R7's room yelling, "[R7], shut up and go to bed, shut up and go to bed, [R7], its time to go to bed, just shut up." The document further indicated the NA reported the incident to two other nurses who told her to write a statement and place it in the DON's inbox.

On 8/7/20, a facility report to the SA indicated a nursing assistant (NA) reported she was walking toward the wing four hallway, and could hear a nurse through the doors loudly telling at a resident to, "Shut up and go to bed." The report further indicated the incident occurred on 8/6/20, but was not reported to the director of nursing (DON) and the administrator until the following day.

On 9/3/20, at 10:06 a.m. the administrator stated four staff members were aware of the incident, but it was not reported to him until the following day. The administrator stated it should have been reported to him immediately.

The facility policy Abuse Prohibition Vulnerable Adult Plan dated 7/5/19, directed to ensure residents in the facility were not subjected to abuse by anyone. The policy further directed all staff were responsible for reporting any situation that was considered abuse or neglect, and to

F 609

current.
All staff educated on Abuse Prohibition/Vulnerable Adult Plan policy with regards to immediately reporting any suspected abuse to the DON & Administrator.
Date of Compliance: 10/7/2020
Reoccurrence will be prevented by: Audit of 5 staff members conducted weekly x 4 weeks then monthly x2 months to assure staff know who to report any suspected abuse to, how to report it, and when to report it via verbal conversation. The results of these audits will be shared with the facility QAPI committee for input on the need to increase, decrease, or discontinue the audits.
Corrections will be monitored by: Social Services Director/Designee

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F 609	Continued From page 10 notify the administrator immediately of any allegations of abuse or suspected abuse. The policy directed suspected abuse shall be reported to the SA no later than two hours after forming a suspicion of abuse.	F 609		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section).	F 655		10/7/20

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F 655	Continued From page 11 §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure a baseline care plan was developed within 48 hours of admission for 1 of 6 residents (R111) reviewed for accidents. Findings include: R111's Admission Record printed 9/4/20, indicated R111 was admitted to the facility on 8/24/20, and diagnoses included chronic pain, supraventricular tachycardia (abnormally fast heart rhythm), heart failure, muscle weakness, and chronic kidney disease. A review of R111's medical record lacked a baseline care plan. On 9/4/20, at 1:50 p.m. licensed practical nurse unit coordinator (LPN)-C was interviewed and verified R111 did not have a baseline care plan. On 9/4/20, at 2:45 p.m. the director of nursing (DON) was interviewed and verified a baseline was to be developed within 24 hours of admission.	F 655	F655: Baseline Care Plan Immediate Corrective Action: R111 Baseline Care Plan was completed on 8/31/2020 Action as it Applies to Others: Care Planning policy was reviewed and remained current. All current residents care plans were reviewed to ensure that their baseline care plans were completed and locked. All management team members were educated on the need to complete/lock the Baseline Care Plan within 48 hours of admission. Date of Compliance: 10/7/2020 Reoccurrence will be prevented by: Audit of 5 resident admissions conducted weekly x 4 weeks then monthly x2 months to assure Baseline Care Plans are completed within 48 hours of admission. The results of these audits will be shared with the facility QAPI committee for input on the need to increase, decrease, or discontinue the audits. Corrections will be monitored by:	

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F 655	Continued From page 12 A facility policy on baseline care plans was requested but not provided.	F 655	Administrator/Designee	
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide nail care and remove facial hair for 3 of 8 residents (R21, R215, R45) reviewed for activities of daily living (ADLs) and who were dependent on staff for ADL assistance. Findings include: R21's Admission Record dated 9/4/20, indicated R21's diagnoses included wedge compression fracture of the T11-T12 vertebrae (fracture of the lower part of the spine). R21's admission Minimum Data Set (MDS) dated 6/24/20, indicated R21 was cognitively intact, and required one assist with personal hygiene needs. R21's care plan dated 6/30/20, directed staff to provide assistance of one for personal hygiene. R21's weekly skin inspections indicated R45 had not been shaved or had his nails trimmed since admission on 6/18/20. On 9/1/20, at 10:41 a.m. R21 was interviewed	F 677	F677: ADL Care Provided for Dependent Residents Immediate Corrective Action: Nail Care and Facial Hair Care was completed for residents R21, R215, & R45. Action as it Applies to Others: ADL Assistance per Care Plan policy was reviewed and remained current. All residents were offered/received assistance with nail care/facial hair removal. All nurses and NARs were educated on providing nail care and removal of facial hair for residents based on resident preference. Date of Compliance: 10/7/2020 Reoccurrence will be prevented by: Observation audit of 5 residents conducted weekly x 4 weeks then monthly x2 months to ensure facial hair is trimmed and nail care is provided. The results of these audits will be shared with the facility QAPI committee for input on the need to increase, decrease, or discontinue the audits.	10/7/20

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F 677	Continued From page 13	F 677		

and stated he did not own clippers and has asked staff to trim his fingernails and beard. R21 was observed to have long, jagged fingernails on both hands, and long facial hair.

On 9/2/20, at 7:26 a.m. R21 was observed in bed, and his nails and facial hair remained long and untrimmed.

On 9/2/20, at 7:28 a.m. R21 put his call light on and asked nursing assistant (NA)-D if he could have his bath. NA-D stated R21's bath was scheduled for that evening.

On 9/3/20, at 9:33 a.m. R21 was observed, and fingernails and facial hair remained long. R21 was interviewed and stated he did not get his bath as scheduled last evening.

ON 9/3/20, at 11:03 a.m. licensed practical nurse (LPN)-F stated if a resident refused a bath, staff was to document refusals on a weekly skin inspection sheet, and report the refusal to the nurse. R21 reviewed R21's weekly skin inspection sheet dated 9/2/20, and noted a zero with a line drawn through, which indicated R21 did not get his shower. R21 further stated she heard staff did not have time last evening to give R21 his shower. LPN-F stated staff should try and get his shower completed that day.

On 9/3/20, at 3:19 p.m. R21 was interviewed and stated he still had not been offered a shower, and it was important to him to get a shower, and have his fingernails and facial hair trimmed.

On 9/3/20, at 3:20 p.m. nursing assistant (NA)-I verified R21 did not get a bath/shower last evening as scheduled. NA-I stated nail care and

Corrections will be monitored by:
DON/Nurse Managers/Designee

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shaving was completed on bath/shower day and as needed. NA-I stated it looked like R21's had had not been shaved or nails trimmed in several weeks.

On 9/3/20, at 3:56 p.m. the director of nursing (DON) stated residents should be offered to be shaved and nails trimmed on bath/shower day. The DON further stated if a resident declined cares, it was expected to reproach the resident three times, have a different staff member reproach, and if continued to decline, document the refusal. The DON stated if baths were unable to get done, it was expected to notify the nurse, ask for assistance, offer at a later time, and document on the weekly skin inspection sheet.

R215's Admission Record dated 9/4/20, indicated R21's diagnoses included a wedge compression fracture of second lumbar vertebral (fracture of the spine) .

R215's admission MDS dated 9/1/20, indicated R21's cognition was moderately impaired, and required extensive assistance with personal hygiene.

R215's care plan dated 8/28/20, indicated R21 was to be dressed, groomed, and bathed.

R215's weekly skin inspection dated 8/28/20, indicated R21 received assistance with a bed bath, R21 was not shaved, and fingernails and toenails were not trimmed.

On 8/31/20, at 5:39 p.m. R215 was observed to have dark facial hairs on the upper lip, and long jagged fingernails with a brown debris underneath and along the sides of the nails on both hands.

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On 9/2/20, at 12:47 p.m. R215 was observed in her room and had just finished with lunch. R21's fingernails remained long with a brown debris underneath fingernails. R215 continued to have dark facial hairs above upper lip.

On 9/3/20, at 9:01 a.m. R215's nails remained long and dirty dirty, and facial hairs noted above the upper lip. R215 was interviewed and stated she preferred to have her nails shorter, and facial hair removed.

On 9/3/20, at 3:26 p.m. licensed practical nurse (LPN)-F verified R215's facial hair to upper lip and fingernails were long and dirty. LPN-F asked R215 if she would like to have her fingernails soaked and trimmed, and her hair removed from her upper lip and stated R215 stated "yes."

On 9/4/20, at 3:56 p.m. the DON stated residents should be offered shaving and nail care each bath day and documented on the weekly skin inspections sheets.

R45's Admission Record dated 9/3/20, indicated R45's diagnoses included visual loss and muscle weakness.

R45's annual MDS dated 7/30/20, indicated R45 had intact cognition. R45's MDS further indicated he had severely impaired vision, and required extensive assistance with personal hygiene.

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F 677	Continued From page 16 R45's care plan dated 7/29/20, indicated R45 required extensive assistance grooming. R45's care plan directed staff to shave R45 as needed. Review of R45's weekly skin inspections dated 8/26/20, and 8/31/20, indicated shaving assistance was last documented on 8/26/20. On 8/31/20, at 5:13 p.m. R45 was observed to have long facial hair. On 9/2/20, at 8:22 a.m. nursing assistant (NA)-F and NA-G were observed to perform personal cares and transferred R45 to his wheelchair. An electric razor was noted on a table near R45's window. NA-F and NA-G did not offer to shave R45. On 9/2/20, at 2:25 p.m. R45 was interviewed and he stated his preference was to be clean shaven. R45 stated, "I like smoothe skin." R45 stated his preference was to be shaven every few days, and preferred to be shaven now. On 9/2/20, at 2:33 p.m. NA-I confirmed R45 needed staff assistance with shaving. NA-I stated R45 did not have the dexterity to shave himself. NA-I stated he believed R45 was legally blind. R45 was observed with NA-I, and NA-I confirmed the presence of facial hair. NA-I stated he believed the facial hair was present "a day or two." On 9/2/20, at 2:51 p.m. NA-H was interviewed and stated R45 was blind, however, shaved himself. NA-H stated R45 required set up assistance, and staff placed a gown over him. NA-H stated R45 was very precise and particular. NA-H confirmed R45 had facial hair and stated it	F 677		

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F 677	Continued From page 17 was "a little longer" than a five o'clock shadow. NA-H stated he was unaware when R45 was last shaven, and further stated R45 was shaved on shower days. On 9/3/20, at 9:28 a.m. LPN-B stated R45 needed staff assistance with shaving. LPN-B confirmed staff shaved R45, and stated he was blind. On 9/3/20, at 2:20 p.m. the director of nursing (DON) stated R45 needed staff assistance with shaving. The DON stated staff were expected to shave R45. The facility policy Monarch Healthcare ADL Assistance revised 5/18, directed based upon resident/resident representative desires, assessment and care plan, ADL assistance will be provided to any residents deemed necessary. Some examples would be shaving males and females as needed, and fingernails and toenails to be clean and trimmed.	F 677		
F 679 SS=E	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced	F 679		10/7/20

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by:
Based on observation, interview, and document review, the facility failed to ensure meaningful activities were provided for 4 of 4 residents (R111, R16, R28, and R45) reviewed for activities.

Findings include:

R111's Admission Record printed 9/4/20, indicated diagnoses included chronic pain, heart failure, and chronic kidney disease.

R111's care plan initiated 8/31/20, indicated R111 was at risk for increased depression and anxiety related to decreased socialization due to federal guidelines while managing Coronavirus-19. Interventions included assessments for risk of social isolation, and provide appropriate independent activities per resident likes and wishes. R111's care plan lacked identification of R111's specific activity needs and preferences.

R111's Activity Participation Review dated 8/31/20, indicated R111 enjoyed one on ones with staff and his own independent activity in his room, and would participate in hallway activities of his choosing. R111's favorite activities, special accomplishments, and/or new interests included watching TV, exercises, the daily chronicles, short stories, trivia, and visiting with staff and his roommate. R111's activity-related focuses including needs, strengths and preferences was determined to remain appropriate and current as per R111's care plan. R111's Activity Participation Review did not address activities R111 had actually attended or participated in.

The facility Activity Record of Participation undated, indicated R111 had been provided with

F 679

F679: Activities Meet Interests/Needs of Each Resident
Immediate Corrective Action:
R111, R16, R28, & R45 were reassessed including family interviews to assure all activities planned were sufficient, meaningful, and additional activities added if indicated.
Action as it Applies to Others:
Activity Programs policy was reviewed and remained current.
All residents will be reassessed to assure activities planned are meaningful and sufficient.
Activity Department staff will be re-educated on the process for assessing and planning for sufficient and meaningful activities for those residents requiring activity set up.
Date of Compliance: 10/7/2020
Reoccurrence will be prevented by: Audit of 5 residents requiring activities set up conducted weekly x 4 weeks then monthly x2 months to assure activities are sufficient and meaningful via verbal or non verbal response. The results of these audits will be shared with the facility QAPI committee for input on the need to increase, decrease, or discontinue the audits.
Corrections will be monitored by: Activity Director/Designee

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the Daily Chronicle, but lacked documentation of any one to one visits, participation in any activities, and provision of independent activity materials, such as books or magazines.

On 9/1/20, at 10:28 a.m. R111 was observed sitting in his room, a quarantine sign was hanging on his door, and no activity materials were visible in his room. R111's TV was turned toward his roommate. R111 stated there were no activities going on, and he got bored.

On 9/2/20, at 2:35 p.m. R111 was observed to be sitting in his room with the door mostly closed. R111 had no activity materials, and the TV was on towards R111's roommate.

On 9/2/20, at 2:45 p.m. R111 was sitting in his room, and said he had just returned from exercises. R111 stated there was nothing to do. R111 pointed at the quarantine sign on his door and asked, "Do you know what I can do in here?" R111 stated it was worse than being in prison. R111 stated he liked to read, but couldn't see very well. R111 had no reading materials in his room.

On 9/3/20, at 10:23 a.m. R111 was in his room, talking on the phone, with no individual activity materials in sight.

On 9/4/20, at 1:12 p.m. nursing assistant (NA) -G stated R111 had been in quarantine, and she had not seen him doing anything. NA-G stated she was not sure what activity staff do for residents.

On 9/4/20, at 1:43 p.m. licensed practical nurse (LPN)-F stated R111 had not done any activities, but had been in therapy. LPN-F stated R111 went outside with therapy staff earlier that day, and

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was happy about that. LPN-F stated no staff do activities with any residents, other than dropping off a flier in their rooms.

On 9/4/20, at 2:45 p.m. the director of nursing (DON) stated activities should do one-to-one activities, but was not sure what was happening. The DON stated activity staff try to think of ways for residents to participate.

The facility policy Activity Programs revised 6/18, directed the activities program was provided to support the well-being of the resident, was based on the comprehensive resident-centered assessment and resident preferences, and included facility-organized group activities, independent individual activities and assisted individual activities. The policy indicated activity programs were designed to meet the needs and interests of the residents and activity participation was to be documented in the resident's medical record.

R16's significant change MDS dated 8/12/20, indicated he was severely cognitively impaired, and required extensive assistance for all activities of daily living (ADLs). The activity preference section of R16's MDS was not completed.

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R16's Care Area Assessment (CAA) for Activities dated 8/30/20, indicated R16 showed little interest or pleasure in doing things. The CAA indicated R16 was dependent on staff for setting up and engaging him in activities, and indicated R16 was confined to his room related to infection. The CAA further indicated staff were to provide one to one room visits, and indicated R16 liked watching television, listening to classical music, and liked the window open for fresh air.

R16's care plan dated 8/30/20, indicated he was dependent on staff for setting up and engaging in activities due to cognitive deficits and physical limitations. The care plan directed staff to converse with R16 while providing care, and open the window for fresh air. The care plan also indicated R16 liked to watch television, converse with family on the IPad, and listen to classical music. R16's care plan further indicated a risk for increased depression and anxiety related to decreased socialization.

R16's Activity Participation Review dated 8/11/20, indicated R16 enjoyed the Daily Chronicles, short stories, tons of puns, and staff reading to him.

On 9/1/20, at 9:07 a.m. R16 was observed lying on his back in bed with no television or radio on in his room. At 10:14 a.m. R16 remained in bed with his eyes open and no television or radio on. At 10:16 a.m. activity aide (AA)-A was in another resident room handing out the Daily Chronicles. AA-A left the unit without stopping in R16's room.

On 9/2/20, at 8:33 a.m. R16 was observed laying on his back in bed with no television or radio on in his room. At 9:39 a.m. R16's television was on, R16 was laying on the bed with his eyes closed,

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and not engaged in the program.

On 9/3/20, at 8:28 a.m. R16 was again observed lying in bed with no television or radio on. Staff had awakened R16 prior to 7:30 a.m. R16 was shifting around in the bed and appeared restless.

Facility documents titled Wing 3 dated 7/17/20 - 9/2/20, included a list of residents on the unit and identified the following:

7/17/20, R16 watched television
7/21/20, activity log was pre-filled out on a computer and indicated independent activity, watching television, visits with staff and Daily Chronicles, 10 minutes. The log lacked any indication the activities were completed.
7/22/20 - 7/27/20, pre-filled activity log indicated the same as 7/21/20.
7/28/20, activity log was left blank.
7/30/20 and 7/31/20, the pre-filled activity log was again provided but no indication activities were completed.
8/1/20 - 8/19/20, no activity attendance was provided.
8/20/20, R16 had a one to one visit talking about the weather, and current events were read to him.
8/24/20, indicated Daily Chronicles were read to R16.
8/27/20, staff sat with R16 and talked about the day.
9/1/20, R16 had a visit from family.
9/2/20, indicated daily chronicles.
The activity logs lacked evidence of weekend activity programming.

On 9/3/20, at 11:28 a.m. nursing assistant (NA-)-J stated R16 watched television and had an IPad if he wanted to use it. NA-J stated sometimes R16

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got up in his chair, and sometimes not.

R28's admission MDS dated 6/30/20, indicated he was severely cognitively impaired, and he required assistance from staff to transfer. The MDS indicated locomotion off the unit had not occurred during the assessment period. R28's MDS further indicated it was somewhat important to do his favorite activities, go outside and get fresh air, and listen to music.

R28's care plan dated 7/17/20, indicated R28 displayed little or no activity involvement, and indicated he would participate in one to one activity with staff. The care plan directed staff to inform R28 of scheduled activities, and praise efforts for attendance of hallway activities.

A facility document titled Wing 3 dated 7/17/20 - 9/2/20, included a list of residents on the unit and identified the following:

7/17/20, no activity identified.
7/21/20, activity log was pre-filled out on a computer and indicated independent activity, watching television and one to one, Daily Chronicles 10 minutes. There was no indication the activities were completed.
7/22/20 - 7/24/20, and 7/27/20, Pre-filled attendance log provided, but no indication the activities were completed.
7/28/20, copy of chronicle, R28 was not interested in library cart but showed him items and he accepted three different items.
7/30/20, 7/31/20, pre-filled attendance sheet provided with no indication activity was completed.
8/1/20 - 8/17/20, no activity attendance was provided.

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8/18/20, Daily Chronicles.
8/21/20, Daily Chronicles.
8/24/20, Daily Chronicles.
8/27/20, Enjoying television, provided chronicles but R28 was tired and declined further interaction.
8/29/20, Daily Chronicles.
9/2/20, Daily Chronicles.
The activity logs lacked evidence of weekend activity programming.

On 9/1/20, at 9:01 a.m. R28 was sitting up in his wheelchair in his room with the television on. At 10:16 a.m. AA-A was on the unit handing out the Daily Chronicles. AA-A left the unit without stopping in R28's room.

On 9/2/20, at 7:45 a.m. R28 was in his room laying in bed. At 9:09 a.m. R28 remained in his bed, no staff had entered room or engaged him in any way. He remained laying in bed at 10:03 a.m.

On 9/3/20, at 11:26 a.m. NA-J was interviewed and stated staff assisted R28 to get up in his chair, and stated he watched television and looked outside. NA-J stated R29 did not come out of his room. NA-J further stated the nursing staff did not provide any activities to residents, only the activities staff did activities. NA-J stated R28 got papers from activity staff, but did not know if he participated.

On 9/3/20, at 2:54 p.m. the administrator stated the activity director was new. The administrator stated when she started, someone from another facility developed the guide based on previous assessments (the guide referred to the activity log that was pre-filled out). The administrator stated the direct care staff did activities with residents, but they were "probably" not documented. The

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F 679	Continued From page 25 administrator stated when the activity director first started she did most of the activities, but stated since COVID-19, most of the activities were one to one visits. The administrator stated the Daily Chronicles was a hand out that described what activities were occurring each day, and sometimes had other things like a word search. The administrator stated the activity department handed them out to residents, and went over it with them. The administrator stated R16 had an IPad set up with things, and had a bird feeder outside his window. The administrator stated activities staff would go in and chat with R16 in his room, and said it was difficult to have him outside his room due to infection control concerns. The administrator stated he did not know R28 well, but said if something was written down for an activity, it was probably done. R45's Admission Record dated 9/3/20, indicated R45's diagnoses included visual loss, muscle weakness, and hearing loss. R45's annual MDS dated 7/30/20, indicated R45 had intact cognition, had severely impaired vision, and had highly impaired hearing. R45's activity self-assessment indicated he enjoyed being around animals, time outdoors, and keeping up with the news. R45's activity self-assessment lacked indication he enjoyed listening to music	F 679		

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THE EMERALDS AT GRAND RAPIDS LLC	**2801 SOUTH HIGHWAY 169 GRAND RAPIDS, MN 55744**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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and reading books, newspapers or magazines.

R45's care plan reviewed 7/29/20, indicated R45 was dependent on staff for activities, cognitive stimulation, social interactions, and well-being. R45's care plan further indicated he independently pursued activities, and he liked to listen to a transistor radio or the television. R45 refused to go outside or attend group activities.

R45's Care Conference form dated 8/3/20, indicated R45 relied on staff for activities, and participated in one-on-one activities with staff. The form further indicated R45 did not have interest in activities due vision and hearing loss.

R45's July 2020 activity log indicated the following activities were documented:
- Delivered mail and "talked a bit" on one occurrence.
- Watched television on one occurrence.
- Listened to transistor radio on eight occurrences.
- No other activities were documented.

R45's August activity log indicated the following activities were documented:
- Visited with staff and "current events" on one occurrence.
- The Daily Chronicles on five occurrences.
- Visited by staff "about his needs" on one occurrence.
- Chatted about fall and "reviewed today's events" on one occurrence.
- Verbal interactions through day on one
-R45 refused to walk on one occurrence.
- No other activities were documented.

On 8/31/20, at 4:44 p.m. R45 was observed

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sitting in a wheelchair in his room. R45 had a bedside table in front of him, and the lights were off in the room. R45 was facing forward toward a wall. The television was noted to be off, and no radio was observed in R45's room. R45 stated he used to enjoy fishing, reading, and watching television.

On 8/31/20, at 6:00 p.m. R45 was observed sitting in a wheelchair in his room. R45 was eating dinner. R45 was facing forward toward a wall. The television was noted to be off.

On 9/2/20, at 8:22 a.m. NA-F was observed to assist R45 with morning cares, transferred him to a wheelchair, and placed a bedside table in front of him. The TV was noted to be off. At 8:47 a.m. activities assistant (AA)-B entered R45's room and placed a mug on his bedside table. AA-B then exited the room. From 9:29 a.m. to 10:17 a.m., R45 was seated in a wheelchair and facing forward toward a wall. R45's television remained off. At 12:43 p.m. R45 was seated in a wheelchair facing forward toward a wall. R45's television remained off. At 1:03 p.m. AA-A was observed to walk past R45's room and entered several resident's rooms and offered them an opportunity to attend an exercise activity. AA-A did not enter R45's room. At 1:42 p.m. At 2:14 p.m. R45 was observed lying in bed and appeared to be awake. NA-I entered R45's room and stated R45 he was "just kind of laying around."

On 9/2/20, at 2:25 p.m. R45 stated, "I don't do anything." R45 stated he was "bored" and tried to keep himself comfortable by lying in bed most of the time. The television was noted to be off.

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On 9/3/20, at 8:37 a.m. R45 was observed to be eating breakfast in his room. At 8:52 a.m. R45 was observed to be facing toward a wall. R45's television was noted to be off and no radio was observed in the room.

On 9/3/20, at 8:54 a.m. NA-D stated R45 liked to listen to the radio, but not often. NA-D stated he did not know if there was a radio in R45's room right now. NA-D stated he did not know if R45 attended activities. NA-F stated in the past, staff assisted R45 to play bingo. NA-D stated staff provided "a daily sheet" and was "pretty sure" they read it to him. NA-D stated R45 listened to his roommates television. NA-D stated R45 "found peace" with "peace and quiet." NA-D stated R45 barely talked. When asked what types of activities were provided to R45, NA-D stated restorative therapy walked him.

On 9/3/20, at 08:52 a.m. R45 was observed to be in his room facing forward toward a wall. R45's television was noted to be off.

On 9/3/20, at 9:12 a.m. NA-E stated R45 didn't "have much going on." NA-E stated R45 was unable to see and had hearing issues. NA-E stated there was not much for R45 to do due him being blind and hard of hearing. NA-E stated he believed music was provided in the past, and R45 was just "living day-to-day." When asked about R45's activity participation, NA-E stated restorative staff provided R45 with exercises.

On 9/3/20, at 9:41 a.m. AA-B entered R45's room and offered him the Daily Chronicle.

On 9/3/20, at 9:46 a.m. AA-B stated R45 was unable to hear well "at all," and he did not engage

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F 679	Continued From page 29 with television or music. AA-B further stated R45 "doesn't see" and staff cannot give him word searches or other paper activities. AA-B stated she was unsure if other sensory stimulation activities had been offered to R45. AA-B stated activities staff would talk with R45 about his life. AA-B stated R45 "wants to be in bed" and he "likes to sleep." AA-B stated restorative staff "does some stuff with him" but was unsure of the frequency provided when asked about other activity participation. On 9/3/20, at 10:19 a.m. LPN-C stated R45 was a very quiet man and didn't like to attend activities. LPN-C stated R45 liked to lay down, and used to listen to the radio but was too hard of hearing now. LPN-C stated, "I don't know what they do to engage him," and further stated, "I can't say I have seen activities over here talking with R45 in the last 2 weeks." LPN-C stated restorative therapy walked with him. On 9/3/20, at 2:17 p.m. the DON stated R45 was in restorative therapy, and stated, "I guess you could call that an activity." The DON stated she would have to ask the activities department about other activities R45 was in. The DON stated she would expect staff to offer R45 activities.	F 679		
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	F 684		10/7/20

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F 684	Continued From page 30 practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure Ace wraps and heel boots were applied for 1 of 2 residents (R17) reviewed for quality of care. Findings include: R17's Admission Record dated 9/4/20, indicated R17's diagnoses included dementia. R17's Care Area Assessment (CAA) dated 6/12/20, indicated R17 had severe cognitive impairment. R17's care plan dated 7/10/20, indicated R17 had a history of scratching and directed Ace wraps to be applied in the morning (a.m.) to legs for edema. R17's care plan further directed blue boots to be put on when up in the wheelchair and in bed for cushion. R17's treatment administration record (TAR) dated 9/4/20, directed Ace wraps to legs to be applied in the a.m. and off in the p.m. The TAR further directed blue boots to both feet while in bed, and when up in the wheelchair. On 9/2/20, at 8:13 a.m. R17 was observed sitting in her wheelchair watching television, and was not wearing Ace wraps to her legs or blue boots. On 9/3/20, at 9:00 a.m. R17 was observed sitting in her wheelchair, and did not have Ace wraps or blue boots on.	F 684	F684: Quality of Care Immediate Corrective Action: R17's needs were reassessed. Heel boots were discontinued, and ace wraps were applied. Action as it Applies to Others: Care Planning policy was reviewed and remained current. All residents requiring ace wraps and heel boots will be reassessed to ensure these interventions are appropriate and care planned. All nurses and NARs will be re-educated on ensuring resident wraps and heel boots are applied per care plan. Date of Compliance: 10/7/2020 Reoccurrence will be prevented by: Observation audit of 5 residents requiring heel boots and ace wraps conducted weekly x 4 weeks then monthly x2 months to assure heel boots and ace wraps applied per care plan. The results of these audits will be shared with the facility QAPI committee for input on the need to increase, decrease, or discontinue the audits. Corrections will be monitored by: DON/Nurse Managers/Designee	

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F 684	Continued From page 31 On 9/3/20, at 11:01 a.m. licensed practical nurse (LPN)-F stated R17 was to have her Ace wraps on during the day, and her blue heel boots on while in bed and in the wheelchair. LPN-F further stated the nurses apply the Ace wraps in the morning, and the nursing assistants apply the blue boots. On 9/3/20, at 1:29 a.m. nursing assistant (NA)-P stated resident care was directed by the resident's care plan. NA-P verified R17 was supposed to have blue boots on when up in the wheelchair and in bed. On 9/3/20, at 2:51 p.m. LPN-F stated she did not put R17's Ace wrap on that morning, and planned to put them on later in the day. LPN-F verified she signed R17's TAR and indicated she had put R17's Ace wraps and blue boots on, and they were not on. On 9/4/20, at 4:41 p.m. the director of nursing (DON) stated she would expect staff to follow the resident's plan of care, and further stated treatments should be signed off on the TAR after the treatment was completed, and not before. The DON further stated the concern for heel protectors and Ace wraps not being applied as directed could lead to worsening edema and pressure injuries. The facility policy Care Planning revised 6/19, directed each resident will have a person centered care plan developed by the interdisciplinary team for the purpose of meeting the resident's individual medical, physical, psychosocial, and functional needs.	F 684		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices	F 689		10/7/20

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F 689	Continued From page 32 CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure an appropriate smoking assessment was completed for 1 of 1 residents (R30) reviewed for smoking. Findings include: R30's Admission Record indicated diagnosis that included quadriplegia, and a traumatic brain injury. R30's quarterly Minimum Data Set (MDS) dated 7/2/20, identified intact cognition, and required total assistance for activities of daily living (ADLs) including locomotion on and off the unit. The MDS further identified R30 had upper extremity impairment to both sides. R30's care plan dated 7/13/20, identified R30 had a self care deficit related to limited mobility. R30's care plan for smoking dated 8/31/20, indicated he currently smoked at the facility. The care plan indicated R30 had a device used to assist with smoking, and had been assessed to smoke independently with assistance only to light the cigarette.	F 689	F689: Free of Accidents Hazards/Supervision/Devices Immediate Corrective Action: R30 was given a new adaptive device for smoking. Action as it Applies to Others: Smoking policy was reviewed and remained current. All residents that smoke were reassessed for safe smoking and new interventions put in place as needed. Nurse Managers will be re-educated on completing resident smoking evaluations and putting appropriate interventions in place. Date of Compliance: 10/7/2020 Reoccurrence will be prevented by: Observation audit of 5 smokers to ensure they are smoking safely and have appropriate interventions in place weekly x 4 weeks then monthly x2 months. The results of these audits will be shared with the facility QAPI committee for input on the need to increase, decrease, or discontinue the audits. Corrections will be monitored by: DON/Nurse Managers/Designee	

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On 5/5/20, a progress note indicated R30 had been outside smoking, and when the nursing assistant (NA) went outside to get him, she found that R30 had caught his cigarette on the adaptive device he had rigged to try to smoke, and could not get it off. The progress note indicated, "if NA had not gone outside he [R30] could have burnt himself."

R30's Smoking Evaluation dated 5/6/20, indicated he was currently smoking, and identified cognitive loss and a dexterity problem. The assessment indicated R30 required the use of a cigarette extension/holder, and indicated writer observed R30 smoking. R30 needed adaptive equipment that the activities department was going to pick up. The assessment further indicated R30 needed staff to light the cigarette, then could use his arms, hands and adaptive equipment to smoke independently.

R30's Smoking Evaluation dated 8/31/20, indicated he was currently smoking, and had a cognitive loss and a dexterity problem. The assessment identified the use of a cigarette extension/holder, and indicated R30 required staff to light the cigarette and was then able to use his arms, hands and adaptive equipment to smoke independently.

On 8/31/20, at 4:18 p.m. R30 was observed outside smoking a cigarette independently. R30's right hand was wrapped in a bandage, and a stylus was sticking out the top of the bandage. The stylus was used to aide R30 in use of his phone and tablet. On the left side of R30's right hand, a yellow plastic clothes pin was sticking out of the bandage. The clothes pin was stained a dark brown and appeared burnt.

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On 9/2/20, at 12:46 p.m. R30 was observed outside smoking a cigarette. When R30 finished his cigarette, he was observed to drop the still lit cigarette butt on the grass next to his chair.

On 9/3/20, at 8:35 a.m. nursing assistant (NA)-A was interviewed and stated a few days prior, R30's family member had called the facility because he had told her staff were not checking on him when he was outside. NA-A stated R30 needed staff to assist him with lighting his cigarette, stated staff took R30 outside, and R30 "had this thing on his hand, and we light the cigarette and he does it that way." NA-A stated R30 could ask when he wanted a cigarette, and would call the facility if he needed something when he was outside, but could not get himself in or out of the building independently. NA-A stated she thought they checked on R30 every hour when outside following the phone call from his family member.

On 9/3/20, at 1:51 p.m. the director of rehabilitation (DOR) stated R30 had a universal cuff to use his phone and his IPad with a stylus, and used a clothes pin to smoke. The DOR stated R30 was able to use the clothespin to get the cigarette to his mouth, and when he was done he could get rid of the cigarette. The DOR stated R30 disposed of his cigarette on the ground. The DOR stated they had ordered something different to assist R30 with smoking and it had arrived the previous day but had not been implemented yet. The DOR stated he had been outside when R30 was smoking, but had not assessed him, and stated it was up to nursing to determine if residents could smoke safely.

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At 9:45 a.m. the director of social services (DSS) stated she would typically go out and see if residents were safe to smoke, whether or not a smoking apron was needed, or if assistance to light the cigarette was needed. The DSS stated R30 needed assistance to light a cigarette and was able to "ash" the cigarette appropriately, but disposed of his cigarette butts on the ground. The DSS stated a new smoking device had been ordered and said "we don't like that clip he's using, it's plastic and it could melt." The DSS further stated R30 was supposed to be checked on every 30 minutes while outside, because he felt once he was out there staff did not check on him.

At 1:37 p.m. registered nurse (RN)-A stated initially she did not think R30 was safe to smoke. RN-A stated physical therapy rigged up the clothes pin that was connected to R30's hand. RN-A stated R30 was not able to dispose of his cigarette in an ashtray. RN-A further stated she usually completed the smoking assessments and said in regard to R30, "I did not rig up the clothespin, they [therapy] did so..."

At 2:19 p.m. the DOR confirmed that the therapy department did "rig" up the clothes pin so R30 could smoke, but stated therapy did not complete a formal assessment.

At 3:32 p.m. the director of nursing (DON) stated the nurse manager or social services department watched residents to make sure they were safe to smoke independently. The DON stated the criteria for safe, independent smoking included being able to hold a cigarette, not drop hot ashes, and properly dispose of the cigarette in the canister. The DON stated she had not observed

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F 689	Continued From page 36 R30 smoking. The facility policy Resident Smoking Agreement undated, directed the purpose of providing residents with the safest smoking environment possible, and to provide the smoking supervision each resident requires. The policy identified three smoking categories: able to smoke independently without an apron, requirement of an apron to smoke safely, and resident requiring smoking supervision to be safe. The policy did not identify the criteria for the smoking categories.	F 689		
F 697 SS=D	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to effectively provide pain management for 1 of 3 residents (R260) reviewed for pain. This resulted in actual harm to R260 when her pain was not relieved. Findings include: R260's Admission Record printed on 9/3/20, indicated she was admitted on 8/14/20, with diagnoses which included fracture of the right pubis, fracture of right ischium (lower posterior hip bone), and anxiety disorder. R260's admission Minimum Data Set (MDS)	F 697	F697: Pain Management Immediate Corrective Action: R260 was seen on 9/9/20 by nurse practitioner for confusion and pain. NP orders to increase Mobic and continue using Tylenol. Foley catheter was also discontinued as MD noted it was causing resident pain. Action as it Applies to Others: Pain Assessment & Management policy was reviewed and remains current All residents reviewed for proper pain management interventions to ensure pain is controlled. All nurses educated on recognizing and	10/7/20

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completed on 9/1/20, indicated R260 was severely cognitively impaired. R260's MDS indicated she received as needed pain medications (PRN), had pain present almost constantly, the pain made it difficult to function, and limited her day to day activities. R260's MDS indicated she rated her pain a nine on a scale of one to ten.

R260's Care Area Assessment (CAA) dated 8/30/20, indicated pain as a potential problem. Staff were directed to administer medications as ordered, to monitor for effectiveness of PRN pain medication, and document in the Medication Administration Record (MAR). The CAA further indicated R260 stated the pain medication did help her.

R260's care plan initiated on 8/17/20, indicated staff should use pain medication as ordered by the medical doctor (MD), document effectiveness of pain, and encourage the resident to verbalize discomfort.

R260's Order Summary Report with active orders through 9/3/20, indicated R260 had an order for Percocet (narcotic pain medication) tablet 5-325 milligrams (mg) one tablet by mouth every six hours as needed (PRN) for pain ordered on 8/21/20, acetaminophen (Tylenol) tablet 325 mg, give 650 mg by mouth two times a day for pain, ordered on 8/27/20, meloxicam (a non-steroidal anti-inflammatory drug used to relieve pain) 7.5 mg by mouth one a day with food, ordered on 9/3/20.

On 9/2/20, at 9:25 a.m. nursing assistants (NA)-K and NA-L were observed attempting to assist R260 with cares and dressing. The NAs asked

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responding/following up on pain concerns of residents. NARs were educated on notifying nurse immediately of any complaints (verbal or non-verbal) of pain for follow-up.
Date of Compliance: 10/7/2020
Reoccurrence will be prevented by: Audit of 5 residents using pain medication conducted weekly x 4 weeks then monthly x2 months to assure pain interventions are effective. The results of these audits will be shared with the facility QAPI committee for input on the need to increase, decrease, or discontinue the audits.
Corrections will be monitored by: DON/Nurse Managers/Designee

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE EMERALDS AT GRAND RAPIDS LLC	2801 SOUTH HIGHWAY 169 GRAND RAPIDS, MN 55744

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R260 if she could sit up, she agreed, but when they attempted to move her from lying in her bed to sitting on the edge of her bed, R260 resisted, saying it hurt too much. NA-K and NA-L layed R260 back down on her bed sideways. R260 stated, "It's the fracture," and said she had forgotten that she had a fracture. The NAs rolled her side to side, and placed a lift sheet under her. During repositioning, R260 said she was in lots of pain, and described the pain as sharp and shooting. R260 did not want to get dressed or have any cares completed after attempting to get out of bed.

-at 1:18 p.m. NA-K and NA-C entered to dress R260 for a clinic appointment. R260 kept repeating, "Ow" and "It hurts." R260 resisted attempts at dressing and getting out of bed, and layed back down on the bed. NA-K and NA-C let her rest briefly, and continued dressing her. NA-K and NA-C had R260 stand up, and transferred her quickly to the wheelchair. During the transfer, R260 continued to say "Ow."
-at 1:49 p.m. NA-K was interviewed. NA-K stated R260 usually complained of pain when going from laying to sitting in bed. NA-K stated she informed registered nurse (RN)-C about R260's pain.
-at 1:59 p.m. RN-C was interviewed. RN-C stated the NAs had informed her R260 was in pain in the morning, and did not want to get up or get dressed. RN-C stated she had given R260 scheduled acetaminophen (Tylenol), and she tried not to give confused residents narcotics. RN-C stated she should have pre-medicated R260 prior to her clinic appointment this afternoon.
-at 2:39 p.m. R260 was observed crying out in pain as she was assisted from the wheelchair

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back into her bed following her return from the clinic. R260 stated she had been in pain since she left for the appointment. R260 stated once she was back in bed, the pain was less.
-at 3:04 p.m. RN-A was interviewed, and stated she did not see R260 when she returned from the clinic. RN-A stated, "She is always like this when you want her to do something." RN-A stated she would expect staff to complete a pain assessment on R260 every shift.

On 9/2/20, the physician's note from orthopedic clinic visit indicated the resident was alert, confused, in a lot of pain, and refusing meals.

On 9/3/20, at 9:49 a.m. R260 was resting in bed, and stated she was "hurting today."
-at 10:05 a.m. NA-A was interviewed. NA-A stated when she was assisting R260 with cares in the morning, R260 had called out "Ow, ow." NA-A stated she could only get R260 to sit on the edge of the bed, and stand long enough to pull up her pants. NA-A had planned to get R260 out of bed, but could not accomplish this because of R260's pain. NA-A stated she informed the nurse of R260's pain, and also told the nurse R260 would not get out of bed. NA-A was told by the nurse to try again later.
-at 10:34 a.m. licensed practical nurse (LPN)-D was interviewed. LPN-D did not know when R260 was last medicated for pain. LPN-D stated she had not completed a pain assessment on R260, and had not seen R260 move yet today. LPN-D stated she would need to see R260 move to complete a pain assessment.
-at 1:50 p.m. R260 was observed trying to get out of bed. LPN-D went to get another staff to help get R260 back into bed. R260 stated, "Oh I hurt so bad." LPN-D stated R260's last PRN pain

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F 697	Continued From page 40 medication was given on 9/3/20, at 12:27 a.m. -at 2:30 p.m. the director of nursing (DON) was interviewed. The DON stated she would have expected staff to pre-medicate R260 prior to her clinic appointment on 9/2/20. On 8/20/20, progress note by nurse practitioner indicated resident's pain was controlled with Percocet. The facility policy Pain Assessment and Management revised 3/15, defined pain management as the process of alleviating the resident's pain to a level that is acceptable to the resident, and is based on his or her clinical condition and established treatment goals. The care process included the following: a. Assessing the potential for pain; b. Effectively recognizing the presence of pain; The policy indicated the resident should be observed during rest and movement for physiological and behavioral (non-verbal) signs of pain. Resisting care was described as a behavior to monitor, as were limitations in his or her level of activity due to the presence of pain, guarding, rubbing or favoring a particular part of the body, difficulty eating or loss of appetite.	F 697		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.	F 761		10/7/20

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F 761	Continued From page 41 §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure insulin pens were labeled with current medication orders for administration for 2 of 3 residents (R37, R58) observed for insulin administration. In addition, the facility failed to ensure topical treatments ointments and creams were stored separately to prevent cross contamination for 9 residents (R38, R261, R33, R34, R20, R23, R44, R112, and R16) reviewed for medication storage. Findings include: R37's Admission Record printed 9/3/20, indicated R37's diagnoses included diabetes. R37's Order Summary Report with active orders as of 9/3/20, included physician orders for: - insulin Aspart FlexPen Solution Pen-injector, inject 5 units subcutaneously three times a day	F 761	F761: Label/Store Drugs & Biologicals Immediate Corrective Action: R37 & R58 insulin pens are now correctly labeled with current medication orders for administration. R112 discharged from facility on 9/14/20. R38, R261, R33, R34, R20, R23, R44, R112, and R16 creams and ointments are stored separately and nursing staff are now squeezing a single use amount into a disposable cup to take into the resident's room, then dispose of the cup so as not to cross contaminate. Action as it Applies to Others: Storage of Medications & Topical Application of Ointment & Cream policies were reviewed and remain current All insulin pens were reviewed for appropriate labels. All medicated ointments/creams are now being	

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and,
- insulin Aspart solution, inject as per sliding scale; if 150-199=2 units; 200-249=4 units; 250-299=6 units; 300-349=8 units; 350+=10 units, subcutaneously three times a day.

On 8/31/20, at 5:40 p.m. registered nurse (RN)-D prepared to administer insulin Aspart to R37, and dialed up 5 units on the insulin pen, per the orders on the Medication Administration Record (MAR). The pharmacy label with administration directions on R37's insulin Aspart pen, directed to inject 7 units three times daily, and per sliding scale. RN-D verified the pharmacy label did not match R37's current medication orders on the MAR. RN-D stated she would go by the orders on the MAR, as they were the current orders. RN-D stated R37's insulin pen should have a change-in-directions sticker on it to alert nurses of the change in orders, and proceeded to return R37's insulin pen to the medication cart without applying a change-in-directions sticker on the insulin pen.

On 9/3/20, at 2:50 p.m. licensed practical nurse (LPN)-F verified R37's insulin Aspart pen did not have a change-in-directions sticker on it and the pharmacy label directions did not match the physician orders on the MAR. LPN-F verified R37's insulin pen should have had a change-in-directions sticker on it.

On 9/3/20, at 3:15 p.m. director of nursing (DON) verified a change-in-direction sticker should have been placed on R37's insulin pen when there was a change in directions. DON verified there was a risk for giving the wrong dose of insulin when the pharmacy label did not match the physician

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administered per the single use method stated above.
Nurses & TMAs were educated on proper labeling of insulin pens and proper administration/storage of ointments and creams.
Date of Compliance: 10/7/2020
Reoccurrence will be prevented by: Audit of 5 resident insulin pens conducted weekly x 4 weeks then monthly x2 months to assure pens are labeled appropriately. Observation audit of 5 residents being administered ointments/creams conducted weekly x 4 weeks then monthly x2 months to assure ointments and creams are being administered & stored appropriately. The results of these audits will be shared with the facility QAPI committee for input on the need to increase, decrease, or discontinue the audits.
Corrections will be monitored by: DON/Nurse Managers/Designee

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orders on the MAR.

R58's Admission Record printed 9/3/20, indicated R58's diagnoses included diabetes.

R58's Order Summary Report with active orders as of 9/3/20, indicated R58 had orders for:
-insulin Aspart FlexPen Solution Pen-injector; inject 16 units subcutaneously three times a day, dated 8/13/20.
-insulin Aspart solution pen injector; inject per sliding scale: if 201-250-2 units; 251-300=4 units; 301-350=6 units; 351-400=8 units; 401-600=MD call provider, subcutaneously four times a day, dated 8/5/20.
-insulin detemir solution pen-injector; inject 44 units subcutaneously in the morning for diabetes, dated 8/27/20.

On 9/3/20, at 7:23 a.m. LPN-G was observed during administration of insulin to R58. R58's insulin Aspart pharmacy label was noted to direct administration of 14 units three times a day with meals and per sliding scale. R58's physician orders on the MAR directed to inject 16 units three times daily. In addition, R58's Levemir pharmacy label was noted to direct administration of 40 units subcutaneously daily, and R58's physician orders on the MAR directed to inject 44 units subcutaneously daily.

On 9/3/20, at 3:36 p.m. LPN-H verified R58's insulin pharmacy labels did not match the physician order directives on R58's MAR. LPN-H stated she looked at the MAR for the correct medication orders when administering medications. LPN-H wrote "see MAR" on both insulin pens.

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F 761	Continued From page 44 On 9/3/20, at 4:14 p.m. DON verified pharmacy labels should match physician orders on the MAR. R38's Admission Record printed 9/3/20, indicated R38's diagnoses included psoriasis, cellulitis (infection of the skin tissues), and a history of severe sepsis (body's extreme life threatening reaction to an infection). R38's Order Summary Report with active orders as of 9/3/20, included orders for triamcinolone acetonide ointment 0.1% (used to treat the itching, redness, dryness, crusting, scaling, inflammation, and discomfort of various skin conditions to right hand topically twice daily for psoriasis.) On 9/2/20, at 7:39 a.m. R38's door was closed, a contact precautions for special enteric precautions sign was posted on R38's door. R261's Admission Record printed 9/3/20, indicated R261's diagnoses include heart failure and diabetes. R261's Order Summary Report with active orders as of 9/3/20, included orders for Nystatin cream to infection area topically as needed for infection; and triamcinolone acetonide cream 0.1% to rash topically as needed three times daily. R33's Admission Record printed 9/3/20, indicated R33's diagnoses included chronic respiratory failure with hypoxia, history of pneumonia, dependence on a respirator, and tracheostomy. R33's Order Summary Report with active orders as of 9/3/20, included orders for lidocaine gel for	F 761		

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F 761	Continued From page 45 trach insertion in the morning on the 10th of each month, Asper-Flex Cream 10% (trolamine salicylate) to knee topically as needed for knee pain, to be kept in resident room for nurse to apply; clotrimazole cream 1% (antifungal medicated cream) to rash topically three times a day to rash; Eucerin cream to feet topically twice daily for dry skin; and silver sulfadiazine cream 1% to G-tube site topically in the morning. R33's undated Pocket Care Plan indicated R33 was on contact and droplet precautions related to a resistive organism in the sputum. R34's Admission Record printed 9/3/20, indicated R34's diagnoses included bradycardia (slow heart rhythm), stroke, and tracheostomy. R34's Order Summary Report with active orders as of 9/3/20, included orders for menthol-zinc oxide ointment 0.44-20.6% to erythematous (reddened) areas topically twice daily; and triamcinolone acetonide cream 0.025% to facial rash as needed until clear. R20's Admission Record printed 9/3/20, indicated R20's diagnoses included diabetes, bilateral lower leg amputations, tracheostomy, a Methicillin Resistant Staphylococcus Aureus (MRSA) infection (bacteria that is resistant to some commonly-used antibiotics), cardiac pacemaker, and history of respiratory failure. R20's Order Summary Report with active orders as of 9/3/20, included orders for betamethasone valerate cream 0.1% (reduces the swelling, itching, and redness related to skin conditions) to skin rash topically every 12 hours as needed.	F 761		

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F 761	Continued From page 46 R23's Admission Record printed 9/3/20, indicated R23's diagnoses included acute and chronic respiratory failure, diabetes, MRSA, cardiac pacemaker, and history of pseudomonas aeruginosa (organism that causes infections, including pneumonia). R23's Order Summary Report with active orders as of 9/3/20, included orders for clotrimazole-betamethasone cream 1-0.05% to rash topically twice daily as needed; and Eucerin cream to dry skin as needed for dry skin. R23's undated Pocket Care Plan indicated R23 was on contact precautions due to MRSA in her wounds. R44's Admission Record printed 9/3/20, indicated R44's diagnoses included chronic respiratory failure, diseases of the bronchus, history of pulmonary embolism, history of sudden cardiac arrest, and tracheostomy. R44's Order Summary Report with active orders as of 9/3/20, included orders for Lidocaine gel for insertion of trach during changing every month, calmoseptine ointment 0.44-20.6% to decubitus regions topically three times daily; clotrimazole cream 1% to skin topically twice daily for yeast; Desitin cream 13% (zinc oxide) to bottom topically every 6 hours prn rash and skin irritation; Menthol-Methyl Salicylate Ointment to skin topically every 6 hours as needed for joint and muscle pain four times daily; Vicks VapoRub ointment 4.7-1.2-2.6% (camphor-eucalyptus-menthol) to fingernail/toenails topically every 12 hours as needed for pain; and zinc oxide ointment 40% to bottom topically every 6 hours as needed for skin	F 761		

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irritation four times a day.

R112's Admission Record printed 9/3/20, indicated R112's diagnoses included pneumonia due to MRSA, respiratory failure, history of oral cancer, and cellulitis.

R112's Order Summary Report with active orders as of 9/3/20, included orders for barrier cream to skin surrounding feeding tube, hydrocortisone cream 1% (used on the skin to treat swelling, itching and irritation) to feeding tube side topically one time daily; lidocaine gel 2% to coccyx topically as needed for moderate pain three times daily, and Nystatin cream to feeding tube site topically two times daily for site breakdown.

R112's undated Pocket Care Plan indicated R112 was on contact precautions for MRSA in her sputum.

R16's Admission Record printed 9/3/20, indicated R16's diagnoses included chronic respiratory failure, history of pneumonia, cardiac arrhythmia, pseudomonas aeruginosa, and tracheostomy.

R16's Order Summary Report with active orders as of 9/3/20, included orders for A&D ointment to G tube site topically twice daily and to rash/back/side topically as needed for rash twice daily, and triamcinolone acetonide cream 0.025% to around trach site topically twice daily.

R16's undated Pocket Care Plan indicated R16 was on contact and droplet precautions for Carbapenem-resistant pseudomonas aeruginosa (CRPA) in his sputum.

On 9/3/20, at 3:15 p.m. both medication carts

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F 761	Continued From page 48 were checked for medication storage and revealed several topical treatment tubes/containers were stored together in a drawer, without any separation. Topical treatments stored together in the first cart included: -R38's triamcinolone acetonide -R261's triamcinolone acetonide and Nystatin -R33's sports cream (Asper-cream) and silver sulfadiazine cream -R34's triamcinolone acetonide -R20's capsaicin -R23's Asper-cream and clotrimazole Topical treatments stored together in the second cart included: -R44's calmoseptine, Desitin, antifungal spray, A&D, clotrizole cream and R112's and R16's topical treatments were in baggies, but in contact with R44's topical treatments. On 9/3/20, at 3:36 p.m. RN-A verified the risk of cross-contamination due to storing topical treatments together that go into each resident's rooms during application. On 9/3/20, at 4:14 p.m. the DON verified the risk of cross-contamination with topical treatments being stored together. A policy for labeling of medications was not provided. The facility policy for Topical Application of Ointment and Cream dated 11/19, lacked directives for storing them separately to prevent cross-contamination.	F 761		

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F 812	Continued From page 49	F 812		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure the kitchen was clean by ensuring ceiling tiles over the food preparation area and the oven hood and its components were free of dust and debris to prevent food contamination. In addition, the facility failed to ensure dirty dishware was not in close proximity to a clean dish drying rack, and the ice machine was free from rusted bolts. Findings include: On 8/31/20, at 3:01 p.m. during the initial kitchen tour with the culinary services director (CSD)-A, three carts of dirty dishes were parked within	F 812	F812: Food Procurement, Store/Prepare/Serve-Sanitary Immediate Corrective Action: Kitchen tiles over the food procurement area, as well as the oven hood, were cleaned. Clean dish cart was relocated away from the dirty area in the kitchen. Rusty bolt in ice machine was removed. Action as it Applies to Others: Dishwasher policy was reviewed and remains current Dietary staff educated on dishwasher policy and storing clean dishes away from dirty dishes. Date of Compliance: 10/7/2020	10/7/20

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THE EMERALDS AT GRAND RAPIDS LLC	2801 SOUTH HIGHWAY 169 GRAND RAPIDS, MN 55744

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F 812	Continued From page 50 three feet of the clean dish drying rack. At 3:05 p.m. a staff member was observed bringing additional dirty dishes into the kitchen, and stacking them atop a rolling cart near the clean dish drying rack. The drying rack held various clean items including glasses, meal trays, and a water carafe. The drying rack was made of metal, and had multiple worn areas with considerable rust. CSD-A confirmed the presence of rust, and confirmed the dirty and clean areas were too close in proximity to each other. The lid of the ice machine was noted to have a rusty screw on the underside, with a visible orange drip line leading down from the screw into the area that held the ice. No rust was observed on the ice. CSD-A stated the ice machine was cleaned once per month. CSD confirmed the presence of the rusty screw and orange drip and stated, "It looks like rust." During kitchen tour, copious amounts of dust were observed on the oven hood and the sprinkler system, directly above the stovetop where food was being prepared. Dusty accumulation was observed on the electrical box above the oven hood and its piping. CSD-A stated the oven hood was professionally cleaned once every 6 months, and cleaned by maintenance every month. CSD-A confirmed the presence of dust and stated, "I see a little dust, not a lot, it was done in March so they should be coming." CSD-A confirmed the presence of dust on the ceiling tiles and fire sprinkler directly above the food preparation area and stated, "Looks like dust." Food was being prepared directly below the dusty ceiling. On 8/31/20, at 5:59 p.m. dried orange and brown food was observed splattered on the ceiling tile immediately outside the kitchen doors.	F 812	Reoccurrence will be prevented by: Weekly observation audit of the dishwashing area x 4 weeks then monthly x2 months to ensure clean dishes are stored away from the dirty dishes, ceiling tiles, and oven hood are clean. The results of these audits will be shared with the facility QAPI committee for input on the need to increase, decrease, or discontinue the audits. Corrections will be monitored by: Culinary Services Director/Designee	

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F 812	Continued From page 51 On 9/1/20, at 11:32 a.m. dust remained on the ceiling tiles and fire sprinkler directly above the food preparation area. On 9/2/20, at 9:17 a.m. the paper towel dispenser was empty, and a roll of paper towels had been placed on one of the empty clean drying rack poles. Dietary aide (DA)-A used these paper towels to dry her hands after washing. The dust remained on the ceiling tiled and sprinkler directly above the food preparation area. Food was being prepared directly below this area. At 09:49 A.M. dried food remained on the ceiling tile immediately outside of the kitchen doors. On 9/2/20, at 1:20 p.m. the DCS-A confirmed the presence of dust on the ceiling and sprinkler above the food prep area and stated, "There is still dust up there, it can fall in the food." The DCS-A also confirmed food splatter on the ceiling outside of the kitchen doors and stated, "I am not sure what that is or how it even got up there." The facility policy Food Receiving and Storage revised October 2017, directed food services, or other designated staff, will maintain clean food storage areas at all times.	F 812		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted	F 842		10/7/20

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F 842	Continued From page 52	F 842		

to do so.

§483.70(i) Medical records.
§483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-
(i) Complete;
(ii) Accurately documented;
(iii) Readily accessible; and
(iv) Systematically organized

§483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-
(i) To the individual, or their resident representative where permitted by applicable law;
(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.

§483.70(i)(4) Medical records must be retained for-
(i) The period of time required by State law; or

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F 842	Continued From page 53 (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure proper retention of medical records for 3 of 5 residents (R11, R23, R33) reviewed for unnecessary meds. Findings include: R11's Admission Record printed 9/4/20, indicated R11's diagnoses included gout, pain, hypokalemia (low potassium), major depressive disorder, atrial fibrillation (irregular heart rhythm), chronic kidney disease, bipolar disorder, anxiety disorder, osteoarthritis, diabetes, and hypertension. R11's medical record lacked evidence of consultant pharmacist reviews for 9/19, 10/19, and 11/19. R11's consultant pharmacist Summary Report	F 842	F842: Resident Records-Identifiable Information Immediate Corrective Action: Pharmacy recommendations are now being retained and uploaded to the individual residents' medical record. Action as it Applies to Others: Records Retention Schedule was reviewed and remains current DON and Medical Records Director were educated on Record Retention schedule and uploading pharmacy recommendations into the residents' medical record. Date of Compliance: 10/7/2020 Reoccurrence will be prevented by: Weekly audit of 3 resident pharmacy reviews x 4 weeks then monthly x2 months to ensure pharmacy recommendations are being retained and	

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F 842	Continued From page 54 dated 12/19, indicated irregularities were identified. The facility was unable to provide the consultant pharmacist's Consultation Report with identification of the specific irregularities and recommendations, or evidence of the physician's follow-up to the irregularities. A consultant pharmacist Prospective Medication Review dated 2/14/20, indicated R11 had a physician order for Potassium Cl 50 millequivelants extended release by mouth twice a day for hypokalemia. the consultant pharmacist identified this as a high dose of potassium and requested confirmation by the physician that it was the correct dose by midnight of the next calendar day. R11's Prospective Medication Review had a hand written note by the medical records staff, indicating the original potassium order at this dose was written on 4/23/18. R11's medical record lacked evidence of a review of R11's potassium order by a physician by 2/15, at 11:59 p.m. as directed by the consultant pharmacist. R11's consultant pharmacist Summary Report for 4/20, indicated irregularities were identified. The facility was unable to provide the consultant pharmacist's Consultation Report with identification of the specific irregularities and recommendations, or evidence of the physician's follow-up to the irregularities. R11's consultant pharmacist Summary Report for 5/20, indicated no irregularities were identified. R11's consultant pharmacist Summary Report for 6/20, indicated irregularities were identified. The facility was unable to provide the consultant	F 842	uploaded to the residents medical record. The results of these audits will be shared with the facility QAPI committee for input on the need to increase, decrease, or discontinue the audits. Corrections will be monitored by: Medical Records Director/Designee	

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F 842	Continued From page 55 pharmacist's Consultation Report with identification of the specific irregularities and recommendations, or evidence of the physician's follow-up to the irregularities. R11's consultant pharmacist Summary Report for 7/20, indicated irregularities were identified. R11's consultant pharmacist Summary Report for 9/20, indicated irregularities were identified. The facility was unable to provide the consultant pharmacist's Consultation Report with identification of the specific irregularities and recommendations. On 9/4/20, at 2:50 p.m. director of nursing (DON) verified they were unable to locate the remaining recommendations and physician follow-up for residents for whom records were requested. The facility policy Medication Regimen Reviews revised 5/19, directed the consultant pharmacist would provide a written copy of all medication regimen reports, which would be maintained as part of each resident's permanent record, along with the physician responses. The facility Records Retention Schedule updated 11/14, directed Medical records to retain consultant reports for 2 years in the medical record.	F 842		

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F 842	Continued From page 56 R23's Admission Record printed on 9/4/20, indicated R23's diagnoses included dependence on respirator (ventilator) status, anxiety disorder, acute respiratory distress syndrome, chronic respiratory failure with hypoxia, major depressive disorder, chronic pain, and restless legs syndrome. R23's medical record lacked evidence of consultant pharmacist reviews for 9/19, 10/19, and 11/2019. R33's Admission Record printed on 9/4/20, indicated R33's diagnoses included chronic respiratory failure with hypoxia, dependence on respirator (ventilator) status, and tracheostomy status. R33's medical record lacked evidence of consultant pharmacist reviews for 9/19, 10/19, 11/19, and 2/20. In addition the 3/20, consultant pharmacist review identified irregularities, no report was found. On 9/4/20, at 4:06 p.m. the administrator was interviewed and verified the facility was required to keep medical records for a specified time period. On 9/4/20, at 4:15 p.m. the consultant pharmacist was interviewed and verified there should have been monthly medication reviews in R23's record. He stated that he took over the role of consultant pharmacist in December of 2019.	F 842		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control	F 880		10/7/20

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F 880	Continued From page 57 The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (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	F 880		

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F 880	Continued From page 58 involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to perform hand hygiene after direct contact with residents and high touch environmental surfaces in quarantined residents rooms and subsequently passing meal trays for 6 of 25 residents (R48, R56, R59, R211, R2100, and R21) reviewed for dining. Further, the facility failed to ensure their comprehensive infection prevention and control program (IPCP) included surveillance of all potential infections; ongoing, comprehensive analysis of all collected surveillance data; and, demonstrated investigation(s) of developed infections to help	F 880	F880:Infection Prevention & Control Immediate Corrective Action: Staff were educated on performing hand hygiene in between room trays. Action as it Applies to Others: Facility policy on Infection Prevention and Control Program policy was reviewed and remains current. Infection Control Nurse/ADON and DON educated on proper infection control tracking including surveillance of all potential infections; ongoing, comprehensive analysis of all collected	

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prevent potential recurrence and/or spread within the facility. This had the potential to affect all 64 residents residing in the facility at the time of the survey.

Findings include:

R46's Admission Record printed 9/3/20, indicated R46's diagnoses included dementia, chronic obstructive respiratory disease (COPD), and diabetes.

R57's Admission Record printed 9/3/20, indicated R57's diagnoses included COPD and chronic kidney disease.

R110's Admission Record printed 9/3/20, indicated R110's diagnoses included aftercare following joint replacement, emphysema, and COPD. R

R11's Admission Record printed 9/3/20, indicated R11's diagnoses included atrial fibrillation (irregular heart rhythm), diabetes, congestive heart failure, and history of cancer.

R11's care plan initiated 6/10/20, indicated R11 was on contact precautions for Methicillin-Resistive Staphylococcus Aureus (MRSA-organism resistive to some antibiotics).

R111's Admission Record printed 9/3/20, indicated R111's was admitted on 8/24/20, and diagnoses included urinary tract infection, heart failure, rheumatoid arthritis, and chronic kidney disease.

R111 was on quarantine precautions related to new admission to the facility, and room door had

surveillance data, and demonstrated investigation of developed infections to help prevent potential recurrence or spread within the facility.
Handwashing/Hand Hygiene policy was reviewed and remains current.
All nurses and NARs were educated on performing hand hygiene in between room trays.
Date of Compliance: 10/7/2020
Reoccurrence will be prevented by:
Weekly observation audit of 5 staff to assure they are completing hand hygiene appropriately after direct contact with residents, high touch surfaces, high touch environmental services, and meal delivery x 4 weeks then monthly x2 months. The results of these audits will be shared with the facility QAPI committee for input on the need to increase, decrease, or discontinue the audits.
Corrections will be monitored by:
DON/Nurse Managers/Designee

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a quarantine sign posted on it.

R12's Admission Record printed 9/3/20, indicated R12's diagnoses included a history of sepsis (the body's extreme, life-threatening response to an infection), COPD, diabetes, acute respiratory failure, history of pneumonia and dysphagia (problems swallowing).

R12's room door had a quarantine sign posted on it.

On 8/31/20, at 5:45 p.m. nursing assistant (NA)-M was serving meal trays to each room, from a cart with individual trays.

On 8/31/20, at 6:06 p.m. nursing assistant (NA)-M was serving meal trays to each room, from a cart with individual trays. NA-M had gloves and a faceshield on. NA-M brought a tray into R46's room, left the room, did not remove gloves and/or sanitize hands, got another tray from the cart and served it to R110, moved a glass for R110, and left the room, without removing gloves and/or sanitizing hands. NA-M got another tray from the cart, brought the tray into R57, positioned R57 in his wheelchair up to the tray table, and with the same gloves, knocked on R11's door, brought in a tray from the cart, without wearing a gown, left R11's "precautions" room without sanitizing or changing gloves.
NA-M picked up another tray from the cart without sanitizing or changing gloves, delivered it to R12. After passing a tray to R12, when questioned, NA-M verified she had been wearing the same gloves from room to room, touched resident's environment, and went into R11's "precautions room" without wearing a gown, or changing gloves, and went right into R12's room to deliver

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a tray and touched his belongings.

During the same time, NA-N picked delivered fluids to each room. NA-N changed gloves between each room, but did not sanitize between glove changes.

On 8/31/20, at 6:13 p.m. NA-M and NA-N verified they should have been sanitizing between glove changes, between each resident.

On 9/3/20, at 4:14 p.m. director of nursing (DON) verified there was a risk of cross-contamination when gloves aren't changed and hands are not washed or sanitized between each resident while passing meal trays.

The facility policy and procedure for Handwashing/Hand Hygiene revised 8/19, directed staff to use an alcohol-based hand rub or soap and water before and after assisting a resident with meals, handling food, after removing gloves, before and after direct contact with residents or contaminated equipment.

On 9/1/20, at 12:03 p.m. nursing assistant (NA)-B delivered meals to residents R48 and R56, exited the room, and without performing hand hygiene took another meal from the cart and delivered it to R59. NA-B then delivered a meal to R211, who was in quarantine. Without performing hand hygiene, NA-B delivered a meal to quarantined resident R210. NA-B touched and moved items on R210's bedside table including a water glass and soda can. NA-B exited the room, did not perform hand hygiene, and pushed the food cart down the hall, and brought a meal tray into R21's room, who was quarantined.

F 880 Continued From page 62 F 880

On 9/1/20, at 12:30 p.m. NA-B was interviewed and stated she did not sanitize her hands while passing meal trays. NA-B stated, "I must have spaced it, I am usually really good about hand hygiene."

On 9/3/20, at 10:23 a.m. licensed practical nurse (LPN)-A was interviewed and stated if staff were going in and out of rooms they should be using hand sanitizer properly and they should should be doing proper hand hygiene.

On 9/3/20, at 2:17 p.m. the DON stated when staff was going from resident to resident rooms she would expect they would perform hand hygiene.

On 9/3/20, the last twelve months infection control line listings were requested for review from the infection control preventionist/registered nurse (RN)-B. The provided information was reviewed and identified the following data separated by each month.

The facility Antibiotic Tracking Sheets, dated 6/4/20, to 6/25/20, and 7/2/20, to 7/31/20, identified line listings used to record infections within the facility. The data collected included various items tracked including, but not limited to, resident names, room numbers, infection types, symptoms, onset dates, laboratory or organism results, antibiotic usage and if transmission-based precautions were needed/used.

Healthcare Associated Infection Summary Report by Resident Days dated June 2020, and July 2020, tracked a breakdown of specific infections (respiratory, urinary tract infections [UTIs], skin,

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	245495	A. BUILDING ______ B. WING ______	C 09/04/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE EMERALDS AT GRAND RAPIDS LLC	2801 SOUTH HIGHWAY 169 GRAND RAPIDS, MN 55744

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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gastrointestinal, bloodstream, other, and ventilator associated pneumonia) and resident days, which when calculated indicated the month's total infection rate. The bottom of the form identified an area for "Specific Trends" and "Actions Taken."

JUNE 2020:

The line listing (outlined above) identified a total of 12 resident infections between three listed units (unit 2, unit 3, and unit 4):

- Unit 2 had an identified UTI which listed a urine specimen had been collected after symptom onset of 6/4/20, however, the tracking sheet did not identify the organism for which seven days of antibiotics had been administered.

-Unit 3 had identified a single infection each for UTI, pneumonia, upper respiratory infection and skin infection, along with a single infection identified as, "Other." The UTI listed a urine specimen had been collected after symptom onset of 6/17/20, however, the tracking sheet failed to identify the organism for which six days of antibiotics had been administered. The pneumonia infection sputum (coughed up mucus) culture obtained after symptom onset of 6/17/20 identified extended-spectrum beta-lactamase (ESBL, an enzyme that prevents certain antibiotics from being able to kill the bacteria). The upper respiratory infection listed a sputum culture was obtained for symptom onset of 6/23/20, however, failed to identify the organism for which seven days of antibiotics were administered.

-Unit 4 had identified a single skin infection and

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five UTI. All five UTI were each identified to have different symptoms listed, however, urine cultures for two of the UTI identified proteus mirabilis (a bacteria) with symptom onsets of 6/4/20, and 6/19/20, respectively. Two of the other UTI identified escherichia coli (a bacteria), in which one further identified ESBL, with symptom onsets of 6/22/20, and 6/23/20, respectively.

The line listing failed to indicate antibiotic end dates for three of the resident infections, results of reported wound cultures for the two skin infections, and further failed to identify when all of the infections listed had resolved symptoms. The line listing did not indicate or identify any residents had been tracked for non-antibiotic treated infections (i.e. viral infections, common cold symptoms).

The infection summary report (outlined above) dated June 2020, identified a total of seven facility infections with a total of 1432.00 resident days. A series of equations were listed which identified the facility had an infection rate of 4.89 % (percent). The "Specific Trends" section listed: "Unit 2- 1 UTI, Unit 4 - 5 UTI, Unit 4 - skin 1, Unit 3 - 1 pneumonia. The "Actions Taken" section listed: "Hand washing audits in place for each wing. Different organisms." The infection summary report failed to show documentation of a comprehensive analysis of the infections for June 2020.

JULY 2020:

The line listing (outlined above) identified a total of 14 resident infections between three listed units (unit 2, unit 3, and unit 4):

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F 880	Continued From page 65	F 880		

- Unit 2 had identified four UTI and one pneumonia. All four of the UTI were each identified to have different symptoms listed. One urine culture for symptom onset of 7/9/20, reported to be obtained per the resident's request with no other symptoms indicated, identified enterococcus avium (a bacteria) and another resident's urine culture obtained for symptom onset of 7/30/20, identified enteroccus faecalis (a bacteria). Another urine culture obtained identified escherichia coli with ESBL for symptom onset of 7/30/20. One urine culture failed to identify the organism result. The pneumonia infection indicated the resident was seen in the emergency department but the line listing did not indicate results of the x-ray report listed to have occurred on 7/27/20.

-Unit 3 had identified one skin infection, one ear infection, one pneumonia, and one UTI, with a single infection listed as "Other." The UTI listed a urine culture was completed for symptom onset of 7/22/20, however, failed to identify the organism for which three days of antibiotics were administered.

-Unit 4 had identified one pneumonia infection, one UTI, and two infections listed as "Other." One UTI indicated a urine culture obtained after symptom onset of 7/22/20, which identified the organisms to be escherichia coli and ESBL. A urine culture report dated 7/23/20, with a nurse practitioner note further indicated the resident diagnosed with ESBL also had evidence of pneumonia in addition to the UTI. This was not listed on the line listing form.

The line listing failed to identify two of the residents tracked for UTI and "Other" had an

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Continued From page 66
antibiotic reassessment performed in regards to antibiotic stewardship processes. Further, the line listing failed to identify when all of the infections listed had resolved symptoms. The line listing did not indicate or identify any residents had been tracked for non-antibiotic treated infections.

The infection summary report (outlined above) dated July 2020, identified a total of 11 facility infections with a total of 1729.00 resident days. A series of equations were listed which identified the facility had a infection rate of 6.36%. The "Specific Trends" section listed: "no specific trends." The "Actions Taken" section listed: "11 total infections. 3 residents with pneumonia. 2 residents with cellulitis. 6 residents with UTI's." The infection summary report failed to show documentation of a comprehensive analysis of the infections for July 2020.

The facility did not provide documented evidence demonstrating the facility had conducted a comprehensive analysis of the facility acquired infections to determine if any of the infections identified were potentially related and/or spread within the facility or respective unit(s), despite having had multiple infections with the same causative organisms throughout the facility. Further, there was no provided evidence the facility had correlated the resident' infection data with staff illnesses to determine if any of the infections were related. In addition, the facility did not provide documented evidence the facility had a system for tracking non-antibiotic treated infections.

On 9/3/20, at 10:06 a.m. the DON and RN-B were interviewed. RN-B stated she reviewed the electronic health system "dashboard" each day

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she works, and monitors every resident who is on antibiotics, which she then adds to a monthly line listing. The DON stated at the end of the month the line listings are reviewed to see if there are trends and to see if staff education was required. Both the DON and RN-B denied a comprehensive analysis was documented prior to the infection data being brought to the facility monthly QAPI (Quality Assurance and Performance Improvement) committee. Any analysis completed during the QAPI committee was not kept with the infection control reports, however, was kept with the QAPI meeting minutes. Neither the DON nor RN-B offered to provide any analysis which may have been completed prior to or during the QAPI meetings to show support of a comprehensive infection analysis process.

On 9/3/20, at 3:32 p.m. a follow-up interview was conducted with RN-B in which she stated the monthly line listings were only for those infections that required antibiotic treatment. RN-B explained non-antibiotic infections were placed on a "24 hour board" in which nursing staff would chart on those residents. RN-B confirmed she did not track non-antibiotic infections.

The facility Infection Prevention and Control Program policy dated 8/19/20, directed the scope of the plan was "... comprehensive in that is addresses detection, prevention and control of infections among residents and personnel." The policy further directed surveillance tools are used for recognizing the occurrence of infections, recording their number and frequency, detecting outbreaks and epidemics, monitoring employee infections, and detecting unusual pathogens with infection control implications. Culture reports, sensitivity data, and antibiotic usage reviews are

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F 880	Continued From page 68 included in the facility surveillance activities, in which surveillance data and reporting information is used to inform the committee of potential issues and trends. The policy identified the infection preventionist collected data from the nursing units, categorized each infection by body site, and recorded the absolute number of infections. The policy lacked any direction or guidance on how identified infections would be investigated to reduce the risk of recurrence or when to ensure a comprehensive analysis was to be completed. Further, the policy lacked any information on how the program would track non-antibiotic treated infections or if/when investigations into the infections would be done.	F 880		

DIRECTED PLAN OF CORRECTION

A Directed Plan of Correction (DPOC) is imposed in accordance with 42 CFR § 488.424. Your facility must include the following in their POC for the deficient practice cited at F880:

TRACKING AND TRENDING INFECTION CONTROL PROGRAM

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- Address how the facility will identify other residents having the potential to be affected by the same deficient practice.

POLICIES/PROCEDURES/SYSTEM CHANGES:

- The facility's Quality Assurance and Performance Improvement Committee must conduct a root cause analysis (RCA) to identify the problem(s) that resulted in this deficiency and develop intervention or corrective action plan to prevent recurrence.

The Infection Preventionist and Director of Nursing, shall complete the following:

- Review and revise policies for infection surveillance as needed.
- Develop and implement an infection control program sign and symptom tracking tool to monitor all residents and staff for communicable, respiratory infection, according to the CDC guidelines.
- Ensure that the charge nurse for each shift documents all resident and employee infections on the facility's shared infection tracking log. Compliance and review of the infection control log will be completed by the Infection Preventionist daily. The data will be analyzed for possible trends/outbreaks. The Infection Preventionist will investigate any potential outbreaks and follow up as appropriate.
- Conduct rounds throughout the facility to ensure staff is exercising appropriate use of personal protective equipment and to ensure infection control procedures are followed on each unit. Ad hoc education will be provided to persons who are not correctly utilizing equipment and/or infection prevention/control practices. Such monitoring will continue until the facility has been infection free for at least four weeks.
- Review infection prevention tracking and trending. Any unexpected increases in infection must be reported to the Medical Director, Public Health Department, and the state survey agency in order to obtain further assistance to control infection.

TRAINING/EDUCATION:

- As a part of corrective action plan, the facility must provide training for the Infection Preventionist, the Director of Nursing, nursing leadership/management, and facility administration. The training must cover standard infection control practices, active surveillance, tracking and trending for a comprehensive infection control program. The facility may use

training resources made available by the Centers for Disease Control and Prevention or a program developed by well-established centers of geriatric health services education, such as schools of medicine or nursing, centers for aging, and area health education centers with established programs in geriatrics.

- Include documentation of the training completed with a timeline for completion.
- The training may be provided by the Director of Nursing, Infection Preventionist, or Medical Director with an attestation statement of completion.
- Tier three or four concerns (harm or IJ) training must be provided by a contracted outside infection prevention consultant.
- Online infection prevention training courses may be utilized. The CDC and MDH websites have several infection control training modules and materials.

CDC RESOURCES:

- Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic.
  https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html
- Infection Control Guidance for Healthcare Professionals about Coronavirus (COVID-19)
  https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control.html

CMS RESOURCES:

- CMS & CDC Offer a specialized, online Infection Prevention and Control Training For Nursing Home Staff in the Long-Term Care Setting

https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/QAPI/downloads/GuidanceforRCA.pdf

MDH RESOURCES:

- Infection Prevention and Control Guidelines
  https://www.health.state.mn.us/facilities/patientsafety/infectioncontrol/guidelines.html
- Infection Control Precautions
  https://www.health.state.mn.us/facilities/patientsafety/infectioncontrol/pre/index.html
- National Healthcare Safety Network (NHSN)
  https://www.health.state.mn.us/facilities/patientsafety/infectioncontrol/nhsn.html
- COVID-19 Toolkit: Information for Long-term Care Facilities (PDF)
  https://www.health.state.mn.us/diseases/coronavirus/hcp/ltctoolkit.pdf
- Responding to and Monitoring COVID-19 Exposures in Health Care Settings (PDF)
  https://www.health.state.mn.us/diseases/coronavirus/hcp/response.pdf
- COVID-19 Infection Prevention and Control and Cohorting in Long-term Care (PDF)
  https://www.health.state.mn.us/diseases/coronavirus/hcp/ltcipchohort.pdf

MONITORING/AUDITING:

Monitoring of approaches to ensure infections are controlled will include:

- The Infection Preventionist and Director of Nursing, each day and more often as necessary, will review infection prevention tracking and trending logs and data analysis. Any unexpected increases in infection will result in communication with the Medical Director, Public Health Department and the state survey agency in order to obtain further assistance to control

infection.
- The Director of Nursing, Infection Preventionist, or designee will review the results of audits and monitoring with the Quality Assurance Program Improvement (QAPI) program.

EQUIPMENT/ENVIRONMENT

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- Address how the facility will identify other residents having the potential to be affected by the same deficient practice.

POLICIES/PROCEDURES/SYSTEM CHANGES:

- The facility's Quality Assurance and Performance Improvement Committee must conduct a root cause analysis (RCA) to identify the problem(s) that resulted in this deficiency and develop intervention or corrective action plan to prevent recurrence.
- The director of housekeeping, director of maintenance, and director of nursing must review policies and procedures regarding disinfecting multiuse/shared equipment/items and/or environmental disinfection to ensure they meet the CDC guidance for disinfection in health care facilities and follow disinfectant product manufacturer directions for use including contact time.

TRAINING/EDUCATION:

- The Director of Housekeeping/Maintenance, and/or Director of Nursing, or Infection Preventionist must train all staff responsible for resident care equipment and environment on the facility policies/practices for proper disinfection, including following manufacturer direction for use. Each staff person must demonstrate competency at the conclusion of the training. Training and competency testing must be documented. The Minnesota Department of Health (MDH), Center for Disease Control (CDC), and Environmental Protection Agency have education materials that may be used for training.

  - CDC: Infection Control Guidelines and Guidance Library. https://www.cdc.gov/infectioncontrol/guidelines/index.html/eic_in_HCF_03.pdf
  - MDH COVID-19 Toolkit. https://www.health.state.mn.us/diseases/coronavirus/hcp/ltctoolkit.pdf
  - EPA: List N: Disinfectants for Use Against SARS-CoV-2 (COVID-19) https://www.epa.gov/pesticide-registration/list-n-disinfectants-use-against-sars-cov-2-covid-19

CDC RESOURCES:
Infection Control Guidance: https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control.html
CDC: Isolation Precautions Guideline:
https://www.cdc.gov/infectioncontrol/guidelines/isolation/index.html
CDC: Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings (2007): https://www.cdc.gov/infectioncontrol/guidelines/isolation/index.html
CDC: Personal Protective Equipment: https://www.cdc.gov/niosh/ppe/

Healthcare Infection Prevention and Control FAQs for COVID-19:
https://www.cdc.gov/coronavirus/2019-ncov/hcp/faq.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F2019-ncov%2Fhcp%2Finfection-control-faq.html

MDH RESOURCES:
Personal Protective Equipment (PPE) for Infection Control:
https://www.health.state.mn.us/facilities/patientsafety/infectioncontrol/ppe/index.html
MDH Contingency Standards of Care for COVID-19: Personal Protective Equipment for Congregate Care Settings (PDF): https://www.health.state.mn.us/communities/ep/surge/crisis/ppegrid.pdf
Interim Guidance on Facemasks as a Source Control Measure (PDF):
https://www.health.state.mn.us/diseases/coronavirus/hcp/maskssource.pdf
Interim Guidance on Alternative Facemasks (PDF):
https://www.health.state.mn.us/diseases/coronavirus/hcp/masksalt.pdf
Aerosol-Generating Procedures and Patients with Suspected or Confirmed COVID-19 (PDF):
https://www.health.state.mn.us/diseases/coronavirus/hcp/aerosol.pdf
Droplet Precautions:
https://www.health.state.mn.us/facilities/patientsafety/infectioncontrol/pre/droplet.html
Airborne Precautions:
https://www.health.state.mn.us/facilities/patientsafety/infectioncontrol/pre/droplet.html

MONITORING/AUDITING:

- The Director of Nursing, the Infection Preventionist, and/or other facility leadership will conduct audits for proper cleaning and disinfection of resident use equipment/environmental cleaning, on all shifts every day for one week, then may decrease frequency as determined by compliance.

HAND HYGIENE

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice.

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice.

POLICIES/PROCEDURES/SYSTEM CHANGES:

- The facility's Quality Assurance and Performance Improvement Committee must conduct a root cause analysis (RCA) to identify the problem(s) that resulted in this deficiency and develop intervention or corrective action plan to prevent recurrence.

The Infection Preventionist and Director of Nursing, shall complete the following:

- Review hand hygiene policies and procedures to ensure they meet CDC guidance, and revise as needed.

TRAINING/EDUCATION:

- As a part of corrective action plan, the facility must provide training for the Infection Preventionist, the

Director of Nursing, all staff providing direct care to residents, and all staff entering resident's rooms, whether it be for residents' dietary needs or cleaning and maintenance services. The training must cover standard infection control practices, including but not limited to, transmission-based precautions and adequately caring for and disinfecting shared medical equipment. Findings of the RCA should also be incorporated into staff training.

- The Infection Preventionist, Director of Nursing and Clinical Education Coordinator must implement competency assessments for staff on proper hand hygiene and develop a system to ensure all staff have received the training and are competency
- Online infection prevention training courses may be utilized. The CDC and MDH websites have several infection control training modules and materials.

https://www.health.state.mn.us/people/handhygiene/ (MDH)
Hand Hygiene (MDH) https://www.health.state.mn.us/people/handhygiene/index.html
Hand Hygiene for Health Professionals (MDH)
https://www.health.state.mn.us/people/handhygiene/index.html
Cleaning Hands with Hand Sanitizer (MDH)
https://www.health.state.mn.us/people/handhygiene/clean/index.html
CDC: Guideline for Hand Hygiene in Health-Care Settings (CDC)
https://www.cdc.gov/mmwr/preview/mmwrhtml/rr5116a1.htm
WHO Guidelines on Hand Hygiene in Health Care (WHO)
https://apps.who.int/iris/bitstream/handle/10665/44102/9789241597906_eng.pdf;jsessionid=A770590E49844880F6F3E1D8F22F0841?sequence=1
Hand Hygiene in Outpatient and Home-based Care and Long-term Care Facilities (WHO)
https://www.who.int/gpsc/5may/hh_guide.pdf

CDC RESOURCES:
Infection Control Guidance: https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control.html
CDC: Isolation Precautions Guideline: https://www.cdc.gov/infectioncontrol/guidelines/isolation/index.html
CDC: Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings (2007): https://www.cdc.gov/infectioncontrol/guidelines/isolation/index.html
CDC: Personal Protective Equipment: https://www.cdc.gov/niosh/ppe/
Healthcare Infection Prevention and Control FAQs for COVID-19:
https://www.cdc.gov/coronavirus/2019-ncov/hcp/faq.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F2019-ncov%2Fhcp%2Finfection-control-faq.html

MDH RESOURCES:
Personal Protective Equipment (PPE) for Infection Control:
https://www.health.state.mn.us/facilities/patientsafety/infectioncontrol/ppe/index.html
MDH Contingency Standards of Care for COVID-19: Personal Protective Equipment for Congregate Care Settings (PDF): https://www.health.state.mn.us/communities/ep/surge/crisis/ppegrid.pdf
Interim Guidance on Facemasks as a Source Control Measure (PDF):
https://www.health.state.mn.us/diseases/coronavirus/hcp/maskssource.pdf
Interim Guidance on Alternative Facemasks (PDF):
https://www.health.state.mn.us/diseases/coronavirus/hcp/masksalt.pdf
Aerosol-Generating Procedures and Patients with Suspected or Confirmed COVID-19 (PDF):
https://www.health.state.mn.us/diseases/coronavirus/hcp/aerosol.pdf
Droplet Precautions: https://www.health.state.mn.us/facilities/patientsafety/infectioncontrol/pre/droplet.html
Airborne Precautions: https://www.health.state.mn.us/facilities/patientsafety/infectioncontrol/pre/droplet.html

MONITORING/AUDITING:

- The Director of Nursing, the Infection Preventionist and other facility leadership will conduct audits on all shifts, every day for one week, then may decrease the frequency based upon compliance. Audits should continue until 100% compliance is met.

The Director of Nursing, Infection Preventionist or designee will review the results of audits and monitoring with the Quality Assurance Program Improvement (QAPI) program.

In accordance with 42 CFR § 488.402(f), this remedy is effective 15 calendar days from the date of the enforcement letter. The DPOC may be completed on or after that date. The effective date is not a deadline for completion of the DPOC. However, a revisit will not be approved prior to receipt of documentation confirming the DPOC was completed. To demonstrate that the facility successfully completed the DPOC, the facility must provide all of the following documentation. Documentation should be uploaded as attachments through ePOC.

Imposition of this DPOC does not replace the requirement that the facility must submit a complete POC for all cited deficiencies (including F880) within 10 days after receipt of the Form CMS 2567.

Item	Checklist: Documents Required for Successful Completion of the Directed Plan
1	Documentation of the RCA and intervention or corrective action plan based on the results with signatures of the QAPI Committee members.
2	Documentation that the interventions or corrective action plan that resulted from the RCA was fully implemented
3	Content of the training provided to staff, including a syllabus, outline, or agenda, as well as any other materials used or provided to staff for the training
4	Names and positions of all staff that attended and took the trainings
5	Staff training sign-in sheets
6	Summary of staff training post-test results, to include facility actions in response to any failed post-tests
7	Documentation of efforts to monitor and track progress of the interventions or corrective action plan

In order to speed up our review, identify all submitted documents with the number in the "Item" column.

Attach all items into ePOC.

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
September 24, 2020

Administrator
The Emeralds At Grand Rapids Llc
2801 South Highway 169
Grand Rapids, MN 55744

Re: State Nursing Home Licensing Orders
Event ID: ZR7711

Dear Administrator:

The above facility was surveyed on August 31, 2020 through September 4, 2020 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:

Teresa Ament, Unit Supervisor
Duluth Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Duluth Technology Village
11 East Superior Street, Suite 290
Duluth, Minnesota 55802-2007
Email: teresa.ament@state.mn.us
Phone: (218) 302-6151

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,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00299	A. BUILDING: ______ B. WING ______	C 09/04/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE EMERALDS AT GRAND RAPIDS LLC	**2801 SOUTH HIGHWAY 169 GRAND RAPIDS, MN 55744**

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2 000	Initial Comments	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 8/31/20, through 9/4/20, surveyors of this Department's staff visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed.

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2 000	Continued From page 1 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. 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	2 265		10/7/20

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2 265	Continued From page 2 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 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 observation, interview, and document review, the facility failed to ensure the primary care provider was notified timely when weight gained and edema occurred for 1 of 3 residents (R18) reviewed for edema. R18's Admission Record printed 9/4/20, indicated R18's diagnoses included hypertension, and acute respiratory failure. R18's Minimum Data Set (MDS) dated 8/19/20, indicated R18 was cognitively intact, required	2 265	F580: Notification of Change Immediate Corrective Action: R18 physician was notified of weight gain and edema on 9/4/20. Action as it Applies to Others: Change in a Resident's Condition or Status policy was reviewed and remains current. All residents were reviewed for weight gain/edema to ensure that MD has been notified. All nurses were re-educated on Resident's	

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2 265	Continued From page 3 limited assistance with bed mobility, transfers, dressing, personal hygiene, and required extensive assistance with toileting. R18's medical record indicated the following weights: On 8/12/20, weight was 117 pounds (lbs) On 8/17/20, weight was 116 lbs On 8/24/20, weight was 123.4 lbs (7.4 lbs. weight increase in seven days) On 9/3/20, weight was 125.5 lbs R18's medical record lacked indication the physician or nurse practitioner (NP) was notified on 8/24/20, at the time of R18's 7.4 lbs weight gain. On 8/27/20, a progress note indicated R18 had no edema. On 8/29/20, two separate progress notes indicated R18 had edema to the left foot and lower leg. On 8/30/20, a progress note indicated R18 had edema to the left foot and lower leg. On 8/31/20, a progress note indicated R18 had edema to the foot. On 9/1/20, a progress note indicated R18 had edema in left foot. R18's progress notes lacked indication the MD was notified of R18's edema. On 9/1/20, at 9:45 a.m. the top of R18's left foot and toes were observed to be swollen. R18 stated she told licensed practical nurse (LPN)-C her left foot was swollen, she was gaining weight,	2 265	Condition or Status policy to include timely MD notification of a resident change in weight of +/- 5 lbs or per MD order. Date of Compliance: 10/7/2020 Reoccurrence will be prevented by: Audit of 5 residents with a change in condition will be conducted weekly x 4 weeks then monthly x2 months to assure physician is notified of resident changes in condition. The results of these audits will be shared with the facility QAPI committee for input on the need to increase, decrease, or discontinue the audits. Corrections will be monitored by: DON/Nurse Managers/Designee	

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2 265	Continued From page 4	2 265		

and requested to have a diuretic (medication that removes excess fluid) ordered. R18 stated she had gained over 7 lbs in a week, and was concerned her left foot and toes were swollen.

On 9/2/20, at 7:30 a.m. R18's was observed propelling herself in the hallway in her wheelchair and R18's left lower leg was observed to be swollen.

On 9/3/20, at 10:55 a.m. LPN-F stated she was unaware R18 had a weight gain of 7.4 lbs in a week prior to that day. LPN-F verified R18's medical record lacked indication R18's physician was notified of R18's 7.4 lbs weight gain, and edema prior to 9/2/20. LPN-F stated a physician should be notified of a weight gain of five lbs or greater in a week.

On 9/3/20, at 11:35 a.m. LPN-C stated she reviewed resident weights weekly. LPN-C stated she was aware of R18's weight gain the week of 8/24/20. LPN-C stated she did not notify the NP of R18's weight gain and edema because R18 was already on the NP's schedule to bee seen on 8/24/20. LPN-C stated was unsure why R18 was not seen by the NP on 8/24/20, or 8/26/20. LPN-C stated she added R18 to the NP's schedule on 9/2/20, because of her weight gain. LPN-C stated the NP should have been notified immediately of R18's weight gain and edema, and further stated LPN-C should have followed up with the NP prior to 9/2/20.

On 9/3/20, at 3:01 p.m. LPN-I stated she was responsible for keeping the NP rounding schedule. LPN-I stated the nurses would request a resident to be seen by the NP, and LPN-I would add the resident to the NP's schedule and the reason for the visit. LPN-I stated R18 was

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2 265	Continued From page 5	2 265		

scheduled to be seen on 8/24/20, for an initial NP visit after her admission to the facility. LPN-I stated the NP was running out of time that day, and R18 was rescheduled to be seen on 8/26/20. LPN-I stated R18 was not seen by the NP on 8/26/20. LPN-I verified according the NP's schedule, the reason listed R18's was to be seen on 8/24/20, and 8/26/20, was for an initial visit, and weight gain was also listed. LPN-I verified the NP did not see R18 until 9/2/20.

On 9/4/20, at 3:51 p.m. the director of nursing (DON) stated she expected the physician or NP to be notified of any weight gain over five lbs either by fax or phone the day the weight increase was discovered. The DON further stated a weight gain of 7.4 lbs would be a concern of changes in underlying medical conditions.

The facility policy Change in Resident's Condition or Status revised 5/17, directed to promptly notify the resident's physician of changes in the resident's medical/mental condition and/or status.

SUGGESTED METHOD OF CORRECTION:
The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure residents/family representatives are notified of a change in condition or treatment.
The Director of Nursing or designee could educate all appropriate staff on the policies and procedures.
The Director of Nursing or designee could develop monitoring systems to ensure ongoing compliance.

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

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2 695	Continued From page 6	2 695		
2 695	MN Rule 4658.0470 Subp. 1 Retention, Storage, and Retrieval; Retention Subpart 1. Retention. A resident's records must be preserved for a period of at least five years following discharge or death. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure proper retention of medical records for 3 of 5 residents (R11, R23, R33) reviewed for unnecessary meds. Findings include: R11's Admission Record printed 9/4/20, indicated R11's diagnoses included gout, pain, hypokalemia (low potassium), major depressive disorder, atrial fibrillation (irregular heart rhythm), chronic kidney disease, bipolar disorder, anxiety disorder, osteoarthritis, diabetes, and hypertension. R11's medical record lacked evidence of consultant pharmacist reviews for 9/19, 10/19, and 11/19. R11's consultant pharmacist Summary Report dated 12/19, indicated irregularities were identified. The facility was unable to provide the consultant pharmacist's Consultation Report with identification of the specific irregularities and recommendations, or evidence of the physician's follow-up to the irregularities. A consultant pharmacist Prospective Medication Review dated 2/14/20, indicated R11 had a physician order for Potassium Cl 50	2 695	F842: Resident Records-Identifiable Information Immediate Corrective Action: Pharmacy recommendations are now being retained and uploaded to the individual residents' medical record. Action as it Applies to Others: Records Retention Schedule was reviewed and remains current DON and Medical Records Director were educated on Record Retention schedule and uploading pharmacy recommendations into the residents' medical record. Date of Compliance: 10/7/2020 Reoccurrence will be prevented by: Weekly audit of 3 resident pharmacy reviews x 4 weeks then monthly x2 months to ensure pharmacy recommendations are being retained and uploaded to the residents medical record. The results of these audits will be shared with the facility QAPI committee for input on the need to increase, decrease, or discontinue the audits. Corrections will be monitored by: Medical Records Director/Designee	10/7/20

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2 695	Continued From page 7	2 695		

millequivelants extended release by mouth twice a day for hypokalemia. the consultant pharmacist identified this as a high dose of potassium and requested confirmation by the physician that it was the correct dose by midnight of the next calendar day. R11's Prospective Medication Review had a hand written note by the medical records staff, indicating the original potassium order at this dose was written on 4/23/18.

R11's medical record lacked evidence of a review of R11's potassium order by a physician by 2/15, at 11:59 p.m. as directed by the consultant pharmacist.

R11's consultant pharmacist Summary Report for 4/20, indicated irregularities were identified. The facility was unable to provide the consultant pharmacist's Consultation Report with identification of the specific irregularities and recommendations, or evidence of the physician's follow-up to the irregularities.

R11's consultant pharmacist Summary Report for 5/20, indicated no irregularities were identified.

R11's consultant pharmacist Summary Report for 6/20, indicated irregularities were identified. The facility was unable to provide the consultant pharmacist's Consultation Report with identification of the specific irregularities and recommendations, or evidence of the physician's follow-up to the irregularities.

R11's consultant pharmacist Summary Report for 7/20, indicated irregularities were identified.

R11's consultant pharmacist Summary Report for 9/20, indicated irregularities were identified. The facility was unable to provide the consultant

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2 695	Continued From page 8	2 695		

pharmacist's Consultation Report with identification of the specific irregularities and recommendations.

On 9/4/20, at 2:50 p.m. director of nursing (DON) verified they were unable to locate the remaining recommendations and physician follow-up for residents for whom records were requested.

The facility policy Medication Regimen Reviews revised 5/19, directed the consultant pharmacist would provide a written copy of all medication regimen reports, which would be maintained as part of each resident's permanent record, along with the physician responses.

The facility Records Retention Schedule updated 11/14, directed Medical records to retain consultant reports for 2 years in the medical record.

R23's Admission Record printed on 9/4/20, indicated R23's diagnoses included dependence on respirator (ventilator) status, anxiety disorder, acute respiratory distress syndrome, chronic respiratory failure with hypoxia, major depressive disorder, chronic pain, and restless legs syndrome.

R23's medical record lacked evidence of consultant pharmacist reviews for 9/19, 10/19, and 11/2019.

R33's Admission Record printed on 9/4/20, indicated R33's diagnoses included chronic respiratory failure with hypoxia, dependence on respirator (ventilator) status, and tracheostomy status.

R33's medical record lacked evidence of

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2 695	Continued From page 9 consultant pharmacist reviews for 9/19, 10/19, 11/19, and 2/20. In addition the 3/20, consultant pharmacist review identified irregularities, no report was found. On 9/4/20, at 4:06 p.m. the administrator was interviewed and verified the facility was required to keep medical records for a specified time period. On 9/4/20, at 4:15 p.m. the consultant pharmacist was interviewed and verified there should have been monthly medication reviews in R23's record. He stated that he took over the role of consultant pharmacist in December of 2019. SUGGESTED METHOD OF CORRECTION: The Director of Nursing, medical record director, or designee could develop, review, and/or revise policies and procedures to ensure appropriate retention of medical records. The Director of Nursing or designee could educate all appropriate staff on the policies and procedures. The Director of Nursing or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 695		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in	2 830		10/7/20

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2 830	Continued From page 10 the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure an appropriate smoking assessment was completed for 1 of 1 residents (R30) reviewed for smoking. Findings include: R30's Admission Record indicated diagnosis that included quadriplegia, and a traumatic brain injury. R30's quarterly Minimum Data Set (MDS) dated 7/2/20, identified intact cognition, and required total assistance for activities of daily living (ADLs) including locomotion on and off the unit. The MDS further identified R30 had upper extremity impairment to both sides. R30's care plan dated 7/13/20, identified R30 had a self care deficit related to limited mobility. R30's care plan for smoking dated 8/31/20, indicated he currently smoked at the facility. The care plan indicated R30 had a device used to assist with smoking, and had been assessed to smoke independently with assistance only to light the cigarette.	2 830	F689: Free of Accidents Hazards/Supervision/Devices Immediate Corrective Action: R30 was given a new adaptive device for smoking. Action as it Applies to Others: Smoking policy was reviewed and remained current. All residents that smoke were reassessed for safe smoking and new interventions put in place as needed. Nurse Managers will be re-educated on completing resident smoking evaluations and putting appropriate interventions in place. Date of Compliance: 10/7/2020 Reoccurrence will be prevented by: Observation audit of 5 smokers to ensure they are smoking safely and have appropriate interventions in place weekly x 4 weeks then monthly x2 months. The results of these audits will be shared with the facility QAPI committee for input on the need to increase, decrease, or discontinue the audits. Corrections will be monitored by: DON/Nurse Managers/Designee	

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THE EMERALDS AT GRAND RAPIDS LLC	2801 SOUTH HIGHWAY 169 GRAND RAPIDS, MN 55744

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On 5/5/20, a progress note indicated R30 had been outside smoking, and when the nursing assistant (NA) went outside to get him, she found that R30 had caught his cigarette on the adaptive device he had rigged to try to smoke, and could not get it off. The progress note indicated, "if NA had not gone outside he [R30] could have burnt himself."

R30's Smoking Evaluation dated 5/6/20, indicated he was currently smoking, and identified cognitive loss and a dexterity problem. The assessment indicated R30 required the use of a cigarette extension/holder, and indicated writer observed R30 smoking. R30 needed adaptive equipment that the activities department was going to pick up. The assessment further indicated R30 needed staff to light the cigarette, then could use his arms, hands and adaptive equipment to smoke independently.

R30's Smoking Evaluation dated 8/31/20, indicated he was currently smoking, and had a cognitive loss and a dexterity problem. The assessment identified the use of a cigarette extension/holder, and indicated R30 required staff to light the cigarette and was then able to use his arms, hands and adaptive equipment to smoke independently.

On 8/31/20, at 4:18 p.m. R30 was observed outside smoking a cigarette independently. R30's right hand was wrapped in a bandage, and a stylus was sticking out the top of the bandage. The stylus was used to aide R30 in use of his phone and tablet. On the left side of R30's right hand, a yellow plastic clothes pin was sticking out of the bandage. The clothes pin was stained a dark brown and appeared burnt.

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On 9/2/20, at 12:46 p.m. R30 was observed outside smoking a cigarette. When R30 finished his cigarette, he was observed to drop the still lit cigarette butt on the grass next to his chair.

On 9/3/20, at 8:35 a.m. nursing assistant (NA)-A was interviewed and stated a few days prior, R30's family member had called the facility because he had told her staff were not checking on him when he was outside. NA-A stated R30 needed staff to assist him with lighting his cigarette, stated staff took R30 outside, and R30 "had this thing on his hand, and we light the cigarette and he does it that way." NA-A stated R30 could ask when he wanted a cigarette, and would call the facility if he needed something when he was outside, but could not get himself in or out of the building independently. NA-A stated she thought they checked on R30 every hour when outside following the phone call from his family member.

On 9/3/20, at 1:51 p.m. the director of rehabilitation (DOR) stated R30 had a universal cuff to use his phone and his IPad with a stylus, and used a clothes pin to smoke. The DOR stated R30 was able to use the clothespin to get the cigarette to his mouth, and when he was done he could get rid of the cigarette. The DOR stated R30 disposed of his cigarette on the ground. The DOR stated they had ordered something different to assist R30 with smoking and it had arrived the previous day but had not been implemented yet. The DOR stated he had been outside when R30 was smoking, but had not assessed him, and stated it was up to nursing to determine if residents could smoke safely.

At 9:45 a.m. the director of social services (DSS) stated she would typically go out and see if

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residents were safe to smoke, whether or not a smoking apron was needed, or if assistance to light the cigarette was needed. The DSS stated R30 needed assistance to light a cigarette and was able to "ash" the cigarette appropriately, but disposed of his cigarette butts on the ground. The DSS stated a new smoking device had been ordered and said "we don't like that clip he's using, it's plastic and it could melt." The DSS further stated R30 was supposed to be checked on every 30 minutes while outside, because he felt once he was out there staff did not check on him.

At 1:37 p.m. registered nurse (RN)-A stated initially she did not think R30 was safe to smoke. RN-A stated physical therapy rigged up the clothes pin that was connected to R30's hand. RN-A stated R30 was not able to dispose of his cigarette in an ashtray. RN-A further stated she usually completed the smoking assessments and said in regard to R30, "I did not rig up the clothespin, they [therapy] did so..."

At 2:19 p.m. the DOR confirmed that the therapy department did "rig" up the clothes pin so R30 could smoke, but stated therapy did not complete a formal assessment.

At 3:32 p.m. the director of nursing (DON) stated the nurse manager or social services department watched residents to make sure they were safe to smoke independently. The DON stated the criteria for safe, independent smoking included being able to hold a cigarette, not drop hot ashes, and properly dispose of the cigarette in the canister. The DON stated she had not observed R30 smoking.

The facility policy Resident Smoking Agreement

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undated, directed the purpose of providing residents with the safest smoking environment possible, and to provide the smoking supervision each resident requires. The policy identified three smoking categories: able to smoke independently without an apron, requirement of an apron to smoke safely, and resident requiring smoking supervision to be safe. The policy did not identify the criteria for the smoking categories.

Based on observation, interview, and document review, the facility failed to effectively provide pain management for 1 of 3 residents (R260) reviewed for pain. This resulted in actual harm to R260 when her pain was not relieved.

Findings include:

R260's Admission Record printed on 9/3/20, indicated she was admitted on 8/14/20, with diagnoses which included fracture of the right pubis, fracture of right ischium (lower posterior hip bone), and anxiety disorder.

R260's admission Minimum Data Set (MDS) completed on 9/1/20, indicated R260 was severely cognitively impaired. R260's MDS indicated she received as needed pain medications (PRN), had pain present almost constantly, the pain made it difficult to function, and limited her day to day activities. R260's MDS indicated she rated her pain a nine on a scale of one to ten.

R260's Care Area Assessment (CAA) dated 8/30/20, indicated pain as a potential problem. Staff were directed to administer medications as ordered, to monitor for effectiveness of PRN pain medication, and document in the Medication Administration Record (MAR). The CAA further

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indicated R260 stated the pain medication did help her.

R260's care plan initiated on 8/17/20, indicated staff should use pain medication as ordered by the medical doctor (MD), document effectiveness of pain, and encourage the resident to verbalize discomfort.

R260's Order Summary Report with active orders through 9/3/20, indicated R260 had an order for Percocet (narcotic pain medication) tablet 5-325 milligrams (mg) one tablet by mouth every six hours as needed (PRN) for pain ordered on 8/21/20, acetaminophen (Tylenol) tablet 325 mg, give 650 mg by mouth two times a day for pain, ordered on 8/27/20, meloxicam (a non-steroidal anti-inflammatory drug used to relieve pain) 7.5 mg by mouth one a day with food, ordered on 9/3/20.

On 9/2/20, at 9:25 a.m. nursing assistants (NA)-K and NA-L were observed attempting to assist R260 with cares and dressing. The NAs asked R260 if she could sit up, she agreed, but when they attempted to move her from lying in her bed to sitting on the edge of her bed, R260 resisted, saying it hurt too much. NA-K and NA-L layed R260 back down on her bed sideways. R260 stated, "It's the fracture," and said she had forgotten that she had a fracture. The NAs rolled her side to side, and placed a lift sheet under her. During repositioning, R260 said she was in lots of pain, and described the pain as sharp and shooting. R260 did not want to get dressed or have any cares completed after attempting to get out of bed.

-at 1:18 p.m. NA-K and NA-C entered to dress R260 for a clinic appointment. R260 kept

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repeating, "Ow" and "It hurts." R260 resisted attempts at dressing and getting out of bed, and layed back down on the bed. NA-K and NA-C let her rest briefly, and continued dressing her. NA-K and NA-C had R260 stand up, and transferred her quickly to the wheelchair. During the transfer, R260 continued to say "Ow."
-at 1:49 p.m. NA-K was interviewed. NA-K stated R260 usually complained of pain when going from laying to sitting in bed. NA-K stated she informed registered nurse (RN)-C about R260's pain.
-at 1:59 p.m. RN-C was interviewed. RN-C stated the NAs had informed her R260 was in pain in the morning, and did not want to get up or get dressed. RN-C stated she had given R260 scheduled acetaminophen (Tylenol), and she tried not to give confused residents narcotics. RN-C stated she should have pre-medicated R260 prior to her clinic appointment this afternoon.
-at 2:39 p.m. R260 was observed crying out in pain as she was assisted from the wheelchair back into her bed following her return from the clinic. R260 stated she had been in pain since she left for the appointment. R260 stated once she was back in bed, the pain was less.
-at 3:04 p.m. RN-A was interviewed, and stated she did not see R260 when she returned from the clinic. RN-A stated, "She is always like this when you want her to do something." RN-A stated she would expect staff to complete a pain assessment on R260 every shift.

On 9/2/20, the physician's note from orthopedic clinic visit indicated the resident was alert, confused, in a lot of pain, and refusing meals.

On 9/3/20, at 9:49 a.m. R260 was resting in bed, and stated she was "hurting today."

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-at 10:05 a.m. NA-A was interviewed. NA-A stated when she was assisting R260 with cares in the morning, R260 had called out "Ow, ow." NA-A stated she could only get R260 to sit on the edge of the bed, and stand long enough to pull up her pants. NA-A had planned to get R260 out of bed, but could not accomplish this because of R260's pain. NA-A stated she informed the nurse of R260's pain, and also told the nurse R260 would not get out of bed. NA-A was told by the nurse to try again later.
-at 10:34 a.m. licensed practical nurse (LPN)-D was interviewed. LPN-D did not know when R260 was last medicated for pain. LPN-D stated she had not completed a pain assessment on R260, and had not seen R260 move yet today. LPN-D stated she would need to see R260 move to complete a pain assessment.
-at 1:50 p.m. R260 was observed trying to get out of bed. LPN-D went to get another staff to help get R260 back into bed. R260 stated, "Oh I hurt so bad." LPN-D stated R260's last PRN pain medication was given on 9/3/20, at 12:27 a.m.
-at 2:30 p.m. the director of nursing (DON) was interviewed. The DON stated she would have expected staff to pre-medicate R260 prior to her clinic appointment on 9/2/20.

On 8/20/20, progress note by nurse practitioner indicated resident's pain was controlled with Percocet.

The facility policy Pain Assessment and Management revised 3/15, defined pain management as the process of alleviating the resident's pain to a level that is acceptable to the resident, and is based on his or her clinical condition and established treatment goals. The care process included the following:
a. Assessing the potential for pain;

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2 830	Continued From page 18 b. Effectively recognizing the presence of pain; The policy indicated the resident should be observed during rest and movement for physiological and behavioral (non-verbal) signs of pain. Resisting care was described as a behavior to monitor, as were limitations in his or her level of activity due to the presence of pain, guarding, rubbing or favoring a particular part of the body, difficulty eating or loss of appetite. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could develop or revise policies/procedures to ensure appropriate smoking assessments were completed. In addition, the DON or designee could develop or revise policies/procedures related to management of pain. The DON or designee, could train staff in implementation of the policies and plan of care. The DON or designee could perform random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		
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	2 920	F677: ADL Care Provided for Dependent	10/7/20

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2 920	Continued From page 19 review, the facility failed to provide nail care and remove facial hair for 3 of 8 residents (R21, R215, R45) reviewed for activities of daily living (ADLs) and who were dependent on staff for ADL assistance. Findings include: R21's Admission Record dated 9/4/20, indicated R21's diagnoses included wedge compression fracture of the T11-T12 vertebrae (fracture of the lower part of the spine). R21's admission Minimum Data Set (MDS) dated 6/24/20, indicated R21 was cognitively intact, and required one assist with personal hygiene needs. R21's care plan dated 6/30/20, directed staff to provide assistance of one for personal hygiene. R21's weekly skin inspections indicated R45 had not been shaved or had his nails trimmed since admission on 6/18/20. On 9/1/20, at 10:41 a.m. R21 was interviewed and stated he did not own clippers and has asked staff to trim his fingernails and beard. R21 was observed to have long, jagged fingernails on both hands, and long facial hair. On 9/2/20, at 7:26 a.m. R21 was observed in bed, and his nails and facial hair remained long and untrimmed. On 9/2/20, at 7:28 a.m. R21 put his call light on and asked nursing assistant (NA)-D if he could have his bath. NA-D stated R21's bath was scheduled for that evening. On 9/3/20, at 9:33 a.m. R21 was observed, and	2 920	Residents Immediate Corrective Action: Nail Care and Facial Hair Care was completed for residents R21, R215, & R45. Action as it Applies to Others: ADL Assistance per Care Plan policy was reviewed and remained current. All residents were offered/received assistance with nail care/facial hair removal. All nurses and NARs were educated on providing nail care and removal of facial hair for residents based on resident preference. Date of Compliance: 10/7/2020 Reoccurrence will be prevented by: Observation audit of 5 residents conducted weekly x 4 weeks then monthly x2 months to ensure facial hair is trimmed and nail care is provided. The results of these audits will be shared with the facility QAPI committee for input on the need to increase, decrease, or discontinue the audits. Corrections will be monitored by: DON/Nurse Managers/Designee	

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fingernails and facial hair remained long. R21 was interviewed and stated he did not get his bath as scheduled last evening.

ON 9/3/20, at 11:03 a.m. licensed practical nurse (LPN)-F stated if a resident refused a bath, staff was to document refusals on a weekly skin inspection sheet, and report the refusal to the nurse. R21 reviewed R21's weekly skin inspection sheet dated 9/2/20, and noted a zero with a line drawn through, which indicated R21 did not get his shower. R21 further stated she heard staff did not have time last evening to give R21 his shower. LPN-F stated staff should try and get his shower completed that day.

On 9/3/20, at 3:19 p.m. R21 was interviewed and stated he still had not been offered a shower, and it was important to him to get a shower, and have his fingernails and facial hair trimmed.

On 9/3/20, at 3:20 p.m. nursing assistant (NA)-I verified R21 did not get a bath/shower last evening as scheduled. NA-I stated nail care and shaving was completed on bath/shower day and as needed. NA-I stated it looked like R21's had had not been shaved or nails trimmed in several weeks.

On 9/3/20, at 3:56 p.m. the director of nursing (DON) stated residents should be offered to be shaved and nails trimmed on bath/shower day. The DON further stated if a resident declined cares, it was expected to reproach the resident three times, have a different staff member reproach, and if continued to decline, document the refusal. The DON stated if baths were unable to get done, it was expected to notify the nurse, ask for assistance, offer at a later time, and document on the weekly skin inspection sheet.

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2 920	Continued From page 21 R215's Admission Record dated 9/4/20, indicated R21's diagnoses included a wedge compression fracture of second lumbar vertebral (fracture of the spine) . R215's admission MDS dated 9/1/20, indicated R21's cognition was moderately impaired, and required extensive assistance with personal hygiene. R215's care plan dated 8/28/20, indicated R21 was to be dressed, groomed, and bathed. R215's weekly skin inspection dated 8/28/20, indicated R21 received assistance with a bed bath, R21 was not shaved, and fingernails and toenails were not trimmed. On 8/31/20, at 5:39 p.m. R215 was observed to have dark facial hairs on the upper lip, and long jagged fingernails with a brown debris underneath and along the sides of the nails on both hands. On 9/2/20, at 12:47 p.m. R215 was observed in her room and had just finished with lunch. R21's fingernails remained long with a brown debris underneath fingernails. R215 continued to have dark facial hairs above upper lip. On 9/3/20, at 9:01 a.m. R215's nails remained long and dirty dirty, and facial hairs noted above the upper lip. R215 was interviewed and stated she preferred to have her nails shorter, and facial hair removed. On 9/3/20, at 3:26 p.m. licensed practical nurse (LPN)-F verified R215's facial hair to upper lip and fingernails were long and dirty. LPN-F asked R215 if she would like to have her fingernails	2 920		

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soaked and trimmed, and her hair removed from her upper lip and stated R215 stated "yes."

On 9/4/20, at 3:56 p.m. the DON stated residents should be offered shaving and nail care each bath day and documented on the weekly skin inspections sheets.

R45's Admission Record dated 9/3/20, indicated R45's diagnoses included visual loss and muscle weakness.

R45's annual MDS dated 7/30/20, indicated R45 had intact cognition. R45's MDS further indicated he had severely impaired vision, and required extensive assistance with personal hygiene.

R45's care plan dated 7/29/20, indicated R45 required extensive assistance grooming. R45's care plan directed staff to shave R45 as needed.

Review of R45's weekly skin inspections dated 8/26/20, and 8/31/20, indicated shaving assistance was last documented on 8/26/20.

On 8/31/20, at 5:13 p.m. R45 was observed to have long facial hair.

On 9/2/20, at 8:22 a.m. nursing assistant (NA)-F and NA-G were observed to perform personal cares and transferred R45 to his wheelchair. An electric razor was noted on a table near R45's window. NA-F and NA-G did not offer to shave R45.

On 9/2/20, at 2:25 p.m. R45 was interviewed and he stated his preference was to be clean shaven. R45 stated, "I like smoothe skin." R45 stated his preference was to be shaven every few days, and preferred to be shaven now.

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On 9/2/20, at 2:33 p.m. NA-I confirmed R45 needed staff assistance with shaving. NA-I stated R45 did not have the dexterity to shave himself. NA-I stated he believed R45 was legally blind. R45 was observed with NA-I, and NA-I confirmed the presence of facial hair. NA-I stated he believed the facial hair was present "a day or two."

On 9/2/20, at 2:51 p.m. NA-H was interviewed and stated R45 was blind, however, shaved himself. NA-H stated R45 required set up assistance, and staff placed a gown over him. NA-H stated R45 was very precise and particular. NA-H confirmed R45 had facial hair and stated it was "a little longer" than a five o'clock shadow. NA-H stated he was unaware when R45 was last shaven, and further stated R45 was shaved on shower days.

On 9/3/20, at 9:28 a.m. LPN-B stated R45 needed staff assistance with shaving. LPN-B confirmed staff shaved R45, and stated he was blind.

On 9/3/20, at 2:20 p.m. the director of nursing (DON) stated R45 needed staff assistance with shaving. The DON stated staff were expected to shave R45.

The facility policy Monarch Healthcare ADL Assistance revised 5/18, directed based upon resident/resident representative desires, assessment and care plan, ADL assistance will be provided to any residents deemed necessary. Some examples would be shaving males and females as needed, and fingernails and toenails to be clean and trimmed.

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2 920	Continued From page 24 SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and/or revise the current grooming and personal hygiene policies and procedures to ensure nail care and hygiene is completed and maintained. The DON or designee could educate the appropriate staff on the policies/procedures. The DON or designee could develop a monitoring system to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 920		
21015	MN Rule 4658.0610 Subp. 7 Dietary Staff Requirements- Sanitary conditi Subp. 7. Sanitary conditions. Sanitary procedures and conditions must be maintained in the operation of the dietary department at all times. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure the kitchen was clean by ensuring ceiling tiles over the food preparation area and the oven hood and its components were free of dust and debris to prevent food contamination. In addition, the facility failed to ensure dirty dishware was not in close proximity to a clean dish drying rack, and the ice machine was free from rusted bolts. Findings include: On 8/31/20, at 3:01 p.m. during the initial kitchen tour with the culinary services director (CSD)-A,	21015	F812: Food Procurement, Store/Prepare/Serve-Sanitary Immediate Corrective Action: Kitchen tiles over the food procurement area, as well as the oven hood, were cleaned. Clean dish cart was relocated away from the dirty area in the kitchen. Rusty bolt in ice machine was removed. Action as it Applies to Others: Dishwasher policy was reviewed and remains current Dietary staff educated on dishwasher policy and storing clean dishes away from dirty dishes.	10/7/20

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21015	Continued From page 25 three carts of dirty dishes were parked within three feet of the clean dish drying rack. At 3:05 p.m. a staff member was observed bringing additional dirty dishes into the kitchen, and stacking them atop a rolling cart near the clean dish drying rack. The drying rack held various clean items including glasses, meal trays, and a water carafe. The drying rack was made of metal, and had multiple worn areas with considerable rust. CSD-A confirmed the presence of rust, and confirmed the dirty and clean areas were too close in proximity to each other. The lid of the ice machine was noted to have a rusty screw on the underside, with a visible orange drip line leading down from the screw into the area that held the ice. No rust was observed on the ice. CSD-A stated the ice machine was cleaned once per month. CSD confirmed the presence of the rusty screw and orange drip and stated, "It looks like rust." During kitchen tour, copious amounts of dust were observed on the oven hood and the sprinkler system, directly above the stovetop where food was being prepared. Dusty accumulation was observed on the electrical box above the oven hood and its piping. CSD-A stated the oven hood was professionally cleaned once every 6 months, and cleaned by maintenance every month. CSD-A confirmed the presence of dust and stated, "I see a little dust, not a lot, it was done in March so they should be coming." CSD-A confirmed the presence of dust on the ceiling tiles and fire sprinkler directly above the food preparation area and stated, "Looks like dust." Food was being prepared directly below the dusty ceiling. On 8/31/20, at 5:59 p.m. dried orange and brown food was observed splattered on the ceiling tile immediately outside the kitchen doors.	21015	Date of Compliance: 10/7/2020 Reoccurrence will be prevented by: Weekly observation audit of the dishwashing area x 4 weeks then monthly x2 months to ensure clean dishes are stored away from the dirty dishes, ceiling tiles, and oven hood are clean. The results of these audits will be shared with the facility QAPI committee for input on the need to increase, decrease, or discontinue the audits. Corrections will be monitored by: Culinary Services Director/Designee	

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On 9/1/20, at 11:32 a.m. dust remained on the ceiling tiles and fire sprinkler directly above the food preparation area.

On 9/2/20, at 9:17 a.m. the paper towel dispenser was empty, and a roll of paper towels had been placed on one of the empty clean drying rack poles. Dietary aide (DA)-A used these paper towels to dry her hands after washing. The dust remained on the ceiling tiled and sprinkler directly above the food preparation area. Food was being prepared directly below this area. At 09:49 A.M. dried food remained on the ceiling tile immediately outside of the kitchen doors.

On 9/2/20, at 1:20 p.m. the DCS-A confirmed the presence of dust on the ceiling and sprinkler above the food prep area and stated, "There is still dust up there, it can fall in the food." The DCS-A also confirmed food splatter on the ceiling outside of the kitchen doors and stated, "I am not sure what that is or how it even got up there."

The facility policy Food Receiving and Storage revised October 2017, directed food services, or other designated staff, will maintain clean food storage areas at all times.

SUGGESTED METHOD OF CORRECTION:
The dietary manager, or designee could review and/or revise the current kitchen and food service hygiene policies and procedures to ensure cleanliness of the fans over the food preparation and service areas were cleaned to prevent contamination of food.
The dietary manager or designee could educate the appropriate staff on the policies/procedures.
The dietary manager or designee could develop a monitoring system to ensure ongoing compliance.

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21015	Continued From page 27 TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21015		
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 perform hand hygiene after direct contact with residents and high touch environmental surfaces in quarantined residents rooms and subsequently passing meal trays for 6 of 25 residents (R48, R56, R59, R211, R2100, and R21) reviewed for dining. Further, the facility failed to ensure their comprehensive infection prevention and control program (IPCP) included surveillance of all potential infections; ongoing, comprehensive analysis of all collected surveillance data; and, demonstrated investigation(s) of developed infections to help prevent potential recurrence and/or spread within the facility. This had the potential to affect all 64 residents residing in the facility at the time of the survey. Findings include: R46's Admission Record printed 9/3/20, indicated R46's diagnoses included dementia, chronic obstructive respiratory disease (COPD), and diabetes.	21375	F880:Infection Prevention & Control Immediate Corrective Action: Staff were educated on performing hand hygiene in between room trays. Action as it Applies to Others: Facility policy on Infection Prevention and Control Program policy was reviewed and remains current. Infection Control Nurse/ADON and DON educated on proper infection control tracking including surveillance of all potential infections; ongoing, comprehensive analysis of all collected surveillance data, and demonstrated investigation of developed infections to help prevent potential recurrence or spread within the facility. Handwashing/Hand Hygiene policy was reviewed and remains current. All nurses and NARs were educated on performing hand hygiene in between room trays. Date of Compliance: 10/7/2020 Reoccurrence will be prevented by: Weekly observation audit of 5 staff to	10/7/20

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R57's Admission Record printed 9/3/20, indicated R57's diagnoses included COPD and chronic kidney disease.

R110's Admission Record printed 9/3/20, indicated R110's diagnoses included aftercare following joint replacement, emphysema, and COPD. R

R11's Admission Record printed 9/3/20, indicated R11's diagnoses included atrial fibrillation (irregular heart rhythm), diabetes, congestive heart failure, and history of cancer.

R11's care plan initiated 6/10/20, indicated R11 was on contact precautions for Methicillin-Resistive Staphylococcus Aureus (MRSA-organism resistive to some antibiotics).

R111's Admission Record printed 9/3/20, indicated R111's was admitted on 8/24/20, and diagnoses included urinary tract infection, heart failure, rheumatoid arthritis, and chronic kidney disease.

R111 was on quarantine precautions related to new admission to the facility, and room door had a quarantine sign posted on it.

R12's Admission Record printed 9/3/20, indicated R12's diagnoses included a history of sepsis (the body's extreme, life-threatening response to an infection), COPD, diabetes, acute respiratory failure, history of pneumonia and dysphagia (problems swallowing).

R12's room door had a quarantine sign posted on it.

On 8/31/20, at 5:45 p.m. nursing assistant

Provider's Plan of Correction (21375):

assure they are completing hand hygiene appropriately after direct contact with residents, high touch surfaces, high touch environmental services, and meal delivery x 4 weeks then monthly x2 months. The results of these audits will be shared with the facility QAPI committee for input on the need to increase, decrease, or discontinue the audits.
Corrections will be monitored by:
DON/Nurse Managers/Designee

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(NA)-M was serving meal trays to each room, from a cart with individual trays.

On 8/31/20, at 6:06 p.m. nursing assistant (NA)-M was serving meal trays to each room, from a cart with individual trays. NA-M had gloves and a faceshield on. NA-M brought a tray into R46's room, left the room, did not remove gloves and/or sanitize hands, got another tray from the cart and served it to R110, moved a glass for R110, and left the room, without removing gloves and/or sanitizing hands. NA-M got another tray from the cart, brought the tray into R57, positioned R57 in his wheelchair up to the tray table, and with the same gloves, knocked on R11's door, brought in a tray from the cart, without wearing a gown, left R11's "precautions" room without sanitizing or changing gloves. NA-M picked up another tray from the cart without sanitizing or changing gloves, delivered it to R12. After passing a tray to R12, when questioned, NA-M verified she had been wearing the same gloves from room to room, touched resident's environment, and went into R11's "precautions room" without wearing a gown, or changing gloves, and went right into R12's room to deliver a tray and touched his belongings.

During the same time, NA-N picked delivered fluids to each room. NA-N changed gloves between each room, but did not sanitize between glove changes.

On 8/31/20, at 6:13 p.m. NA-M and NA-N verified they should have been sanitizing between glove changes, between each resident.

On 9/3/20, at 4:14 p.m. director of nursing (DON) verified there was a risk of cross-contamination when gloves aren't changed and hands are not

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washed or sanitized between each resident while passing meal trays.

The facility policy and procedure for Handwashing/Hand Hygiene revised 8/19, directed staff to use an alcohol-based hand rub or soap and water before and after assisting a resident with meals, handling food, after removing gloves, before and after direct contact with residents or contaminated equipment.

On 9/1/20, at 12:03 p.m. nursing assistant (NA)-B delivered meals to residents R48 and R56, exited the room, and without performing hand hygiene took another meal from the cart and delivered it to R59. NA-B then delivered a meal to R211, who was in quarantine. Without performing hand hygiene, NA-B delivered a meal to quarantined resident R210. NA-B touched and moved items on R210's bedside table including a water glass and soda can. NA-B exited the room, did not perform hand hygiene, and pushed the food cart down the hall, and brought a meal tray into R21's room, who was quarantined.

On 9/1/20, at 12:30 p.m. NA-B was interviewed and stated she did not sanitize her hands while passing meal trays. NA-B stated, "I must have spaced it, I am usually really good about hand hygiene."

On 9/3/20, at 10:23 a.m. licensed practical nurse (LPN)-A was interviewed and stated if staff were going in and out of rooms they should be using hand sanitizer properly and they should should be doing proper hand hygiene.

On 9/3/20, at 2:17 p.m. the DON stated when staff was going from resident to resident rooms she would expect they would perform hand

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hygiene.

On 9/3/20, the last twelve months infection control line listings were requested for review from the infection control preventionist/registered nurse (RN)-B. The provided information was reviewed and identified the following data separated by each month.

The facility Antibiotic Tracking Sheets, dated 6/4/20, to 6/25/20, and 7/2/20, to 7/31/20, identified line listings used to record infections within the facility. The data collected included various items tracked including, but not limited to, resident names, room numbers, infection types, symptoms, onset dates, laboratory or organism results, antibiotic usage and if transmission-based precautions were needed/used.

Healthcare Associated Infection Summary Report by Resident Days dated June 2020, and July 2020, tracked a breakdown of specific infections (respiratory, urinary tract infections [UTIs], skin, gastrointestinal, bloodstream, other, and ventilator associated pneumonia) and resident days, which when calculated indicated the month's total infection rate. The bottom of the form identified an area for "Specific Trends" and "Actions Taken."

JUNE 2020:

The line listing (outlined above) identified a total of 12 resident infections between three listed units (unit 2, unit 3, and unit 4):

- Unit 2 had an identified UTI which listed a urine specimen had been collected after symptom

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onset of 6/4/20, however, the tracking sheet did not identify the organism for which seven days of antibiotics had been administered.

-Unit 3 had identified a single infection each for UTI, pneumonia, upper respiratory infection and skin infection, along with a single infection identified as, "Other." The UTI listed a urine specimen had been collected after symptom onset of 6/17/20, however, the tracking sheet failed to identify the organism for which six days of antibiotics had been administered. The pneumonia infection sputum (coughed up mucus) culture obtained after symptom onset of 6/17/20 identified extended-spectrum beta-lactamase (ESBL, an enzyme that prevents certain antibiotics from being able to kill the bacteria). The upper respiratory infection listed a sputum culture was obtained for symptom onset of 6/23/20, however, failed to identify the organism for which seven days of antibiotics were administered.

-Unit 4 had identified a single skin infection and five UTI. All five UTI were each identified to have different symptoms listed, however, urine cultures for two of the UTI identified proteus mirabilis (a bacteria) with symptom onsets of 6/4/20, and 6/19/20, respectively. Two of the other UTI identified escherichia coli (a bacteria), in which one further identified ESBL, with symptom onsets of 6/22/20, and 6/23/20, respectively.

The line listing failed to indicate antibiotic end dates for three of the resident infections, results of reported wound cultures for the two skin infections, and further failed to identify when all of the infections listed had resolved symptoms. The line listing did not indicate or identify any residents had been tracked for non-antibiotic

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treated infections (i.e. viral infections, common cold symptoms).

The infection summary report (outlined above) dated June 2020, identified a total of seven facility infections with a total of 1432.00 resident days. A series of equations were listed which identified the facility had an infection rate of 4.89 % (percent). The "Specific Trends" section listed: "Unit 2- 1 UTI, Unit 4 - 5 UTI, Unit 4 - skin 1, Unit 3 - 1 pneumonia. The "Actions Taken" section listed: "Hand washing audits in place for each wing. Different organisms." The infection summary report failed to show documentation of a comprehensive analysis of the infections for June 2020.

JULY 2020:

The line listing (outlined above) identified a total of 14 resident infections between three listed units (unit 2, unit 3, and unit 4):

- Unit 2 had identified four UTI and one pneumonia. All four of the UTI were each identified to have different symptoms listed. One urine culture for symptom onset of 7/9/20, reported to be obtained per the resident's request with no other symptoms indicated, identified enterococcus avium (a bacteria) and another resident's urine culture obtained for symptom onset of 7/30/20, identified enteroccus faecalis (a bacteria). Another urine culture obtained identified escherichia coli with ESBL for symptom onset of 7/30/20. One urine culture failed to identify the organism result. The pneumonia infection indicated the resident was seen in the emergency department but the line listing did not indicate results of the x-ray report listed to have occurred on 7/27/20.

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-Unit 3 had identified one skin infection, one ear infection, one pneumonia, and one UTI, with a single infection listed as "Other." The UTI listed a urine culture was completed for symptom onset of 7/22/20, however, failed to identify the organism for which three days of antibiotics were administered.

-Unit 4 had identified one pneumonia infection, one UTI, and two infections listed as "Other." One UTI indicated a urine culture obtained after symptom onset of 7/22/20, which identified the organisms to be escherichia coli and ESBL. A urine culture report dated 7/23/20, with a nurse practitioner note further indicated the resident diagnosed with ESBL also had evidence of pneumonia in addition to the UTI. This was not listed on the line listing form.

The line listing failed to identify two of the residents tracked for UTI and "Other" had an antibiotic reassessment performed in regards to antibiotic stewardship processes. Further, the line listing failed to identify when all of the infections listed had resolved symptoms. The line listing did not indicate or identify any residents had been tracked for non-antibiotic treated infections.

The infection summary report (outlined above) dated July 2020, identified a total of 11 facility infections with a total of 1729.00 resident days. A series of equations were listed which identified the facility had a infection rate of 6.36%. The "Specific Trends" section listed: "no specific trends." The "Actions Taken" section listed: "11 total infections. 3 residents with pneumonia. 2 residents with cellulitis. 6 residents with UTI's." The infection summary report failed to show documentation of a comprehensive analysis of

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the infections for July 2020.

The facility did not provide documented evidence demonstrating the facility had conducted a comprehensive analysis of the facility acquired infections to determine if any of the infections identified were potentially related and/or spread within the facility or respective unit(s), despite having had multiple infections with the same causative organisms throughout the facility. Further, there was no provided evidence the facility had correlated the resident' infection data with staff illnesses to determine if any of the infections were related. In addition, the facility did not provide documented evidence the facility had a system for tracking non-antibiotic treated infections.

On 9/3/20, at 10:06 a.m. the DON and RN-B were interviewed. RN-B stated she reviewed the electronic health system "dashboard" each day she works, and monitors every resident who is on antibiotics, which she then adds to a monthly line listing. The DON stated at the end of the month the line listings are reviewed to see if there are trends and to see if staff education was required. Both the DON and RN-B denied a comprehensive analysis was documented prior to the infection data being brought to the facility monthly QAPI (Quality Assurance and Performance Improvement) committee. Any analysis completed during the QAPI committee was not kept with the infection control reports, however, was kept with the QAPI meeting minutes. Neither the DON nor RN-B offered to provide any analysis which may have been completed prior to or during the QAPI meetings to show support of a comprehensive infection analysis process.

On 9/3/20, at 3:32 p.m. a follow-up interview was

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conducted with RN-B in which she stated the monthly line listings were only for those infections that required antibiotic treatment. RN-B explained non-antibiotic infections were placed on a "24 hour board" in which nursing staff would chart on those residents. RN-B confirmed she did not track non-antibiotic infections.

The facility Infection Prevention and Control Program policy dated 8/19/20, directed the scope of the plan was "... comprehensive in that is addresses detection, prevention and control of infections among residents and personnel." The policy further directed surveillance tools are used for recognizing the occurrence of infections, recording their number and frequency, detecting outbreaks and epidemics, monitoring employee infections, and detecting unusual pathogens with infection control implications. Culture reports, sensitivity data, and antibiotic usage reviews are included in the facility surveillance activities, in which surveillance data and reporting information is used to inform the committee of potential issues and trends. The policy identified the infection preventionist collected data from the nursing units, categorized each infection by body site, and recorded the absolute number of infections. The policy lacked any direction or guidance on how identified infections would be investigated to reduce the risk of recurrence or when to ensure a comprehensive analysis was to be completed. Further, the policy lacked any information on how the program would track non-antibiotic treated infections or if/when investigations into the infections would be done.
SUGGESTED METHOD FOR CORRECTION: The director of nursing (DON) or designee, could develop or revise the policies and procedures related to infection control program and surveillance.

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21375	Continued From page 37 The DON or designee could provide education to all involved staff. The DON or designee could develop a monitoring system to ensure ongoing compliance and report the findings to the Qualify Assurance Committee. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21375		
21435	MN Rule 4658.0900 Subp. 1 Activity and Recreation Program; General Subpart 1. General requirements. A nursing home must provide an organized activity and recreation program. The program must be based on each individual resident's interests, strengths, and needs, and must be designed to meet the physical, mental, and psychological well-being of each resident, as determined by the comprehensive resident assessment and comprehensive plan of care required in parts 4658.0400 and 4658.0405. Residents must be provided opportunities to participate in the planning and development of the activity and recreation program. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure meaningful activities were provided for 4 of 4 residents (R111, R16, R28, and R45) reviewed for activities. Findings include: R111's Admission Record printed 9/4/20, indicated diagnoses included chronic pain, heart failure, and chronic kidney disease.	21435	F679: Activities Meet Interests/Needs of Each Resident Immediate Corrective Action: R111, R16, R28, & R45 were reassessed including family interviews to assure all activities planned were sufficient, meaningful, and additional activities added if indicated. Action as it Applies to Others: Activity Programs policy was reviewed and	10/7/20

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21435	Continued From page 38 R111's care plan initiated 8/31/20, indicated R111 was at risk for increased depression and anxiety related to decreased socialization due to federal guidelines while managing Coronavirus-19. Interventions included assessments for risk of social isolation, and provide appropriate independent activities per resident likes and wishes. R111's care plan lacked identification of R111's specific activity needs and preferences. R111's Activity Participation Review dated 8/31/20, indicated R111 enjoyed one on ones with staff and his own independent activity in his room, and would participate in hallway activities of his choosing. R111's favorite activities, special accomplishments, and/or new interests included watching TV, exercises, the daily chronicles, short stories, trivia, and visiting with staff and his roommate. R111's activity-related focuses including needs, strengths and preferences was determined to remain appropriate and current as per R111's care plan. R111's Activity Participation Review did not address activities R111 had actually attended or participated in. The facility Activity Record of Participation undated, indicated R111 had been provided with the Daily Chronicle, but lacked documentation of any one to one visits, participation in any activities, and provision of independent activity materials, such as books or magazines. On 9/1/20, at 10:28 a.m. R111 was observed sitting in his room, a quarantine sign was hanging on his door, and no activity materials were visible in his room. R111's TV was turned toward his roommate. R111 stated there were no activities going on, and he got bored.	21435	remained current. All residents will be reassessed to assure activities planned are meaningful and sufficient. Activity Department staff will be re-educated on the process for assessing and planning for sufficient and meaningful activities for those residents requiring activity set up. Date of Compliance: 10/7/2020 Reoccurrence will be prevented by: Audit of 5 residents requiring activities set up conducted weekly x 4 weeks then monthly x2 months to assure activities are sufficient and meaningful via verbal or non verbal response. The results of these audits will be shared with the facility QAPI committee for input on the need to increase, decrease, or discontinue the audits. Corrections will be monitored by: Activity Director/Designee	

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On 9/2/20, at 2:35 p.m. R111 was observed to be sitting in his room with the door mostly closed. R111 had no activity materials, and the TV was on towards R111's roommate.

On 9/2/20, at 2:45 p.m. R111 was sitting in his room, and said he had just returned from exercises. R111 stated there was nothing to do. R111 pointed at the quarantine sign on his door and asked, "Do you know what I can do in here?" R111 stated it was worse than being in prison. R111 stated he liked to read, but couldn't see very well. R111 had no reading materials in his room.

On 9/3/20, at 10:23 a.m. R111 was in his room, talking on the phone, with no individual activity materials in sight.

On 9/4/20, at 1:12 p.m. nursing assistant (NA) -G stated R111 had been in quarantine, and she had not seen him doing anything. NA-G stated she was not sure what activity staff do for residents.

On 9/4/20, at 1:43 p.m. licensed practical nurse (LPN)-F stated R111 had not done any activities, but had been in therapy. LPN-F stated R111 went outside with therapy staff earlier that day, and was happy about that. LPN-F stated no staff do activities with any residents, other than dropping off a flier in their rooms.

On 9/4/20, at 2:45 p.m. the director of nursing (DON) stated activities should do one-to-one activities, but was not sure what was happening. The DON stated activity staff try to think of ways for residents to participate.

The facility policy Activity Programs revised 6/18, directed the activities program was provided to support the well-being of the resident, was based

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on the comprehensive resident-centered assessment and resident preferences, and included facility-organized group activities, independent individual activities and assisted individual activities. The policy indicated activity programs were designed to meet the needs and interests of the residents and activity participation was to be documented in the resident's medical record.

R16's significant change MDS dated 8/12/20, indicated he was severely cognitively impaired, and required extensive assistance for all activities of daily living (ADLs). The activity preference section of R16's MDS was not completed.

R16's Care Area Assessment (CAA) for Activities dated 8/30/20, indicated R16 showed little interest or pleasure in doing things. The CAA indicated R16 was dependent on staff for setting up and engaging him in activities, and indicated R16 was confined to his room related to infection. The CAA further indicated staff were to provide one to one room visits, and indicated R16 liked watching television, listening to classical music, and liked the window open for fresh air.

R16's care plan dated 8/30/20, indicated he was dependent on staff for setting up and engaging in activities due to cognitive deficits and physical limitations. The care plan directed staff to converse with R16 while providing care, and open the window for fresh air. The care plan also indicated R16 liked to watch television, converse with family on the IPad, and listen to classical music. R16's care plan further indicated a risk for increased depression and anxiety related to decreased socialization.

R16's Activity Participation Review dated 8/11/20,

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indicated R16 enjoyed the Daily Chronicles, short stories, tons of puns, and staff reading to him.

On 9/1/20, at 9:07 a.m. R16 was observed lying on his back in bed with no television or radio on in his room. At 10:14 a.m. R16 remained in bed with his eyes open and no television or radio on. At 10:16 a.m. activity aide (AA)-A was in another resident room handing out the Daily Chronicles. AA-A left the unit without stopping in R16's room.

On 9/2/20, at 8:33 a.m. R16 was observed laying on his back in bed with no television or radio on in his room. At 9:39 a.m. R16's television was on, R16 was laying on the bed with his eyes closed, and not engaged in the program.

On 9/3/20, at 8:28 a.m. R16 was again observed lying in bed with no television or radio on. Staff had awakened R16 prior to 7:30 a.m. R16 was shifting around in the bed and appeared restless.

Facility documents titled Wing 3 dated 7/17/20 - 9/2/20, included a list of residents on the unit and identified the following:

7/17/20, R16 watched television
7/21/20, activity log was pre-filled out on a computer and indicated independent activity, watching television, visits with staff and Daily Chronicles, 10 minutes. The log lacked any indication the activities were completed.
7/22/20 - 7/27/20, pre-filled activity log indicated the same as 7/21/20.
7/28/20, activity log was left blank.
7/30/20 and 7/31/20, the pre-filled activity log was again provided but no indication activities were completed.
8/1/20 - 8/19/20, no activity attendance was provided.

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8/20/20, R16 had a one to one visit talking about the weather, and current events were read to him.
8/24/20, indicated Daily Chronicles were read to R16.
8/27/20, staff sat with R16 and talked about the day.
9/1/20, R16 had a visit from family.
9/2/20, indicated daily chronicles.
The activity logs lacked evidence of weekend activity programming.

On 9/3/20, at 11:28 a.m. nursing assistant (NA-)-J stated R16 watched television and had an IPad if he wanted to use it. NA-J stated sometimes R16 got up in his chair, and sometimes not.

R28's admission MDS dated 6/30/20, indicated he was severely cognitively impaired, and he required assistance from staff to transfer. The MDS indicated locomotion off the unit had not occurred during the assessment period. R28's MDS further indicated it was somewhat important to do his favorite activities, go outside and get fresh air, and listen to music.

R28's care plan dated 7/17/20, indicated R28 displayed little or no activity involvement, and indicated he would participate in one to one activity with staff. The care plan directed staff to inform R28 of scheduled activities, and praise efforts for attendance of hallway activities.

A facility document titled Wing 3 dated 7/17/20 - 9/2/20, included a list of residents on the unit and identified the following:

7/17/20, no activity identified.
7/21/20, activity log was pre-filled out on a computer and indicated independent activity, watching television and one to one, Daily

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Chronicles 10 minutes. There was no indication the activities were completed.
7/22/20 - 7/24/20, and 7/27/20, Pre-filled attendance log provided, but no indication the activities were completed.
7/28/20, copy of chronicle, R28 was not interested in library cart but showed him items and he accepted three different items.
7/30/20, 7/31/20, pre-filled attendance sheet provided with no indication activity was completed.
8/1/20 - 8/17/20, no activity attendance was provided.
8/18/20, Daily Chronicles.
8/21/20, Daily Chronicles.
8/24/20, Daily Chronicles.
8/27/20, Enjoying television, provided chronicles but R28 was tired and declined further interaction.
8/29/20, Daily Chronicles.
9/2/20, Daily Chronicles.
The activity logs lacked evidence of weekend activity programming.

On 9/1/20, at 9:01 a.m. R28 was sitting up in his wheelchair in his room with the television on. At 10:16 a.m. AA-A was on the unit handing out the Daily Chronicles. AA-A left the unit without stopping in R28's room.

On 9/2/20, at 7:45 a.m. R28 was in his room laying in bed. At 9:09 a.m. R28 remained in his bed, no staff had entered room or engaged him in any way. He remained laying in bed at 10:03 a.m.

On 9/3/20, at 11:26 a.m. NA-J was interviewed and stated staff assisted R28 to get up in his chair, and stated he watched television and looked outside. NA-J stated R29 did not come out of his room. NA-J further stated the nursing staff did not provide any activities to residents, only the

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activities staff did activities. NA-J stated R28 got papers from activity staff, but did not know if he participated.

On 9/3/20, at 2:54 p.m. the administrator stated the activity director was new. The administrator stated when she started, someone from another facility developed the guide based on previous assessments (the guide referred to the activity log that was pre-filled out). The administrator stated the direct care staff did activities with residents, but they were "probably" not documented. The administrator stated when the activity director first started she did most of the activities, but stated since COVID-19, most of the activities were one to one visits. The administrator stated the Daily Chronicles was a hand out that described what activities were occurring each day, and sometimes had other things like a word search. The administrator stated the activity department handed them out to residents, and went over it with them. The administrator stated R16 had an IPad set up with things, and had a bird feeder outside his window. The administrator stated activities staff would go in and chat with R16 in his room, and said it was difficult to have him outside his room due to infection control concerns. The administrator stated he did not know R28 well, but said if something was written down for an activity, it was probably done.

R45's Admission Record dated 9/3/20, indicated R45's diagnoses included visual loss, muscle weakness, and hearing loss.

R45's annual MDS dated 7/30/20, indicated R45 had intact cognition, had severely impaired vision, and had highly impaired hearing. R45's activity self-assessment indicated he enjoyed being around animals, time outdoors, and keeping up

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with the news. R45's activity self-assessment lacked indication he enjoyed listening to music and reading books, newspapers or magazines.

R45's care plan reviewed 7/29/20, indicated R45 was dependent on staff for activities, cognitive stimulation, social interactions, and well-being. R45's care plan further indicated he independently pursued activities, and he liked to listen to a transistor radio or the television. R45 refused to go outside or attend group activities.

R45's Care Conference form dated 8/3/20, indicated R45 relied on staff for activities, and participated in one-on-one activities with staff. The form further indicated R45 did not have interest in activities due vision and hearing loss.

R45's July 2020 activity log indicated the following activities were documented:
- Delivered mail and "talked a bit" on one occurrence.
- Watched television on one occurrence.
- Listened to transistor radio on eight occurrences.
- No other activities were documented.

R45's August activity log indicated the following activities were documented:
- Visited with staff and "current events" on one occurrence.
- The Daily Chronicles on five occurrences.
- Visited by staff "about his needs" on one occurrence.
- Chatted about fall and "reviewed today's events" on one occurrence.
- Verbal interactions through day on one
-R45 refused to walk on one occurrence.
- No other activities were documented.

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On 8/31/20, at 4:44 p.m. R45 was observed sitting in a wheelchair in his room. R45 had a bedside table in front of him, and the lights were off in the room. R45 was facing forward toward a wall. The television was noted to be off, and no radio was observed in R45's room. R45 stated he used to enjoy fishing, reading, and watching television.

On 8/31/20, at 6:00 p.m. R45 was observed sitting in a wheelchair in his room. R45 was eating dinner. R45 was facing forward toward a wall. The television was noted to be off.

On 9/2/20, at 8:22 a.m. NA-F was observed to assist R45 with morning cares, transferred him to a wheelchair, and placed a bedside table in front of him. The TV was noted to be off. At 8:47 a.m. activities assistant (AA)-B entered R45's room and placed a mug on his bedside table. AA-B then exited the room. From 9:29 a.m. to 10:17 a.m., R45 was seated in a wheelchair and facing forward toward a wall. R45's television remained off. At 12:43 p.m. R45 was seated in a wheelchair facing forward toward a wall. R45's television remained off. At 1:03 p.m. AA-A was observed to walk past R45's room and entered several resident's rooms and offered them an opportunity to attend an exercise activity. AA-A did not enter R45's room. At 1:42 p.m. At 2:14 p.m. R45 was observed lying in bed and appeared to be awake. NA-I entered R45's room and stated R45 he was "just kind of laying around."

On 9/2/20, at 2:25 p.m. R45 stated, "I don't do anything." R45 stated he was "bored" and tried to keep himself comfortable by lying in bed most of the time. The television was noted to be off.

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On 9/3/20, at 8:37 a.m. R45 was observed to be eating breakfast in his room. At 8:52 a.m. R45 was observed to be facing toward a wall. R45's television was noted to be off and no radio was observed in the room.

On 9/3/20, at 8:54 a.m. NA-D stated R45 liked to listen to the radio, but not often. NA-D stated he did not know if there was a radio in R45's room right now. NA-D stated he did not know if R45 attended activities. NA-F stated in the past, staff assisted R45 to play bingo. NA-D stated staff provided "a daily sheet" and was "pretty sure" they read it to him. NA-D stated R45 listened to his roommates television. NA-D stated R45 "found peace" with "peace and quiet." NA-D stated R45 barely talked. When asked what types of activities were provided to R45, NA-D stated restorative therapy walked him.

On 9/3/20, at 08:52 a.m. R45 was observed to be in his room facing forward toward a wall. R45's television was noted to be off.

On 9/3/20, at 9:12 a.m. NA-E stated R45 didn't "have much going on." NA-E stated R45 was unable to see and had hearing issues. NA-E stated there was not much for R45 to do due him being blind and hard of hearing. NA-E stated he believed music was provided in the past, and R45 was just "living day-to-day." When asked about R45's activity participation, NA-E stated restorative staff provided R45 with exercises.

On 9/3/20, at 9:41 a.m. AA-B entered R45's room and offered him the Daily Chronicle.

On 9/3/20, at 9:46 a.m. AA-B stated R45 was unable to hear well "at all," and he did not engage with television or music. AA-B further stated R45

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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
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"doesn't see" and staff cannot give him word searches or other paper activities. AA-B stated she was unsure if other sensory stimulation activities had been offered to R45. AA-B stated activities staff would talk with R45 about his life. AA-B stated R45 "wants to be in bed" and he "likes to sleep." AA-B stated restorative staff "does some stuff with him" but was unsure of the frequency provided when asked about other activity participation.

On 9/3/20, at 10:19 a.m. LPN-C stated R45 was a very quiet man and didn't like to attend activities. LPN-C stated R45 liked to lay down, and used to listen to the radio but was too hard of hearing now. LPN-C stated, "I don't know what they do to engage him," and further stated, "I can't say I have seen activities over here talking with R45 in the last 2 weeks." LPN-C stated restorative therapy walked with him.

On 9/3/20, at 2:17 p.m. the DON stated R45 was in restorative therapy, and stated, "I guess you could call that an activity." The DON stated she would have to ask the activities department about other activities R45 was in. The DON stated she would expect staff to offer R45 activities.

SUGGESTED METHOD OF CORRECTION:
The Activity Director or designee could develop, review, and/or revise policies and procedures to ensure resident's have an indivdualized activity program that meets their needs.
The Activity Director or designee could educate all appropriate staff on the policies and procedures.
The Activity Director or designee could develop monitoring systems to ensure ongoing compliance.

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21435	Continued From page 49 TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21435		
21620	MN Rule 4658.1345 Labeling of Drugs Drugs used in the nursing home must be labeled in accordance with part 6800.6300. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure insulin pens were labeled with current medication orders for administration for 2 of 3 residents (R37, R58) observed for insulin administration. In addition, the facility failed to ensure topical treatments ointments and creams were stored separately to prevent cross contamination for 9 residents (R38, R261, R33, R34, R20, R23, R44, R112, and R16) reviewed for medication storage. Findings include: R37's Admission Record printed 9/3/20, indicated R37's diagnoses included diabetes. R37's Order Summary Report with active orders as of 9/3/20, included physician orders for: - insulin Aspart FlexPen Solution Pen-injector, inject 5 units subcutaneously three times a day and, - insulin Aspart solution, inject as per sliding scale; if 150-199=2 units; 200-249=4 units; 250-299=6 units; 300-349=8 units; 350+=10 units, subcutaneously three times a day. On 8/31/20, at 5:40 p.m. registered nurse (RN)-D prepared to administer insulin Aspart to R37, and	21620	F761: Label/Store Drugs & Biologicals Immediate Corrective Action: R37 & R58 insulin pens are now correctly labeled with current medication orders for administration. R112 discharged from facility on 9/14/20. R38, R261, R33, R34, R20, R23, R44, R112, and R16 creams and ointments are stored separately and nursing staff are now squeezing a single use amount into a disposable cup to take into the resident's room, then dispose of the cup so as not to cross contaminate. Action as it Applies to Others: Storage of Medications & Topical Application of Ointment & Cream policies were reviewed and remain current All insulin pens were reviewed for appropriate labels. All medicated ointments/creams are now being administered per the single use method stated above. Nurses & TMAs were educated on proper labeling of insulin pens and proper administration/storage of ointments and creams. Date of Compliance: 10/7/2020 Reoccurrence will be prevented by: Audit	10/7/20

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dialed up 5 units on the insulin pen, per the orders on the Medication Administration Record (MAR). The pharmacy label with administration directions on R37's insulin Aspart pen, directed to inject 7 units three times daily, and per sliding scale. RN-D verified the pharmacy label did not match R37's current medication orders on the MAR. RN-D stated she would go by the orders on the MAR, as they were the current orders. RN-D stated R37's insulin pen should have a change-in-directions sticker on it to alert nurses of the change in orders, and proceeded to return R37's insulin pen to the medication cart without applying a change-in-directions sticker on the insulin pen.

On 9/3/20, at 2:50 p.m. licensed practical nurse (LPN)-F verified R37's insulin Aspart pen did not have a change-in-directions sticker on it and the pharmacy label directions did not match the physician orders on the MAR. LPN-F verified R37's insulin pen should have had a change-in-directions sticker on it.

On 9/3/20, at 3:15 p.m. director of nursing (DON) verified a change-in-direction sticker should have been placed on R37's insulin pen when there was a change in directions. DON verified there was a risk for giving the wrong dose of insulin when the pharmacy label did not match the physician orders on the MAR.

R58's Admission Record printed 9/3/20, indicated R58's diagnoses included diabetes.

R58's Order Summary Report with active orders as of 9/3/20, indicated R58 had orders for:
-insulin Aspart FlexPen Solution Pen-injector; inject 16 units subcutaneously three times a day,

Provider's Plan of Correction:

of 5 resident insulin pens conducted weekly x 4 weeks then monthly x2 months to assure pens are labeled appropriately. Observation audit of 5 residents being administered ointments/creams conducted weekly x 4 weeks then monthly x2 months to assure ointments and creams are being administered & stored appropriately. The results of these audits will be shared with the facility QAPI committee for input on the need to increase, decrease, or discontinue the audits.
Corrections will be monitored by: DON/Nurse Managers/Designee

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dated 8/13/20.
-insulin Aspart solution pen injector; inject per sliding scale: if 201-250-2 units; 251-300=4 units; 301-350=6 units; 351-400=8 units; 401-600=MD call provider, subcutaneously four times a day, dated 8/5/20.
-insulin detemir solution pen-injector; inject 44 units subcutaneously in the morning for diabetes, dated 8/27/20.

On 9/3/20, at 7:23 a.m. LPN-G was observed during administration of insulin to R58. R58's insulin Aspart pharmacy label was noted to direct administration of 14 units three times a day with meals and per sliding scale. R58's physician orders on the MAR directed to inject 16 units three times daily. In addition, R58's Levemir pharmacy label was noted to direct administration of 40 units subcutaneously daily, and R58's physician orders on the MAR directed to inject 44 units subcutaneously daily.

On 9/3/20, at 3:36 p.m. LPN-H verified R58's insulin pharmacy labels did not match the physician order directives on R58's MAR. LPN-H stated she looked at the MAR for the correct medication orders when administering medications. LPN-H wrote "see MAR" on both insulin pens.

On 9/3/20, at 4:14 p.m. DON verified pharmacy labels should match physician orders on the MAR.

R38's Admission Record printed 9/3/20, indicated R38's diagnoses included psoriasis, cellulitis (infection of the skin tissues), and a history of severe sepsis (body's extreme life threatening reaction to an infection).

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R38's Order Summary Report with active orders as of 9/3/20, included orders for triamcinolone acetonide ointment 0.1% (used to treat the itching, redness, dryness, crusting, scaling, inflammation, and discomfort of various skin conditions to right hand topically twice daily for psoriasis.)

On 9/2/20, at 7:39 a.m. R38's door was closed, a contact precautions for special enteric precautions sign was posted on R38's door.

R261's Admission Record printed 9/3/20, indicated R261's diagnoses include heart failure and diabetes.

R261's Order Summary Report with active orders as of 9/3/20, included orders for Nystatin cream to infection area topically as needed for infection; and triamcinolone acetonide cream 0.1% to rash topically as needed three times daily.

R33's Admission Record printed 9/3/20, indicated R33's diagnoses included chronic respiratory failure with hypoxia, history of pneumonia, dependence on a respirator, and tracheostomy.

R33's Order Summary Report with active orders as of 9/3/20, included orders for lidocaine gel for trach insertion in the morning on the 10th of each month, Asper-Flex Cream 10% (trolamine salicylate) to knee topically as needed for knee pain, to be kept in resident room for nurse to apply; clotrimazole cream 1% (antifungal medicated cream) to rash topically three times a day to rash; Eucerin cream to feet topically twice daily for dry skin; and silver sulfadiazine cream 1% to G-tube site topically in the morning.

R33's undated Pocket Care Plan indicated R33

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was on contact and droplet precautions related to a resistive organism in the sputum.

R34's Admission Record printed 9/3/20, indicated R34's diagnoses included bradycardia (slow heart rhythm), stroke, and tracheostomy.

R34's Order Summary Report with active orders as of 9/3/20, included orders for menthol-zinc oxide ointment 0.44-20.6% to erythematous (reddened) areas topically twice daily; and triamcinolone acetonide cream 0.025% to facial rash as needed until clear.

R20's Admission Record printed 9/3/20, indicated R20's diagnoses included diabetes, bilateral lower leg amputations, tracheostomy, a Methicillin Resistant Staphylococcus Aureus (MRSA) infection (bacteria that is resistant to some commonly-used antibiotics), cardiac pacemaker, and history of respiratory failure.

R20's Order Summary Report with active orders as of 9/3/20, included orders for betamethasone valerate cream 0.1% (reduces the swelling, itching, and redness related to skin conditions) to skin rash topically every 12 hours as needed.

R23's Admission Record printed 9/3/20, indicated R23's diagnoses included acute and chronic respiratory failure, diabetes, MRSA, cardiac pacemaker, and history of pseudomonas aeruginosa (organism that causes infections, including pneumonia).

R23's Order Summary Report with active orders as of 9/3/20, included orders for clotrimazole-betamethasone cream 1-0.05% to rash topically twice daily as needed; and Eucerin cream to dry skin as needed for dry skin.

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R23's undated Pocket Care Plan indicated R23 was on contact precautions due to MRSA in her wounds.

R44's Admission Record printed 9/3/20, indicated R44's diagnoses included chronic respiratory failure, diseases of the bronchus, history of pulmonary embolism, history of sudden cardiac arrest, and tracheostomy.

R44's Order Summary Report with active orders as of 9/3/20, included orders for Lidocaine gel for insertion of trach during changing every month, calmoseptine ointment 0.44-20.6% to decubitus regions topically three times daily; clotrimazole cream 1% to skin topically twice daily for yeast; Desitin cream 13% (zinc oxide) to bottom topically every 6 hours prn rash and skin irritation; Menthol-Methyl Salicylate Ointment to skin topically every 6 hours as needed for joint and muscle pain four times daily; Vicks VapoRub ointment 4.7-1.2-2.6% (camphor-eucalyptus-menthol) to fingernail/toenails topically every 12 hours as needed for pain; and zinc oxide ointment 40% to bottom topically every 6 hours as needed for skin irritation four times a day.

R112's Admission Record printed 9/3/20, indicated R112's diagnoses included pneumonia due to MRSA, respiratory failure, history of oral cancer, and cellulitis.

R112's Order Summary Report with active orders as of 9/3/20, included orders for barrier cream to skin surrounding feeding tube, hydrocortisone cream 1% (used on the skin to treat swelling, itching and irritation) to feeding tube side topically one time daily; lidocaine gel 2% to coccyx

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21620	Continued From page 55 topically as needed for moderate pain three times daily, and Nystatin cream to feeding tube site topically two times daily for site breakdown. R112's undated Pocket Care Plan indicated R112 was on contact precautions for MRSA in her sputum. R16's Admission Record printed 9/3/20, indicated R16's diagnoses included chronic respiratory failure, history of pneumonia, cardiac arrhythmia, pseudomonas aeruginosa, and tracheostomy. R16's Order Summary Report with active orders as of 9/3/20, included orders for A&D ointment to G tube site topically twice daily and to rash/back/side topically as needed for rash twice daily, and triamcinolone acetonide cream 0.025% to around trach site topically twice daily. R16's undated Pocket Care Plan indicated R16 was on contact and droplet precautions for Carbapenem-resistant pseudomonas aeruginosa (CRPA) in his sputum. On 9/3/20, at 3:15 p.m. both medication carts were checked for medication storage and revealed several topical treatment tubes/containers were stored together in a drawer, without any separation. Topical treatments stored together in the first cart included: -R38's triamcinolone acetonide -R261's triamcinolone acetonide and Nystatin -R33's sports cream (Asper-cream) and silver sulfadiazine cream -R34's triamcinolone acetonide -R20's capsaicin -R23's Asper-cream and clotrimazole	21620		

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Topical treatments stored together in the second cart included:
-R44's calmoseptine, Desitin, antifungal spray, A&D, clotrizole cream
and R112's and R16's topical treatments were in baggies, but in contact with R44's topical treatments.

On 9/3/20, at 3:36 p.m. RN-A verified the risk of cross-contamination due to storing topical treatments together that go into each resident's rooms during application.

On 9/3/20, at 4:14 p.m. the DON verified the risk of cross-contamination with topical treatments being stored together.

A policy for labeling of medications was not provided.

The facility policy for Topical Application of Ointment and Cream dated 11/19, lacked directives for storing them separately to prevent cross-contamination.

SUGGESTED METHOD OF CORRECTION:
The director of nursing (DON) or designee, could develop and implement policies/procedures related to medication labels with current medication orders.
The director of nursing (DON) or designee could complete staff training related to medication labels with current medication orders.
The director of nursing (DON) or designee could perform random audits to ensure compliance.

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

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21695	Continued From page 57	21695		
21695	MN Rule 4658.1415 Subp. 4 Plant Housekeeping, Operation, & Maintenance Subp. 4. Housekeeping. A nursing home must provide housekeeping and maintenance services necessary to maintain a clean, orderly, and comfortable interior, including walls, floors, ceilings, registers, fixtures, equipment, lighting, and furnishings. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure a wheelchair was cleaned and in sanitary condition for 1 of 8 residents (R45) reviewed for environment. Findings include: R45's Admission Record dated 9/3/20, indicated R45's diagnoses included visual loss, cataract, and muscle weakness. R45's annual Minimum Data Set (MDS) dated 7/30/20, indicated R45 was cognitively intact. R45's MDS further indicated he had severely impaired vision, used a wheelchair, and required extensive assistance with transfers. R45's care plan dated 7/29/20, directed staff to clean equipment when visibly soiled and at least weekly. On 9/2/20, at 8:22 a.m. R45's wheelchair cushion was observed to have dried, yellow, and white crusted food debris on it. The food debris was approximately four inches (in.) by two in. Nursing assistant (NA)-G and NA-F were in R45's room. NA-G was observed to stand over R45's	21695	F584: Safe/Clean/Comfortable/Homelike Environment Immediate Corrective Action: R45's wheelchair was cleaned on 9/4/20 Action as it Applies to Others: All resident wheelchairs and cushions were cleaned. Nursing and maintenance staff educated on importance of cleaning wheelchairs monthly per schedule and when soiled. Date of Compliance: 10/7/2020 Reoccurrence will be prevented by: Audit of 5 resident wheelchairs/cushions for cleanliness will be conducted weekly x 4 weeks then monthly x2 months to assure resident wheelchairs/cushions are clean. The results of these audits will be shared with the facility QAPI committee for input on the need to increase, decrease, or discontinue the audits. Corrections will be monitored by: Maintenance Supervisor/Designee	10/7/20

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wheelchair and looked at the wheelchair cushion. NA-G then walked to R45's bathroom and NA-F was observed to also look at R45's wheelchair. NA-G and NA-F then transferred R45 to his wheelchair. R45 was seated directly on top of the soiled wheelchair cushion.

On 9/2/20, at 10:25 a.m., R45 was observed being transferred, by NA-H, from his wheelchair to the bed. R45's wheelchair cushion remained soiled.

On 9/2/20, at 10:30 a.m., NA-H was interviewed and confirmed R45's wheelchair cushion was soiled. NA-H stated, he believed it was egg residue on R45's wheelchair. NA-H stated he did not notice the residue when he got R45 up. NA-H stated wheelchair cleaning was completed weekly and when spills occurred.

On 9/3/20, at 2:22 p.m., the director of nursing (DON) stated she expected staff to clean a wheelchair cushion when it was dirty.

A wheelchair cleaning schedule was requested but not provided by the facility

A policy on wheelchair cleaning was requested but not provided by the facility.

SUGGESTED METHOD OF CORRECTION:
The Director of Nursing (DON) or designee could develop, review, and/or revise policies and procedures on wheelchair cleaning.
The DON or designee could educate all appropriate staff on the policies and procedures.
The DON or designee could develop monitoring systems to ensure ongoing compliance.

TIME PERIOD FOR CORRECTION: Twenty-one

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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
21695	Continued From page 59 (21) days.	21695		
21980	MN St. Statute 626.557 Subd. 3 Reporting - Maltreatment of Vulnerable Adults Subd. 3. Timing of report. (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless: (1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, clause (4). (b) A person not required to report under the provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point. (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency. (e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this	21980		10/7/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00299	A. BUILDING: ____ B. WING ____	C 09/04/2020

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21980	Continued From page 60 subdivision. If the reporter or a facility, at any time believes that an investigation by a lead agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead agency shall consider this information when making an initial disposition of the report under subdivision 9c. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to immediately report an allegation of abuse to the stated agency (SA) for 1 of 2 residents (R7) reviewed for abuse. Findings include: R7's quarterly Minimum Data Set (MDS) dated 8/16/20, indicated she was severely cognitively impaired, and required extensive assistance for bed mobility, and total assistance for transfers. On 8/6/20, an untitled facility document indicated around 6:40 p.m., a nursing assistant (NA) went to the unit, and as she approached the doors she heard a nurse in front of the medication cart facing R7's room yelling, "[R7], shut up and go to bed, shut up and go to bed, [R7], its time to go to bed, just shut up." The document further indicated the NA reported the incident to two other nurses who told her to write a statement and place it in the DON's inbox.	21980	F609: Reporting of Alleged Violations Immediate Corrective Action: R7 discharged from facility on 9/19/20 Action as it Applies to Others: Abuse Prohibition/Vulnerable Adult Plan policy was reviewed and remained current. All staff educated on Abuse Prohibition/Vulnerable Adult Plan policy with regards to immediately reporting any suspected abuse to the DON & Administrator. Date of Compliance: 10/7/2020 Reoccurrence will be prevented by: Audit of 5 staff members conducted weekly x 4 weeks then monthly x2 months to assure staff know who to report any suspected abuse to, how to report it, and when to report it via verbal conversation. The results of these audits will be shared with the facility QAPI committee for input on the need to increase, decrease, or discontinue the audits.	

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21980	Continued From page 61	21980		

On 8/7/20, a facility report to the SA indicated a nursing assistant (NA) reported she was walking toward the wing four hallway, and could hear a nurse through the doors loudly telling at a resident to, "Shut up and go to bed." The report further indicated the incident occurred on 8/6/20, but was not reported to the director of nursing (DON) and the administrator until the following day.

On 9/3/20, at 10:06 a.m. the administrator stated four staff members were aware of the incident, but it was not reported to him until the following day. The administrator stated it should have been reported to him immediately.

The facility policy Abuse Prohibition Vulnerable Adult Plan dated 7/5/19, directed to ensure residents in the facility were not subjected to abuse by anyone. The policy further directed all staff were responsible for reporting any situation that was considered abuse or neglect, and to notify the administrator immediately of any allegations of abuse or suspected abuse. The policy directed suspected abuse shall be reported to the SA no later than two hours after forming a suspicion of abuse.

SUGGESTED METHOD OF CORRECTION:
The Administrator, Social Services Director, Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure immediate reporting, protection of resident, and thorough investigation of abuse allegations.
The Administrator, Social Services Director, Director of Nursing or designee could educate all appropriate staff on the policies and procedures.
The Administrator, Social Services Director, Director of Nursing or designee could develop

Corrections will be monitored by: Social Services Director/Designee

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21980	Continued From page 62 monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21980		

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	245495	A. BUILDING **01 - MAIN BUILDING 01** B. WING ___	**09/02/2020**

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K 000	INITIAL COMMENTS FIRE SAFETY 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 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. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey The Emeralds at Grand Rapids 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. IF OPTING TO USE AN EPOC, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K TAGS) TO:	K 000		

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

Electronically Signed — 09/25/2020

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 HEALTH CARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 445 MINNESOTA STREET, SUITE 145 ST. PAUL, MN 55101-5145, or By e-mail to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency The Emeralds at Grand Rapids is a 1-story building with a partial basement and was constructed at 4 different times. The original building was constructed in 1963, is 1 story with a partial basement, and was determined to be of Type II(111) construction. In 1968 a one story addition, without a basement, was constructed south and west of the original building, and was determined to be of Type II (111) construction. In 1980 a one story addition was constructed to the north of the original building, was determined to be a type V (111) construction, and is separated with a 2-hour fire barrier. This building is no longer used by residents and is staff only. In 2001 two other one story additions were built, one north of the west wing (a chapel) and one south	K 000		

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K 000	Continued From page 2 of the west wing (special cares unit) which were determined to be Type II (111) construction and separated with 2-hour fire barriers. The building is divided into 8 smoke zones by 30-minute and 2-hour fire barriers. The facility is fully sprinkler protected and has a fire alarm system with smoke detection in the corridor system and in all sleeping rooms that is monitored for automatic fire department notification. The facility has a capacity of 93 beds and had a census of 64 at the time of the survey. The requirements at 42 CFR Subpart 483.70(a) are NOT MET.	K 000		
K 132 SS=D	Multiple Occupancies - Contiguous Non-Health CFR(s): NFPA 101 Multiple Occupancies - Contiguous Non-Health Care Occupancies Non-health care occupancies that are located immediately next to a Health Care Occupancy, but are primarily intended to provide outpatient services are permitted to be classified as Business or Ambulatory Health Care Occupancies, provided the facilities are separated by construction having not less than 2-hour fire resistance-rated construction, and are not intended to provide services simultaneously for four or more inpatients. Outpatient surgical departments must be classified as Ambulatory Health Care Occupancy regardless of the number of patients served. 18.1.3.4.1, 19.1.3.4.1	K 132		10/7/20

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K 132	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on observations and staff interview, it was revealed that 1 of 3 - two hour fire separation was found not in compliance with NFPA 101 "The Life Safety Code" 2012 edition (LSC) sections 8.2.1.3 and 19.1.3.4. These deficient conditions could allow the products of combustion to travel from one building to another, which could negatively affect 20 of 93 residents. Findings include: On 01/22/2020, at 11:22 a.m., during the facility tour it was observed that there is a through penetration found on the Chapel side in the 2 hour fire barrier around conduit located above the ceiling tile over the fire doors. This deficient condition was verified by a Maintenance Supervisor.	K 132	K132 1. Fire caulking was completed for the 2 hour fire barrier around conduit above the ceiling tile over the fire doors. 2. 9/3/2020 3. Maintenance Director	
K 345 SS=F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on staff interview and a review of the	K 345	K345	10/7/20

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K 345	Continued From page 4 available documentation, the facility has not maintained the fire alarm system testing and maintenance documentation in accordance with NFPA 72 National Fire Alarm Code 2010 edition. This deficient practice could affect 93 of 93 residents. Findings include: On 09/02/2020, at 10:00 a.m., during the review of all available fire alarm maintenance and testing documentation for the last 12 months, and an interview with the Maintenance Supervisor it was revealed that the facility did not conduct a semi-annual visual inspection of the fire alarm initiating devices. This deficient condition was confirmed by a Maintenance Supervisor.	K 345	1. The semi annual inspection of the alarm initiating devices was completed on 9/11/20 2. 9/11/20 3. Maintenance Director	
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____________________ b) Who provided system test ____________________________ c) Water system supply source	K 353		10/7/20

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K 353	Continued From page 5 __________________________ 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 observations and staff interview, the automatic sprinkler system is not installed and maintained in accordance with NFPA 13 the Standard for the Installation of Sprinkler Systems 2010 edition. The failure to maintain the sprinkler system in compliance with NFPA 13 (10) could allow system being place out of service causing a decrease in the fire protection system capability in the event of an emergency that could affect 93 of 93 residents. Findings include: 1. On 09/02/2020, at 11:41 a.m., during the facility tour observations revealed that in the wing 3 storage room the sprinkler head had corrosion on the actuator and plug. 2. On 09/02/2020, at 12:06 a.m., during the facility tour observations revealed that the facility has 20 year old fast response sprinkler heads with a manufacture date of 2000 which the facility did not have a representative sample tested or replaced at the time of the inspection. This deficient condition was confirmed by a Maintenance Supervisor.	K 353	K353 1. Wing 3 storage room sprinkler head with corrosion on the actuator and plug was replaced. Fast response sprinkler heads will be inspected onsite. 2. 9/30/2020 3. Maintenance Director	
K 363 SS=E	Corridor - Doors CFR(s): NFPA 101	K 363		10/7/20

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K 363	Continued From page 6 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc.	K 363		

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K 363	Continued From page 7 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility had a corridor door that did not meet the requirements of NFPA 101 "The Life Safety Code" 2012 edition, section 19.3.6.3. This deficient practice could affect 30 of 93 residents. Findings include: On 09/02/2020, at 11:49 a.m., during the facility tour observations revealed that the storage closets located in the 300 wing corridor by resident room 310 and in the 400 wing corridor by resident room 406 have double doors that do not positively latch into the frame. This deficient condition was confirmed by a Maintenance Supervisor.	K 363	K363 1. Latches for closet doors were replaced so that they positively latch into the frame. 2. 9/11/20 3. Maintenance Director	
K 712 SS=F	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by:	K 712		10/7/20

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K 712	Continued From page 8 Based on review of reports, records and staff interview, it was determined that the facility failed to conduct several fire drills in accordance with the NFPA 101 "The Life Safety Code" 2012 edition (LSC) section 19.7.1.6, during the last 12-month period. This deficient practice could affect 93 of 93 residents. Findings include: On 09/02/2020 at 10:15 a.m., during the review of all available fire drill documentation and interview with the Maintenance Supervisor it was revealed that the facility did not send a fire alarm signal during the fire drills to the monitoring company for 6 of 12 fire drills. This deficient condition was confirmed by a Maintenance Supervisor.	K 712	K712 1. The facility is now sending a fire alarm signal during fire drills to the monitoring company. 2. 9/30/2020 3. Maintenance Director	
K 911 SS=E	Electrical Systems - Other CFR(s): NFPA 101 Electrical Systems - Other List in the REMARKS section any NFPA 99 Chapter 6 Electrical Systems requirements that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Chapter 6 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and interview with the staff the facility had multiple deficient conditions affecting the facility's electrical system that were not in accordance with the NFPA 101 "The Life	K 911	K911 1. The electrical panel labeled L3 electrical breakers are.now labeled. The cover was replaced on the electrical	10/7/20

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K 911	Continued From page 9 Safety Code" 2012 edition, NFPA 70 "National Electrical Code" 1999 edition, and the NFPA 99 "Health Care Facilities Code" 2012 edition. This deficient practice could affect 28 of 93 residents. Findings include: 1. On 09/02/2020 at 1208 a.m., during the facility tour observations revealed that the electrical panel labeled L3 did not have the electrical breakers labeled. following 2. On 09/02/2020 at 12:20 a.m., during the facility tour observations revealed that the electrical junction box located in the wing 2 medication room was missing exposing wires. The cover was replaced at the time of the inspection. This deficient condition was verified by the Maintenance Supervisor.	K 911	junction box located in the wing 2 medication room. 2. 9/24/2020 3. Maintenance Director	
K 920 SS=B	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for	K 920		10/7/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245495	A. BUILDING **01 - MAIN BUILDING 01** B. WING ______	**09/02/2020**

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K 920	Continued From page 10 PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by: Based on observation and interview with the staff the facility had multiple deficient conditions affecting the facility's electrical system that were not in accordance with the NFPA 101 "The Life Safety Code" 2012 edition (LSC) section 9.1.2, the NFPA 70 "National Electrical Code" 2011 edition and the NFPA 99 " Healthcare Facilities Code" 2012. This deficient practice could affect 4 of 42 residents. Findings include: On 09/02/2020 at 11:22 a.m., during the facility tour observations revealed that there is an extension cord being used in place of permanent wiring located in the corridor by resident room 210. The extension cord was removed at the time of the inspection. This deficient condition was confirmed by a Maintenance Supervisor.	K 920	K920 1. Extension cord by room 210 was removed. 2. 9/2/2020 3. Maintenance Director	

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K 923	Continued From page 11	K 923		
K 923 SS=D	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather.	K 923		10/7/20

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K 923	Continued From page 12 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observations and staff interview, that the oxygen storage room was not maintained in accordance with NFPA 99 Standards for Health Care Facilities 2012. This deficient practice could create an oxygen enriched atmosphere that could contribute to rapid fire growth. This could negatively affect 20 of 93 residents. Findings include: 1. On 09/02/2020 at 11:30 a.m., during the facility tour observations revealed in the oxygen storage room located by the Wing 2 common area the oxygen cylinders were not separated by full and empty at the time of the inspection. 2. On 09/02/2020 at 11:30 a.m., during the facility tour observations revealed in the oxygen storage room located by the Wing 2 common area has a door that did not positively latch into the frame at the time of the inspection. 3. On 09/02/2020 at 11:30 a.m., during the facility tour observations revealed in the oxygen storage room located by the Wing 2 common area has a corridor door that has louvers located in the lower section of the door. This deficient practice was confirmed by the Maintenance Supervisor.	K 923	K923 1. All oxygen was removed from the wing 2 common area. Wing 2 common area door was repaired so it now positively latches into the frame. Louvers on this door were replaced with a metal plate. 2. 9/24/30 3. Maintenance Director	